Hennepin Healthcare

Flu and Worksite Wellness Program

2018 PATIENT SERVICES COORDINATORS (PSCs)TRAINING

Flu/Worksite Wellness Program Overview
MVNA

1. Program Overview
2. Wellness Staff Website
3. Scheduling
4. Payroll/Timesheets
5. Registration Form
6. Other Forms
7. 2018 Flu Vaccinations
8. Review Roles and Responsibilities
9. Conclusion

Please hold questions until the end of the presentation!

Blue Folder

- Bring to **every** clinic!

Office Team:

Who Do you Contact During Office Hours?

- Danielle Rice, Business Analyst– Questions about scheduling
  - Danielle.Rice@hcmed.org or 612-617-4624
- Nan Lomen, Clinical Staff Supervisor – Clinical questions
  - Nanette.Lomen@hcmed.org or 612-916-2661
- Mary Watkins, Principle Office Specialist – Questions about payroll/mileage
  - Mary.Watkins@hcmed.org or 612-617-4706

Other Team Members:

- Paula Abramson, Sales and Account Manager
- Glory Barduson, Clinic Coordinator
- Jeanne Portoghese, Clinic Coordinator
- Marni Radcliffe, Clinic Coordinator

Who do you call?

- Office Hours: Monday –Friday 8am-4:30pm
- Flu Room Phone: 612-617-4620
- After Hours:
  - If you do call the flu room number after hours, leave a message for the next business day.

- **“What if I need to talk to someone BEFORE the next business day?”**
  - Call Nan’s cell at 612-916-2661 for after hours emergencies. Please only use this for an issue that needs attention before the start of the next business day.
    - For example, if you are too sick to work your clinic the next morning.

Key Chain

We are now Hennepin Healthcare!

Our Mission

We partner with our community, our patients and their families to ensure access to outstanding care for everyone, while improving health and wellness through teaching, patient and community education, and research.

Our Values

- Patient & Family Centered
- Excellence
- Teamwork
- Respect
- Integrity
- Compassion

2018 Dress Code

- PSCs: Logo vest provided

- Business casual attire at all clinics:
  - -Dress pants (no shorts or capris or denim)
  - -Closed toe shoes
  - -Wear solid color shirt under vest
    - *Short or long sleeves

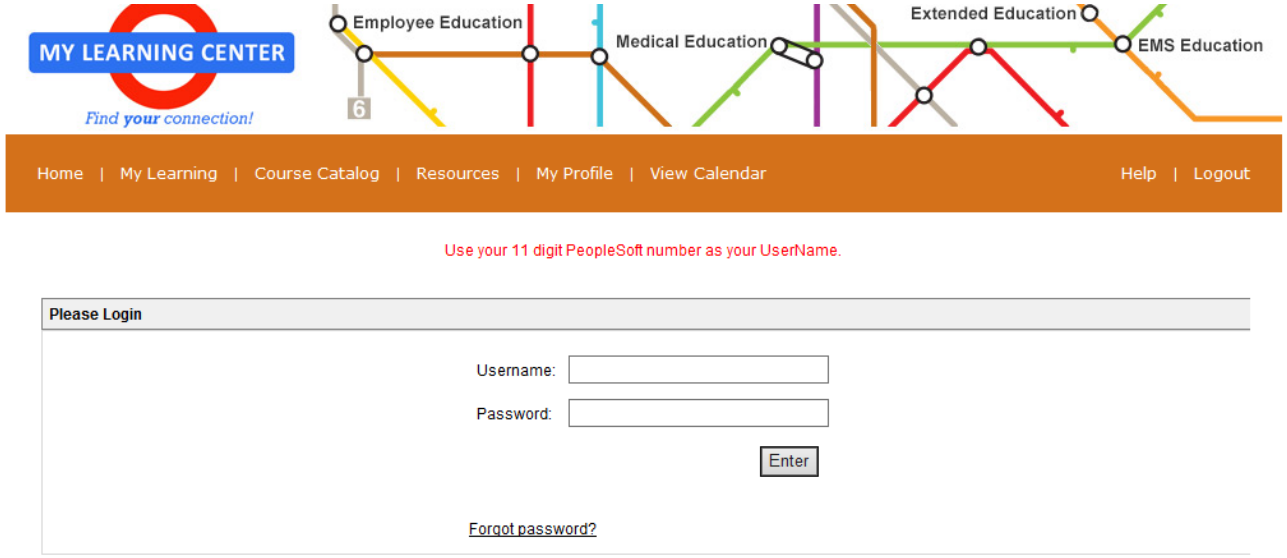
- Always wear your name badge at every clinic!

Computer Responsibilities

- ✓ Check your email daily for Updates – check your junk/spam mail.
- ✓ Check your schedule board regularly
- ✓ Save Clinic Confirmations and Account Sheets
- ✓ Hennepin Healthcare Email – Check weekly
- ✓ Online Trainings

Online Training

- Your login info is on your new key chains.



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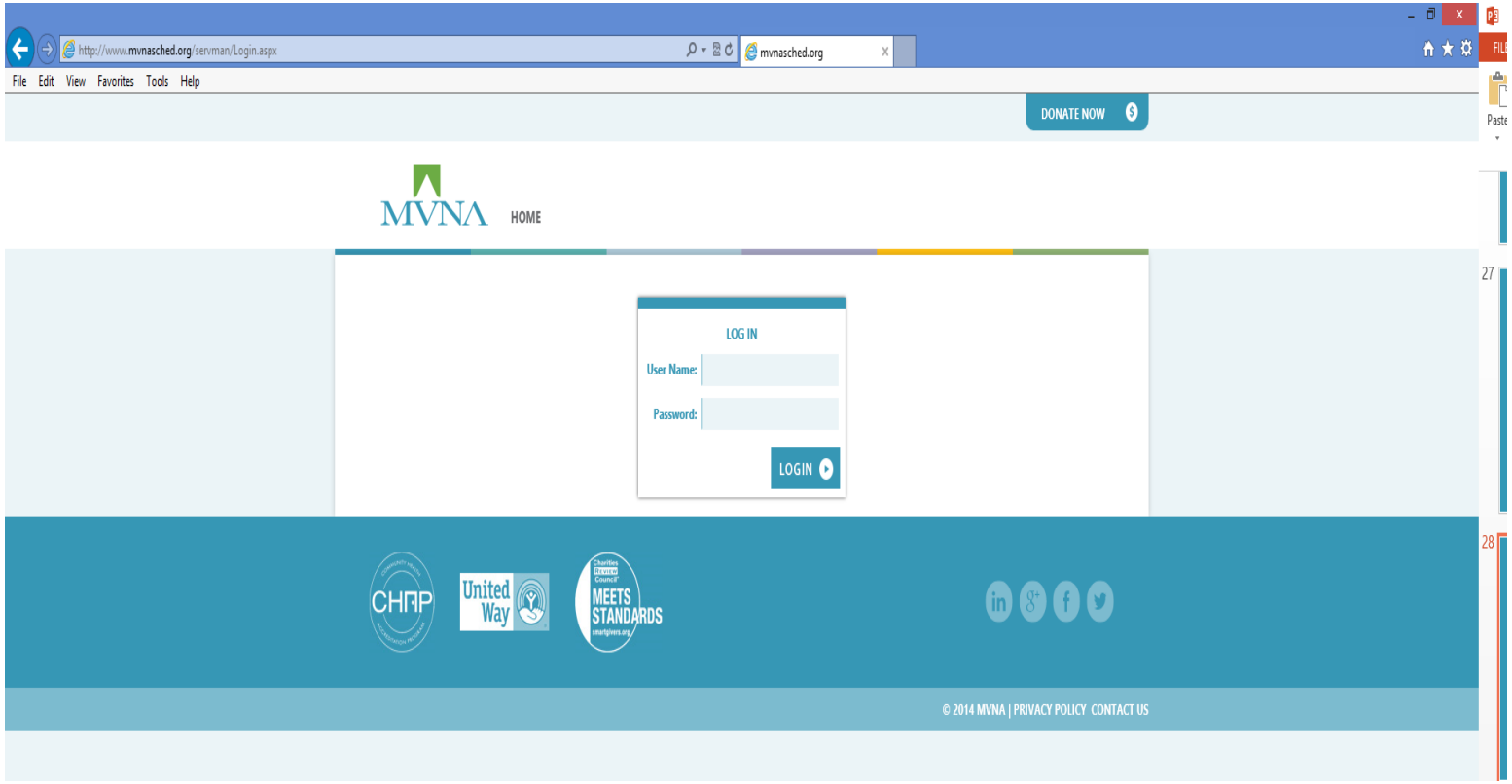
WELLNESS STAFF WEBSITE

Accessing the Wellness Staff Log-in Site

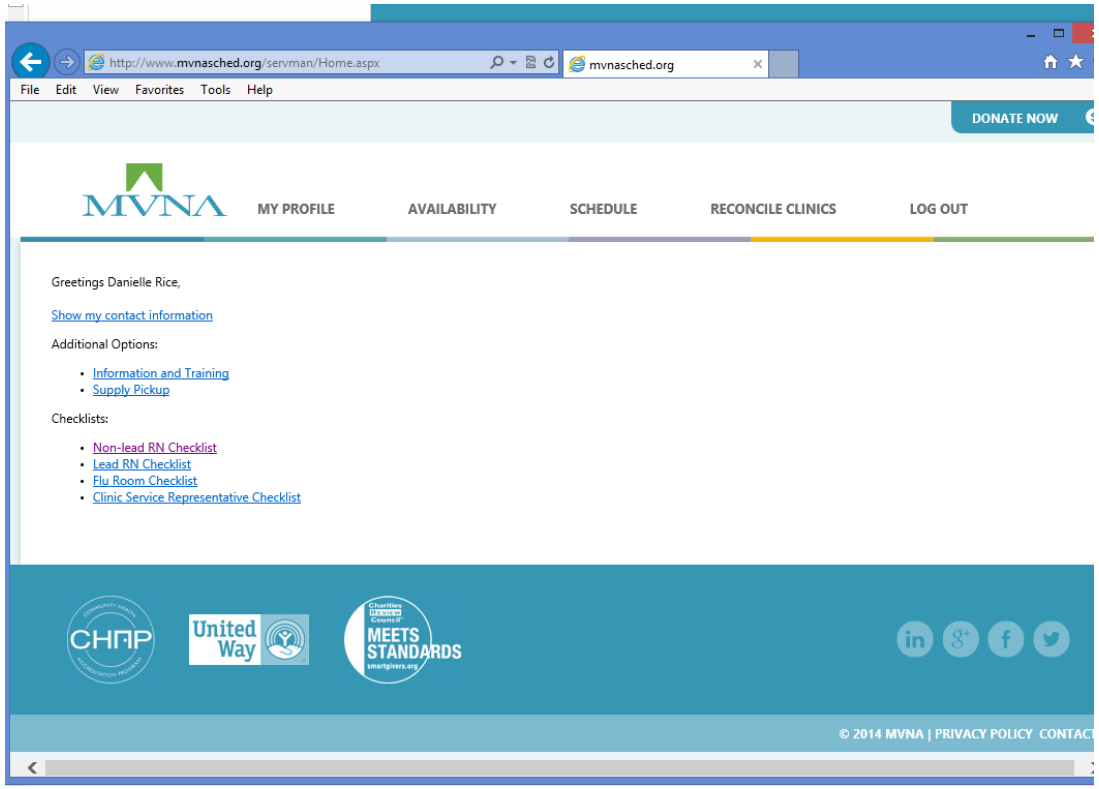
- ❑Go to https://mvnasched.hcmed.org/servman/Login.aspx
- ❑Danielle will also send the link in an email – Save this email!
- ❑Bookmark this link the first time!
- ❑We call this the Wellness Staff Site
- ❑Your username and password are on the Keychain

Accessing the Wellness Staff Log-in Site

Enter log-in page with your username and password.



