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)

<table>
<thead>
<tr>
<th>NAME OF CO-WORKER:</th>
<th>PAY PERIOD ENDING:</th>
</tr>
</thead>
<tbody>
<tr>
<td>OFFICE/CENTER:</td>
<td>DEPARTMENT:</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>WEEK DATES</th>
<th>PTO</th>
<th>EIB</th>
<th>HOL</th>
<th>FMLA</th>
<th>JURY</th>
<th>BRVM*</th>
<th>E/PD**</th>
<th>OTHER***</th>
<th>UNPAID****</th>
<th>TOTALS</th>
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</table>

TOTALS

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

<table>
<thead>
<tr>
<th>WEEK DATES</th>
<th>PTO</th>
<th>EIB</th>
<th>HOL</th>
<th>FMLA</th>
<th>JURY</th>
<th>BRVM*</th>
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<th>TOTALS</th>
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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

HR55-11/00, rev. 08/06
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:

HR7-08/06
ADORERS OF THE BLOOD OF CHRIST
AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

Please print or type

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Department</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Home Address</th>
<th>City/State/Zip</th>
<th>Home Telephone</th>
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</table>

Please check appropriate box

- [ ] NEW DIRECT DEPOSIT
- [ ] CHANGE IN DIRECT DEPOSIT

(REMEMBER, completing a new direct deposit authorization cancels all previous deposit authorizations)

<table>
<thead>
<tr>
<th>CHECKING ACCOUNT #1</th>
<th>SAVINGS ACCOUNT #1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Institution</td>
<td>Financial Institution</td>
</tr>
<tr>
<td>Address</td>
<td>Address</td>
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<tr>
<td>Bank Number *</td>
<td>Bank Number *</td>
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<tr>
<td>Acct Number *</td>
<td>Acct Number *</td>
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<tr>
<td>Deposit Amount Please check one</td>
<td>Deposit Amount Please check one</td>
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<tr>
<td>Net Pay or Balance</td>
<td>Net Pay or Balance</td>
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</table>

<table>
<thead>
<tr>
<th>CHECKING ACCOUNT #2</th>
<th>SAVINGS ACCOUNT #2</th>
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</thead>
<tbody>
<tr>
<td>Financial Institution</td>
<td>Financial Institution</td>
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<tr>
<td>Address</td>
<td>Address</td>
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<tr>
<td>Bank Number *</td>
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<td>Acct Number *</td>
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<tr>
<td>Deposit Amount Please check one</td>
<td>Deposit Amount Please check one</td>
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<td>$_______________</td>
<td>$_______________</td>
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<tr>
<td>Net Pay or Balance</td>
<td>Net Pay or Balance</td>
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</tbody>
</table>

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 VOIED 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] ___________________________ __________
[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

<table>
<thead>
<tr>
<th>Co-Worker’s Name:</th>
<th>(Last)</th>
<th>(First)</th>
<th>(Middle Initial)</th>
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<tbody>
<tr>
<td>Address:</td>
<td>(Street)</td>
<td>(City)</td>
<td>(State)</td>
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<tr>
<td>Center/Office:</td>
<td>Job Title:</td>
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<tr>
<td>Date of Hire:</td>
<td>Marital Status:</td>
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<td># of Dependent Children Under Your Responsibility in Your Household:</td>
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<tr>
<td>Source(s) of <em>Average Weekly Income, after taxes</em>, in Your Household:</td>
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<td>Yours:______________</td>
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<td>Your Spouse's:________________________</td>
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<td>Other:__________________________</td>
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<td>Reason for applying for assistance:</td>
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<tr>
<td>Signature of Co-Worker:</td>
<td>Date:</td>
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*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.*
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: _____________________________________________________________

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## PERSONAL DATA

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<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Social Security Number</th>
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<th>Street Address</th>
<th>Home Phone</th>
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<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Business Phone</th>
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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: ________________________________

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## EDUCATION

<table>
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<tr>
<th>SCHOOL</th>
<th>NAMES &amp; LOCATIONS OF SCHOOLS</th>
<th>COURSE(S) OF STUDY</th>
<th>DATES OF ATTENDANCE</th>
<th>DIPLOMA/GED/CERTIFICATE/DEGREE</th>
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<td>HIGH SCHOOL</td>
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<td>COLLEGE</td>
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<td>OTHER</td>
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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: ________________________________

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## BUSINESS SKILLS

(if applicable to position applying for)

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<thead>
<tr>
<th>Typing</th>
<th>WPM</th>
<th>Medical Transcription</th>
<th>Ten Key by Touch</th>
<th>Dictaphone</th>
<th>Word Processor</th>
<th>Computer Skills</th>
<th>Medical Terminology</th>
<th>ICD-9 CM Coding</th>
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Other: ________________________________

## STATE LICENSE/CERTIFICATION/REGISTRATION

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<tr>
<th>Organization</th>
<th>State</th>
<th>Registration Number</th>
<th>Expiration Date</th>
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# EMPLOYMENT HISTORY

