eTenet Security form for Contingent labor
***All areas needs to be completed**

Add user to eTenet ☐ **Remove user access** ☐

*** First Name**	
*** Middle Name**	
*** Last Name**	
*** Full SSN #**	
*** Birthdate (month and day only)**	
*** Title**	
*** Facility**	
*** Department**	
*** Phone**	
***Personal Email address**	
***Tenet Leader Sponsoring Access**	
*** Reason for Access**	
*** If Patient Information is to be accessed, is there a Business Associate Agreement and/or Contract**	Please check with the hospital Compliance Officer to ensure that a BA agreement is required and if so, that there is one in place. Please ask Compliance Officer to sign and date below once access is approved and forward to Information Systems when done.

eTenet Security form for Contingent labor
***All areas needs to be completed**

Security Statement

Computer access privileges are granted to Tenet contract employees at the lowest possible level pursuant to the efficient performance of the employee's duties and must be used only for Tenet authorized business. Computer access devices, such as user identity codes and passwords, remain the property of Tenet and are not to be divulged to any other person unless approved by Perot Systems Security. Unauthorized access to, use and possession of, removal of, and/or damage to company records is a breach of the Tenet corporate policy and may result in disciplinary and/or legal action.

I agree to keep my access code confidential and to guard the confidentiality of all system information. As a Tenet contract employee, I share responsibility for the protection of Tenet's information assets and will be held accountable for maintaining their integrity, confidentiality, and availability.

Violation of this policy will be grounds for disciplinary action, up to and including termination. Tenet Healthcare Corporation reserves the right to pursue legal prosecution under local, state, and federal statutes.

I have read and understood the content of the above Security Statement and agree to accept and abide by the policies stated herein. Initial here ->

Contract Employee Signature: _____Date: _____

Health Request for RELIGIOUS Exemption from Vaccination

Clinician Name _____
Clinician Phone number/Department _____
Clergy name_____
Clergy Contact information (phone/email) _____

Vaccination Requirement TDAP

Request for TDAP **Immunization Exemption for Religious Reasons**

I_____ request that I be exempted from immunization as my personal observances prevent me from receiving the TDAP vaccine.

(Please describe below your sincerely held religious belief, practice, or observance that prevents you from receiving the-vaccine and attach any literature or other written materials that support you request for religious exemption)

Health Request for Medical Declination from Vaccination

Clinician Name _____
Clinician Phone number/Department _____
Physician (Healthcare Provider) name_____
Physician (Healthcare Provider) Contact information (phone/email)
_____

Vaccination Requirement TDAP

Request for TDAP **Immunization Exemption for Medical Reasons**

I_____ request that I be exempted from immunization as my personal health would be detrimentally affected by the administration of this vaccination

(Please describe below your history with having this vaccination administered and any adverse reactions it may have caused)

_____

_____

_____

PLEASE IDENTIFY PARTICIPANT

☐ Employee ☐ Volunteer
☐ MD/LIP's ☐ Student
☐ Contractor
Agency: _____

MARKET/PRACTICE NAME

2018-2019 INFLUENZA SEASON

All Tenet healthcare professionals can reduce the chance of acquiring and spreading the flu by electing to receive an annual flu vaccination. If you decline to receive immunization (regardless of reason), you must wear a surgical mask (except in the main lobby or cafeteria of a healthcare facility) throughout the flu season; minimal start date will be November 10, end date will be March 31, unless an outbreak extends flu precautions.

Please read the CDC Vaccine Information Sheet (VIS) for influenza vaccine. Review the information below and sign either the consent or declination of vaccine. For more on the flu, visit www.cdc.gov.

FLU Vaccine Consent

I verify that I have read the current CDC VIS, and to the best of my knowledge I have no contraindications to flu vaccine. I request that this flu vaccine be administered to me and that if side effects occur I can call [enter contact name/phone or department] to report them. The Physician Practice/Facility is not responsible for any side effects I may experience as a result of the immunization.

_____ _____ _____
Signature Date Employee/ Contractor (w/agency)
Student / Volunteer

UNIQUE ID _____ **PRINT NAME** _____
First Middle or MI Last

Administered by: _____ Manufacturer/Brand: _____

Lot #: _____ Exp. Date: ___/___/_____ ☐Left Deltoid ☐ Right Deltoid

***Already received flu vaccine ☐ Yes, Where: _____

**NOTE: Written confirmation of vaccine administration must be sent to [ENTER NAME OR DEPARTMENT HERE]

FLU Vaccine Declination

Medical Contraindications for Flu Vaccination: *Check if applicable (documentation required)*

Significant reaction to Flu shot in the past ☐ Yes ☐ No
History of Guillain-Barre syndrome ☐ Yes ☐ No

All healthcare personnel declining vaccination are required to wear a mask while at work from 11/10/18 through 3/31/19

Declining Influenza Vaccine for Reason Other Than Medical Contraindication

If after thoughtful consideration, you have reasons not to receive this flu vaccination as a healthcare worker, please give your reason for not having flu vaccine administered.

Religious reasons ☐ Yes ☐ No
Explain:

_____
Employee Signature Print Employee Name Date Dept.

List Any Other Tenet Facilities At Which You Work

_____ _____

_____ _____

1. Has your license or certification in any state, been investigated, suspended or had disciplinary action taken against it? Y or N

   If yes, please explain: ☐ ☐

Healthcare professional: _____

Date: _____

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►**START HERE:** **Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative