HEADWATERS
Health Care Centre

EMPLOYEE INFORMATION

Name:

Address:

Apt#

City:

Postal Code:

Phone # (1):

Date of Birth:

Phone # (2):

Male ◯ Female ◯

SIN#:

Nonbinary ◯

EMERGENCY CONTACT INFORMATION

Name:

Relationship:

Phone # 1:

Phone # 2:

Signature of

Employee:

Date:

Clear Form

HEADWATERS
Health Care Centre

DIRECT DEPOSIT AUTHORIZATION

SECTION A – EMPLOYEE INFORMATION:

** If changing your Bank Account please do not close your current account until after your first pay has been deposited into your new account.

Please check appropriate box below:

☐ Initial Set-Up ☐ Change of Financial Institution, Branch or Account ☐ Add/Remove Secondary Account

By signing below, I authorize Headwaters Health Care Centre to deposit my payments (payroll and expense reimbursement) directly to the account(s) at the Financial Institution(s) designated on this form.

Employee Name: Date:

Signature:

SECTION B – BANKING INFORMATION:

Attach a void personalized cheque for each account or a printout from your financial institution showing the bank, transit and account number.

Primary Account for Deposit

ATTACH A VOID CHEQUE OR PRINTOUT HERE

2nd Account for Deposit (optional)

Amount of pay to be deposited to the second account (payroll only): $

ATTACH A VOID CHEQUE OR PRINTOUT HERE

Please return this completed form to the Human Resources Department. Please note that it must be submitted by the Monday prior to the desired effective pay date.

SECTION C – TO BE COMPLETED BY HUMAN RESOURCES ONLY:

Entered By: **Date:**

Audited By: Verbal Confirmation: ☐ Delivered in Person: ☐

Emailed accpay@headwatershealth.ca: ☐

HEADWATERS Health Care Centre

HOOPP – Healthcare of Ontario Pension Plan
Enrollment / Waiver

Name:

Social Insurance #: / / **Date of Birth:**

Email: **Phone #:**

Option A: Enrollment Declaration:

I consent to the use of all information contained on this form and any additional personal information which I may hereafter provide to the administrators of the Plan, including my social insurance number, plus information related to my salary and employment record, as may be required to administer the Plan. My consent extends to any disclosures by the Plan administrators to the Plan's auditors, actuaries and/or other professional advisors for the purposes of administering the Plan. I also understand that any information collected or requested via this document is solely for the purpose of administering the Plan and will not be disclosed to any other party, except as previously indicated, without my consent. I certify that the information contained in this form is correct to the best of my knowledge.

I hereby consent to Headwaters Health Care Centre to deduct my HOOPP contribution from my pay. I understand that HOOPP will contact me to provide additional information regarding beneficiaries and other personal information.

Employee Signature: **Date:**

Option B: Waiver of Contributions:

☐ I am a part time/casual employee and I am electing **not** to enroll in HOOPP at this time.

I will not be making contributions to the plan, nor will my employer do so on my behalf; I will not be entitled to a pension or any other benefits from the plan with respect to my employment with the employer; I have the right to cancel this waiver and enroll in at any time on a go forward basis (not retroactive) by providing my employer with an new enrollment form and this waiver will no longer be effective; and I will be required to join the plan if I become a full time employee with my employer.

Employee Signature: **Date:**

Human Resources Only:

☐ Enrolled on HOOPP Insight ☑ Witholdings entered in Meditech Enrollment Date:
☐ Contract Updated in Meditech (if applicable)

Human Resources: **Date:**

MONTHLY PARKING PERMIT REQUEST FORM

TO PROPERLY PROCESS YOUR REQUEST, WE NEED YOU TO READ AND ACCEPT THE TERMS AND CONDITIONS LISTED ON THE BACK OF THIS APPLICATION FORM. WE ALSO NEED YOU TO FILL OUT AT LEAST THE REQUIRED INFORMATION BELOW, INDICATED BY.*

* Full Name: _____

Email: _____

* Street Address: _____

* City: _____ * Province: _____ * Postal Code: _____

* Work Phone No. (with area code) _____ * Home Phone No. (with area code) _____

Fax No. (with area code) _____

* Parking Lot: _____

PLEASE DESCRIBE THE VEHICLE(S) YOU WILL BE PARKING:

	* PRIMARY VEHICLE	* ALTERNATE VEHICLE (2)	* ALTERNATE VEHICLE (3)
Make/Model			
Plate No.			

