Phone: 973-467-8502 | Email: johnr@aquinashealthcare.com | Business Hours: 8am - 5pm

Application For Employment

266B MORRIS AVE, SPRINGFIELD, NJ, 07081

Aquinas Healthcare takes affirmative action to select the best-qualified applicants without regard to race, color, creed, national origin, gender, sexual preference, age, religion, or disability where accommodations will not impose an undue hardship on the agency. Our Company is an equal opportunity employer.

Dear Applicant:

Home care does not make a difference in the lives of neighbors we serve by making it possible for them to stay at home during difficult times, and live independent lives with dignity. We know that providing care to people in their home is both a professionally challenging and personally rewarding career. If you are chosen to become a new member of our team you too will play an important role in people's lives and our community.

The work here at Aquinas Healthcare requires a person who is honest, dependable, and competent and gets satisfication from helping others. We know this because that is what our clients tell us they expect, and what has made our staff successful.

If you are new to home care or an experienced care provider, we thank you for considering Aquinas Healthcare and its mission of caring to improve people's lives.

Thank you, Aquinas Healthcare Management

Instructions

Please make sure you fill out the following application form completely. Answer all questions and sign and date the application form at the end. Incomplete or wrong information can cause a delay in processing your application. Part of the selection process will include a personal interview, reference, and criminal history background check, health exam, and gathering citizenship documentation.

I. PERSONAL INFORMATION

Name Phone

Address: Street *Apartment Number*

City *State* *Zip* *Email Address*

Do you drive? Yes No

If no, how do you get assignments? Birthdate

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Please check YES or NO for each question **Yes** **No**

Are you 18 years old or older?

Do you currently have a valid professional license or occupational certification?

Do you have your own transportation?
(Direct Care Staff will be required to travel throughout all of our service area)

Are you legally eligible for employment in United States? if NO, what is your status?

Do you have any relatives working for our Company?

II. POSITION DESIRED

Check the box for the position you are applying for Office Staff Certified Home Health Aide

Registered Nurse Certified Nurse Aide CMA/RMA Licensed Practical Nurse

How did you hear about this position?

What date can you start? How many hours a week can your work?

Are you available for *(check all that apply)* Days Evenings Nights

Weekends Live-in Short 1-2 Hour Shifts

III. EDUCATION AND TRAINING

Check the highest grade you have completed 9- 10 11 12 13 14 15 16

Name of School Beginning with High School Subject / Degree Awarded

1.

2.

3.

CCHA Training:

Location Date training completed

Occupation State Licensing Authority Number Dates: Initial / Expiration

1.

2.

Malpractice Insurance Carrier Policy Number Expiration Date

Check here if not required

Check the following software you can use:

Word Processing Spreadsheet Windows Other

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Check the special skills you are experienced in   Telephone/Switchboard   Greeting the public

Data Entry   Scheduling   Accounting / Bookkeeping   Payroll   Customer Service

Other

IV. EMPLOYMENT HISTORY

I, hereby authorize **Aquinas Healthcare** to request and receive from all prior employers within one year of the date of this application, any and all pertinent information concerning my prior employment and its termination, including the reasons for such termination.

List your three (3) most recent employers now, starting with your current or most recent job

I. Current / Most Recent Employer's Name

Address

Street *Suite*

City *State* *Zip*

Phone

Date of Employment From To

Position / Title

Briefly describe your duties

Supervisor's Name

Wage / Salary

Reason For Leaving

I. Current / Most Recent Employer's Name

Address

Street *Suite*

City *State* *Zip*

Phone

Date of Employment From To

Position / Title

Briefly describe your duties

Supervisor's Name

Wage / Salary

Reason For Leaving

I. Current / Most Recent Employer's Name

Address

Street *Suite*

City *State* *Zip*

Phone

Date of Employment From To

Position / Title

Briefly describe your duties

Supervisor's Name

Wage / Salary

Reason For Leaving

V. PERSONAL REFERENCES *(No family or close friends)*

Name	Address	Phone
1.		
2.		

