Pamir Healthcare Services LLC

The New Era Of Healthcare

Application for employees

Personal Information

Date: _____

PLEASE PRINT OR USE ALL CAPITAL LETTERS IN WRITING YOUR NAME AND ADDRESS

Last Name: _____ First Name: _____ MI: ____

Date of Birth: _____ Email address: _____

Social Security Number: _____ EIN: _____ { } Male { } Female

Street Address: _____ City: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Name: _____ Phone number: _____

EMPLOYMENT INFORMATION Date available for work: _____

Certification: (Check all applicable): [ ]Nurse [ ]CAN/HHA [ ]PCA [ ]MedTech [ ]OTHER: _____

Shift Desired: (Check all applicable): [ ]Part Time [ ]Full Time [ ]Day Shift [ ]Night Shift

Days of Availability: [ ]All [ ]Mon [ ]Tues [ ]Wed [ ]Thurs [ ]Fri [ ]Sat [ ]Sun Hours: _____

Do you possess a valid Driver's License? [ ]YES [ ]NO

Do you have your own transportation? [ ]YES [ ]NO

Have you applied at **Pamir Healthcare** before? [ ]YES [ ]NO If so, When: _____

How were you referred to us? _____

Name of Person Who Referred: _____ Contact Number: _____

Can you perform all the job-related functions of the position(s) you are applying for? [ ]YES [ ]NO

If no, please explain: _____

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Education

School Name Location Dates(s) Attended Graduated Yes/No Area of Study

_____

_____

_____

_____

Certification(s): _____ State: _____

Do you have documentation of this certification: [ ]YES [ ]NO

If not, please explain: _____

_____

Work Experience – provide information about your employment for the past 5 years. Start with the most recent experience

Dates	*Company*	*Address*	*Job Title/Description*	*Salary*	*Reason for Leaving*

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Do you have a Background Check: [ ]YES [ ]NO

Have you ever been charged or convicted of abuse, neglect, assault, exploitation, deprivation or injury of any person - [ ]YES [ ]NO If "YES", please explain:

_____

_____

Have you been screened for TB? [ ]YES [ ]NO When: _____

Have you been exposed to TB or Hepatitis? [ ]YES [ ]NO Please explain:_____

_____

I understand that the clients I will be working with are clients of Pamir Healthcare. I also understand that if my employment with Pamir Healthcare ends for any reason, I cannot work with that client or their family for at least one year, either independently or through another agency. I acknowledge that violating this policy may result in legal action by Pamir Healthcare. I understand that this is an employee position, and I will be classified as a W-2 employee. Pamir Healthcare will handle all required tax withholdings and reporting in accordance with federal and state regulations. I certify that the answers provided herein are true and complete to the best of my knowledge

_____ _____

Signature of Applicant *Date*

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Caregiver Skill Assessment Form

Name: _____

Directions: for each task listed, please answer the two questions listed. Competence means "The ability to perform the procedures safely, correctly, effectively and professionally." Scale: 1-4, Where 1 means the least competency; and 4 means the highest competency.

Task		Have you ever done this before?		Are you competent performing? Please circle the number				Comments
ACTIVITIES OF DAILY LIVING	Bathing	Yes	No	1	2	3	4	
	Personal Hygiene (i.e. Hair, oral, nail and skin care)	Yes	No	1	2	3	4	
	Toileting (i.e. bladder, bowel, bed pan, routines, e.t.c.)	Yes	No	1	2	3	4	
	Dressing & Changing Clothes	Yes	No	1	2	3	4	
	Mobility & Transfers	Yes	No	1	2	3	4	
	Eating & Drinking	Yes	No	1	2	3	4	
INSTRUMENTAL ACTIVITIES	Meal Preparation	Yes	No	1	2	3	4	
	Light Housekeeping	Yes	No	1	2	3	4	
	Grocery Shopping	Yes	No	1	2	3	4	
	Transportation/Traveling in the Community	Yes	No	1	2	3	4	
	Laundry	Yes	No	1	2	3	4	
	Handling Money	Yes	No	1	2	3	4	
	Using the Telephone	Yes	No	1	2	3	4	
	Reading of Specific Items	Yes	No	1	2	3	4	
	Wash Equipment	Yes	No	1	2	3	4	
	Other	Yes	No	1	2	3	4	

