ADORERS OF THE BLOOD OF CHRIST
UNITED STATES REGION
ABSENCE REPORT

(FOR EXEMPT/SALARIED CO-WORKERS ONLY: Show all absences away from usual work location)

(Please attach approved Leave Request and/or supporting documentation for any absences for these two weeks)

NAME OF CO-WORKER: **PAY PERIOD ENDING:**

OFFICE/CENTER: **DEPARTMENT:**

Absence from regular office schedule for following reasons (enter # of hours):

WEEK DATES	PTO	EIB	HOL	FMLA	JURY	BRVM*	E/PD**	OTHER***	UNPAID****	TOTALS
TOTALS										

Absence from regular office schedule for following reasons (enter # of hours):

WEEK DATES	PTO	EIB	HOL	FMLA	JURY	BRVM*	E/PD**	OTHER***	UNPAID****	TOTALS
TOTALS										

***TOTAL ABSENCE*:** _____

***TOTAL PAID TIME*:** _____

CO-WORKER'S SIGNATURE: **DATE:**

SUPERVISOR/ADMINISTRATOR'S APPROVAL: **DATE:**

LEGEND: *BRVM = Bereavement
**E/PD = Educational/Professional Development
***Other/Paid = Identify
****Unpaid = Unpaid Absence

HR6-9/00, rev. 08/07/06

ADORERS OF THE BLOOD OF CHRIST
UNITED STATES REGION

ACKNOWLEDGEMENT OF RECEIPT OF HUMAN RESOURCES POLICIES MANUAL

I acknowledge receipt of the current Human Resources Policies Manual, on ASC website.

Name of Co-Worker (*please print*)

Signature of Co-Worker

Date

ADORERS OF THE BLOOD OF CHRIST
UNITED STATES REGION

COMPLAINT, CONCERN OR APPEAL FORM

CO-WORKER: **DATE:**

JOB TITLE: **OFFICE/CENTER:**

On **the following occurred:**
(mo/day/year) **(Description of complaint, concern or appeal)**

On **I discussed this with**
(mo/day/year) **(insert name of supervisor or other person)**

in the presence of:
(insert name of observer or witness, if applicable)

The following was the decision/outcome of that discussion:

I request that this decision/outcome be re-evaluated and re-considered, because of the following:

☐ **Please see attached pertinent documents.**

Signature of Co-Worker: **Date:**

Received by: **Date:**

Cc: Director of Human Resources

ADORERS OF THE BLOOD OF CHRIST
UNITED STATES REGION

CONFIDENTIALITY AGREEMENT

The Adorers are committed to ensuring the protection of Sisters' and co-workers' information, except on a "need to know" basis to external and/or internal agencies.

Any information learned on the job concerning the business and private matters of the Adorers of the Blood of Christ, including data about the Sisters, their families, co-workers, business associates, volunteers or benefactors is confidential and restricted. Private information, including telephone numbers and addresses of the Sisters or co-workers, is not to be distributed to anyone unless instructed to do so by the Head of a Region Office/Center Administrator or the Director of Human Resources.

Confidential and restricted information will be identified or clarified by the supervisor.

Confidential and restricted information cannot be revealed to any internal agents, except under the direction of the supervisor or with his/her approval.

Consultations amongst co-workers directly related to services to the Sisters will occur only as required and with those co-workers who have a "need to know." Consultations amongst supervisory, managerial, administrative, and Region Leadership personnel related to co-worker issues will occur only as required and with those personnel who have a "need to know."

Any request for information from external agencies regarding current or former co-workers of the Adorers of the Blood of Christ should be directed to the Head of a Region Office/Center Administrator or the Director of Human Resources.

Breach of confidentiality will result in implementation of the ***COACHING AND CORRECTIVE ACTION*** policy up to and including termination, and may subject a co-worker to legal action.

I have read and understand the information above, and will comply with the Adorers' Confidentiality Agreement.