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VI. GENERAL INFORMATION

List other skills, languages, training, volunteer experience or hobbies you feel qualify for you position.

Why do you want to work for us?

What makes work most satisfying to you?

►Type your initials here to attest that all information you have provided is complete, accurate & truthful

Date

This application will be kept on file for ninety days (90) from the date expired. After this time a new application must be completed for consideration of employment.

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CHAPTER 191 - DANIELLE'S LAW

AN ACT concerning staff working with persons with developmental disabilities or traumatic brain injury and supplementing Titles 30 and 45 of the Revised Statues

BE ENACTED by the Senate and General Assembly of the State of New Jersey
C.30:6D-5. I Short Title

1. This act shall be known and may be cited as "Danielle's Law."
C.30:6D-5. I Definitions relative to staff working with persons with developmental disabilities, traumatic brain injury.
2. As used in this act:
"Commissioner" means the Commissioner of Human Services, "Department" means Department of Human Services "Facility for persons with developmental disabilities" means a facility for persons with developmental disabilities as defined in section 3 of P.L. 1977, c. 82 (C.30-6D-3). "Facility for persons with traumatic brain injury" means a facility for persons with traumatic brain injury that is operated by, by or under contract with the department. "Life-threatening emergency" means a situation in which a prudent person could reasonably believe that immediate intervention is necessary to protect the life of a person receiving services at a facility for persons with developmental disabilities or a facility for persons with traumatic brain injury or from a public or private agency, or to protect the lives of other persons at the facility or agency, from an immediate threat or actual occurrence of a potentially fatal injury, impairment to bodily functions or dysfunction of a bodily organ or part. "Public or private agency" means an entity under contract with, licensed by or working in collaboration with the department to provide services for persons with developmental disabilities or traumatic brain injury.
C.30:6D-5.3 Responsibilities of staff at facility for persons with developmental disabilities, traumatic brain injury.

3. a. A member of the staff at a facility for persons with developmental disabilities or a facility for persons with traumatic brain injury or a member of the staff at a public or private agency who in either case works directly with persons with developmental disabilities or traumatic brain injury, shall be required to call the "911 emergency" telephone service for assistance in the event of a life-threatening emergency at the facility or the public or private agency, and to report that call to the department, in accordance with policies and procedures established by regulation of the commissioner. The facility or the public or private agency, as applicable, and the department shall maintain a record of such calls under the policy to be established pursuant to this section.
b. The department shall ensure that appropriate training is provided to each member or the staff at a facility for persons with developmental disabilities or a facility for persons with developmental disabilities or traumatic brain injury, to effectuate the purposes of subsection a. of this section.
C.30:6D-5.4 Violations, penalties.
4. A member of the staff at a facility for persons with developmental disabilities or a facility for persons with traumatic brain injury or a member of the staff at a public or private agency who violates the provisions of section 3 this act shall be liable to a civil penalty of $5,000 for the first offense, $10,000 for the second offense and $25,000 for the third and each subsequent offense, to be sued for and collected in a summary proceeding by the commissioner pursuant to the "Penalty Enforcement Law of 1999" P.L. 1999 c.274 (C.2A:58-10 et seq.)
C.30-6D-5.5 Record of Violations.
5. The department shall maintain a record of violations of the provisions of section 3 of this act, which shall be included in the criteria that the department considers in making a decision on whether to renew the license of a facility or whether to renew a contract with a public or private agency, as a applicable.
P.L. 2003 CHAPTER 1912
C.45:1-21.3 Violation of the responsibility to make 911 call, forfeit me of license, authorization to practice.
6. A health care professional licensed or otherwise authorized to practice as a health care professional pursuant to Title 45 of the Revised Statues who violates the provisions of section
3 of P.L. 2003, c. 191 (C:30:6D-5.3) shall, in addition to being liable to a civil penalty pursuant to section 4 of P.L. 2003, c. 191 (C.30-6D-5.4), be subject to revocation of that individual's professional license or other authorization to practice as a health care professional by the appropriate licensing board in the Division of Consumer Affairs in the Department of Law and Public Safety, after appropriate notice and opportunity for a hearing.
C.30-6D-5.6 Rules, regulations
7. The Commissioner of Human Services, pursuant to the "Administrative Procedure Act,"
P.L. 1968 c.410 (C:52 14B-I et seq.) shall adopt rules and regulations necessary to effectuate the purposes of this act.
8. This act shall take effect on the 180th day after enactment, but the Commissioner of
Human Services may take such anticipatory administrative action in advance as shall be necessary for the implementation of the act. Approved October 26, 2003.

