CIL Western Wisconsin

Phone 800.228.3287 | Fax 715.233.1083 | cilww@cilww.com | www.cilww.com

Main Office
2920 Schneider Ave SE
Menomonie, WI 54751

Branch Office
2021 Cenex Drive, Suite D
Rice Lake, WI 54868

Dear Potential Staff:

Attached please find our employment packet for the Center for Independent Living for Western Wisconsin (CILWW), Inc. Personal Assistance Services (PAS) Program. Please follow instructions, complete, and return to CILWW/PAS, 2920 Schneider Ave SE, Menomonie, WI 54751.

Employment Application: To be filled out, signed and dated by employee.

Background Check and Information & Release: To be filled out, signed and dated by employee.

Background Information Disclosure: Business Name to be Center for Independent Living for Western Wisconsin, Inc. To be filled out, signed and dated by employee on back.

Direct Care Competency: To be filled out thoroughly and completely by employee (this form to be completed for personal care only, it does not apply to respite, mentoring or supportive home care services).

TB Screening Tool: To be filled out and signed off by a Registered Nurse. Testing required only if form shows a need.
The TB screening is NOT required if only Supportive Home Care is being provided.

If your intent is to provide cares to an individual who is currently not part of our program, that individual needs to contact us so pre-enrollment can begin.

This is NOT an offer for employment. You will receive a offer of employment letter in which you will need to respond to after completing the application and orientation.

Please call with any questions at 800.228.3287.

Respectfully,

CILWW/PAS

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EMPLOYMENT APPLICATION

This Facility is an equal opportunity employer and fully subscribes to the principles of Equal Employment Opportunity. It is the policy of this Facility to provide employment, compensation and other benefits related to employment based on qualifications, without regard to race, color, religion, national origin, age, sex, veteran status or disability, or any other basis prohibited by federal or state law. As an equal opportunity employer, this Facility intends to comply fully with all federal and state laws and the information requested on this application will not be used for any purpose prohibited by law. Disabled applicants may request any needed accommodation.

PLEASE PRINT PLAINLY—BE SURE TO SIGN THIS APPLICATION

PERSONAL INFORMATION

Last Name: _____ First: _____ Middle: _____

Social Security #: _____ D.O.B:_____

Address_____
Street City State Zip

Home Phone: _____ Work Phone: _____

***Email:** _____

Have you been previously employed by this facility? If yes, please give dates of employment, position held, and your name while employed. ○ Yes ○ No

_____

Who referred you to this Facility: ☐ Our Advertisement ☐ Job Service
☐ Friend/Relative ☐ Walk In ☐ Other_____

EMPLOYMENT DESIRED

Position applying for: _____

Consumer in which you will be providing cares for: _____

When are you available to begin work? _____

Days And Hours Available to work?	Hours	Days And Hours Available to work?	Hours
Sunday		Thursday	
Monday		Friday	
Tuesday		Saturday	
Wednesday			

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EDUCATION

School Attended	Address	Years Attended	Phone Number

If currently in school, expected graduation date: _____

List any special skills or qualifications which you feel are relevant to the job for which you are applying:

_____

PROFESSIONAL LICENSES and/or CERTIFICATIONS

License/Registration #, Organization or State Issued Profession, Date Issued, Expiration Date

_____

Any Restrictions on your License? ○ Yes ○ No

If yes, explain _____

CPR Certified? ○ Yes ○ No First Aid Certified? ○ Yes ○ No

Other Certifications? ○ Yes ○ No

Please list _____

Are you currently on the Nursing Assistant Registry? ○ Yes ○ No

MILITARY

Were you in the Armed Forces? ○ Yes ○ No

If so, what Branch _____ From_____ To_____

GENERAL INFORMATION

If hired, can you provide documentation verifying citizenship or eligibility to work in the U.S.? ○ Yes ○ No

If hired, can you provide proof that you are at least 18 years of age, or if under 18, do you have a permit to work? ○ Yes ○ No

Do you have any commitments to another employer? If yes, please state with whom and explain how they may affect your employment with our facility? ○ Yes ○ No

If Yes,_____

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Have you ever been convicted of or plead guilty to a crime (felony, misdemeanor or other criminal offense, including a civil forfeiture), or are any other criminal charges pending against you? ○ Yes ○ No
If yes, for what, when and where. _____

Conviction of a criminal offense will not necessarily disqualify your employment.