Printed Name of Co-Worker: _____

Signature of Co-Worker: _____ **Date:** _____

HR23-10/05, rev. 05/06

ADORERS OF THE BLOOD OF CHRIST
UNITED STATES REGION

DEDUCTION CHANGE FORM

TO PAYROLL OFFICE:

Please make the following payroll deduction changes, effective pay period ending: _____

On behalf of: _____

Federal Tax Withholding: _____

Extra Federal Tax Withholding: _____

State Tax Withholding: _____

Extra State Tax Withholding: _____

Medical Insurance Premium: _____

Dental Insurance Premium: _____

Supplemental Insurance Premium: _____

Retirement Plan Contribution: _____

Tax Shelter Annuity: _____

Employee Helping Employee Fund Contribution: _____

Other: _____

Requested by (ASC Representative): _____ Date: _____

ADORERS OF THE BLOOD OF CHRIST

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

Please print or type

Last Name	First Name	Department

Home Address	City/State/Zip	Home Telephone

Please check appropriate box

☐ **NEW DIRECT DEPOSIT**

☐ **CHANGE IN DIRECT DEPOSIT**
(REMEMBER, completing a new direct deposit authorization cancels all previous deposit authorizations)

CHECKING ACCOUNT #1	
Financial Institution	
Address	
Bank Number *	
Acct Number *	
Deposit Amount	Please check **one** ☐ $ _____ ☐ Net Pay or Balance

SAVINGS ACCOUNT #1	
Financial Institution	
Address	
Bank Number *	
Acct Number *	
Deposit Amount	Please check **one** ☐ $ _____ ☐ Net Pay or Balance

CHECKING ACCOUNT #2	
Financial Institution	
Address	
Bank Number *	
Acct Number *	
Deposit Amount	Please check **one** ☐ $ _____ ☐ Net Pay or Balance

SAVINGS ACCOUNT #2	
Financial Institution	
Address	
Bank Number *	
Acct Number *	
Deposit Amount	Please check **one** ☐ $ _____ ☐ Net Pay or Balance

I hereby authorize the Adorers of the Blood of Christ to deposit funds into my account(s) at the above named financial institution(s).

Employee Signature	Date

*** PLEASE ATTACH A VOIDED CHECK OR DEPOSIT SLIP FOR EACH ACCOUNT.**

ADORERS OF THE BLOOD OF CHRIST
UNITED STATES REGION

EMPLOYEE DATA RECORD CHANGE

(Please PRINT)

TO: **Center Administrator, Immediate Supervisor and/or Region Department Head**

DATE: _____

RE: **Change in My Personnel Record**

Please make the following change(s) in my personnel record, as noted below:

New Name:_____

New Home Address: _____
(Street Address) *(City)* *(State)* *(Zip Code)*

New Alternate Home Address: _____
(Street Address) *(City)* *(State)* *(Zip Code)*

New Home Phone: (_____) _____ **New Cell/Mobile Phone:** (_____)_____

NEW EMERGENCY CONTACT INFORMATION:

New Name: _____ **Relationship:** _____

New Telephone(s): (_____)_____ (_____)_____ (_____)_____
(Home) *(Work)* *(Alternate)*

New Address: _____
(Street Address) *(City)* *(State)* *(Zip Code)*

New Marital Status: Married___ Single___ Divorced___ Widowed___

Additional Education Completed:

	# years completed	**Graduated?**	**Major/Degree/Specialty**
_____ (High School)	_____	_____	_____
_____ (Vocational School)	_____	_____	_____
_____ (College/University)	_____	_____	_____
_____ (Post-Graduate College/University)	_____	_____	_____

Co-Worker's Printed Name:_____**Co-Worker's Signature:**_____

HR53-10/06

ADORERS OF THE BLOOD OF CHRIST
UNITED STATES REGION

EMPLOYEE HELPING EMPLOYEE FUND
Confidential
Application for Emergency Assistance

Co-Worker's Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (Zip Code)

Center/Office: _____ **Job Title:** _____

Date of Hire: _____ **Marital Status:** **M S D W**
(Circle one)

# of Dependent Children Under Your Responsibility in Your Household: _____

Source(s) of *Average Weekly Income, after taxes,* in Your Household: _____

Yours:_____

Your Spouse's:_____

Other:_____

Reason for applying for assistance: _____

_____

_____

_____

Signature of Co-Worker: _____ **Date:** _____

IMPORTANT: Please fully complete this form, and place it in an envelope, along with any bills, estimates, notices and/or other documents which will support your application for emergency assistance. You may mail it directly to the Chair of the EHEF Committee, Director of Human Resources, Adorers of the Blood of Christ, United States Region, 4233 Sulphur Avenue, St. Louis, MO 63109, or you may give it to the Administrative Assistant at your work location who will forward it to the St. Louis Office.

