Reset Form

EMPLOYEE RECORDS

State Form 5440 (R5 / 3-18)
INDIANA STATE DEPARTMENT OF HEALTH
DIVISION OF LONG TERM CARE

Facility label
Date *(month, day, year)*

FACILITY COMPLETES COLUMNS A, B, AND C. MAKE ADDITIONAL COPIES AS NEEDED. Include all contractual consultants.

A. FULL NAME	B. JOB TITLE	C. START DATE *(mm/dd/yyyy)*		D. LICENSE OR CERT.	E. PRE-EMPLOYMENT SCREENING		F. PHYSICAL EXAM	G. TB TEST				H. JOB DESC.	I. ORIENT.		J. IN-SERVICES		
					Criminal	References		1st Step	2nd Step	Chest X-ray	Annual Risk Assessment		General	Specific	Resident Rights	Dementia	Abuse
1.	Administrator																
2.	Director of Nursing																
3.	Medical Director																
4.	Beautician																
5.	Dementia Care Director																
6.	Pharmacist																
7.	Registered Dietician																
8.	Activity Director																
9.	Social Service / SSD																
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EMPLOYEE RECORDS *(continued)*

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					Criminal	References		1st Step	2nd Step	Chest X-ray	Annual Risk Assessment		General	Specific	Resident Rights	Dementia	Abuse
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