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AQUINAS HEALTHCARE EMPLOYEE HEALTH HISTORY

Name: Date of Birth:

Address:

MEDICAL HISTORY: (To be completed by the **Employee** prior to the physical examination. Check all that apply.)

High Blood Pressure
Tuberculosis
Syphilis/STD
Diabetes
Foot Problems
Alcoholism

Fainting/Dizziness
Kidney Trouble
Heart Trouble
Asthma
Painful/Weak Joints
Fractures

Back Pain/Trouble
Shortness of Breath
Arthritis
Epilepsy
Walking Difficulty
Hip/Knee Trouble

Surgery (When? What kind?)

Allergies (Please list)

Do you have any disabilities? (Specify)

Do you have a present physical complaints or conditions that require any accommodations? Yes No

What?

► I consider that my present health to be good, that this history is correct, I am able to do the essential functions of the job and I have disclosed all conditions needing special consideration.

► Type your initials here to attest that the above information regarding your personal health is accurate to the best of your knowledge:

Date:

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HEPATITIS B VACCINATION ACCEPTANCE/DECLINATION

Hepatitis B is a liver infection caused by the Hepatitis B virus (HBV). Hepatitis B is transmitted when blood, semen, or another body fluid from a person infected with the Hepatitis B virus enters the body of someone who is not infected. This can happen through sexual contact; sharing needles, syringes, or other drug-injection equipment; or from mother to baby ay birth. For some people, hepatitis B is an acute, or short-term, illness but for others, it can become a long-term, chronic infection.

Hepatitis B vaccine is available to employees who could be expected to come into contact with human blood and other potentially infectious materials in then course of their work. The vaccine is usually given as a 3-shot series over a 6-month period. Some people should not get this vaccine;

- If you have any severe, life-threatening allergies. If you ever had a life-threatening allergic reaction after a dose of hepatitis B vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Ask your health care provider if you want information about vaccine components.
- If you are not feeling well. If you have a mild illness such as a cold, you can probably get the vaccine today**.** If you are moderately or severely ill, you should probably wait until you recover The doctor can advise you.

Please indicate if you would like to have or want to decline the Hepatitis B vaccination by checking the appropriate 1 box below Please check only 1 box and the second box would mean you want the shots, so please read carefully.

I have already received the Hepatitis B vaccination I completed the HBV vaccination series on

(A copy of the written record will be requested)

Date

The Hepatitis B vaccination has been explained to me and I accept participation in the vaccination series and have not yet been vaccinated. I realize this is a series of 3 different shots over a 6 month period. I will be required to have these shots done at a provider of Aquinas Healthcare's choice as they will pay the cost.

(Declination Statement) I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to me: however, I decline hepatitis B vaccination at this time. I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection, and that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine. I can receive the vaccination series at no charge to me. as long as I am still currently employed by Aquinas Healthcare.

► **Type your initials here to attest that you understand the hepatitis B risks and that you may revisit or change your answer at a later date:**

Date:

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CONFIDENTIALITY AGREEMENT

I understand that **Aquinas Healthcare** has a legal and ethical responsibility to safeguard the privacy of all clients and to protect the confidentiality of their personal health information Additionally. **Aquinas Healthcare** must assure the confidentiality of its human resource, payroll, fiscal, research, computer systems, legal, planning and management information (collectively "Confidential Information")

In the course of my employment at **Aquinas Healthcare**. I understand that I may come into the possession of Confidential Information including client's protected health information.

I further understand that I must sign and comply with this agreement in order to get authorization for access to any of **Aquinas Healthcare** protected Confidential and Client health information.

1. I will not discuss any Confidential Information including client personal health information to anyone who does not have a need to know and not discuss this Confidential Information in any public place including public transportation in the hallways or lobbies of buildings and the office, elevators or anywhere except in that clients home or to staff members who have a right to know the information for treatment purposes in a private area of the office It is not acceptable to discuss Confidential Information in public areas even if a client's name is not used, such a discussion may raise doubts among clients and our respect for their privacy.
2. I will not disclose any Confidential Information, including Client personal health information with others including my family or friends, who do not have a need to know it, unless the client has provided a property executed written.
3. authorization to release the information or as set forth in the law and where the client has consented to the disclosure of such information.
4. I understand that my personal access code user TD(s), and passwords(s) used to access the **Aquinas Healthcare** computer system phone system, voice mail or internet are also an integral aspect of this Confidential Information I will not willingly inform another person or knowingly use another person's personal access code, user ID(s), and passwords(s) used to access the Aquinas Healthcare computer system phone system, voice mail, or Internet.
5. I will not make inquiries about Confidential Information for other personnel who do not have proper authorization to access such Confidential Information.
6. I will not make any unauthorized transmissions, inquires, modifications, or purging of **C**onfidential Information from **Aquinas Healthcare** computer system, written documentation or other media.
7. I will log off any computer or terminal prior to leaving it unattended.
8. I will comply with any security or privacy policy promulgated by **Aquinas Healthcare** to protect the security and privacy of Confidential information
9. I will immediately report to my supervisor any activities by any person, including myself, that is a violation of this Agreement or breach of Confidential Information
10. Upon termination of my employment, I will immediately return any documents or other media containing Confidential Information.
11. I agree that my obligations under this Agreement will continue after the termination of my employment.
12. I understand that violation of this Agreement may result in disciplinary action, up to and including termination in accordance with **Aquinas Healthcare** policy. as well as legal liability.
13. I further understand that all computer access activity is subject to audit.

By signing this Confidentiality Agreement. I understand and agree to its terms and restrictions and agree that I have read the above Agreement and agree to comply with all its terms.

Print Name: Date:

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Date:

Dear: (reference)

has applied for a position here at **Aquinas Healthcare**. The above applicant has given you as a work reference. In New Jersey health care entities, must report to other health care entities disciplinary actions taken against an employee for professional misconduct, improper patient care or other actions that negatively affect the health care professionals ability to treat patients (Cullen Act), in addition to the other legally required information on this reference. As such we are asking for your cooperation in completing the following information. We thank you for your prompt response and it will be held in strict confidence. Please let us know if you have any question regarding this request

Best Regards, **Aquinas Healthcare** Management

I give my consent to the Aquinas Healthcare to thoroughly investigate my background and verify all information given to the Agency on applications. related papers and interviews. I authorize all employers, individuals, schools, and firms named therein to provide any information requested about me, and I release them from all liability for damages in providing this information. I have given Aquinas Healthcare my permission to contact you in relation to my application.

Applicant's Name **Date**

1. This applicant gave us the following information in relation to your firm:

Latest Job Title:

Dates of Employment: From: To: Full Time Part Time

Reason for leaving:

► Is this information correct? Yes No, please correct information.

Latest Job Title:

Dates of Employment: From: To: Full Time Part Time

Reason for leaving:

2. Are you aware of any reports to the NJ Board of Nursing for this applicant? Yes No

Your Name: Date:

Title: Relation to Applicant:

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Date

Dear (reference)

has applied for a position here at Aquinas Healthcare. The above applicant has given you as a personal reference. As such we are asking for your cooperation in completing the following information. We thank you for your prompt response and it will be held in strict confidence.
Please let us know if you have any questions regarding this request.