Wellness Staff Log-in Site Overview



- **One-Stop shop for:**
  - Access Training materials
  - Timesheet/Expense Forms
  - Submit your Availability
  - Check your Schedule

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SCHEDULING

Overview of 2018 Scheduling Process

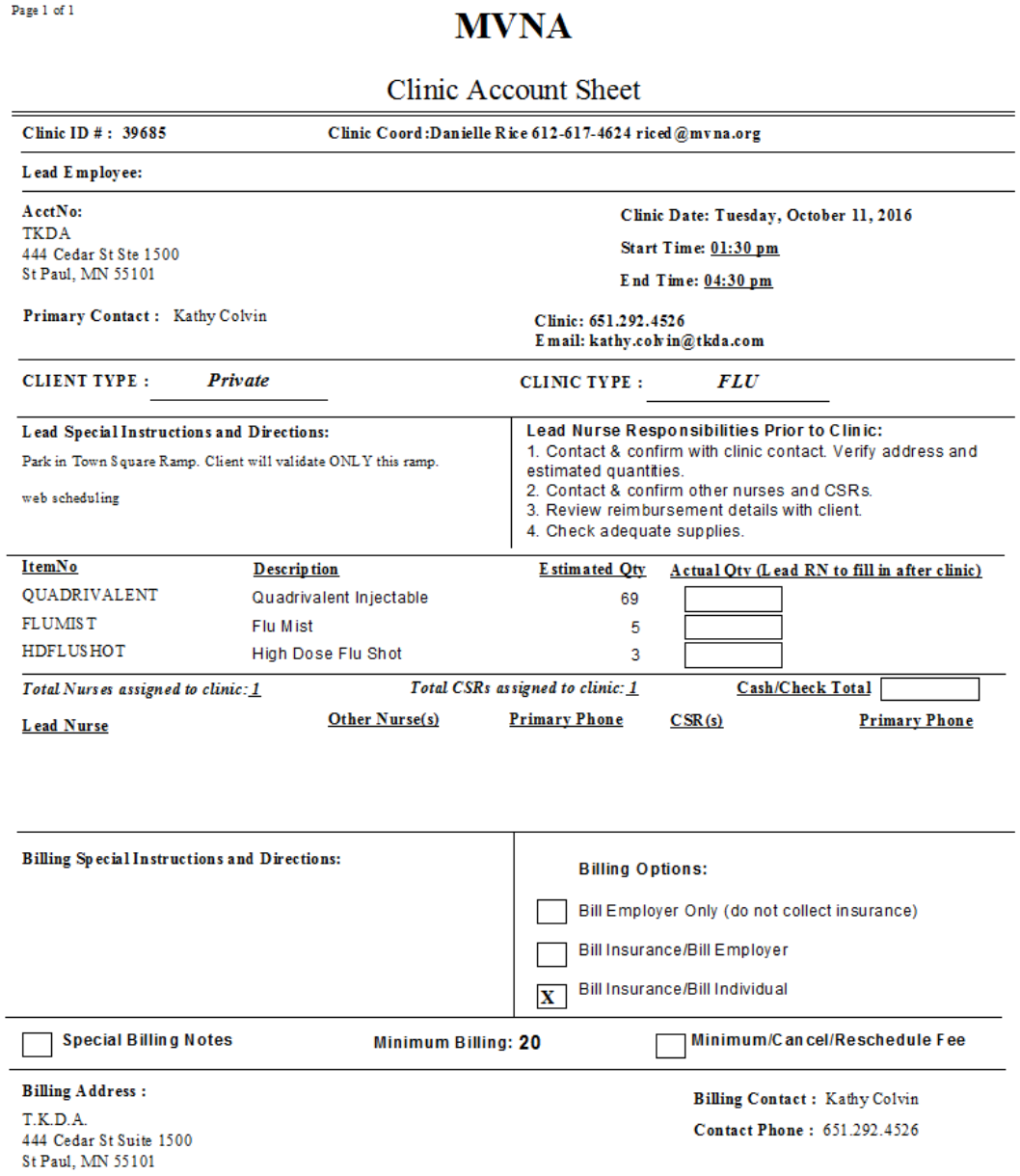
- You will submit your availability from the Wellness Staff log-in page. All availability must be updated ***at least three full weeks*** in advance.
- You will complete a survey about which geographic areas (zones) you prefer to work.
- You will be scheduled based on your availability & zones selected.
- You can check your weekly schedule from the MVNA staff log-in page

Clinic Assignments

- You will have all your clinic assignments at least two weeks in advance.
- You will be contacted before being scheduled into a last minute clinic.
- You will receive an email notification of each individual clinic you are scheduled at.
- All scheduled clinics will also appear on your schedule board.
- You will also receive an email with the Account Sheet attached 1 week before your clinic.
- You are responsible for checking your schedule board frequently and closely as changes may occur. Contact Danielle Rice at 612-617-4624 immediately about conflicts/errors/questions.
- No reminders will be sent from the office about clinics. The Clinic Lead will contact the client and all staff at least 2-4 days before the clinic. If you do not hear from your Clinic Lead at least 24 hours before the clinic please contact the office staff immediately.

Clinic Confirmations

- Two Weeks Prior: You will receive an email notification of each individual clinic you are scheduled at. **SAVE THESE EMAILS.**
- One Week Prior: You will also receive an email with the account sheet attached with all the clinic information, including:
  - Who the Lead RN is
  - Staffs' contact info
  - Clinic address and contact info
  - Special Instructions
  - Etc.



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MVNA

Clinic Account Sheet

Clinic ID # : 39685 **Clinic Coord :Danielle Rice 612-617-4624 riced@mvna.org**

Lead Employee:

AcctNo:
TKDA
444 Cedar St Ste 1500
St Paul, MN 55101

Clinic Date: Tuesday, October 11, 2016
Start Time: 01:30 pm
End Time: 04:30 pm

Primary Contact : Kathy Colvin

Clinic: 651.292.4526
Email: kathy.colvin@tkda.com

CLIENT TYPE : *Private* **CLINIC TYPE :** *FLU*

Lead Special Instructions and Directions:
Park in Town Square Ramp. Client will validate ONLY this ramp.

web scheduling

Lead Nurse Responsibilities Prior to Clinic:
1. Contact & confirm with clinic contact. Verify address and estimated quantities.
2. Contact & confirm other nurses and CSRs.
3. Review reimbursement details with client.
4. Check adequate supplies.

ItemNo	Description	Estimated Qty	Actual Qty (Lead RN to fill in after clinic)
QUADRIVALENT	Quadrivalent Injectable	69	
FLUMIST	Flu Mist	5	
HDFLUSHOT	High Dose Flu Shot	3	

Total Nurses assigned to clinic: 1 *Total CSRs assigned to clinic: 1* Cash/Check Total

Lead Nurse | Other Nurse(s) | Primary Phone | CSR(s) | Primary Phone

Billing Special Instructions and Directions:

Billing Options:
- ☐ Bill Employer Only (do not collect insurance)
- ☐ Bill Insurance/Bill Employer
- ☒ Bill Insurance/Bill Individual

☐ Special Billing Notes **Minimum Billing: 20** ☐ Minimum/Cancel/Reschedule Fee

Billing Address :
T.K.D.A.
444 Cedar St Suite 1500
St Paul, MN 55101

Billing Contact : Kathy Colvin
Contact Phone : 651.292.4526

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Go to site:
https://mvnasched.hcmed.org/servman/Login.aspx

Entering Availability on Website

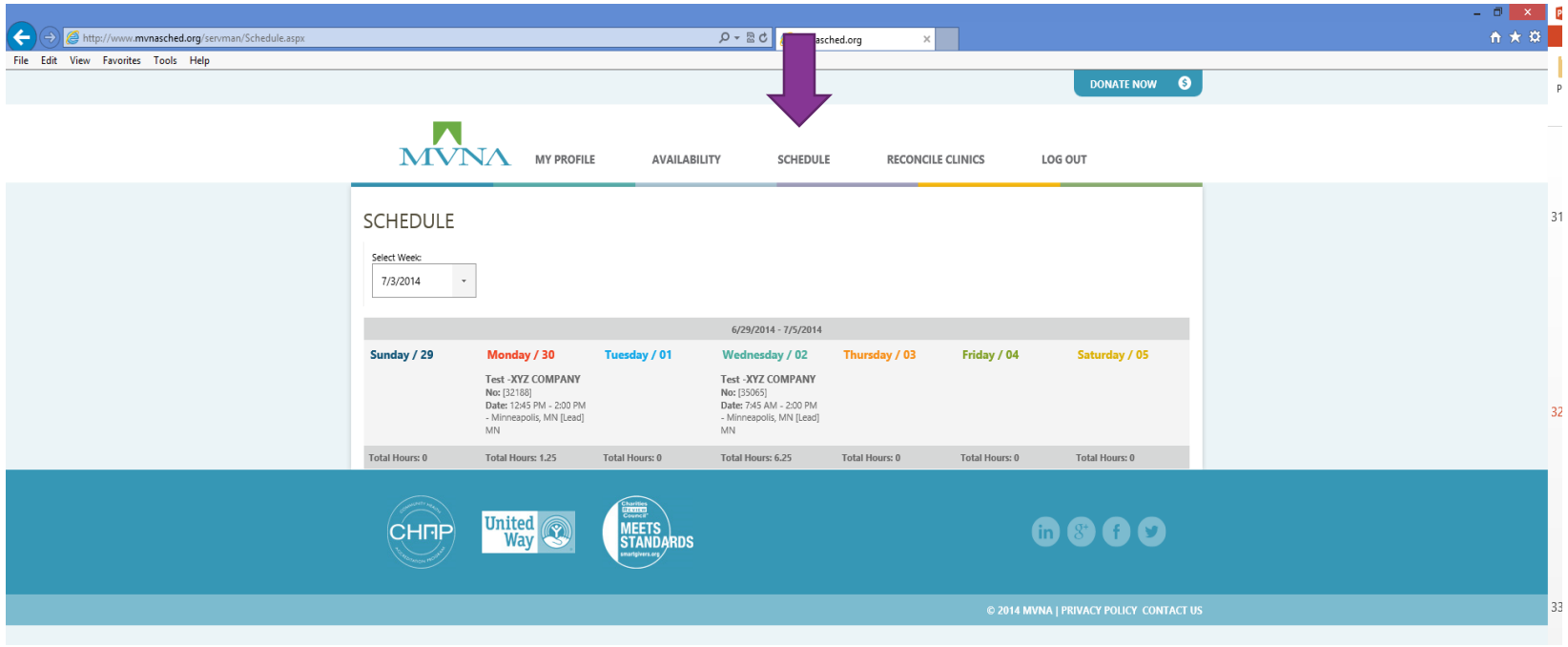
Highlight the timeframes that you are available each day.
Yellow=Available

Entering your Availability

- You are required to enter your availability at least 3 full weeks in advance.
- The schedule will be created based on your availability. If you make changes to your online availability less than 3 weeks out, the office staff may not see the change. You will be expected to work for each clinic assignment that appears on your schedule.
- If you can not work a clinic that is on your schedule, you must contact Danielle Rice at Danielle.Rice@hcmed.org ASAP.
- You are committing to your availability as indicated on the calendar, and you will be scheduled accordingly. For example, if you submit that you are available all week, expect to be scheduled heavily (20-30 hours). If you only want to work 15 hours a week, only submit about 20 hours of availability.
- Once you submit your availability, you have committed to work those hours (cancelling must be limited to an emergency or illness).

Check schedule board

- ✓You are responsible for checking your schedule board frequently and closely as changes may occur.
- ✓Contact Danielle Rice at 612-617-4624 immediately about conflicts/errors/questions.



Reconciling Clinics

Purpose: Each clinic will need to be reconciled through the Wellness Staff Login site by the lead nurse. By reconciling the clinic, the lead nurse verifies the number of vaccinations performed.

If you are late to a clinic, the lead RN will report this to the office.