Signature: _____ Date: _____

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Reference Check

Please provide three job/professional references including their daytime phone number

Applicant Name: _____

Applicant Home Phone #: _____ Applicant Cell Phone #: _____

1. First Reference Name: _____ Title: _____
   Company Name: _____ Telephone #: _____

   For Office Use Only – Do Not Write In This Space
   Date Contacted: _____ Staff Responsible: _____
   Comments: _____

2. Second Reference Name: _____ Title: _____
   Company Name: _____ Telephone #: _____

   For Office Use Only – Do Not Write In This Space
   Date Contacted: _____ Staff Responsible: _____
   Comments: _____

3. Third Reference Name: _____ Title: _____
   Company Name: _____ Telephone #: _____

   For Office Use Only – Do Not Write In This Space
   Date Contacted: _____ Staff Responsible: _____
   Comments: _____

Applicant Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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Verification of Previous Employment

To Be Completed By The Applicant

I hereby authorize Pamir Healthcare to contact all past employers and other individuals, agencies or entities concerning the information I have supplied and waive, release and hold harmless such individuals, agencies or entities from any claims arising from the information they may provide to Pamir Healthcare.

Applicant's Name: _____

Name of Prior Employer/Company: _____

Address: _____

Phone #: _____ Fax #: _____

Employed From: _____ To: _____

Position with Company: _____

Signature: _____ Date: _____

STOP – FOR OFFICE USE ONLY – PLEASE DO NOT WRITE BELOW THIS LINE

The above applicant has applied for employment/contract with us. Your evaluation will be greatly appreciated.

PHS Signature: _____ Date: _____

TO BE COMPLETED BY FORMER/CURRENT EMPLOYER

Position Held: _____

Employment Dates: From: _____ To: _____

Days Worked: _____ Hours Worked: _____

Reason for Leaving: _____

_____

_____

Your Name: _____ Employer: _____ Title: _____

Signature: _____ Date: _____

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SWORN DISCLOSURE STATEMENT

I understand that the clients I will be working with are clients of Pamir Healthcare. I also understand that if my employment with Pamir Healthcare ends for any reason, I cannot work with that client or their family for at least one year, either independently or through another agency. I acknowledge that violating this policy may result in legal action by Pamir Healthcare which may lead to a fine up to five thousand dollars including all legal fees that may be involved. I understand that this is an employee position, and I will be classified as a W-2 employee. Pamir Healthcare will handle all required tax withholdings and reporting in accordance with federal and state regulations. Alongside this, I will also not be able to disclose my wages or compensation. Knowing this information, I understand that Failure to comply with this sworn disclosure statement will lead to the termination of my employment and that I will no longer be able to work with Pamir Healthcare services. Lastly, I certify that the answers provided herein are true and complete to the best of my knowledge and no critical information was omitted with malicious intent.

Failure to comply with this sworn disclosure statement will lead to a fine up to five thousand dollars including all legal fees that may be involved.

1. _____

Last Name First Middle Maiden Social Security Number

_____

Street/P.O. Box City State Zip Code

2. Have you ever been convicted of a law violation(s) but excluding offenses committed before your eighteenth birthday that were finally adjudicated in a Juvenile court or under a youth offender law?
[ ]YES [ ]NO If YES, list all then explain. _____

_____

_____

_____

_____

_____

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Application for employees

3. Are you the subject of any pending criminal charges? [ ]YES [ ]NO

   If yes, list all and explain. _____

   _____

   _____

   _____

   _____

   _____

4. Conformation: I affirm that the information provided in this application is true and complete to the best of my knowledge. I understand that any falsification, misrepresentation, or omission may result in disqualification from employment or termination of employment with Pamir Healthcare Services LLC. I understand that all information provided is subject to verification.