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

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<tr>
<th>Present or Last Employer</th>
<th>Type of Organization</th>
<th>Telephone ( )</th>
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<table>
<thead>
<tr>
<th>Address</th>
<th>City, State</th>
<th>Zip Code</th>
<th>Hours worked per week</th>
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<thead>
<tr>
<th>Position Held</th>
<th>Department</th>
<th>Name of Supervisor</th>
<th>Employed (Month &amp; Year) From To</th>
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<thead>
<tr>
<th>Job Duties</th>
<th>Last Rate of Pay</th>
<th>Reason for Leaving</th>
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<tr>
<th>Your name (at that time)</th>
<th>May we contact your present employer?</th>
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<tr>
<td></td>
<td>Yes ☐ No ☐</td>
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<tr>
<th>Previous Employer</th>
<th>Type of Organization</th>
<th>Telephone ( )</th>
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<tr>
<th>Address</th>
<th>City, State</th>
<th>Zip Code</th>
<th>Hours worked per week</th>
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<tr>
<th>Position Held</th>
<th>Department</th>
<th>Name of Supervisor</th>
<th>Employed (Month &amp; Year) From To</th>
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<tr>
<th>Job Duties</th>
<th>Last Rate of Pay</th>
<th>Reason for Leaving</th>
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<tr>
<th>Your name (at that time)</th>
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Please explain any gaps in your employment history:

From: _______________ To: _______________ Reason: ____________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

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

<table>
<thead>
<tr>
<th>Branch of Service</th>
<th>Military Occupational Skills</th>
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</table>

Describe your duties and any special training:

<table>
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<tr>
<th>Period of Active Duty (Month and Year)</th>
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<tr>
<td>Start</td>
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<tr>
<td>End</td>
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<tr>
<th>Discharge Date</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Rank at Discharge</th>
</tr>
</thead>
</table>

## 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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Occupation</th>
<th>Telephone</th>
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</table>

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.

HR02-02/01, rev. 06/06
ADORERS OF THE BLOOD OF CHRIST  
UNITED STATES REGION  
TRAVEL AND BUSINESS EXPENSE REPORT – FINANCE OFFICE  
For the Period ____/____/____ to ____/____/____

<table>
<thead>
<tr>
<th>Date:</th>
<th>/</th>
<th>/</th>
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<th>/</th>
<th>/</th>
<th>/</th>
<th>/</th>
<th>TOTALS</th>
</tr>
</thead>
</table>

**Location**

**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 |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE</td>
<td>NAME, COMPANY, TITLE OR OTHER DESCRIPTION</td>
<td>AMOUNT</td>
</tr>
</tbody>
</table>

**TOTAL**

<table>
<thead>
<tr>
<th>AMOUNTS CHARGED TO COMPANY</th>
<th>DATE</th>
<th>PURPOSE OF TRAVEL</th>
<th>FOR ACCOUNTING DEPT. USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>DESCRIPTION</td>
<td>AMOUNT</td>
<td></td>
<td>ACCOUNT NO.</td>
</tr>
</tbody>
</table>

EMPLOYEE NAME (print)______________________________________________________

EMPLOYEE SIGNATURE______________________________________________________  
APPROVED BY:____________________________________________________________

* ATTACH RECEIPTS REGARDLESS OF AMOUNT  
**ATTACH RECEIPTS FOR ANY EXPENSE OVER $25.00
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 Explanation Of Benefits 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 not 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 Explanation Of Benefits 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)
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  - Anesthetist
  - Chiropodist
  - Chiropractor
  - Clinic
  - Dentist
  - Examination
  - Gynecologist
  - Hospital
  - Laboratory
  - Nurse
  - Obstetrician
  - Ophthalmologist
  - Optometrist
  - Oral Surgery
  - Orthodontics
  - Osteopath
  - Pediatrician
  - Physician
  - Physiotherapist
  - Podiatrist
  - Psychiatrist
  - Psychoanalyst
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  - Sanitarium
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This list is intended to be representative of the types of expenses which may not 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):

<table>
<thead>
<tr>
<th>Starting Date</th>
<th>Ending Date</th>
<th>Return to Duties Date</th>
<th>No. of Hours</th>
<th>Leave Type (see codes below)</th>
<th>Notes</th>
<th>Approved</th>
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<td>Y N</td>
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</table>

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 ____________________________

Telephant 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

HR8-11/00  Rev. 06/06
VOLUNTEER APPLICATION

PERSONAL INFORMATION

Please print.

Today’s Date: _________________________

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

Last Name: ___________________________________    First Name: ________________________ MI ______

Current Address
Street: ___________________ State: ______ ZIP: ______
City: ________________ State: ______ ZIP: ______

Permanent address (if different from current)
Street: ___________________ State: ______ ZIP: ______
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: __________

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: __________
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

HR37-11/00    Rev. 08/06
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