I give my consent to Aquinas Healthcare to thoroughly investigate my background and verify all information given to the Agency on applications, related papers and interviews. I authorize all employers, individuals, schools, and firms name therein to provide any information requested about me, and I release them from all liability for damages in providing this information. I have given Aquinas Healthcare my permission to contact you in relation to my application.

Applicant's Signature Date

1. What is your relationship to this applicant?

2. How long have you known this applicant?

► This applicant has applied for a position that requires honesty, trustworthiness and dependability. The responsibilities include providing direct personal care outlined on a written Plan of Care under professional supervision. The work is in support of the client's safety, dignity and well-being. The employee will work in the client's residence or facility to assist with Activities of Daily Living (ADLs) including personal care, grooming, ambulation, companionship, homemaking, meal preparation, housekeeping and other hands on assistance.

3. Would you recommend this applicant for this job? Yes No

If No, why?

Your Comments Please:

Name Date

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Employee Background Checks

In the interest of maintaining the safety and security of our customers, employees, and property, Aquinas Healthcare, Inc., (the "Company") will order a 'consumer report' (a background check) on you in connection with your employment application, and if you are hired, or if you are already work for the Company, may order additional background checks on you for employment purposes.

The background check company, ADP Screening and Selection Services, will prepare the background report for the Company. ADP Screening and Selection Services is located at 301 Remington Street, Fort Collings, CO, 805245, and can be reached toll free at 800-997-9833 or at their Internet Website Address www.adpselect.com.

The background check may contain information concerning your character, general reputation, personal characteristics, mode of living, and credit standing. The types of information that may be ordered include, but are not limited to: Social Security Number verification, criminal, public, educational, military and as appropriate, driving records checks; verification of prior employment; reference, licensing, and certifications check; credit reports; and drug testing results. The information may be obtained from private and public record sources including personal interviews with your associates, friends and neighbors. (An "investigative consumer report" is a background report that includes information form such personal interviews, except in California where that term means any background report and scope of the most common form of investigate consumer report is an investigation into your education and/ or employment history conducted by ADP Screening and Selection Services or another outside organization.

You may request more information about the nature and scope of an investigative consumer report, if any, by telephoning the Company at 973-467-8502. A summary of your rights under the Fair Credit Reporting Act is also being provided to you with this form.

State Specific Notices

If you live or work for the Company in any of the states list below, please note the following:

New Jersey: If you submit a request to us in writing, you have the right to know whether the Company ordered an investigative consumer report from ADP Screening and Selection Services. You may inspect and order a free copy of the report by contacting ADP Screening Solutions.

AUTHORIZATION OF BACKGROUND CHECKS

After carefully reading this Background Check Disclosure and Authorization form, I authorize the Company to order my background report, including investigate consumer reports. I understand that the Company may rely on this authorization to order additional background reports, including investigative consumer reports, during my employment without asking me for my authorization again as allowed by law.

I also authorize the following agencies and entities to disclose to ADP Screening and Selection Services and its agents all information about or concerning me, including but not limited to: my past or present employers; learning institutions, including colleges and universities; law enforcement and all other federal, state and local agencies; federal, state and local courts: the military; credit bureaus; testing facilities; motor vehicle records agencies; all other private and public sector; repositories of information; and any other person, organization, or agency with any information concerning me. The information that can be disclosed to ADP Screening and Selection Services and its agents includes, but is not limited to information concerning my employment history, earnings history, education, credit history, motor vehicle history, criminal history, military service, professional credentials and licenses and substance abuse testing.

I agree the Company may rely on this authorization to order background reports, including investigative consumer reports, firm companies other than ADP Screening and Selection Services without asking me for my authorization again as allowed by law. I also agree that a copy of this form is valid like the signed original. I certify that all of my personal information on this form is true and correct and understand that dishonesty will disqualify me form consideration for employment with the Company, or if I am hired or already work, for the Company, that my employment may be terminated.