Applicant's Signature: _____ Date: _____

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Application for employees

Orientation Documentation

Name: _____

Date: _____

	Initials
1. Objectives and philosophy of the Organization	_____
2. Confidentiality	_____
3. Client Rights	_____
4. Mandated reporting of abuse, neglect and exploitation	_____
5. Applicable personnel policies	_____
6. Emergency preparedness procedures	_____
7. Infection control practices and measures	_____
8. Cultural awareness	_____
9. Applicable laws, regulations and other policies and procedures that Apply to specific positions, specific duties and responsibilities	_____

Applicant signature : _____

PHS Staff signature: _____

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CAREGIVER JOB DESCRIPTION

- Provide personal care service to the client for which the client needs physical assistance. Some examples of personal care are listed below:
  - Ambulation – physically assisting a patient who otherwise would be unable to move about independently
  - Personal hygiene –which includes bathing the patient
  - Dressing – physically applying a patients clothing to the patient's body
  - Toileting – assisting a patient to go to and from toileting facilities and in the activities of toileting.
  - Eating – includes hand feeding a patient who is incapable of self – feeding
- Provide competent, sate of the art care to its patients.
- Follow the Caregiver Service Plan (CSP) to perform the tasks agreed upon.
- For security reasons, the caregiver should not disclose or knowingly permit the disclosure of any information in a client record except to appropriate provider staff, the Client, responsible party (if applicable), the client's physician or other healthcare provider, the regulatory department, other individuals authorized by the client in writing or by subpoena.
- In case of an emergency at the client's home, the caregiver must immediately contact the Client's emergency contact name (as stated in the client's file), and notify the Pamir Healthcare office.
- The caregiver must notify Pamir Healthcare office and the Client's responsible party of any changes in the Client's condition.
- The caregiver is encouraged to report to the office any changes that may improve the quality of care a patient is receiving.
- Reports to Administrator.

Signature: _____ Date: _____

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Application for employees

Confidentiality/HIPAA Agreement

This Confidentiality/HIPAA Agreement between Pamir Healthcare (hereinafter "Company") and, _____ (hereinafter employees) is effective as of _____.

Confidentiality/Application of HIPAA

Pamir Healthcare Services LLC – The New Era of Healthcare

HIPAA, Privacy & Social Media Confidentiality Statement for Home Care Employees

As an employee of Pamir Healthcare Services LLC, I understand that I may have access to protected health information (PHI) and personal client information, including details related to a client's identity, living situation, daily routines, care needs, and other sensitive information. I agree to maintain the confidentiality of all company and client information alongside their affairs. Lastly, I acknowledge that all such information is protected under federal privacy regulations, including 45 CFR §160.103, 45 CFR §164.502(a), and 45 CFR §164.530(c).

Employee Responsibilities

I agree that:

I will only access or use client information as required to perform my job duties.

I will not share, discuss, or disclose any client information with anyone who is not authorized by Pamir Healthcare Services LLC.

I will protect all verbal, written, and electronic information from unauthorized access or viewing.

Photos, Videos, and Social Media Use

I understand and agree that:

I am strictly prohibited from taking photos, videos, or recordings of any client, their home, their family, or their personal belongings for unprofessional purposes.

I will not post, upload, share, or reference any client information, images, or experiences on social media, including Facebook, Instagram, TikTok, Snapchat, WhatsApp, or any other platform.

I will not use my phone or any device to capture or store client information.

I will immediately report any accidental photo, recording, or privacy concern to my supervisor.

Penalties for Violations

I acknowledge that unauthorized use or disclosure of client information—including photos or social media activity—may result in disciplinary action, termination of employment, civil penalties, and legal consequences under 45 CFR §164.530(e).