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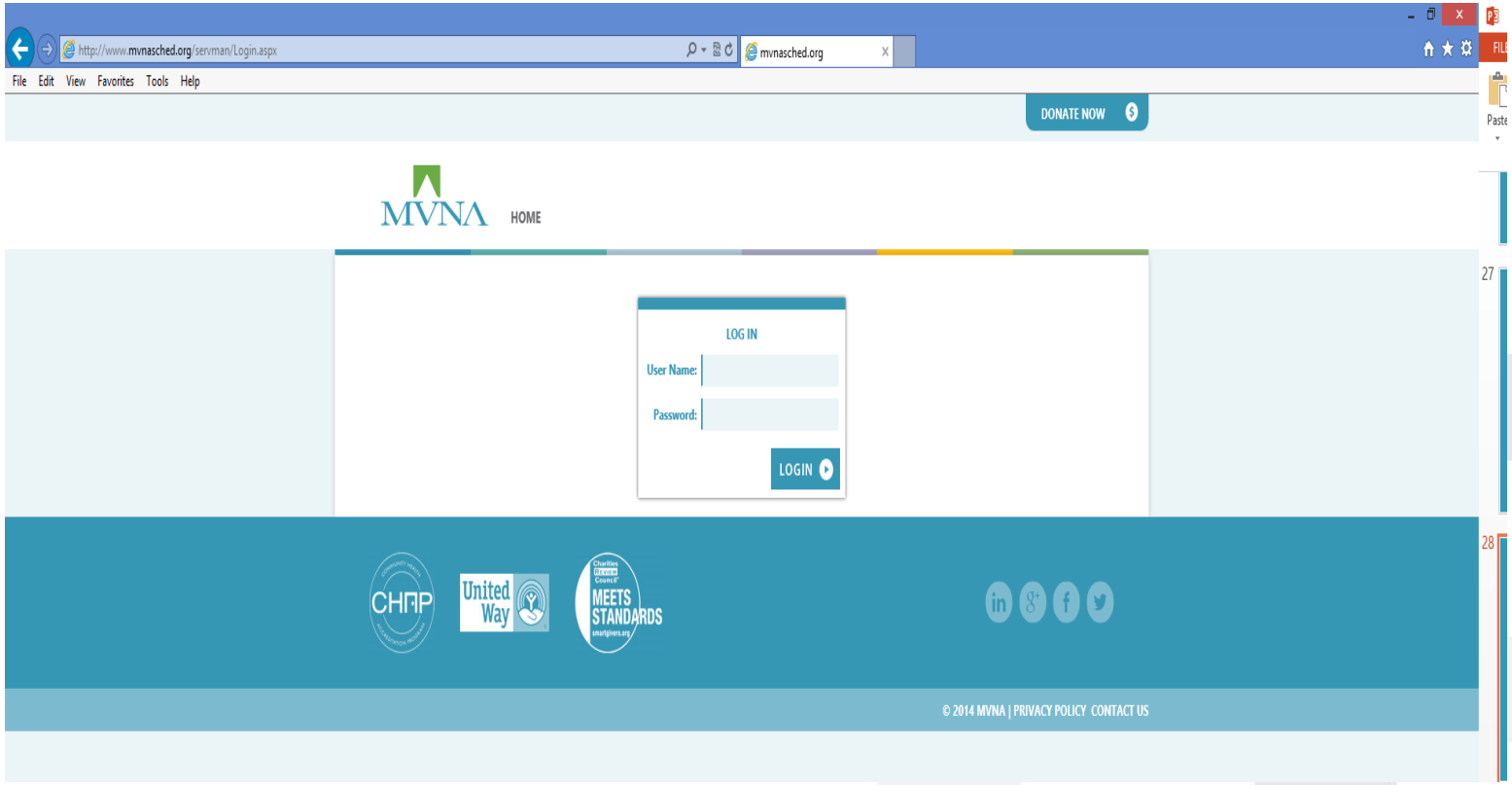
Quiz:

Where do you find your username and password information for the Wellness Staff Website?



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Your Keychain!

The Wellness Staff Login information is on your keychain.

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PAYROLL/TIMESHEETS

Timesheet & Mileage Log

Timesheet and Mileage Log

Employee Name: (Don't forget to print your name!)			PeopleSoft #:		
Date:	**Activity: (Please write clinic #, or "supplies" or "lead responsibilites")**	**Start Time**	**End Time**	**Miles**	**Notes:**

1) Please refer to the "Timesheet 101" document available on the Wellness Staff website for guidelines

2) You are only paid to arrive 15 minutes before the start of a clinic, unless you have made prior arrangments with the office staff.

3) The Lead RN is responsible for reconciling online - they should leave the clinic incomplete and write a message regarding any changes to the clinic length or staff's arrivals/departures.

4) You are NOT paid mileage or drive time to get to your first daily destination, or to return home after your last destination (unless over 25 miles).

5) You ARE paid the mileage in-between assignments, including clinics and supply pick-ups.

6) You ARE paid drive-time in between assingments - please refer to guidelines below:

.1 – 15 miles between clients: 15 minutes of travel time allotted

16.0 – 35 miles between clients: 30 minutes of travel time allotted

36.0 – 55 miles between clients: 45 minutes of travel time allotted

Anatomy of a timesheet

1. Employee Name: Print legibly
2. PeopleSoft #: 11 digit number on your blue key chain
3. Date
4. Activity
5. Start time
6. End time
7. Miles
8. Notes
9. Mileage guidelines

Any part not completed will be returned to you unless perhaps there is no name on it and then it goes into the

"No Name File"

Mileage and Drive Time

Time in-between work assignments (including clinics):

- You are paid drive-time in between assignments. Please refer to guidelines below:
  - .1 – 15 miles between clients: 15 minutes of travel time allotted
  - 16.0 – 35 miles between clients: 30 minutes of travel time allotted
  - 36.0 – 55 miles between clients: 45 minutes of travel time allotted

Use Google Maps or GPS to determine the miles and drive time from clinic to clinic

Add drive time and mileage as a separate line on your time sheet.

Mileage/time getting to your first clinic/getting home from your last clinic:

- No mileage or drive time is paid to get to your first assignment or to return home after your last assignment, *unless* the assignment is over 25 miles.
- Most of you stay within a couple of zones in proximity to your home which means you will be less than 25 miles from your first or last assignment.

Mileage reimbursement needs to be submitted within 60 days of occurrence. Anything submitted after 60 days will not be paid. Mileage will be paid separately from your paycheck and mailed to your address on file.

Clinic Set-up:

- All staff should arrive 15 minutes before the start of the clinic and help set up the clinic.
- The lead will report to MVNA if anyone does not arrive 15 minutes before the clinic start time on the reconcile tab of the Wellness Staff Website.
- All staff should include this 15 minutes on their timesheets.
- You will only be paid to arrive 15 minutes before the clinic. Any exception needs to be pre-approved by the office staff.
- Downtown Only: We will pay for 30 minutes before the clinic start time. Include this 30 minutes on your timesheet.

Sample Timesheet/Mileage Log

Timesheet and Mileage Log

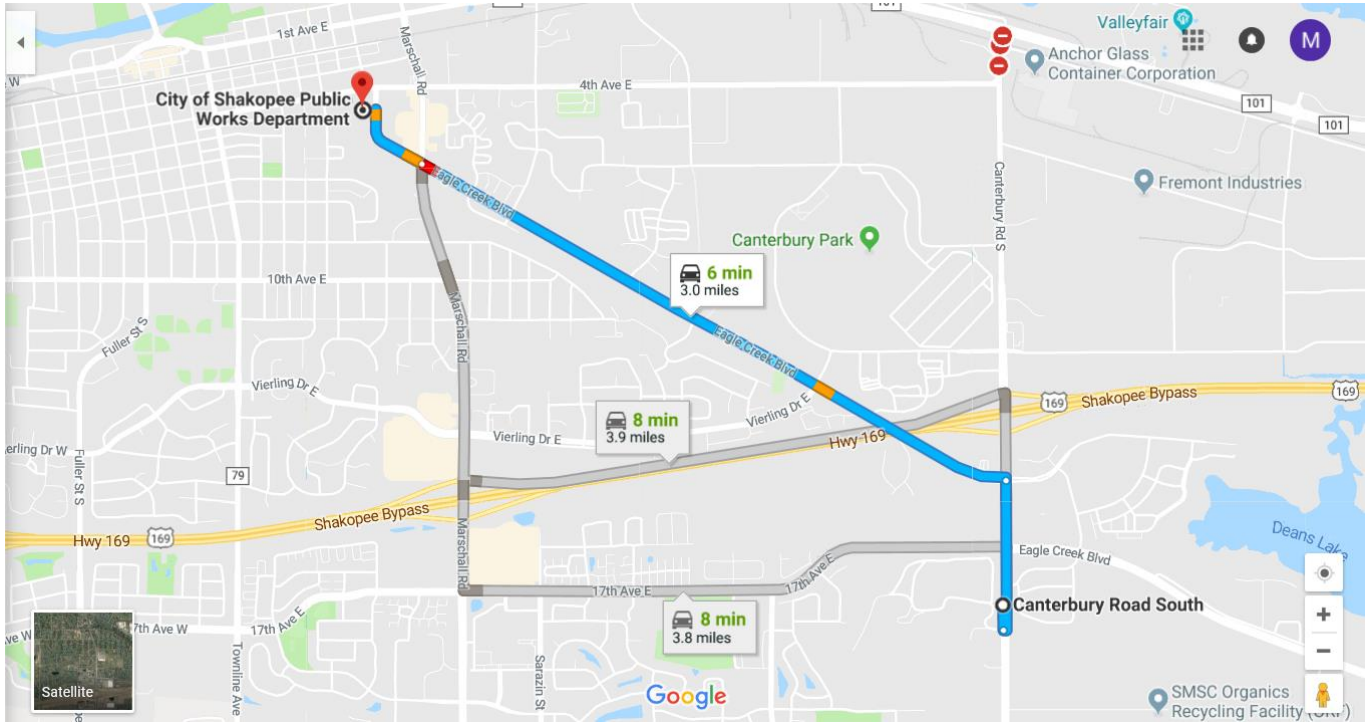
Employee Name: (Don't forget name!)			PeopleSoft #:		
Date:	**Activity: (Please write clinic #, or "supplies" or "lead responsibilites")**	**Start Time**	**End Time**	**Miles**	**Notes:**
9/13/2017	Clinic 43210	7am	8:30am	0	
9/13/2017	drive time	8:30am	8:45am	7	
9/13/2017	clinic 54321	9:15am	11am	0	
9/14/2017	clinic 65432	3:15pm	7:30pm	0	clinic ran 30 min late
9/16/2017	clinic 87653	7am	8:15am	0	
9/16/2017	drive time	8:15am	8:45am	25	
9/16/2017	clinic 76543	9:15am	11am	0	
9/16/2017	drive time	11am	11:15am	13	
9/16/2017	clinic 87654	12:15pm	3pm	0	

.1 – 15 miles between clients: 15 minutes of travel time allotted

16.0 – 35 miles between clients: 30 minutes of travel time allotted

36.0 – 55 miles between clients: 45 minutes of travel time allotted

Tracking Drive Time & Mileage



<u>Actual Drive Time/Mileage:</u>
October 9, 2018

Canterbury Park 43952:
10:45 - arrival
11:00-12:30pm

Drive time/mileage:
15 minutes/3.0 miles
(12:30-12:45pm)

City of Shakopee 44050:
1:15 - arrival
1:30-2:30pm

Examples

#1: Stacy leaves her home to get to her first clinic that is 15 miles from her home. Does she get paid for that drive time?

#2: Nancy goes to her first clinic which is 10 miles away, then she stops at the office to pick up supplies which is 15 minutes from the first clinic, and then drives to her last clinic which is 30 minutes away. What does she get paid for? What is the corresponding drive time and mileage she should log on her timesheet?

#3: Albert has agreed to take a clinic in Mankato that starts at 1pm. He lives in the Twin Cities. What should he record on his timesheet?

#4: Mary has a clinic at 10-11:30am and then another clinic at 2pm. How should she record this on her timesheet?

#5: George is scheduled for a downtown clinic that starts at 10:30am. How should he record this on his timesheet?

Answers

#1: Stacy leaves her home to get to her first clinic that is 15 miles from her home. Does she get paid for that drive time? No because it is less than 25 miles

#2: Nancy goes to her first clinic which is 10 miles away, stops at the office to pick up supplies which is 15 minutes from the last clinic and drives to her next clinic which is 30 minutes away. What does she get paid for? What is the corresponding drive time and mileage she should log on her timesheet? She does not get paid for the first clinic. She gets paid for 15 min supply pick up appt; 15 minutes of drive time and corresponding miles (.1 – 15 miles); 30 minutes of travel times and miles (16.0 – 35 miles)

#3: Albert has agreed to take a clinic in Mankato that starts at 1pm. He lives in the Twin Cities. What should he record on his timesheet? Mileage to and from Mankato OVER 25 miles

#4: Mary has a clinic at 10-11:30am and then another clinic at 2pm. How should she record the mileage and drive time on her timesheet? She needs to figure out the mileage from first clinic to second clinic (Ex: 32 miles) and log those miles and corresponding drive time (Ex: 30 minutes)

#5: George is scheduled for a downtown clinic that starts at 10:30am. What time should he arrive and how should he record this on his timesheet? No drive time if this is his first clinic of the day; but he should still arrive 15 minutes before scheduled clinic and record 30 minutes on his timesheet.

When are timesheets due?

Pay Period Begin Date (Sunday)	Pay Period End Date (Saturday)	Timesheet Due (Friday)	Check Date (Friday)
8/5/2018	8/18/2018	8/17/2018	8/24/2018
8/19/2018	9/1/2018	8/31/2018	9/7/2018
9/2/2018	9/15/2018	9/14/2018	9/21/2018
9/16/2018	9/29/2018	9/28/2017	10/5/2018
9/30/2018	10/13/2018	10/12/2018	10/19/2018
10/14/2018	10/27/2018	10/26/2018	11/2/2018
10/28/2018	11/10/2018	11/9/2018	11/16/2018
11/11/2018	11/24/2018	11/23/2018	11/30/2018
11/25/2018	12/8/2018	12/7/2018	12/14/2018
12/9/2018	12/22/2018	12/21/2018	12/28/2018

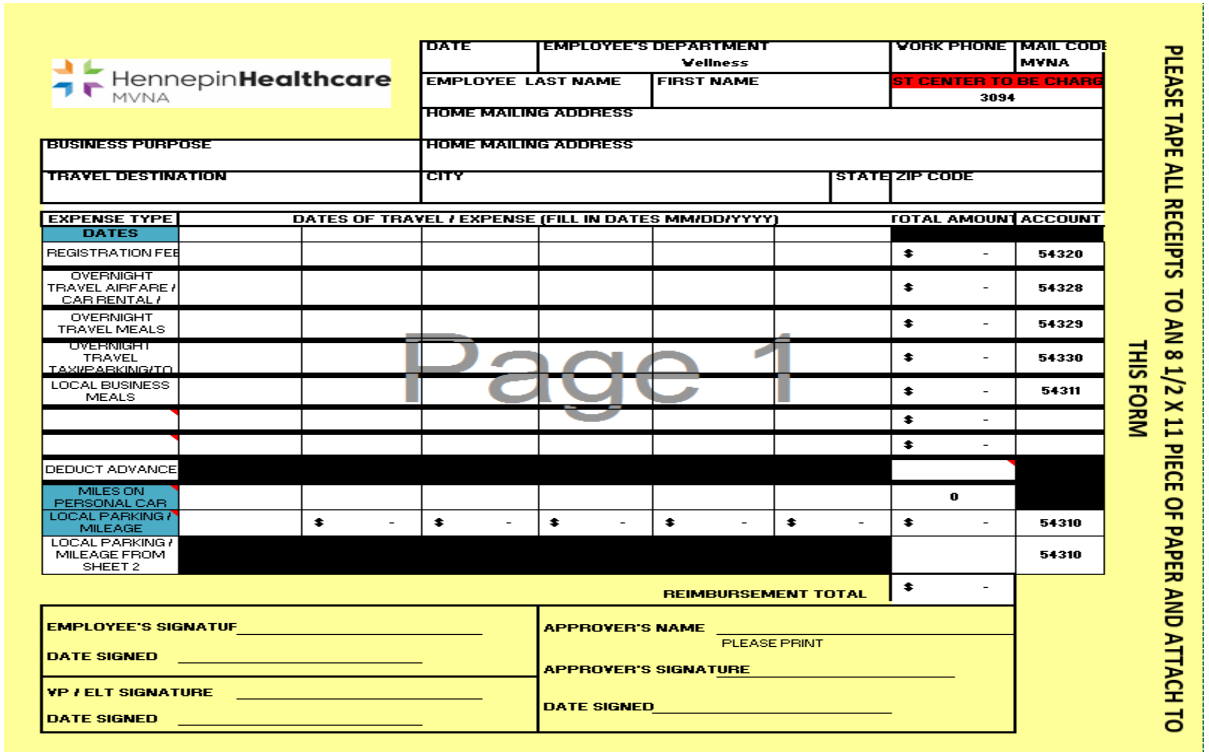
The deadline for submitting timesheets to Mary is 4:30PM Friday

Submitting your timesheets:

- You are required to have your timesheets submitted to Mary by the due date. If your timesheet is late, your time will be paid on the next paycheck. No exceptions.
- Submit in one of the following ways:
  - Email: Mary.Watkins@hcmed.org
  - Fax: 612-617-4772
  - Mail: Attn: Mary Watkins, 2000 Summer St. NE, Ste 100, Minneapolis MN 55413
  - In person at the office
  - **HINT:** Take a picture with your phone and email the picture to Mary!
- It is your responsibility to turn in your time. You will not be paid or reimbursed for time/miles/postage related to submitting your timesheets.

Reimbursement for Parking (or other expenses, such as postage)

- Complete and submit the reimbursement form (available on the Wellness Staff Site)



HennepinHealthcare MVNA

DATE	EMPLOYEE'S DEPARTMENT Wellness		WORK PHONE	MAIL CODE MVNA
EMPLOYEE LAST NAME	FIRST NAME		COST CENTER TO BE CHARGED 3094	
HOME MAILING ADDRESS				
BUSINESS PURPOSE	HOME MAILING ADDRESS			
TRAVEL DESTINATION	CITY	STATE	ZIP CODE	

EXPENSE TYPE	DATES OF TRAVEL / EXPENSE (FILL IN DATES MM/DD/YYYY)						TOTAL AMOUNT	ACCOUNT
DATES								
REGISTRATION FEE							$ -	54320
OVERNIGHT TRAVEL AIRFARE / CAR RENTAL /							$ -	54328
OVERNIGHT TRAVEL MEALS							$ -	54329
OVERNIGHT TRAVEL TAXI/PARKING/TO							$ -	54330
LOCAL BUSINESS MEALS							$ -	54311
							$ -	
							$ -	
DEDUCT ADVANCE								
MILES ON PERSONAL CAR							0	
LOCAL PARKING / MILEAGE		$ -	$ -	$ -	$ -	$ -	$ -	54310
LOCAL PARKING / MILEAGE FROM SHEET 2								54310
						REIMBURSEMENT TOTAL	$ -	

Page 1

EMPLOYEE'S SIGNATUF _____
DATE SIGNED _____
VP / ELT SIGNATURE _____
DATE SIGNED _____

APPROVER'S NAME _____
PLEASE PRINT
APPROVER'S SIGNATURE _____
DATE SIGNED _____

PLEASE TAPE ALL RECEIPTS TO AN 8 1/2 X 11 PIECE OF PAPER AND ATTACH TO THIS FORM

Anatomy of an Expense Report:

Date
Last Name; First Name
Mailing Address
Business Purpose: Flu Clinic Travel
Date(s) of service
Miles on personal car
Local parking fee
Sign and date
Don't forget to submit receipts along with this form

Need help on timesheets?

- First, check the material posted on the Wellness Staff Website:
  - Payroll Timeline
  - Timesheets 101
  - Timesheet & Mileage Log
  - And Instructions on accessing your timesheets/paystubs online

- If you still need help, contact:
  - Mary Watkins, Principal Office Specialist
  - Mary.Watkins@hcmed.org
  - 612-617-4706

- We are expected to be accountable for adhering to federal laws and general regulations, and adhering to protocol.
- Every part of our program is subject to audits by the Hennepin Healthcare System to insure accuracy and integrity.
- Please be mindful of this when you are completing your timesheets and expense reports.
- Purposeful fraudulence is grounds for immediate dismissal.

Hand in your timesheet!! Pass it to the right!

- Don’t forget your name and PeopleSoft # *wink wink*
- Any questions will be answered after the presentation ends.

Thank you!

Hennepin Healthcare

Registration Forms

Registration Form

The form is 2 sided and needs to be fully completed

HennepinHealthcare MVNA

2018-2019 FLU VACCINE

Registration Form

Clinic Number: _____

Employer/Name of Clinic Location:

PRINT IN INK ONLY- REQUIRED INFORMATION FOR CLIENT RECEIVING VACCINE

Last Name

First Name

Middle Name **SSN – last 4 digits**

Sex (M/F) Date of Birth (MM/DD/YYYY) **Age**

Address

City

State **Zip Code**

Phone Number ☐Home or ☐Cell

Complete this box if the patient is under 18 years of age:

Please provide parent/guarantor info below.

☐Same as the Policy Holder (must fully complete Policy Holder box)

☐Other: (If other, must complete information below)

Full Name:

Date of Birth:

Address:

Phone:

Relationship to patient:

Payment Options:

☐ Bill Insurance	☐ Pay Cash or Check	☐Bill Employer	☐Grant Covered
*Accurate & complete information below is required for successful billing	Discounted Cash prices: Quad: $38 High Dose: $65 FluMist: $43 Check # _____		*Any uninsured minors qualify *Adults may qualify at pre-arranged clinics

Hennepin Healthcare/MVNA can bill through any insurance. It is the individual's responsibility to check their coverage.

(#1) Primary Insurance Company Name

Primary Insurance ID#

Group #

(#2) Secondary Insurance Company Name

Secondary Insurance ID#

Group #

Policy Holder/Subscriber:

☐Self (skip section below) ☐Spouse ☐Parent ☐Other _____

Policy Holder Last Name

First Name

Policy Holder Date of Birth (MM/DD/YYY)

Daytime Phone Number ☐Same Phone as Patient

Policy Holder Address ☐Same Address as Patient

City **State** **Zip Code**

Please complete the following questions **Attention:** If you answer yes to any of the questions, further assessment is needed by the nurse.	Form Reviewed by:
1. Does the person to be vaccinated have an egg allergy, latex allergy or serious medication allergy?	☐Yes ☐No
2. Has the person to be vaccinated ever had a serious reaction after receiving a vaccination?	☐Yes ☐No
3. Has the person to be vaccinated ever had Guillain-Barre Syndrome?	☐Yes ☐No
4. Has the person to be vaccinated already received the flu vaccine this flu season?	☐Yes ☐No
5. Is the person to be vaccinated presently ill with a fever, sore throat, or cough?	☐Yes ☐No
FLUMIST ONLY: Only answer #6-15 if you are interested in receiving the FluMist Nasal Spray	
6. Is the person to be vaccinated younger than 2 years old or 50 years of older?	☐Yes ☐No
7. Does the person to be vaccinated have any of the following: HIV, Cancer, organ or bone marrow transplant, rheumatoid arthritis, Chron's disease, multiple sclerosis, Lupus, psoriasis, or reduced immune activity?	☐Yes ☐No
8. Does the person to be vaccinated take any medication that affects the immune system such as prednisone, azathioprine (Imuran), cyclosporine, methotrexate, rituximab, Orencia, or Remicade?	☐Yes ☐No
9. Is the person to be vaccinated in close contact with anyone whose immune system is severely compromised?	☐Yes ☐No
10. Has the person to be vaccinated received any vaccinations in the past 4 weeks?	☐Yes ☐No
11. Does the person to be vaccinated have active, untreated TB?	☐Yes ☐No
12. Is the person to be vaccinated pregnant or you could become pregnant during the next month?	☐Yes ☐No
13. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder?	☐Yes ☐No
14. Is the Child between 2 and 4 years of age, and has been told they have wheezing or asthma in the past 12 months?	☐Yes ☐No
15. If under 18, does the person to be vaccinated receive aspirin therapy or aspirin-containing therapy?	☐Yes ☐No

I had an opportunity to review the CDC VIS for influenza vaccine and ask questions and received answers to my satisfaction. I understand the benefits and risks of the vaccination and expressly authorize a nurse to administer the vaccine to me. I hereby release Hennepin Health Systems (HHS) dba MVNA, its officers, employees, agents; and _____, (company name), its officers, employees, and agents from any and all liability that might arise from vaccination on behalf of me, my heirs and personal representatives. I acknowledge that a copy of HHS dba MVNA's Notice of Privacy Practices is available to me, which provides an explanation of the way in which my health information may be used or disclosed by HHS dba MVNA and of my rights with respect to my health information. I understand I am financially responsible to HHS dba MVNA for any balance not covered by my insurance company(ies) indicated above.