.....

EHEF FUND COMMITTEE USE ONLY

Date Received: _____ **Date Approved:** _____ **Date Disapproved:** _____

Reason for disapproval: _____

Approval Covers: _____

Committee Chair: _____
(Name) (Signature)

ADORERS OF THE BLOOD OF CHRIST
UNITED STATES REGION

EMPLOYEE HELPING EMPLOYEE FUND
Confidential
Contribution Authorization

PLEASE FORWARD THIS COMPLETED FORM TO:

Director of Human Resources
Adorers of the Blood of Christ
4233 Sulphur Avenue
St. Louis, MO 63109

Co-Worker's Name: _____
(Last) **(First)** **(Middle Initial)**

Center/Office: **Department:** _____

As my contribution to the Employee Helping Employee Fund:

1) I authorize the Finance Office to deduct $_____ each pay period from my paycheck, until I notify the Office otherwise.

2) I authorize the Finance Office to deduct $_____ as a one-time deduction for the current plan year of the Fund (which runs August 1st through July 31st each year).

3) I request that deductions from my paycheck toward the Fund be stopped, until further notice.

I understand that deductions or stoppage of deductions will occur within one or two pay periods after the signed authorization is submitted to the Finance Office.

Signature of Co-Worker: **Date:** _____

FINANCE OFFICE USE ONLY

Date Received: **Date Deductions Started:** _____

Handled By: _____
(Printed Name) **(Signature)**

HR46-06/03, rev. 06/06, 03/10

ADORERS OF THE BLOOD OF CHRIST
UNITED STATES REGION

INTERNAL EMPLOYMENT APPLICATION

CO-WORKER: **SS#:**

CENTER/OFFICE: **DEPT.:**

JOB TITLE:

DATE OF HIRE: **CURRENT SALARY:**

I would like to be considered for the job vacancy listed below, and hereby submit my voluntary application.

Name of job:

Department where vacancy exists:

My reason(s) for wanting to leave current job:

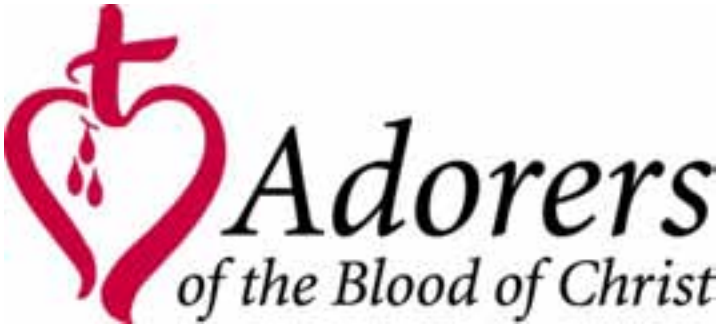
Education & Experience which qualify me for the vacant position:

I understand that I will be equally considered for the vacant position based on my qualifications.

SIGNATURE OF CO-WORKER: **DATE:**

IMMEDIATE SUPERVISOR'S SIGNATURE: **DATE:**

ADMINISTRATOR'S SIGNATURE: **DATE:**



EMPLOYMENT APPLICATION

NAME: _____ **Today's Date:** _____
Last **First** **Middle**

Position(s) Applying for: 1. _____ 2. _____ 3. _____	☐ Regular ☐ Temporary	☐ Full-time ☐ Part-time _____ hrs/wk ☐ Relief _____ hrs/wk ☐ Weekends	☐ Day Shift ☐ Evening Shift ☐ Night Shift ☐ Rotating Shift _____ (Please Specify)

SALARY REQUIREMENTS _____ Date Available: _____

Daytime Phone: _____ Evening Phone: _____

Best time to be reached: _____
_____

FOR PERSONNEL USE ONLY - DO NOT WRITE BELOW THIS LINE

Position Considered: _____ Department: _____

Contacted By: _____

Interview Date/Time: _____ Dir/Supr: _____ Dept: _____

Interview Date/Time: _____ Dir/Supr: _____ Dept: _____

Interview Date/Time: _____ Dir/Supr: _____ Dept: _____

Comments: _____

_____

_____

_____

PERSONAL DATA

Last Name	First Name	MI	Social Security Number
Street Address			Home Phone ( )
City	State	Zip Code	Business Phone ( )

How were you referred to the Adorers of the Blood of Christ?