Applicants signature:

By: _____ Date: _____

Pamir Healthcare Services

By: _____ Date: _____

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PRE-EMPLOYMENT BACKGROUND CHECK AUTHORIZATION

I, _____, understand that as part of the employment process, **Pamir Healthcare** needs to complete a background check on me regarding:

1. Criminal record;
2. Sex and violent offenders Record;
3. Employment Verification
4. Education Verification;
5. License Verification
6. Motor Vehicle Records;
7. Personal Professional Reference Verification;
8. Medical Suitability
9. Drugs/Alcohol

I authorize all federal and state agencies, persons and organizations that may have information relevant to this research to disclose such information to **Pamir Healthcare** or its authorized agent(s).

I understand that this authorization is to be part of the written and signed employment application.

I also understand that I do not have to give authorization for a background check but if I don't give permission my employment application will not be processed further.

I understand that I have specific rights under the federal Fair Credit Reporting Act (FCRA) and may have additional rights under relevant state law.

I further authorized that a photocopy of this authorization may be considered as valid as the original

I hereby certify that all statements on this form are true and correct to the best of my knowledge and belief. I understand that employment **Pamir Healthcare** is contingent upon successful completion of a background check.

_____ _____

Signature Date

Full Name: _____ Telephone No.: _____

Former/Maiden Name: _____

Current Address: _____

Date of Birth: _____ Social Security Number: _____

Current Driver's License Number: _____ State: _____

_____ Deduct $15 from my payroll check to cover the criminal background check.

Initial

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Employer and Employee Agreement

Employer: _____

Business Name: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Applicant:

Last Name: _____ First Name: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

The parties agree as follows:

Duration of Employment

This agreement shall remain active unless either party amicably decides otherwise. However, the term of employment is conditional upon the employee obtaining a valid work permit pursuant to the applicable immigration regulations.

2. Job Description

The employee agrees to carry out the tasks outlined in his/her job title and job description.

The employee shall be compensated at a rate of $_____ per week or $_____ per hour. Compensation shall be paid at agreed-upon intervals.

The employer is responsible for income tax withholding, Social Security and Medicare taxes, or Federal Unemployment Tax Act (FUTA) taxes.

The employer is responsible for depositing income tax withheld or the employer's and employee's Social Security and Medicare taxes.

3. Notice of Resignation

Should the employee wish to terminate this agreement, the employee agrees to provide the employer with at least two (2) weeks' written notice.

4. Notice of Termination of Employment

The employer may terminate the employee's employment without advance notice or severance pay if the employee has violated the terms of this or any other agreement, has been negligent, or has acted in a manner that could have caused harm to a client.

5. Non-Solicitation of Clients

The employee agrees not to solicit or independently accept any clients of the employer during employment with the employer and for a period of one (1) year following termination of employment with the employer.

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IN WITNESS WHERE OF the parties state that they have read, understand and accept all the terms and conditions stipulated in the present agreement

Signature of Employee _____ Date _____

Signature of Employer _____ Date _____

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Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2026

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . **3** $

Step 4: Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

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DIRECT DEPOSIT AUTHORIZATION

LAST NAME _____
FIRST NAME _____
MIDDLE INITIAL _____

BANK NAME AND BRANCH _____

BANK ROUTING NUMBER _____

BANK ACCOUNT NUMBER _____

I hereby request the deposit of my entire paycheck into the above named account on every pay period.

THIS ACCOUNT IS A:
_____ CHECKING ACCOUNT

_____ SAVINGS ACCOUNT

NOTE: Please attach a deposit slip or canceled check to this form to expedite this process.

_____ _____
Employee Signature Date

Direct Deposit will go into effect with the 2nd payroll cycle after submission of this form.

Deductions:_____

_____

_____

Please note that your paychecks are subject to deductions based on certain factors that you will be informed of