Have you ever been suspended from providing services to Medicare or Medicaid patients/clients? ○ Yes ○ No

If yes, for how long and when, if ever, were you reinstated?_____

PRESENT AND PAST EMPLOYMENT

Describe previous experience as a Personal Care Worker or other experience in the Health Care Field. This may include care unpaid, volunteer time and care provided for family members. (If such experience exists, complete equivalency form. Individuals with no such experience will need to complete competency training) Must be trained in the provision of personal care services with a minimum of 40 hours classroom hours or 6 months full-time experience or 1 year half-time experience.

Employer _____ Supervisor's Name _____
Address Supervisor's Title _____
_____ Telephone Number _____
Your Position _____ May we contact: ○ Yes ○ No
Assignment: Full-time ○ Part-time ○ Reason for Leaving: _____
Employed from: _____ to _____ Monthly Salary: _____
Duties of Position:

Employer _____ Supervisor's Name _____
Address Supervisor's Title _____
_____ Telephone Number _____
Your Position _____ May we contact: ○ Yes ○ No
Assignment: Full-time ○ Part-time ○ Reason for Leaving: _____
Employed from: _____ to _____ Monthly Salary: _____
Duties of Position:

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Employer _____ Supervisor's Name _____
Address _____ Supervisor's Title _____
_____ Telephone Number _____
Your Position _____ May we contact: ○ Yes ○ No
Assignment: Full-time ○ Part-time ○ Reason for Leaving: _____
Employed from: _____ to _____ Monthly Salary: _____
Duties of Position:

REFERENCES

List three professional references (non relatives) we may contact.

NAME	ADDRESS, CITY, STATE, ZIP	PHONE NUMBER

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EMPLOYMENT UNDERSTANDING

Please read the following statements carefully before you initial each paragraph and sign your name.

"I HEREBY CERTIFY that the answers given by me to the above questions and statements are true and correct and hereby voluntarily authorize this Facility to contact references, past or present employers, persons, schools, law enforcement agencies and any other sources of information which may be relevant to my application for employment. Further, I release from all liability or responsibility all persons, companies or corporations supplying such information. I voluntarily grant this release to support my application for employment at Center for Independent Living for Western Wisconsin, Inc. and agree to inform the Facility of any special concerns I may have related to information which may be discovered during this investigation in the space below. I further understand that all information and documents acquired by Center for Independent Living for Western Wisconsin will be maintained as confidential by the Facility, and that the Facility will not release such information to me. It is understood and agreed that any misrepresentation, false statement, or omissions by me in this Application will be sufficient reason for rejection of my application or for dismissal at any time during my employment, without liability to this Facility. I have read, understand and agree to the above statement. (Please initial here). _____

I further understand that my employment is at will, and that either party is free to terminate the employment relationship at any time without cause. I also understand that no representative of the Facility has the authority to enter into any agreement for employment for any specified period of time and that this Facility is not guaranteeing employment for anyone. No employment contract is created by virtue of my being hired by this Facility. I have read, understand and agree to the above statement. (Please initial here). _____

If employed, I agree to abide by all of the work and safety rules of the Facility. If employed, I will be required to complete an Employment Verification Form (I-9), and within three days show satisfactory evidence of identity and eligibility for employment. I agree to any and all pre-

placement assessment(s) as may be deemed necessary by Center for Independent Living for Western Wisconsin, and further understand that my employment is contingent upon my completion of the Facility pre-placement assessment. I understand that this Facility is committed to maintaining a drug-free workplace. I am aware that the Facility may require a drug test as a part of the hiring process. Also, if employed, I realize that the Facility may conduct post-accident and reasonable suspicion drug and/or alcohol testing of its employees. I have read, understand and agree to the above statement." (Please initial here). _____

SIGNATURE: _____DATE: _____

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BACKGROUND CHECK INFORMATION AND RELEASE

Wisconsin Statutes require employers of individuals involved in the home or personal care of others to conduct extensive caregiver criminal background checks of those considered for employment and/or volunteering, as required by the Wisconsin Caregiver's Law. Please complete the information requested below and sign the form to enable us to comply with these laws.
Conviction of a crime does not automatically disqualify you from employment volunteering.

☐ **Caregiver** ☐ **General**

Name: _____ Sex: ☐ M ☐ F
(you must also list any aliases used)
Social Security Number: _____ Date Of Birth: _____

Alias's:_____

Please list all the cities and states in which you have lived in the past three (3) years and the name by which you were known if different from your name now.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

ACT 172 – Acknowledgement Statement:
The CILWW is required by the Wisconsin Department of Health Services 2007 Wisconsin Act 172 which amended s. 50.065 of the Statutes, to disclose certain information from caregiver background checks to consumers.

By my signature, I understand that by law, The CILWW can release certain conviction information to consumers as required by Wisconsin Act 172. I authorize release of the information to any and all consumers for whom I may potentially provide personal care services. By refusing you will no longer be eligible for employment and/or volunteering.

Employee or Volunteer Signature _____ **Date** _____
(office only: CV-civil, SC-Small Claims, TR-Traffic, PR-Probate)

HFS 12.115 Personal care services, disclosure of convictions. Pursuant to s. 50.065 (2m) (d) Stats.. Table HFS 12.115 lists the crimes for which an entity must disclose under s. 50.065 (2m) (a) 1., Stats., a conviction of a caregiver who provides personal care services to a client or the client's guardian.

Table HFS 12.115

Wisconsin Statutes	Crime
940.19 (3), 1999 Stats	Battery
940.01	First-degree intentional homicide
940.02	First-degree reckless homicide
940.03	Felony murder
940.05	Second-degree intentional homicide
940.12	Assisting suicide
940.19 (2), (4), (5) or (6)	Battery (felony)
940.22 (2) or (3)	Sexual exploitation by therapist; duty to report
940.225 (1), (2) or (3)	1st, 2nd, 3rd degree sexual assault
940.285 (2)	Abuse of individuals at risk
940.29	Abuse of residents of penal facilities
940.295	Abuse or neglect of patients and residents
943.20	Theft
943.201	Unauthorized use of an individual's personal identifying information or documents
943.203	Unauthorized use of an entity's identifying information or documents
943.32	Robbery
943.38	Forgery
943.41	Financial transaction card crimes
948.02 (1) or (2)	1st or 2nd degree sexual assault of a child
948.025	Physical abuse of a child
948.03 (2)(a), (b) or (c)	Sexual exploitation of a child
948.05	Trafficking of a child
948.051	Causing a child to view or listen to sexual activity
948.055	Incest with a child
948.06	Child enticement
948.07	Soliciting a child for prostitution
948.08	Sexual assault of a child placed in substitute care
948.085	Exposing a child to harmful material or harmful descriptions or narrations
948.11 (2)(a) or (am)	Possession of child pornography
948.12	Child sex offender working with children
948.13	Neglecting a child
948.21 (1)	Abduction of another's child; constructive custody
948.3	Child unattended in child care vehicle
948.53	Manufacture, distribution or delivery of a controlled substance or a controlled substance analog
961.41 (1)	Possession with intent to manufacture, distribute or deliver a controlled substance or a controlled substance analog
961.41 (1m)	Possession or attempt to possess a controlled substance or a controlled substance analog
961.43 (1)(a)	Acquire or obtain possession of a controlled substance by misrepresentation, fraud, forgery, deception or subterfuge
961.43 (1)(b)	To make, distribute or possess material designed to reproduce the trademark upon any drug or container or label so as to make a counterfeit substance or to duplicate the physical appearance, form, package or label of a controlled substance
A violation of the law of any other state or United States Jurisdiction that would be violate of a crime listed in this table	

BACKGROUND INFORMATION DISCLOSURE (BID)

- **PENALTY: Knowingly providing false information or omitting information may result in a forfeiture of up to $1,000 and other sanctions as provided in Wis. Admin. Code § DHS 12.05(4).**
- Completion of this form is required under the provisions of Wis. Stat. § 50.065. Failure to comply may result in a denial or revocation of your license, certification, or registration, or denial or termination of your employment or contract.
- Providing your social security number is voluntary; however, your social security number is one of the unique identifiers used to prevent incorrect matches.
- Refer to DQA form F-82064A, *BID Instructions*, for additional information.

Check the box that applies to you.