Are you a citizen of the United States?

☐ Yes ☐ No If No, work permit #_____

Are you at least 16 years of age?

☐ Yes ☐ No

Have you ever applied here before?

☐ Yes ☐ No

If yes, when? _____

Have you ever been employed by the Adorers of the Blood of Christ?

☐ Yes ☐ No If yes: Dates of employment _____

Position: _____ Dept. _____

Have you ever been convicted of a felony? ☐ Yes ☐ No If yes, please explain: _____

_____

Have you ever been discharged from any position? ☐ Yes ☐ No If yes, please explain: _____

_____

EDUCATION

SCHOOL	NAMES & LOCATIONS OF SCHOOLS	COURSE(S) OF STUDY	DATES OF ATTENDANCE	DIPLOMA/GED/ CERTIFICATE/DEGREE
HIGH SCHOOL				
COLLEGE				
OTHER				

List any other information such as volunteer experience, training, special awards or experience which would be pertinent to the position for which you have applied: _____

_____

BUSINESS SKILLS

(if applicable to position applying for)

Typing	_____	WPM	Medical Transcription	☐ Yes	☐ No
Ten Key by Touch	☐ Yes	☐ No	Dictaphone	☐ Yes	☐ No
Word Processor	☐ Yes	☐ No	Computer Skills	☐ Yes	☐ No
Medical Terminology	☐ Yes	☐ No	ICD-9 CM Coding	☐ Yes	☐ No

Software Experience: _____

Other: _____

STATE LICENSE/CERTIFICATION/REGISTRATION

Organization	State	Registration Number	Expiration Date

EMPLOYMENT HISTORY

(ALL DATA MUST BE COMPLETE. ATTACH ADDITIONAL SHEETS IF NECESSARY)

Present or Last Employer		Type of Organization	Telephone ( )
Address	City, State	Zip Code	Hours worked per week
Position Held	Department	Name of Supervisor	Employed (Month & Year) From To
Job Duties			Last Rate of Pay
			Reason for Leaving
Your name (at that time)		May we contact your present employer? ☐ Yes ☐ No	

Previous Employer		Type of Organization	Telephone ( )
Address	City, State	Zip Code	Hours worked per week
Position Held	Department	Name of Supervisor	Employed (Month & Year) From To
Job Duties			Last Rate of Pay
			Reason for Leaving
Your name (at that time)			

Previous Employer		Type of Organization	Telephone ( )
Address	City, State	Zip Code	Hours worked per week
Position Held	Department	Name of Supervisor	Employed (Month & Year) From To
Job Duties			Last Rate of Pay
			Reason for Leaving
Your name (at that time)			

Previous Employer		Type of Organization	Telephone ( )
Address	City, State	Zip Code	Hours worked per week
Position Held	Department	Name of Supervisor	Employed (Month & Year) From To
Job Duties			Last Rate of Pay
			Reason for Leaving
Your name (at that time)			

Please explain any gaps in your employment history:
From: _______________ To: _______________ Reason: ____

____

____

MILITARY

(Complete this section if you served in the U.S. Armed Forces)

Branch of Service	Military Occupational Skills
Describe your duties and any special training:	Period of Active Duty (Month and Year) Start End
	Discharge Date
	Rank at Discharge

EMPLOYMENT REFERENCES

List three employment references that have definite knowledge of your qualifications and skills for the position(s) for which you are applying. (Recent graduates please list instructors.) Do not include personal references.