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Last Name First Name Middle Name

Maiden/ Other Names Year Used

Social Security Number

Driver's License Number State

FOR IDENTIFICATION PURPOSE ONLY: Date of Birth (Month/ Day/ Year)

Addresses Within The Past Seven Years (Use a separate sheet as needed)

Present Street Address

City/ State/ Zip

Prior Street Address

From (Month/ Day/ Year) To (Month/ Day/ Year)

City/ State/ Zip

Name Date: (Month/ Day/ Year)

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Mutual Arbitration Agreement

This Mutual Arbitration Agreement is a contract and covers important issues relating to your rights. It is your sole responsibility to read it and understand it. You are free to seek assistance from independent advisor of your choice outside the Company or to refrain from doing so if that is your choice.

Este Acuerdo de arbitraje mutuo es un contrato y cubre temas importantes relacionados con sus derechos. es su responsabilidad leerlo y entederio. Usted es libre de buscar ayuda de asesores independientes de su eleccion fuera de la Comapañia o absterese de hacerio si es su eleccion.

This Mutual Arbitration Agreement ("Agreement") is between Employee and Aquinas Healthcare ("COMPANY"). The Federal Arbitration Act (9 U.S.C. § et seq.) governs this Agreement, which evidences a transaction involving commerce. ALL DISPUTES COVERED BY THIS AGREEMENT WILL BE DECIDED BY AN ARBITRATO THROUGHT ARBITRATION AND NOT BY WAY OF COURT OR JURY TRIAL.

1. COVERED CLAIMS/ DISPUTES. Except as otherwise provided in the Agreement, this Agreement applies to any and all disputes, past, present, or future that may arise between Employee and COMAPNY, including without limitation any dispute arising out of or related to Employee's application, employment and/or separation of employment with COMPANY, This Agreement applies to covered dispute that COMPANY may gave against Employee or that Employee may have against COMPANY, its parent companies, subsidiaries, related companies and affiliates, or their officer, directors, principals, share holders, members, owners, employees, and managers or agents, any of which may enforce this Agreement as direct or third-party beneficiaries.

The claims subject to arbitration are those that absent this Agreement could be brought under applicable law. Except as it otherwise provides, this Agreement applies, without limitation, to claims based upon or related to discrimination, harassment, retaliation, defamation (including post-employment defamation or retaliation), breach of a contract or covenant, fraud, negligence, emotional distress, breach of fiduciary duty, trade secrets, unfair competition, wages, minimum wage and overtime or other compensation claimed to be owed, breaks, and rest periods, termination, tort claims, equitable claims, and all statutory and common law claims unless specifically excluded below. Except as if otherwise provides , the Agreement convers, without Act, the Age Discrimination in Employment Act, the Family Medical Leave Act. the Fail Labor Standards Act, the Pregnancy Discrimination Act, the Equal Pay Act, the Genetic Information Non-Discrimination Act, each as amended, and all other federal or state legal claims arising out of or relating to Employee's employment or the termination of employment.

Additionally, the Arbitrator, and not any federal, state, or local court or agency, will have the exclusive authority to resolve any dispute relating to the interpretation, applicability, enforceability, or formation of this Agreement. However, the preceding sentence will not apply to the "Class Action Waiver" in Section 3 below.

2. EXCLUDED CLAIMS/DISPUTES. The Agreement does not apply to Claims for worker's Compensation benefits, state disability insurance benefits and unemployment insurance benefits; however. this Agreement applies to retaliation claims based upon seeking such benefits. such as claims for worker's compensation retaliation. This Agreement does not apply to claims for employee benefits under any benefit plan covered by the Employee Retirement Income Security Act Of 1974 or funded by insurance. This Agreement shall be construed to require the arbitration of any claims against a contractor that may not be the subject of a mandatory arbitration agreement as provided by section 8116 Of the Department of Defense ('DODO Appropriations Act for Fiscal Year 2010 (Pub. 111-118). section 8102 of the Department of Defense (DoD") Appropriations Act for Fiscal Year 2011 (Pub. L, 112-10. Division A), and their implementing regulations, or any successor DOD appropriations act addressing the arbitrary Of claims The Agreement also does not apply to any claim that an applicable federal statute expressly states cannot be arbitrated.