☐ Employee / Contractor (including new applicant)
☐ Applicant for a license, certification, or registration (including continuation or renewal)
☐ Household member (lives on premises, but is not a client)
☐ Other – Specify: _____

NOTE: If you are an owner, operator, board member, or non-client resident of a facility regulated by the Division of Quality Assurance (DQA), complete the BID, F-82064 and the Appendix, F-82069, and submit both forms to the address noted in the Appendix Instructions.

Full Legal Name – *First*	*Middle*	*Last*

Position Title (Complete only if a prospective or current employee or contractor.)	Birth Date *(MM/dd/yyyy)*	Sex ☐ Male ☐ Female

Any Other Names By Which You Have Been Known (Including Maiden Name)

Race / Ethnicity (Check ONLY one.) ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black ☐ White ☐ Unknown	Social Security Number

Home Address	City	State	Zip Code

Business Name and Address – Employer or Care Provider (Entity)

A "NO" answer to all questions does not guarantee employment, residency, a contract, or regulatory approval.
Note: The areas below that are designated for responses are expandable.

SECTION A – ACTS, CRIMES, AND OFFENSES THAT MAY ACT AS A BAR OR RESTRICTION

1. Do you have any criminal charges pending against you, including in federal, state, local, military, and tribal courts?

   If **Yes**, list each charge, when it occurred or the date of the charge, and the city and state where the court is located.

   You may be asked to supply additional information, including a copy of the criminal complaint or any other relevant court or police documents.

   Yes ☐ No ☐

2. Were you ever convicted of any crime anywhere, including in federal, state, local, military, and tribal courts?

   If **Yes**, list each crime, when it occurred or the date of the conviction, and the city and state where the court is located.

   You may be asked to supply additional information including a certified copy of the judgment of conviction, a copy of the criminal complaint, or any other relevant court or police documents.

   Yes ☐ No ☐

3. **IMPORTANT: Read before completing item 3.**

   Wis. Stat. § 48.981 Abused and neglected children and abused unborn children. (7)(a) CONFIDENTIALITY. "All reports made under this section, notices provided under sub. (3) (bm), and records maintained by an agency and other persons, officials, and institutions shall be confidential." Reports and records may be disclosed only to the persons identified in this section.

   ☐ **If you are the employer or prospective employer of the person completing this form and are entitled to obtain this information per the above, check this box.**

   Has any government or regulatory agency (other than the police) ever found that you committed child abuse or neglect?

   If the above box has been checked, provide an explanation below, including when and where the incident(s) occurred.

   Yes ☐ No ☐

4. Has any government or regulatory agency (other than the police) ever found that you abused or neglected any person or client?

   If **Yes,** explain, including when and where it happened.

   Yes ☐ No ☐

5. Has any government or regulatory agency (other than the police) ever found that you misappropriated (improperly took or used) the property of a person or client?

   If **Yes**, explain, including when and where it happened.

   Yes ☐ No ☐

6. Has any government or regulatory agency (other than the police) ever found that you **abused an elderly person**?

   If **Yes**, explain, including when and where it happened.

   Yes ☐ No ☐

7. Do you have a government issued credential that is not current or is limited so as to restrict you from providing care to clients?

   If **Yes**, explain, including credential name, limitations or restrictions, and time period.

   Yes ☐ No ☐

SECTION B – OTHER REQUIRED INFORMATION

1. Has any government or regulatory agency ever limited, denied, or revoked your license, certification, or registration to provide care, treatment, or educational services?

   If **Yes,** explain, including when and where it happened.

   Yes ☐ No ☐

2. Has any government or regulatory agency ever denied you permission or restricted your ability to live on the premises of a care providing facility?

   If **Yes,** explain, including when and where it happened and the reason.

   Yes ☐ No ☐

3. Have you been discharged from a branch of the US Armed Forces, including any reserve component?

   If **Yes**, indicate the year of discharge: _____

   Attach a copy of your DD214, if you were discharged within the last three (3) years.

   Yes ☐ No ☐

4. Have you resided outside of Wisconsin in the last three (3) years?

   If **Yes**, list each state and the dates you resided there.

   Yes ☐ No ☐

5. If you are employed by or applying for the State of Wisconsin, have you resided outside of Wisconsin in the last seven (7) years? Yes ☐ No ☐

If **Yes**, list each state and the dates you resided there.

6. Have you had a caregiver background check done within the last four (4) years? Yes ☐ No ☐

If **Yes**, list the date of each check, and the name, address, and phone number of the person, facility, or government agency that conducted each check.