Name	Address	Occupation	Telephone

I certify that the information I have furnished is correct and complete to the best of my knowledge and belief with the understanding that it may be subject to verification with former employers and other persons. I understand and agree that misrepresentation, falsification or omission may be considered sufficient cause for rejection or dismissal if employed. In the event I am employed, I understand that regardless of the shift and job that I am first assigned, I may be required to accept change of job or shift depending on my demonstrated skills after employment and the needs of the Adorers of the Blood of Christ as a condition of initial and continued employment. I understand that I must meet the health standards established by the Adorers of the Blood of Christ as a condition of initial and continued employment. Compliance to these standards will be determined by the required physical examination which includes a drug test. I authorize my past employers to supply any information they have concerning me or my work performance during my association with them and release them from all liability in connection therewith. I understand that if I am employed by the Adorers of the Blood of Christ, the employment relationship will be terminable at will by either party, at any time, with or without notice, with or without cause.

Signature of Applicant _____

(Application active for one year)

AN EQUAL OPPORTUNITY EMPLOYER

All recruitment and hiring at the Adorers of the Blood of Christ are conducted without regard to gender, sexual orientation, race, color, national origin, ethnicity, religion, citizenship status, disability, pregnancy, age, military status, political affiliation, or any other factor protected by law.

ADORERS OF THE BLOOD OF CHRIST
UNITED STATES REGION
TRAVEL AND BUSINESS EXPENSE REPORT – FINANCE OFFICE

For the Period ____/____/____ to ____/____/____

Date:	/	/	/	/	/	/	/	***TOTALS***	
Location									
Personal Auto – Business Miles									
TRAVEL:									
1) Personal Auto @ $_____/miles (per Gov't regulations)									
2) Lodging*									
3) Air/Rail*									
4) Rental Car*									
5) Pkg./Tolls									
6) Taxi/Limo									
7) Tips									
MEALS:									
8) Breakfast**									
9) Lunch**									
10) Dinner**									
BUSINESS:									
11) Meals**									
12) Other**									
13) Telephone									
14) Co. Car Expense*									
15) Emp/Charity Events**									
16) Miscellaneous**									
17) TOTALS ADD LINES 1 - 16									
18) Charge to Company								(	)
19) Advances								(	)
20) NET LINES 17 - 19									
21) Due Company									
22) Due Employee									

BUSINESS-MEALS AND OTHER --EXPLAIN FULLY--		SPECIFIC BUSINESS PURPOSE AND SPECIFIC NATURE OF BUSINESS	AMOUNT	
DATE	NAME, COMPANY, TITLE OR OTHER DESCRIPTION			
		TOTAL		

AMOUNTS CHARGED TO COMPANY			DATE	PURPOSE OF TRAVEL	**FOR ACCOUNTING DEPT. USE ONLY**	
DESCRIPTION	AMOUNT				**ACCOUNT NO.**	**AMOUNT**

EMPLOYEE NAME (print)_____

EMPLOYEE SIGNATURE_____ **APPROVED BY:_____**

* ATTACH RECEIPTS REGARDLESS OF AMOUNT
ATTACH RECEIPTS FOR ANY EXPENSE OVER **$25.00

ADORERS OF THE BLOOD OF CHRIST

HEALTH CARE EXPENSES
FLEXIBLE BENEFITS REIMBURSEMENT FORM

INSTRUCTIONS

NOTE: MISSING OR UNCLEAR INFORMATION WILL DELAY THE PROCESSING OF REIMBURSEMENTS.

1. Complete all items in the "Employee Information/Certification" section.
2. When requesting reimbursement for Health, Dental or Eye Care not paid by insurance, please attach a copy of the insurance carrier's Explanation of Benefits indicating the amounts paid or excluded. However, if you are requesting benefits for which you have no coverage, no ***E****xplanation* ***O****f* ***B****enefits* is required. You must attach copies of statements or invoices indicating incurred dates.
3. When requesting reimbursements for Health Expenses not covered by health insurance, you must submit copies of receipts verifying incurred dates and amounts.
4. Remember: Your signature below certifies that these charges will not be claimed as an income tax deduction.
5. Send completed form to the Administrator at your Center, who will forward it to the ASC Finance Office.

[SEE REVERSE FOR DETAILS OUTLINING QUALIFYING HEALTH EXPENSES]

EMPLOYEE INFORMATION / CERTIFICATION

Name of Employee _____ S.S. Number _____

Home Address _____ City _____ State _____ Zip _____

Amount of Reimbursement Requested: $_____ *[Be sure to attach receipts or EOB form]*

Employee Signature _____ Date _____

EMPLOYER CERTIFICATION

Employer Certification _____ Date _____

Beginning Balance _____.____

Account # 2440-00-0

Amount of this check <____.____>

Balance Remaining _____.____

EXAMPLES OF ELIGIBLE REIMBURSEMENT ACCOUNT EXPENSES
(HEALTH CARE)

- Ambulance hire
- Artificial limbs and breasts (only if reconstructive)
- Braille books and magazines
- Crutches
- Drugs (legal, prescription only or insulin)
- Elastic hose, medically prescribed
- Eye glasses / contact lenses
- Fees for:

Acupuncture	Anesthetist	Chiropodist	Chiropractor
Clinic	Dentist	Examination	Gynecologist
Hospital	Laboratory	Nurse	Obstetrician
Ophthalmologist	Optometrist	Oral Surgery	Orthodontics
Osteopath	Pediatrician	Physician	Physiotherapist
Podiatrist	Psychiatrist	Psychoanalyst	Psychologist
Sanitarium	Surgeon	Surgery	Therapy
X-ray			

- Hearing devices
- Insurance copayments and deductibles
- Membership in cooperative health association
- Needles, syringes and other diabetic-related supplies
- Nursing care
- Oxygen equipment
- Rental of medical or healing equipment (including maintenance)
- Seeing-eye dog and hearing-assisting cat
- Support or corrective devices
- Telephone for deaf
- Medically prescribed therapy treatments

This list is intended to be representative of the types of expenses which may be reimbursed. It is not intended to be complete as other expenses may also be reimbursable under federal tax law.

EXAMPLES OF INELIGIBLE EXPENSES

The following expenses are not eligible for reimbursement under a Section 105 Unreimbursed Medical Expense Program. The Internal Revenue Service has indicated that a "Medical Necessity" test is being applied to determine the eligibility for reimbursement.

- Retin-A
- Smoking cessation programs (even if prescribed by a physician)
- Elective cosmetic surgery
- Medical insurance premiums
- Health club dues
- Dancing lessons
- Rogaine
- Maternity clothing
- Marriage counseling
- Mileage
- Over-the-counter medical supplies & pharmaceuticals (including vitamins and drugs available without a prescription)
- Exercise programs and health spa memberships
- Weight loss programs (even if prescribed by a physician)
- Contact lens solutions
- Nonprescription drugs
- Diaper service
- Swimming lessons
- Household help
- Trips
- Swimming pools, saunas, or exercise equipment

This list is intended to be representative of the types of expenses which may <u>not</u> be reimbursed. It is not intended to be complete as other expenses may also be unreimbursable under federal tax law.

ADORERS OF THE BLOOD OF CHRIST

HEALTH CARE EXPENSES
FLEXIBLE BENEFITS REIMBURSEMENT FORM

INSTRUCTIONS

NOTE: MISSING OR UNCLEAR INFORMATION WILL DELAY THE PROCESSING OF REIMBURSEMENTS.

1. Complete all of items in the "Employee Information / Certification" section.

2. When requesting reimbursement for Health, Dental or Eye Care not paid by insurance, you must attach a copy of the carrier's Explanation of Benefits indicating the amounts paid or excluded. However, if you are requesting benefits for which you have no coverage, no ***E**xplanation **O**f **B**enefits* is required. You must attach copies of statements or invoices indicating incurred dates.

3. When requesting reimbursements for Health Expenses not covered by PPK, you must submit copies of receipts verifying incurred dates and amounts.

4. Please be sure and sign the certification on this form certifying that these charges will not be claimed as an income tax deduction.

5. Send completed form to: Accounts Payable c/o
   Wichita Center
   1165 SW Blvd.
   Wichita, KS 67213

[SEE REVERSE FOR DETAILS OUTLINING QUALIFYING HEALTH EXPENSES]

EMPLOYEE INFORMATION / CERTIFICATION

Name of Employee _____ S.S. Number _____

Home Address _____ City _____ State _____ Zip _____

Amount of Reimbursement Requested: $_____ *[Be sure to attach receipts or EOB form]*

Employee Signature _____ Date _____

EMPLOYER CERTIFICATION

Employer Certification _____ Date _____

Beginning Balance _____.____

Account # 2440-00-0

Amount of this check <____.____>

Balance Remaining _____.____

EXAMPLES OF ELIGIBLE REIMBURSEMENT ACCOUNT EXPENSES
(HEALTH CARE)

- Ambulance hire
- Artificial limbs and breasts (only if reconstructive)
- Braille books and magazines
- Crutches
- Drugs (legal, prescription only or insulin)
- Elastic hose, medically prescribed
- Eye glasses / contact lenses
- Fees for:

Acupuncture	Anesthetist	Chiropodist	Chiropractor
Clinic	Dentist	Examination	Gynecologist
Hospital	Laboratory	Nurse	Obstetrician
Ophthalmologist	Optometrist	Oral Surgery	Orthodontics
Osteopath	Pediatrician	Physician	Physiotherapist
Podiatrist	Psychiatrist	Psychoanalyst	Psychologist
Sanitarium	Surgeon	Surgery	Therapy
X-ray			

- Hearing devices
- Insurance copayments and deductibles
- Membership in cooperative health association
- Needles, syringes and other diabetic-related supplies
- Nursing care
- Oxygen equipment
- Rental of medical or healing equipment (including maintenance)
- Seeing-eye dog and hearing-assisting cat
- Support or corrective devices
- Telephone for deaf
- Medically prescribed therapy treatments

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- Smoking cessation programs (even if prescribed by a physician)
- Elective cosmetic surgery
- Medical insurance premiums
- Health club dues
- Dancing lessons
- Rogaine
- Maternity clothing
- Marriage counseling
- Mileage
- Over-the-counter medical supplies & pharmaceuticals (including vitamins and drugs available without a prescription)
- Exercise programs and health spa memberships
- Weight loss programs (even if prescribed by a physician)
- Contact lens solutions
- Nonprescription drugs
- Diaper service
- Swimming lessons
- Household help
- Trips
- Swimming pools, saunas, or exercise equipment

This list is intended to be representative of the types of expenses which may <u>not</u> be reimbursed. It is not intended to be complete as other expenses may also be unreimbursable under federal tax law.

ADORERS OF THE BLOOD OF CHRIST

LEAVE REQUEST

[Must be submitted to, and approved by, the immediate supervisor for all absences at least three (3) weeks before the first date of absence, except in emergencies]

NAME OF EMPLOYEE: **SS#:**

CENTER/OFFICE: **DEPARTMENT**:

I request to be absent from my regular duties, with or without pay (circle one):

Starting Date	**Ending Date**	**Return to Duties Date**	**No. of Hours**	**Leave Type** (see codes below)	**Notes**	**Approved**
1.						Y N
2.						Y N
3.						Y N
4.						Y N
5.						Y N
6.						Y N
7.						Y N
8.						Y N
9.						Y N
10.						Y N

V – Vacation; S – Sick; J – Jury Duty; H- Holiday; M – Military; B – Bereavement (note relationship to deceased); U – Unpaid
Family/Medical Leave: FB – Birth/adoption/foster care; FC – Care of spouse/child/parent; FI – Illness of Employee

EMPLOYEE'S SIGNATURE: **DATE:**

IMMEDIATE SUPERVISOR'S SIGNATURE: **DATE:**

ADMINISTRATOR'S SIGNATURE: **DATE**:

NOTES:

Distribution: Copy of request to Employee
Copy for Immediate Supervisor

HR5-11/00
Revised 9/05

REQUEST FOR PAYMENT or REIMBURSEMENT
(please circle one)

Check should be issued to:

NAME:_____

ADDRESS:_____

CITY:_____**STATE**_____**ZIP**_____

Amount of Check $_____Date Needed_____

Purpose (will appear on check):_____

_____

Requested by:_____

Additional Comments to Finance Office:_____

_____

FOR OFFICE USE ONLY

Vendor #_____

Due Date_____

Account #_____

Approved by:_____

Please allow 2 weeks for processing

ADORERS OF THE BLOOD OF CHRIST
UNITED STATES REGION

RESIGNATION NOTICE

NAME OF CO-WORKER: **SS#:**

CENTER/OFFICE: **DEPT.:**

JOB TITLE:

I hereby submit my voluntary resignation from the employment of the Adorers of the Blood of Christ.