Regardless of any Other items of this Agreement. clams may be brought before and remedies awarded by an administrative agency if applicable law permits such notwithstanding the existence of an agreement to arbitrate governed by the Federal Arbitration Act Such administrative filings include without limitation claims or charges brought before the Equal Employment Opportunity Commission. U.S. Department of Labor. National Labor Relations Board, Or Office of Federal Contract Compliance Programs. Nothing in this Agreement will prelude or excuse a party from bringing an administrative claim before any agency to fulfill the party's obligation to exhaust administrative remedies before making a claim in arbitration.

3. CLASS ACTION WAIVER. Employee and COMPANY agree to bring any dispute in arbitration On an individual basis may and not as a class or collective action. There will be no right or authority for any dispute to be brought. heard or arbitrated as a class or collective action and the arbitrator will have no authority to hear or preside over any such claim Class Action Waiver"). This Class Action Waiver will not be severable from this Agreement in any matter brought as a class or collective action. Regardless Of anything else in this Agreement and/or the American Arbitration Association ("AAA") rules or procedures. the applicability, enforceability or formation of the Class Action Waiver may be determined by a court not an arbitrator.

4. COVID-19, Contagious viruses, diseases Or similar pandemics are a risk which all employees may encounter as part of being a healthcare employee. The COMPANY makes every effort to protect it's employees, through the supply and use of Personal Protection Equipment (PPE) and on-going education- The World Health Organization has determined that COVID-19 was a Global Pandemic and as so, the Employees should take every precaution to protect themselves. The COMPANY continues to work diligently to protect its employees from exposure to any contagious viruses or health risks. The Employee has been continuously updated by the COMPANY and the media regarding the extremely contagious nature of COVID-19 and all Corona Viruses, which are mainly spread through person to person contact.

Federal, State and World Health Organizations have recommended social distancing when these outbreaks occur. and all employees of the COMPANY are responsible to follow these guidelines while at work as well as outside of work. The Employee knowingly assumes all the foregoing risks and accepts sole responsibility for any injury. illness or death to themselves, their family, co-employee or any person they encounter as a result of becoming infected or sick. These risks include, but are not limited to. personal injury. disability, and death, illness, damage. loss, claim. liability, or expense. of any kind. that I or my family may experience or incur in connection with my employment With the COMPANY. I hereby release, covenant not to sue, not participate in a Class add-on. discharge, and hold harmless the COMPANY. its employees, agents. and representatives, of and from the Claims, including all liabilities, claims. add-ons. damages. costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release Clause includes any Claims based on the actions, omissions, or negligence of the COMPANY. its employees, agents. and representatives. whether a COVID-19 infection or other illness occurs before. during. or after employment with the COMPANY. The COMPANY encourages each employee to communicate any issue or rick they perceive while on the job, so that we may limit any spread of illness to our employees and clients. I agree to report all risks I see or believe to exists to my supervisor immediately.

5. ARBITRATOR SELECTION. The parties will proceed to arbitration before a single arbitrator under the auspices of the AAA and then current AAA Employment Arbitration Rules (the AAA Rules may be found at or by searching for "AAA Employment Arbitration Rules" using as google.com or Bing.com), provided, however, that if there is a conflict between the AAA Rules and this Agreement, this Agreement will govern. Unless the parties mutually agree otherwise, the Arbitrator will be ether an attorney experienced in employment law and licensed to practice law in the state in which the arbitration is convened. or a former judge from any jurisdiction- The AAA will give each party a list of eleven (11) arbitrators drawn from its panel of arbitrators. Ten days after AAA's transmission of the list of neutrals, AAA Will convene a telephone conference and the parties will strike names ultimately from the list of common names until one remains. The party who strikes first will be determined by a coin toss. That person will be designated as the Arbitrator. If for any reason, the individual selected cannot serve. AAA will issue another list of eleven (11) arbitrators and repeat the ultimate striking selection process. If for any reason the AAA will not administer the arbitration, either party may apply to a court of competent Jurisdiction with authority over the location where the arbitration will be conducted to appoint a neutral Arbitrator.