Relationship to Patient: ☐ **Self** **OR** **6 months – 17 years** ☐ **Mother** ☐ **Father** ☐ **Other** _____

Signature: _____ **Date:** _____

Print Name: _____

If not "self", I am the child's parent, authorized representative, or legal guardian and can provide effective consent for this immunization. If applicable, I authorize my child's school to designate a responsible adult to be present at the immunization and to provide direction or assistance if needed.

NURSE ONLY

Manufacturer	Dose	Age	Site	Lot Number (Sticker)	Expiration Date
FluLaval/GSK Quadrivalent	☐ 0.5 ml	☐ 6 months & up	IM Deltoid: **L or R**		
Fluzone/Sanofi Quadrivalent	☐ 0.5 ml	☐ 3 years & up	IM Deltoid: **L or R**		
HighDose Fluzone/ Sanofi	☐ 0.5 ml	☐ 65 years & up	IM Deltoid: **L or R**		
FluMist/ Medimmune	☐ 0.5 ml	☐ 2 to 49 years	Nasal spray		

Vaccine Administrator Signature: _____

RN Name (Please Print): _____ Date: ___/___/2018

Vaccine Information Statement (VIS) offered to client: ☐ (RN to check box) VIS Edition: ___/___/___

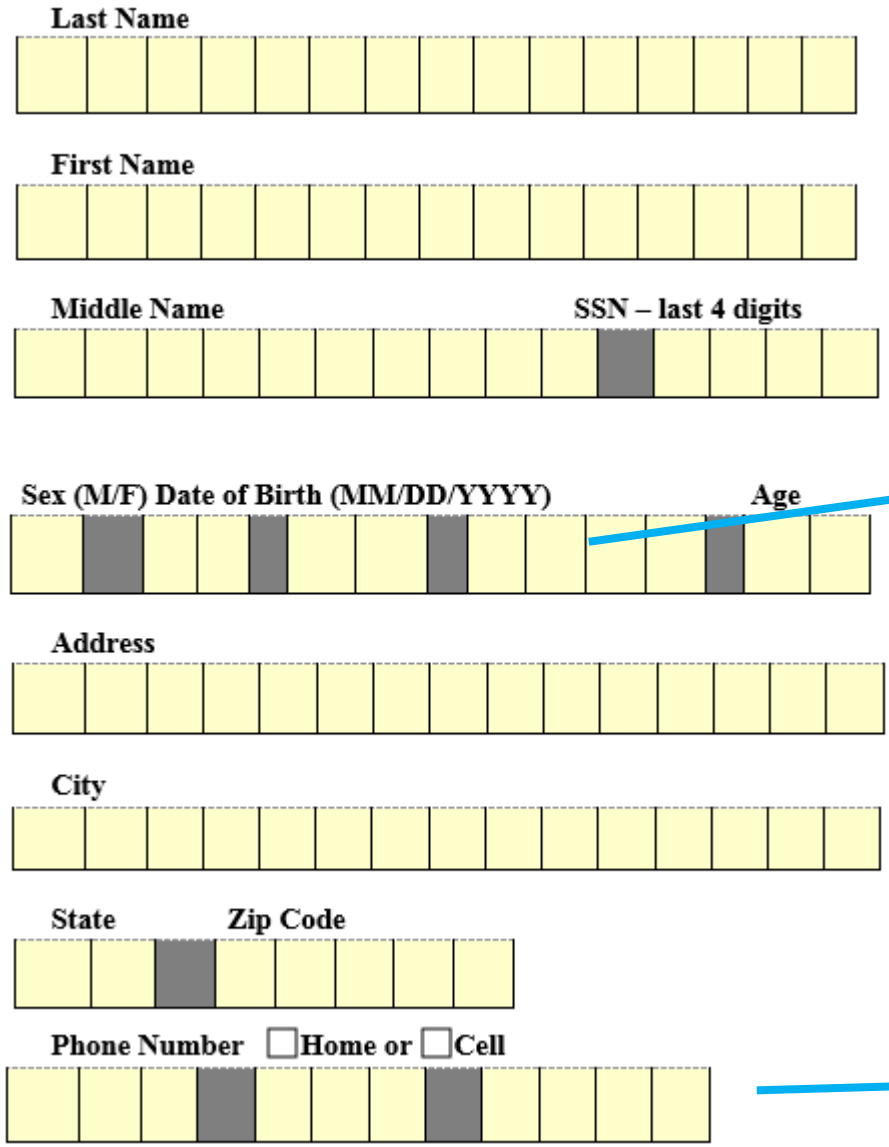
Indicate the Clinic Number in the top right corner of form:

- Clinic Number is listed on the Account Sheet
- Some clinics may have this pre-filled in

HennepinHealthcare MVNA	2018-2019 FLU VACCINE **Registration Form**	Clinic Number: _____ Employer/Name of Clinic Location:

Indicate the Employer/Name of Clinic Location in the top right corner of form:

- Name of client is listed on the Account Sheet
- Some clinics may have this pre-filled in
- Example: General Mills, Oak Creek Elementary School, Salem Covenant Church, etc



This info helps us confirm their ID!

Year must be 4 digits; Ex. 1975

If they have a home phone, that is our preference.

Complete this box if the patient is under 18 years of age:

Please provide parent/guarantor info below.

☐ Same as the Policy Holder (must fully complete Policy Holder box)

☐ Other: (If other, must complete information below)

Full Name:

Date of Birth:

Address:

Phone:

Relationship to patient:

Payment Options:

☐ **Bill Insurance**	☐ **Pay Cash or Check**	☐ **Bill Employer**	☐ **Grant Covered**
*Accurate & complete information below is required for successful billing	Discounted Cash prices: Quad: $38 High Dose: $65 FluMist: $43 Check #_____		*Any uninsured minors qualify *Adults may qualify at pre-arranged clinics

Hennepin Healthcare/MVNA can bill through any insurance. It is the individual's responsibility to check their coverage.

(#1) Primary Insurance Company Name

Primary Insurance ID#

Group #

(#2) Secondary Insurance Company Name

Secondary Insurance ID#

Group #

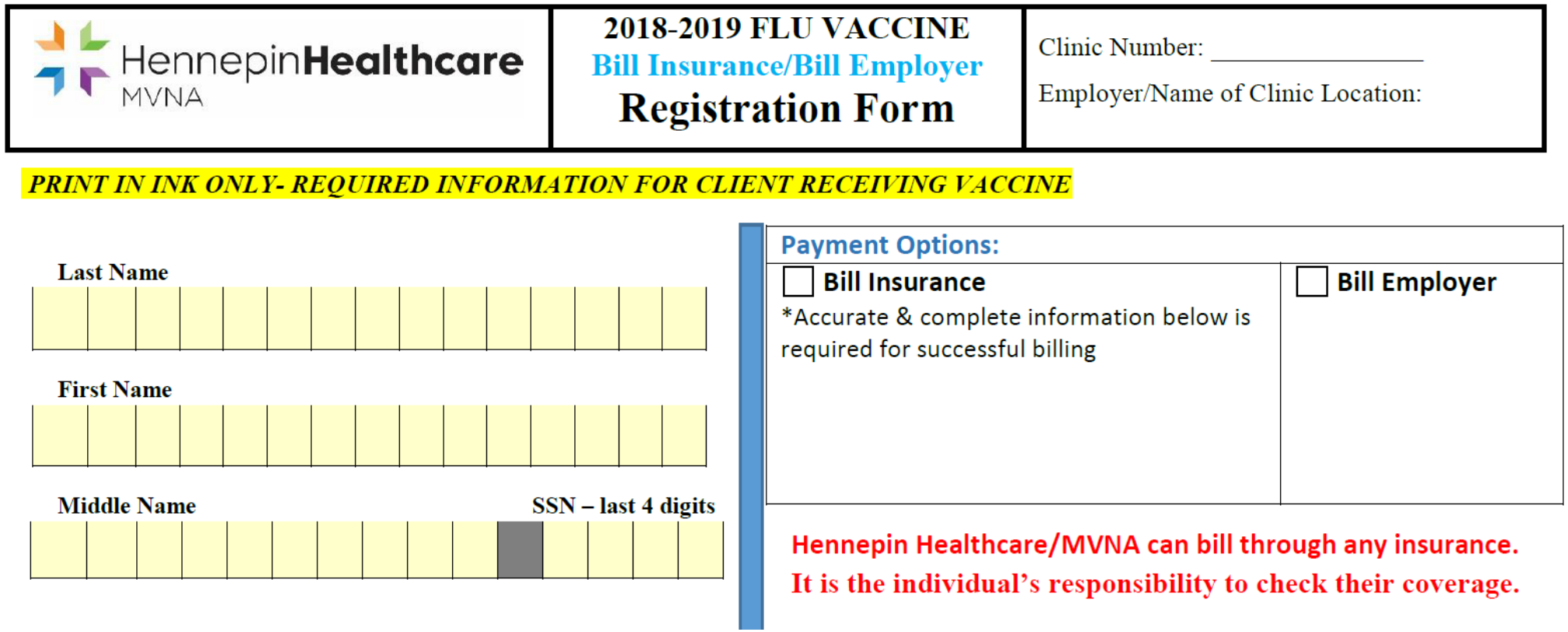
This section changes depending on the clinic's Billing Option

Important Reminder!

Bill Insurance/Bill Employer Registration Form:

Three Billing Options:

1) Bill Insurance/Bill Employer
2) Bill Insurance/Bill Individual
3) Bill Employer Only



HennepinHealthcare MVNA

2018-2019 FLU VACCINE
Bill Insurance/Bill Employer
Registration Form

Clinic Number: _____

Employer/Name of Clinic Location:

PRINT IN INK ONLY- REQUIRED INFORMATION FOR CLIENT RECEIVING VACCINE

Last Name

First Name

Middle Name **SSN – last 4 digits**

Payment Options:

☐ **Bill Insurance**
*Accurate & complete information below is required for successful billing

☐ **Bill Employer**

Hennepin Healthcare/MVNA can bill through any insurance. It is the individual's responsibility to check their coverage.

Bill Insurance/Bill Individual Registration Form:

Three Billing Options:

1) Bill Insurance/Bill Employer
2) Bill Insurance/Bill Individual
3) Bill Employer Only

HennepinHealthcare MVNA

2018-2019 FLU VACCINE
Bill Insurance/Bill Individual
Registration Form

Clinic Number: _____

Employer/Name of Clinic Location:

PRINT IN INK ONLY- REQUIRED INFORMATION FOR CLIENT RECEIVING VACCINE

Last Name

First Name

Middle Name **SSN – last 4 digits**

Payment Options:

☐ **Bill Insurance**	☐ **Pay Cash or Check**	☐ **Grant Covered**
*Accurate & complete information below is required for successful billing	Discounted Cash prices: Quad: $38 High Dose: $65 FluMist: $43 Check #_____	*Any uninsured minors qualify *Adults may qualify at pre-arranged clinics

Hennepin Healthcare/MVNA can bill through any insurance. It is the individual's responsibility to check their coverage.

MVNA

Bill Employer Only Registration Form:

Three Billing Options:

1) Bill Insurance/Bill Employer
2) Bill Insurance/Bill Individual
3) Bill Employer Only

HennepinHealthcare MVNA

2018-2019 FLU VACCINE
Bill Employer
Registration Form

Clinic Number: _____

Employer/Name of Clinic Location:

PRINT IN INK ONLY- REQUIRED INFORMATION FOR CLIENT RECEIVING VACCINE

Last Name

First Name

Middle Name **SSN – last 4 digits**

Payment Options:

☐ **Bill Employer**

MVNA

(#1) Primary Insurance Company Name

Primary Insurance ID#

Group #

(#2) Secondary Insurance Company Name

Secondary Insurance ID#

Group #

Policy Holder/Subscriber:

☐Self (skip section below) ☐Spouse ☐Parent ☐Other _____

Policy Holder Last Name

First Name

Policy Holder Date of Birth (MM/DD/YYY)

Daytime Phone Number ☐Same Phone as Patient

Policy Holder Address ☐Same Address as Patient

City State Zip Code

Grant Covered Flu Vaccinations

When does a patient qualify?

- Any child (18 or younger) who is uninsured
- Any child (18 or younger) who is covered by an MA plan
- Uninsured adults may qualify at specific, pre-arranged clinics. Check the clinic account sheet for any notes.

“Does my insurance cover the flu shot?”

“Is the flu shot free if I have insurance?”

“How do I know if you accept my insurance?”

- NEVER say the flu shot is free!