My last date to work will be:

My reason(s) for leaving is (are):

I request an Exit Interview with the Director of Human Resources to discuss my reason(s) for leaving.

Yes ☐ No ☐

Please forward my last paycheck and my final earnings report to me at:

House # and Street

City State Zip Code

Telephone Number ( )

SIGNATURE OF CO-WORKER: **DATE:**

IMMEDIATE SUPERVISOR'S SIGNATURE: DATE:

ADMINISTRATOR'S SIGNATURE: DATE:

To be completed by Head of Region Office/Center Administrator:

TO PAYROLL: **Final paycheck should include the following:**

Hours Worked Due Employee: _____ **PTO Hours Due Employee: _____**

If Eligible, Employee Requested Retirement/TSA Distribution: __Yes __No

Adorers of the Blood of Christ
United States Region

VOLUNTEER APPLICATION

Today's Date: _____

PERSONAL INFORMATION

Please print.

Circle one: Mr./Ms./Mrs./Miss

Last Name: _____ **First Name: _____ MI _____**

Current Address
Street: _____
City: _____ State: _____ ZIP: _____

Permanent address (if different from current)
Street: _____
City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____

Cell Phone (optional): _____ E-Mail Address: _____

Date of Birth:_____
(Volunteers under age 18 must provide written permission from a parent or guardian and must list a parent or guardian as emergency contact.)

In case of an emergency, notify:

Name:_____

Relationship:_____ Phones: (#1) _____(#2)_____

VOLUNTEER INFORMATION

I am applying for the following volunteer position:

_____

Which days of the week are you available to volunteer? ***(Please circle all that apply)***
Sunday Monday Tuesday Wednesday Thursday Friday Saturday

What hours are you available? Morning (9:00 – 12:00) Afternoon (1:00 – 3:00) Late Afternoon (3:00 – 6:00)

What is your motivation for wanting to volunteer with the Adorers?_____ _____

_____

How did you hear about us?_____

Previous volunteer experience:_____

_____

What are your areas of expertise or special interest?_____

_____

SIGNATURE OF VOLUNTEER APPLICANT:_____DATE:_____

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Parental/Guardian Permission (required for applicants under 18 years of age).

I give my child _____ permission to volunteer at the Adorers of the Blood of Christ.

Signature of Parent or Guardian: _____ **Date:_____**

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HR43-06/06

ADORERS OF THE BLOOD OF CHRIST
UNITED STATES REGION
INSURANCE PLANS
WAIVER FORM

I have been informed of the Insurance Benefit Plans offered by the Adorers of the Blood of Christ, and of the options I have as an **eligible** employee.

I voluntarily agree to participating in or waiving coverage for myself and my eligible family members by completing and signing this form.

MEDICAL

____I want coverage for myself only

____I want coverage for myself and my spouse

____I want coverage for myself and my child(ren)

____I want coverage for myself and all eligible family members

____I ***DO NOT WANT*** coverage for myself nor any family members

DENTAL

____I want coverage for myself only

____I want coverage for myself and one family member

____I want coverage for myself and all eligible family members

____I ***DO NOT WANT*** coverage for myself nor any family members

I understand that there will be no reimbursements to me for any part of the insurance premium paid by the Adorers by my waiving of insurance coverage as noted above.

Print NAME OF CO-WORKER

SIGNATURE OF THE CO-WORKER DATE

ADORERS OF THE BLOOD OF CHRIST
UNITED STATES REGION

RETIREMENT PLAN
WAIVER FORM

I have been informed of the Retirement Benefit Plan offered by the Adorers of the Blood of Christ, and of the options I have as an **eligible** employee.

____I ***DO NOT WANT*** to participate in nor contribute to the Retirement Plan at this time.

I understand that if, at a later date, I decide to participate in and contribute to the Retirement Plan, my contributions and my employer's match will begin on the first pay period of the month.

Print NAME OF CO-WORKER

SIGNATURE OF THE CO-WORKER DATE

HR38-10/08