6. INITIATING ARBITRATION. A party who wishes to arbitrate a claim covered by this Agreement must make a written Request for Arbitration and deliver it to the other party by hand or mail no later than the expiration of the statute of limitations that applicable law prescribes for the claim. The Request for Arbitration shall identify the claims asserted, the factual basis for the claim(s). and the relief and/or remedy sought. The Arbitrator will resolve all disputes regarding the timeliness or property of the Request for Arbitration and apply the statute of limitations that would have applied if the claim(s) had been brought in court

7. RULES/STANDARDS GOVERNING PROCEEDING. The Arbitrator may award any remedy to which a party is entitle under applicable law. but remedies will be limited to those that would be available to a party in their individual capacity for the claims presented to the Arbitrator, and no remedies that otherwise would be available to an individual under applicable law will be forfeited. The parties have the right to conduct adequate civil discovery (including but not limited to individual witness depositions, and requests for production) and present witnesses and evidence to present their cases and defenses and any dispute in this regard will be decided by the Arbitrator. Each party will also have the right to subpoena witnesses and documents, including documents relevant to the case from third parties. At least thirty (30) days before the final hearing. the parties must exchange a list of witnesses, excerpts of depositions to be introduced. and copies of all exhibits to be used.

The location of the arbitration proceeding will be in the country where the Employee last worked for COMPANY unless each party agrees otherwise. The Arbitrator has the authority to hear and rule on pre-hearing disputes. The Arbitrator will have the authority to hear and decide a motion to dismiss and /or a motion for summary judgment by any party, consistent with Rule 12 or Rule 56 of the Federal Rules of Civil Procedure.

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The Arbitrator will issue a written decision or award, stating he essential findings of fact and conclusions of law- A court of competent jurisdiction will have the authority to enter judgment upon the Arbitrator's decision/award.

8. PAYMENT OF FEES. The COMPANY will pay the Arbitrator's and arbitration fees and costs, except for the filing fee as required by the organization through which the arbitration is conducted- If Employee is financially unable to pay a filing fee. Employee will be relieved of the obligation to pay the fifing fee. Disputes regarding the appointment of fees will be decided by the Arbitrator, Each pansy will pay for its own costs and attorney's fees. if any. but if any part prevails on a claim which affords the prevailing party attorneys' fees, the Arbitrator may award reasonable fees to the prevailing party as provided by law.

9. ENTIRE AGREEMENT/SEVERABILITY. This is the complete agreement relating to the resolution of disputes covered by this Agreement. Except as stated above regarding the Class Action Waiver. if any portion of this Agreement is deemed unenforceable, he unenforceable provision will be severed from the Agreement and the remainder of the Agreement will be enforceable. This Agreement will survive the termination of Employee's employment and the expiration of any benefit, and it will apply upon re-employment by the Company if Employee's employment is ended but later renewed. This Agreement Will also continue to apply notwithstanding any change in Employee's duties, responsibilities. position. or title, or if Employee transfers to any affiliate of the COMPANY. This Agreement does not alter the "at-will" status of Employee's employment Notwithstanding any contrary language in any COMPANY policy or employee handbook, this Agreement may not be modified or terminated absent a writing signed (electronically or otherwise) by both parties.

10. CONSIDERATON. The COMPANY and Employee agree that the mutual obligations by the COMPANY and Employee to arbitrate disputes provided adequate consideration for this Agreement

11. AGREEMENT. EMPLOYEE ACKNOWLEDGES THAT EMPLOYEE HAS CAREFULLY READ AND AGREE TO THIS MUTUAL ARBITRATION AGREEMENT TO ARBITRATE. BY SIGNING THIS AGREEMENT, THE COMPANY AND EMPLOYEE ARE GIVING up THEIR RIGHTS TO A COURT OR JURY TRIAL AND AGREEING TO ARBITRATE CLAIMS COVERED BY THIS AGREEMENT.

EMPLOYEE PRINTED NAME DATE