7. Have you ever requested a rehabilitation review with the Wisconsin Department of Health Services, a county department, a private child placing agency, school board, or DHS-designated tribe? Yes ☐ No ☐

If **Yes**, list the review date and the review result. You may be asked to provide a copy of the review decision.

Read and initial the following statement.

_____ I have completed and reviewed this form (F-82064, BID) and affirm that the information is true and correct as of today's date.

Name – Person Completing This Form	Date Submitted

Center for Independent Living
For Western Wisconsin, Inc.
Personal Assistant Services

Direct Care Competency Assessment of Experience

The attached forms are to help determine your skill level, please fill the forms out as **COMPLETELY** and **THOROUGHLY** as you can.

Name of employee: _____ Date of review: _____

Reviewed By:_____

7/5/2016

Assistance Getting In and Out of Bed

Assessment of Experience Questions	Details of Experience for Each Competency
Discuss Who, What, Why, Where and When and the safety related to the following questions:	
1. What specific experience do you have helping someone get in and out of bed?	
2. Describe/show how you would help someone sit up on the edge of the bed and lie down in bed.	
3. Describe/show how adaptive equipment is utilized to assist with task. Give examples of equipment you have used.	

Narrative:_____
_____

☐ **Yes** – Direct Care Worker **has** the necessary experience or training to perform this skill. Continue with verification.
☐ **No** – Direct Care Worker **does not** have the experience. Needs training on this skill. Continue with training and verification.

Assisting with Toileting / Incontinent Care

Assessment of Experience Questions	Details of Experience for Each Competency
Discuss Who, What, Why, Where and When and the safety related to the following questions:	
1. What specific experience do you have helping someone use the toilet, bedpan, urinal, commode or incontinence products?	
2. What are some things you would do when you are helping someone use the toilet?	
3. Describe/show how you would clean bedpans, urinals, and commodes.	
4. Describe/show how you would assist a consumer with cleansing after toilet.	

Narrative:_____
_____

☐ **Yes** – Direct Care Worker **has** the necessary experience or training to perform this skill. Continue with verification.
☐ **No** – Direct Care Worker **does not** have the experience. Needs training on this skill. Continue with training and verification.

Assistance with Bathing/Showering

Assessment of Experience Questions	Details of Experience for Each Competency
Discuss Who, What, Why, Where and When and the safety related to the following questions:	
1. What kinds of baths have you helped with? (Bed Bath, Partial Bath, Sponge Bath, Tub Bath, Shower)	
2. What type of equipment have you used to help someone with bathing?	
3. Describe / show how you would change the linens for a person receiving a bed bath.	

Narrative:_____
_____

☐ **Yes** – Direct Care Worker **has** the necessary experience or training to perform this skill. Continue with verification.
☐ **No** – Direct Care Worker **does not** have the experience. Needs training on this skill. Continue with training and verification.

Assistance with Eating

Assessment of Experience Questions	Details of Experience for Each Competency
Discuss Who, What, Why, Where and When and the safety related to the following questions:	
1. What specific experience do you have helping someone eat? Feeding someone?	
2. What specific experience do you have with special consistencies of food (thickened liquids, soft diet, pureed or ground food)?	

Narrative:_____
_____

☐ **Yes** – Direct Care Worker **has** the necessary experience or training to perform this skill. Continue with verification.
☐ **No** – Direct Care Worker **does not** have the experience. Needs training on this skill. Continue with training and verification.

Assistance Grooming; Teeth, Mouth, Denture, Hair Care, Shaving, and Nail Care

Assessment of Experience Questions	Details of Experience for Each Competency
Discuss Who, What, Why, Where and When and the safety related to the following questions:	
1. What specific experience do you have caring for teeth, mouth, dentures?	
2. What specific experience do you have with hair care?	
3. What specific experience do you have with shaving?	
4. What specific experience do you have with nail care?	

Narrative:_____
_____

☐ **Yes** – Direct Care Worker **has** the necessary experience or training to perform this skill. Continue with verification.
☐ **No** – Direct Care Worker **does not** have the experience. Needs training on this skill. Continue with training and verification.

7/5/2016

Assistance with Dressing and Undressing; T.E.D. Hose

Assessment of Experience Questions	Details of Experience for Each Competency
Discuss Who, What, Why, Where and When and the safety related to the following questions:	
1. What specific experience do you have helping someone get dressed and undressed?	
2. If you were going to apply / remove T.E.D Hose on a consumer, how would you proceed?	