- Your response to questions about insurance coverage should always be: **“Hennepin Healthcare can bill any insurance provider for your vaccination, but it is the individuals’ responsibility to know if the flu shot is a covered benefit.”**

Hennepin Healthcare

The client MUST sign the Registration Form! Double Check every form.

Please complete the following questions **Attention:** If you answer yes to any of the questions, further assessment is needed by the nurse.	Form Reviewed by:
1. Does the person to be vaccinated have an egg allergy, latex allergy or serious medication allergy?	☐Yes ☐No
2. Has the person to be vaccinated ever had a serious reaction after receiving a vaccination?	☐Yes ☐No
3. Has the person to be vaccinated ever had Guillain-Barre Syndrome?	☐Yes ☐No
4. Has the person to be vaccinated already received the flu vaccine this flu season?	☐Yes ☐No
5. Is the person to be vaccinated presently ill with a fever, sore throat, or cough?	☐Yes ☐No
FLUMIST ONLY: Only answer #6-15 if you are interested in receiving the FluMist Nasal Spray	
6. Is the person to be vaccinated younger than 2 years old or 50 years of older?	☐Yes ☐No
7. Does the person to be vaccinated have any of the following: HIV, Cancer, organ or bone marrow transplant, rheumatoid arthritis, Chron's disease, multiple sclerosis, Lupus, psoriasis, or reduced immune activity?	☐Yes ☐No
8. Does the person to be vaccinated take any medication that affects the immune system such as prednisone, azathioprine (Imuran), cyclosporine, methotrexate, rituximab, Orencia, or Remicade?	☐Yes ☐No
9. Is the person to be vaccinated in close contact with anyone whose immune system is severely compromised?	☐Yes ☐No
10. Has the person to be vaccinated received any vaccinations in the past 4 weeks?	☐Yes ☐No
11. Does the person to be vaccinated have active, untreated TB?	☐Yes ☐No
12. Is the person to be vaccinated pregnant or you could become pregnant during the next month?	☐Yes ☐No
13. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder?	☐Yes ☐No
14. Is the Child between 2 and 4 years of age, and has been told they have wheezing or asthma in the past 12 months?	☐Yes ☐No
15. If under 18, does the person to be vaccinated receive aspirin therapy or aspirin-containing therapy?	☐Yes ☐No

PSC Initials after reviewing

I had an opportunity to review the CDC VIS for influenza vaccine and ask questions and received answers to my satisfaction. I understand the benefits and risks of the vaccination and expressly authorize a nurse to administer the vaccine to me. I hereby release Hennepin Health Systems (HHS) dba MVNA, its officers, employees, agents; and _____, (company name), its officers, employees, and agents from any and all liability that might arise from vaccination on behalf of me, my heirs and personal representatives. I acknowledge that a copy of HHS dba MVNA's Notice of Privacy Practices is available to me, which provides an explanation of the way in which my health information may be used or disclosed by HHS dba MVNA and of my rights with respect to my health information. I understand I am financially responsible to HHS dba MVNA for any balance not covered by my insurance company(ies) indicated above.

Relationship to Patient: ☐ Self OR **6 months – 17 years** ☐ Mother ☐ Father ☐ Other _____

Signature: _____ **Date:** _____

Print Name: _____

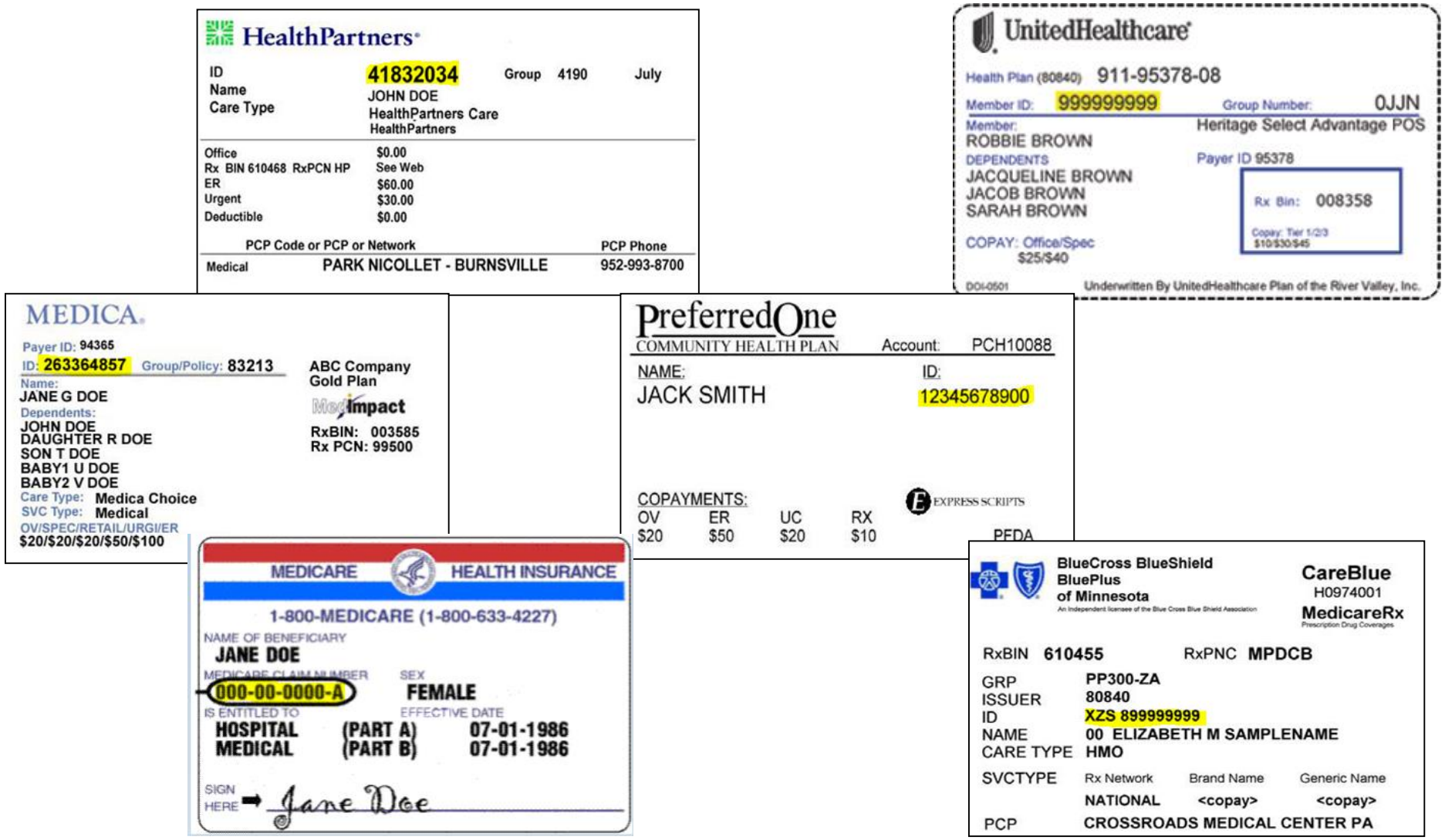
If not "self", I am the child's parent, authorized representative, or legal guardian and can provide effective consent for this immunization. If applicable, I authorize my child's school to designate a responsible adult to be present at the immunization and to provide direction or assistance if needed.

NURSE ONLY					
Manufacturer	**Dose**	**Age**	**Site**	**Lot Number (Sticker)**	**Expiration Date**
FluLaval/GSK **Quadrivalent**	☐ 0.5 ml	☐ 6 months & up	IM Deltoid: **L or R**		
Fluzone/Sanofi **Quadrivalent**	☐ 0.5 ml	☐ 3 years & up	IM Deltoid: **L or R**		
HighDose Fluzone/ Sanofi	☐ 0.5 ml	☐ 65 years & up	IM Deltoid: **L or R**		
FluMist/ Medimmune	☐ 0.2 ml	☐ 2 to 49 years	Nasal spray		

Vaccine Administrator Signature: _____

RN Name (Please Print): _____ Date: ___/___/2018

Vaccine Information Statement (VIS) offered to client: ☐ (RN to check box) VIS Edition: ___/___/___


HealthPartners
ID 41832034 Group 4190 July
Name JOHN DOE
Care Type HealthPartners Care
HealthPartners
Office $0.00
Rx BIN 610468 RxPCN HP See Web
ER $60.00
Urgent $30.00
Deductible $0.00
PCP Code or PCP or Network PCP Phone
Medical PARK NICOLLET - BURNSVILLE 952-993-8700
UnitedHealthcare
Health Plan (80840) 911-95378-08
Member ID: 999999999 Group Number: 0JJN
Member: ROBBIE BROWN
Heritage Select Advantage POS
DEPENDENTS
JACQUELINE BROWN
JACOB BROWN
SARAH BROWN
Payer ID 95378
Rx Bin: 008358
COPAY: Office/Spec $25/$40
Underwritten By UnitedHealthcare Plan of the River Valley, Inc.
MEDICA
Payer ID: 94365
ID: 263364857 Group/Policy: 83213
Name: JANE G DOE
Dependents:
JOHN DOE
DAUGHTER R DOE
SON T DOE
BABY1 U DOE
BABY2 V DOE
Care Type: Medica Choice
SVC Type: Medical
OV/SPEC/RETAIL/URGI/ER
$20/$20/$20/$50/$100
ABC Company
Gold Plan
RxBIN: 003585
Rx PCN: 99500
PreferredOne
COMMUNITY HEALTH PLAN
Account: PCH10088
NAME: JACK SMITH
ID: 12345678900
COPAYMENTS:
OV $20 ER $50 UC $20 RX $10
EXPRESS SCRIPTS
PFDA
MEDICARE HEALTH INSURANCE
1-800-MEDICARE (1-800-633-4227)
NAME OF BENEFICIARY
JANE DOE
SEX
FEMALE
000-00-0000-A
IS ENTITLED TO EFFECTIVE DATE
HOSPITAL (PART A) 07-01-1986
MEDICAL (PART B) 07-01-1986
SIGN HERE
Jane Doe
BlueCross BlueShield
BluePlus
of Minnesota
CareBlue
H0974001
MedicareRx
RxBIN 610455 RxPNC MPDCB
GRP PP300-ZA
ISSUER 80840
ID XZS 899999999
NAME 00 ELIZABETH M SAMPLENAME
CARE TYPE HMO
SVCTYPE Rx Network Brand Name Generic Name
NATIONAL <copay> <copay>
PCP CROSSROADS MEDICAL CENTER PA

Medicare

- Medicare card numbers are usually the participant's SS number with a letter at the end. There is always a letter at the end of the number.

- The card will identify if the participant has:
  - Part A
  - Part A and Part B

Part A provides coverage for hospitalization

Part B provides coverage for regular doctor visits, immunizations, etc.

- **Important:** If the participant does not have a card to present at the clinic and says he has part B coverage, we cannot collect for the vaccination. It is considered "fraud" if we collect payment from a person with Part B coverage. We don't want to be charged with Medicare fraud!

Why a photo ID for Insurance?

Red Flag Law: Enacted to prevent identification fraud

- Ask to see a picture ID (Drivers' License or Work ID Badge) and confirm it matches the Registration Form/Insurance Card

Hennepin Healthcare

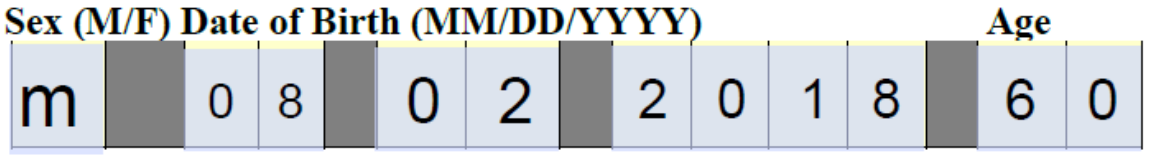
Competency Test:
Review of a Patient Registration Form

*Please find the 3 errors on Mickey Mouse's Registration Form

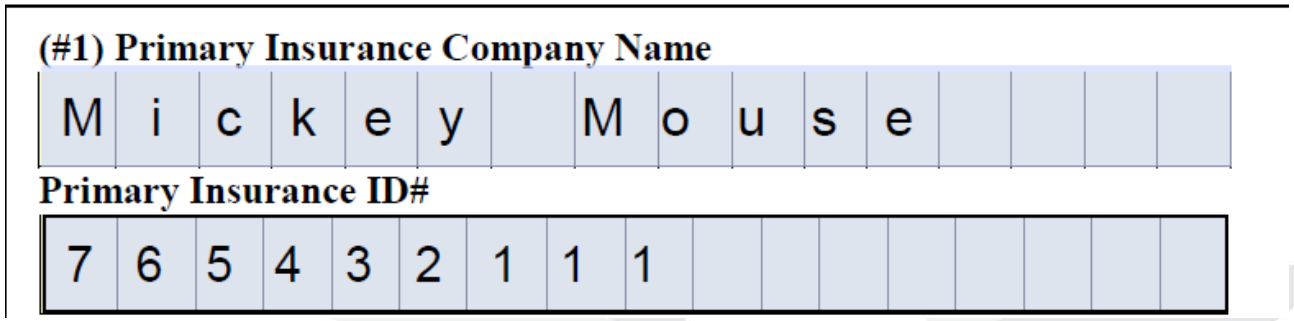
Hennepin Healthcare

Make corrections to the test, sign the bottom and turn in.

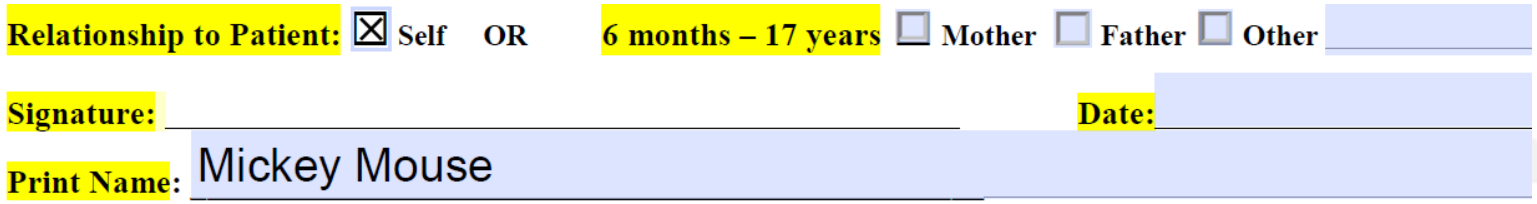
#1: Mickey wrote the current date



#2: Mickey wrote his name instead of the Insurance company name



#3: Mickey didn't sign or date the form



Hennepin Healthcare

OTHER FORMS & DOCUMENTS

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA Compliance includes:

- Medical history discussed between nurse & client.
- Completed consent forms kept out of view and are returned to MVNA as soon as possible.
- An obligation to protect the health information of those we serve.

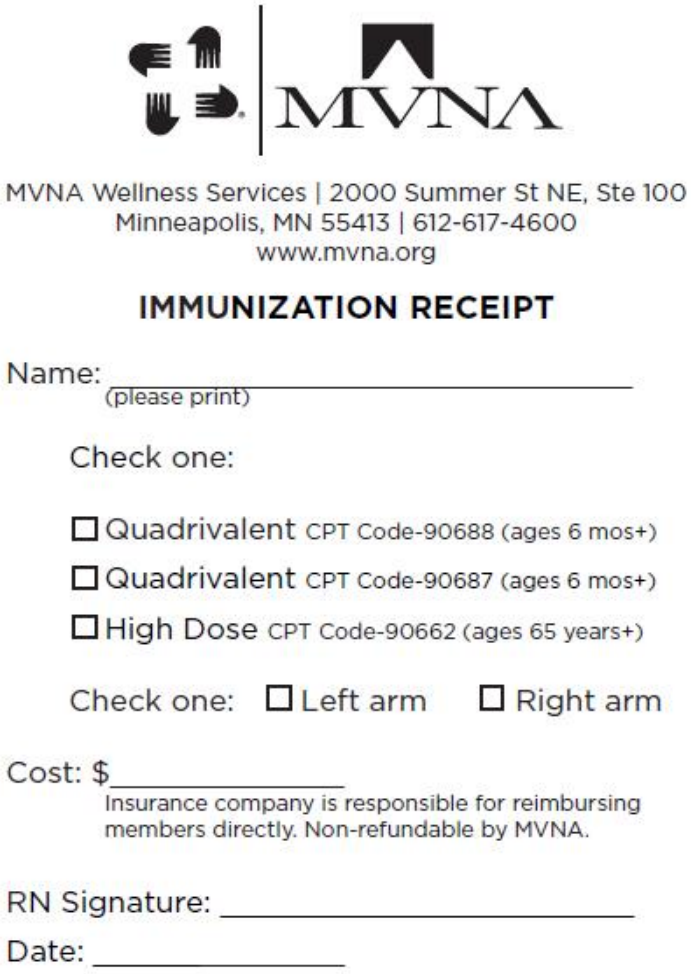
- MVNA distributes a Notice of Privacy Practices Form at clinics.

Release of Medical Records

- Completed Registration Forms are protective health information covered under HIPAA.
- The individual has rights to that information BUT they must release the information before we can share with any third party

Vaccine Receipt

- Some patients may request verification that they received a vaccination from MVNA
- Instruct them to ask the RN to complete a Vaccine Receipt



MVNA Wellness Services | 2000 Summer St NE, Ste 100
Minneapolis, MN 55413 | 612-617-4600
www.mvna.org

IMMUNIZATION RECEIPT

Name: _____
(please print)

Check one:

☐ Quadrivalent CPT Code-90688 (ages 6 mos+)
☐ Quadrivalent CPT Code-90687 (ages 6 mos+)
☐ High Dose CPT Code-90662 (ages 65 years+)

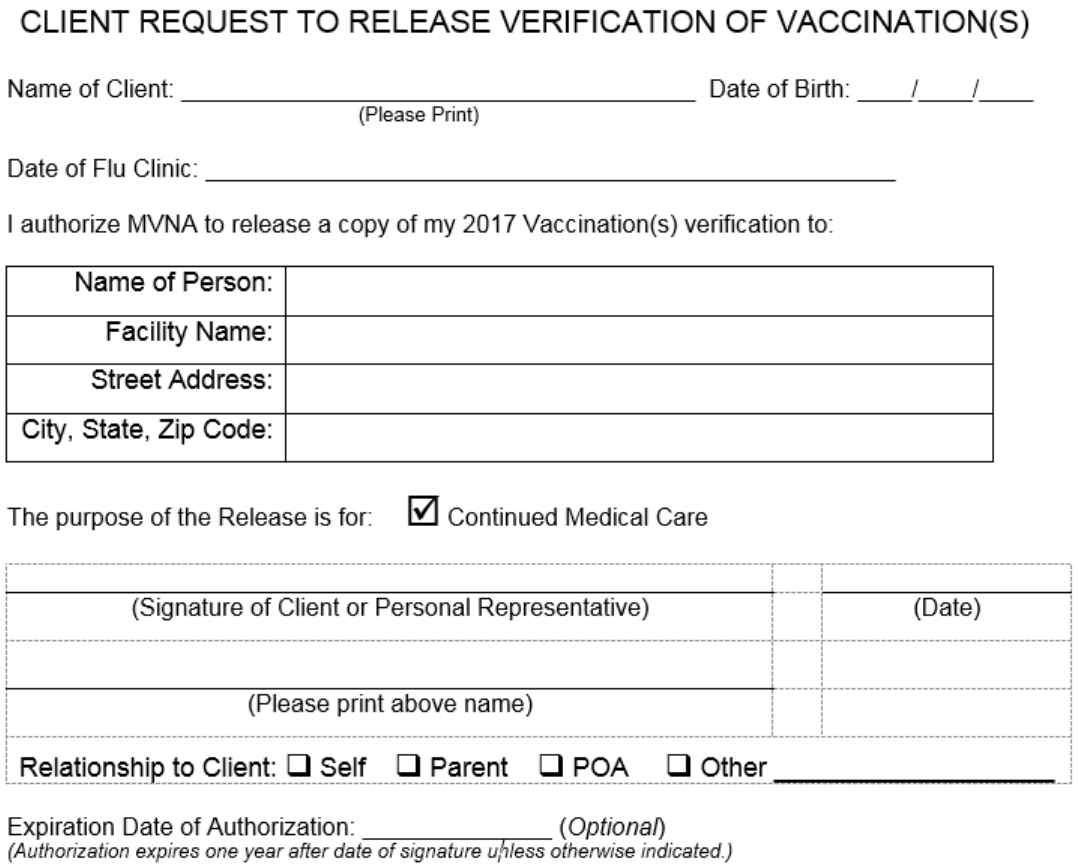
Check one: ☐ Left arm ☐ Right arm

Cost: $_____
Insurance company is responsible for reimbursing members directly. Non-refundable by MVNA.

RN Signature: _____

Date: _____

Long-Term Care Facilities



CLIENT REQUEST TO RELEASE VERIFICATION OF VACCINATION(S)

Name of Client: _____ Date of Birth: ____/____/____
(Please Print)

Date of Flu Clinic: _____

I authorize MVNA to release a copy of my 2017 Vaccination(s) verification to:

Name of Person:	
Facility Name:	
Street Address:	
City, State, Zip Code:	

The purpose of the Release is for: ☑ Continued Medical Care

(Signature of Client or Personal Representative)		(Date)
(Please print above name)		

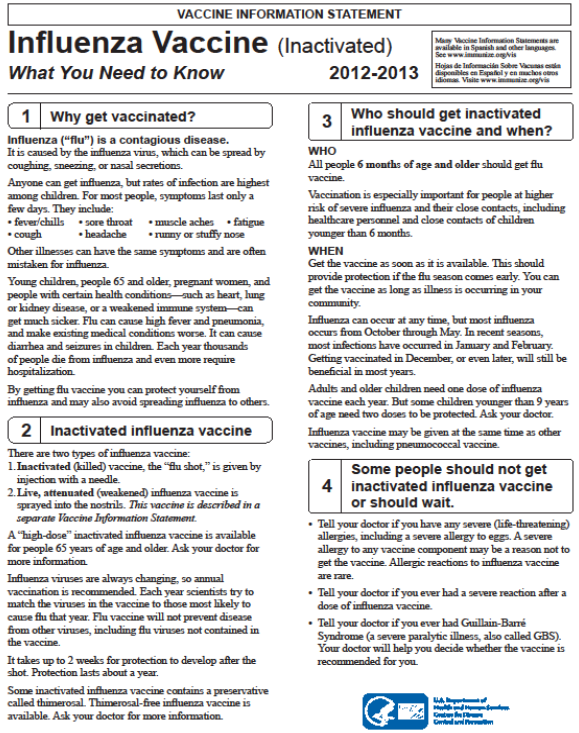
Relationship to Client: ❑ Self ❑ Parent ❑ POA ❑ Other _____

Expiration Date of Authorization: _____ (*Optional*)
(Authorization expires one year after date of signature unless otherwise indicated.)

- Facility will have received this form ahead of clinic
- Participants may bring this form to clinic, along with their registration form
- Must be fully completed for us to release information
- HHC Medical Records will send flu shot verification to the party that the info was released to
- Lead RN will turn in with the Registration Form Packet

Vaccine Information Statement (VIS)

- Vaccine Information Statements are information sheets produced by the Centers for Disease Control and Prevention (CDC).
- Federal law requires that a VIS be offered whenever vaccinations are given (before each dose).
- A VIS explains both the benefits and risks of a vaccine to adults and parents or legal representatives of children and adolescents.



VACCINE INFORMATION STATEMENT

Influenza Vaccine (Inactivated)

What You Need to Know **2012-2013**

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de Información Sobre Vacunas están disponibles en Español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Influenza ("flu") is a contagious disease.
It is caused by the influenza virus, which can be spread by coughing, sneezing, or nasal secretions.

Anyone can get influenza, but rates of infection are highest among children. For most people, symptoms last only a few days. They include:
• fever/chills • sore throat • muscle aches • fatigue
• cough • headache • runny or stuffy nose

Other illnesses can have the same symptoms and are often mistaken for influenza.

Young children, people 65 and older, pregnant women, and people with certain health conditions—such as heart, lung or kidney disease, or a weakened immune system—can get much sicker. Flu can cause high fever and pneumonia, and make existing medical conditions worse. It can cause diarrhea and seizures in children. Each year thousands of people die from influenza and even more require hospitalization.

By getting flu vaccine you can protect yourself from influenza and may also avoid spreading influenza to others.