Narrative:_____
_____

☐ **Yes** – Direct Care Worker **has** the necessary experience or training to perform this skill. Continue with verification.
☐ **No** – Direct Care Worker **does not** have the experience. Needs training on this skill. Continue with training and verification.

Care of Eyeglasses and Hearing Aids

Assessment of Experience Questions	Details of Experience for Each Competency
Discuss Who, What, Why, Where and When and the safety related to the following questions:	
1. Describe/show how you would clean eyeglasses.	
2. Describe/show how you clean a hearing aid.	
3. Describe/show how you insert a hearing aid.	
4. What do you do if a hearing aid is buzzing?	

Narrative:_____
_____

☐ **Yes** – Direct Care Worker **has** the necessary experience or training to perform this skill. Continue with verification.
☐ **No** – Direct Care Worker **does not** have the experience. Needs training on this skill. Continue with training and verification.

Assistance with Mobility and Ambulation
(Including use of walker, cane, gait belt, arm cuff and crutches)

Assessment of Experience Questions	Details of Experience for Each Competency
Discuss Who, What, Why, Where and When and the safety related to the following questions:	
1. What specific experience have you had helping someone walk?	
2. Describe/demonstrate helping a person with use of: a. Walker b. Cane c. Crutches	
3. Describe/demonstrate the use of a gait belt.	

Narrative:_____

_____

☐ **Yes** – Direct Care Worker **has** the necessary experience or training to perform this skill. Continue with verification.
☐ **No** – Direct Care Worker **does not** have the experience. Needs training on this skill. Continue with training and verification.

Simple Transfers (Including chair, wheelchair, etc., excluding mechanical lifts)

Assessment of Experience Questions	Details of Experience for Each Competency
Discuss Who, What, Why, Where and When and the safety related to the following questions:	
1. Describe/show how you would transfer someone from one surface to another: a. w/c to shower chair b. w/c to toilet c. bed to w/c d. other	
2. When transferring someone where do you position yourself-on their strong side or weak side? Explain your answer.	

Narrative:_____
_____

☐ **Yes** – Direct Care Worker **has** the necessary experience or training to perform this skill. Continue with verification.
☐ **No** – Direct Care Worker **does not** have the experience. Needs training on this skill. Continue with training and verification.

Skin Care

Assessment of Experience Questions	Details of Experience for Each Competency
Discuss Who, What, Why, Where and When and the safety related to the following questions:	
1. What specific experience do you have providing skin care to someone?	
2. What activities are involved in skin care?	
3. What are some observations you should make when doing skin care?	
4. What precautions would you take with non-intact or blistered skin? Rashes?	

Narrative:_____
_____

☐ **Yes** – Direct Care Worker **has** the necessary experience or training to perform this skill. Continue with verification.
☐ **No** – Direct Care Worker **does not** have the experience. Needs training on this skill. Continue with training and verification.

Housekeeping – Meal Preparation - Laundry

Assessment of Experience Questions	Details of Experience for Each Competency
Discuss Who, What, Why, Where and When and the safety related to the following questions:	
1. What experience do you have providing housekeeping services?	
2. Describe/show how you would clean: a. kitchen b. bathroom	
3. What specific experience do you have in preparing meals for someone?	
4. What kind of meals would you make for someone who is on a special diet, for example: a. low fat b. low salt c. diabetic d. high fiber e. low cholesterol What foods would you avoid for each diet?	
5. Describe /show how you would sort someone's laundry and decide what settings to use for the washer and dryer.	

Narrative:_____
_____

☐ **Yes** – Direct Care Worker **has** the necessary experience or training to perform this skill. Continue with verification.
☐ **No** – Direct Care Worker **does not** have the experience. Needs training on this skill. Continue with training and verification.

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TB SCREENING TOOL

Print last name, first name _____ **Date of birth** _____ **Date form** _____

History and risk factors (check response)

Questions	Yes	No	Unknown	Comments
Ever had an adverse reaction to TB Skin Test?	○	○	○	
Born outside of the U.S.?	○	○	○	
Lived in the U.S. less than 5 years?	○	○	○	
Traveled or lived outside of the U.S. in the past 2 years?	○	○	○	
Ever had a positive reaction to TB skin test?	○	○	○	
Ever had a TB blood test?	○	○	○	
Ever had a BCG? (vaccine again Tuberculosis)	○	○	○	
Ever been treated for latent TB infection?	○	○	○	
HIV- infected?	○	○	○	
Have end stage renal disease, diabetes or Silicosis?	○	○	○	
Were you infected with TB less than 2 years ago?	○	○	○	
Undernourished or underweight? (90% of ideal)	○	○	○	
Immune suppressed?	○	○	○	
History of substance abuse?	○	○	○	
Scarring/fibrosis on chest x-ray?	○	○	○	

Symptoms of active TB disease (circle all that are present)

☐ Coughing (>3 weeks) ☐ Night sweats ☐ Weight loss/poor appetite ☐ Coughing up blood
☐ Fever/chills ☐ Fatigue ☐ Chest pain

☐ I am attesting that I have no clinically apparent communicable disease. The above information is true and complete to the best of my knowledge, and I am aware that deliberate misrepresentation may jeopardize my health. I understand that this information is confidential and will not be released without my knowledge and written permission.

Employee Signature _____ **Date** _____

Note: **You must have an RN sign off on this TB Screening tool.** *(If the answer to any of the above questions is YES and/or the employee is showing active symptoms of TB, he/she is required to have a PPD skin test).*

I certify I have reviewed the base line TB screening tool for this employee and find no risks for active TB or clinically apparent communicable disease.

RN signature _____ **printed name** _____ Date _____

CIL Western Wisconsin
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Menomonie, WI 54751
Branch Office
2021 Cenex Drive, Suite D
Rice Lake, WI 54868

I certify I have reviewed the base line TB screening Tool for this employee and request follow up with employee health or their personal physician prior to client contact.

_____ _____
RN signature printed name Date

It has been requested for you to follow up with your health or personal physician prior to consumer contact. The following must be completed.

Please record the size of the induration in millimeters. If there is no reaction, pleaser record it as "0mm".

Date PPD Applied: _____ Date PPD Read: _____

Size of Induration (in mm): _____

Read by: _____ (Health Professional's Name)

Health Professional's Signature: _____

POLICY AND PROCEDURE: TUBERCULOSIS AND COMMUNICABLE DISEASE SCREENING

POLICY:

The physical health of each new employee, prior to having direct patient contact, shall be certified in writing by a physician, physician assistant or registered nurse as having been screened for tuberculosis (TB), and clinically apparent communicable disease that may be transmitted to a patient during the normal performance of the employee's duties. The screening shall occur within 90 days prior to the employee having direct patient contact. (HFS 133.06 (4) (d)) (DHS 105.17 (1r)(b))

Each employee having direct consumer contact shall be screened as needed for clinically apparent communicable disease by a physician, physician assistant, or registered nurse based on the likelihood of their exposure to a communicable disease, including tuberculosis. The exposure to a communicable disease may have occurred in the community of in another location.

PURPOSE:

Prevent the transmission of communicable disease to both CILWW/PAS consumers and employees.

PROCEDURE:

New Employee:

1. CILWW/PAS educate nursing and direct care employees on tuberculosis signs and symptoms and prevention during agency orientation.
2. The newly hired employee will be screened by a Registered Nurse or the employee's Physician for TB and clinically apparent communicable disease. **The screening shall occur within 90 days prior to the employee having direct patient contact.**
3. If any further medical care is needed, including a TB Test, chest x-ray or medication as a result of the TB screening, this care will be at the employee's expense.
4. The employee must be instructed to be alert for signs and symptoms of TB.
5. Applicable CILWW/PAS TB and Infection Control Policies will be explained to the employee upon hire.
6. Documentation will be kept in the employee's health file. Screenings performed by SAI are documented on CILWW/PAS TB Screening Tool.

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Current Employees:

1. Staff are advised to report to their supervisor any exposure or suspected exposure to TB or a communicable disease while working or in the community.
2. The supervisor will arrange for the proper screening of the employee based on the type of exposure or suspected exposure.
3. Appropriate action will be taken upon the completion of the screening and its outcome.
4. All records will be maintained in the employee's health file.
5. Any employee diagnosed with TB disease will be relieved from duties until their physician provides adequate documentation they are no longer infectious.