2 Inactivated influenza vaccine

There are two types of influenza vaccine:
1. **Inactivated** (killed) vaccine, the "flu shot," is given by injection with a needle.
2. **Live, attenuated** (weakened) influenza vaccine is sprayed into the nostrils. *This vaccine is described in a separate Vaccine Information Statement.*

A "high-dose" inactivated influenza vaccine is available for people 65 years of age and older. Ask your doctor for more information.

Influenza viruses are always changing, so annual vaccination is recommended. Each year scientists try to match the viruses in the vaccine to those most likely to cause flu that year. Flu vaccine will not prevent disease from other viruses, including flu viruses not contained in the vaccine.

It takes up to 2 weeks for protection to develop after the shot. Protection lasts about a year.

Some inactivated influenza vaccine contains a preservative called thimerosal. Thimerosal-free influenza vaccine is available. Ask your doctor for more information.

3 Who should get inactivated influenza vaccine and when?

WHO
All people **6 months of age and older** should get flu vaccine.

Vaccination is especially important for people at higher risk of severe influenza and their close contacts, including healthcare personnel and close contacts of children younger than 6 months.

WHEN
Get the vaccine as soon as it is available. This should provide protection if the flu season comes early. You can get the vaccine as long as illness is occurring in your community.

Influenza can occur at any time, but most influenza occurs from October through May. In recent seasons, most infections have occurred in January and February. Getting vaccinated in December, or even later, will still be beneficial in most years.

Adults and older children need one dose of influenza vaccine each year. But some children younger than 9 years of age need two doses to be protected. Ask your doctor.

Influenza vaccine may be given at the same time as other vaccines, including pneumococcal vaccine.

4 Some people should not get inactivated influenza vaccine or should wait.

- Tell your doctor if you have any severe (life-threatening) allergies, including a severe allergy to eggs. A severe allergy to any vaccine component may be a reason not to get the vaccine. Allergic reactions to influenza vaccine are rare.
- Tell your doctor if you ever had a severe reaction after a dose of influenza vaccine.
- Tell your doctor if you ever had Guillain-Barré Syndrome (a severe paralytic illness, also called GBS). Your doctor will help you decide whether the vaccine is recommended for you.

Hennepin Healthcare

2018 FLU VACCINES

Vaccination Choices

- **Quadrivalent**
  - **Covers 4 strains**
  - **Two manufacturers: some is for 6 months and up, some is for 3 years and up**
    - **Ask your lead RN which is at your clinic!**

- **High Dose**
  - **For ages 65 years & older.**
  - **Covers 3 strains**
  - **4 times the protection**
  - **Manufacturer is Fluzone/Sanofi**

- **FluMist WILL be offered again in 2018!**
  - **For ages 2-49 years**
  - **Covers 4 strains**
  - **Nasal Spray**

Flu Vaccine Strains

The World Health Organization (WHO) recommends the following strains for the Quadrivalent vaccine flu season, based on its advisory group's in-depth analysis of the most recent circulating strains and patterns.

❖ The 2017-2018 Quadrivalent Vaccine Strains:

- A/Michigan/45/2015 (H1N1)pdm09-like virus
- **A/Singapore/INFIMH-16-0019/2016 (H3N2)-like virus***
- **B/Colorado/06/2017-like virus (B/Victoria/2/87 lineage)*; and**
- B/Phuket/3073/2013-like virus (B/Yamagata/16/88 lineage)

****Indicates a strain change***

High Dose Flu Vaccine ONLY
65 years of age and older

Clients age 65 and over have the option to receive Fluzone High-Dose which contains 4 times the antigen of the standard dose vaccine which has been shown to elicit a better immune response.

High Dose is **Trivalent** vaccine and covers 3 of the same strains as the quadrivalent :

- A/Michigan/45/2015(H1N1)pdm09-like virus;
- A/Singapore/INFIMH-16-0019/2016(H3N2)-like virus
- B/Colorado/60/2017-like virus(B/Victoria/2/87 lineage)

It is **Trivalent** because A strains are almost always the cause of serious illness in older adults (pneumonia) etc.

Common Question

As a PSC, a patient asks you the following question. What is the BEST answer.

What is the difference between a shot and the FluMist? Your answer should be:

a. There is no difference, they both protect against 4 strains of the flu virus

b. I don’t know

c. That’s a really good question. Go ahead and fill out your registration form, and then ask the nurse. She will be able to answer your questions.

d. I really wouldn’t get the FluMist. Shots are better.

Common Question

As a PSC, a patient asks you the following question. What is the BEST answer.

What is the difference between a shot and the FluMist? Your answer should be:

a. There is no difference, they both protect against 4 strains of the flu virus

b. I don't know

c. That's a really good question. Go ahead and fill out your registration form, and then ask the nurse. She will be able to answer your questions.

d. I really wouldn't get the FluMist. Shots are better.

PSC's should never answer medical questions. Always refer them to the nurse! We never make recommendations on which type of vaccinations someone should get!

Hennepin Employee Flu Vaccination

Every employee of Hennepin Healthcare Employee is required to either get a flu vaccination or fill out a declination form online with the reason they do not wish to receive one.

To get a flu vaccination:

As an employee, you can choose injectable, mist or HD if you qualify.

You can get a vaccination from an nurse at any clinic that you work.

Be sure to use the form in your folder for you vaccination. If you don't it will not be recorded with Hennepin and you will be non compliant.

Vaccinations are no cost to you and we do not need your insurance

If you are going to decline a vaccination:

Later this fall information a link to the declination form will be sent out for you to complete.

Hennepin Healthcare

Roles and Responsibilities

PSC Responsibilities Prior to Clinic:

- ✓ The Account Sheet will be emailed to you 1 week before clinic. Read over the account sheet for any special instructions.
- ✓ Lead RN will bring all supplies to the clinic
- ✓ Lead RN will call PSCs at least 2-4 days before each clinic
  - ✓ PSCs are required to connect with the lead RN before each clinic – if you miss their call, call back!
  - ✓ Report to Nan Lomen or Danielle Rice if you haven't heard from your lead RN at least 24 hours before you clinic.
- ✓ Review the following with the lead RN:
  - Date and time of event
  - Clinic address/location within the building
  - Where to park (when applicable)
  - Billing Option.
  - Review vaccines to be included in clinic and the quantities.

Responsibilities of Patient Services Coordinators (PSCs) During the Clinic:

- ✓ Responsibilities during clinic:
  - ✓ Arrive 15 minutes before clinic start time
  - ✓ Set up the registration table with pens, registration forms, VIS and HIPAA sheets.
  - ✓ Greet each participant and assist them with completion of the registration form as needed.
  - ✓ Help manage the flow of the line/participants, keeping track of who is next in line and keeping the pace moving.
  - ✓ Have fun, be friendly and helpful. Help make it a great experience for each person.
  - ✓ Encourage participation

- ✓ If clinic is slow, talk to the on-site coordinator and ask for their help to announce there is no waiting, etc.

- ✓ If the clinic is slow, lead RN may discharge some staff early.

- ✓ Responsibilities after clinic:
  - You are not expected to stay and help clean up after the clinic end time, because we can not pay for this extra time.

Summary of Job Expectations

Nurses and PSC's

I understand that this job requires me to:

1. Be available at least 15 hours a week, **Monday through Friday** during the hours of 6:00 am and 8:00 pm in 5 hour blocks for the months of **September and October.**
2. Be on time to every clinic. If I am late to a clinic more than one time I am subject to discipline and/or termination.
3. Have a reliable car and current auto insurance
4. Adhere to the dress code as outlined in training when working at clinics and coming to MVNA or Hennepin Healthcare for training or work
5. Complete all training on time
6. Keep current with all required licensing
7. Have computer access for providing availability and receiving work assignments
8. Regularly monitor email for communications from Hennepin Healthcare
9. Have availability by phone & voicemail set up to receive messages
10. Not use my cell phone for personal calls/texting during clinics.

Nurses ONLY

1. Have an Hennepin Healthcare issued compact refrigerator in my home for vaccine storage
2. Willing to work Lead at clinics.
3. Reconcile clinics online within 24 hours of clinic end.

I understand that having a Seasonal Causal position with Worksite Wellness does not guarantee me a job at HCMC.

_____ Date:_____

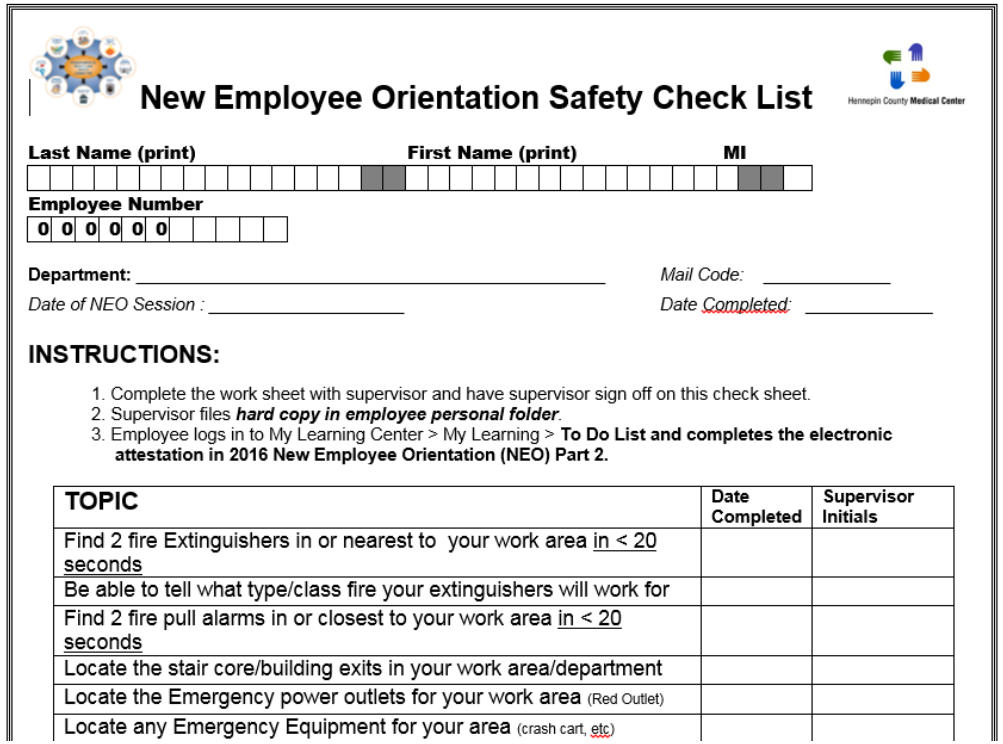
Signature

_____

Print Signature

Job Expectations

Safety Checklist



New Employee Orientation Safety Check List

Hennepin County Medical Center

Last Name (print) **First Name (print)** **MI**

Employee Number

0 0 0 0 0 0

Department: _____ *Mail Code:* _____

Date of NEO Session : _____ *Date Completed:* _____

INSTRUCTIONS:

1. Complete the work sheet with supervisor and have supervisor sign off on this check sheet.
2. Supervisor files ***hard copy in employee personal folder***.
3. Employee logs in to My Learning Center > My Learning > **To Do List and completes the electronic attestation in 2016 New Employee Orientation (NEO) Part 2.**

TOPIC	Date Completed	Supervisor Initials
Find 2 fire Extinguishers in or nearest to your work area in < 20 seconds		
Be able to tell what type/class fire your extinguishers will work for		
Find 2 fire pull alarms in or closest to your work area in < 20 seconds		
Locate the stair core/building exits in your work area/department		
Locate the Emergency power outlets for your work area (Red Outlet)		
Locate any Emergency Equipment for your area (crash cart, etc)		

- Must be turned in today!
- Don't forget your name!

Safety Checklist

Fill in your name, date and People Soft Number

1. The word that will help you remember what to do in the event of a fire is: R.A.C.E
    1. Rescue
    2. Alert
    3. Contain
    4. Extinguish

2. The word that will help you remember hot to use a fire extinguisher is: P.A.S.S.
    1. Pull
    2. Aim
    3. Squeeze
    4. Sweep

3. Sign and date the on the back side

Questions?

Do not leave today without turning in:

1. Timesheet
2. Safety Checklist
3. Competency Test
4. Employee Expectation Sheet

Also be sure to check out a vest before you leave!

Feel free to spend as much time as you would like at the sample registration table.