PLEASE INDICATE PAYMENT TYPE PREFERRED:

[1]Credit Card ◯ [2]Pre-authorized Payment ◯ Cash/Cheque ◯ Payroll ◯

PARKING PASS TO BEGIN THE FIRST DAY OF:

PASS #

[1]**Credit Card - TYPE**

VISA ◯ MASTERCARD ◯ AMEX ◯

Credit Card No. Expiration Date (mm/yy)

[2]**Pre-authorized Payment** : Please provide a void cheque with complete application.

*** PLEASE NOTE: ALL PAYMENTS WILL BE PROCESSED THE 1ST DAY OF THE MONTH ***

◯ YES, I HAVE READ AND AGREED TO THE TERMS AND CONDITIONS AS DETAILED.

SIGNATURE: _____

DATE: _____

PRECISE PARKLINK™

Clear Form

Privacy and Security Acknowledgment Form

I, have received a copy and understand the;

1. Headwaters – Privacy Breach Management Procedure

2. Headwaters – Privacy Pledge

I agree that:

1. I will observe and comply with all policies and procedures of Headwaters Health Care Centre with respect and privacy, confidentiality, and security

2. Except when I am legally authorized to do so and as required in the proper and faithful discharge of my duties or responsibilities, I will not access, use or disclose confidential information that comes to my knowledge or possession by reason of my employment or affiliation with Headwaters Health Care Centre

3. I will not share my access code (e.g. my computer password, voicemail password, pin number for doors locks etc), any my password can and will be used to track accessing of confidential information

4. I will not leave confidential information exposed for others to view (e.g. computer screen or patient record or discuss confidential information in public areas)

5. I will not use Headwaters Health Care Centre information or communication systems to access confidential information unless legally authorized to do so and as required in the proper and faithful discharge of my duties or responsibilities

I understand that a breach of this agreement may be cause for disciplinary action up to and including termination of employment or affiliation with Headwaters Health Care Centre.

I understand that one copy of this agreement will be retained by Headwaters Health Care Centre and acknowledge having received one copy for my personal records.

Print Name: Signature:

Date:

HEADWATERS Health Care Centre

Attendance at Work

Headwaters Health Care Centre ("Headwaters") strives to achieve optimal patient care by maintaining not only an environment which preserves the safety, privacy and dignity of patients and their families, but also a workforce that is highly qualified and dedicated. Thus, a present and committed workforce is crucial to the Headwaters' success.

Regular attendance is an implied term of the employment agreement between Headwaters and its employees and is essential to every job. When employees are absent, regardless of the cause of that absence, they are unable to perform work expected by Headwaters and our patients. Lack of regular attendance at work compromises patient care, affects employee morale and teamwork, and imposes a significant financial burden on the Headwaters resources.

All Headwaters employees are responsible for:

- maintaining a healthy lifestyle that supports regular* and punctual** attendance at work;
- making every reasonable effort to attend to medical and personal appointments outside of their scheduled working hours;
- promptly advising manager/supervisor of absences and the reason(s) for such absences;
- maintaining regular contact with manager or supervisor during any period of absence in accordance with
- departmental protocols and/or procedures.
- providing appropriate medical evidence to Occupational Health in order to:
    - verify illness-related absences as requested by manager or supervisor, and
    - prove fitness to return to work after a period of illness or Disability-related absence;
- notifying Occupational Health / managers / supervisors / Union Representatives of any perceived need for accommodation;
- participating constructively in the search for Accommodation, if Accommodation is required;
- being prepared to assume responsibilities as active participants in accommodating of their own or fellow employees' disability;

* Regular Attendance means attending every scheduled shift

** Punctual Attendance means commencing each shift at the scheduled start time and continuing to be present (outside of scheduled breaks) until the scheduled end time of the shift.

Applications for Medical Absence must be completed if an employee is absent for more than 3 consecutive shifts, if the employee is on the Attendance Assistance Program above Step 2 or if the employee's manager has requested Medical Evidence for a specific absence.

The definition of Short Term Disability Benefit (for eligible employees) is: An insurance benefit that the hospital pays to ensure income is protected when an employee is unable to come to work due to his/her own personal illness or injury.

Excessive and/or unexplained absences and/or failure to provide medical documentation to further support an employee's absence, may result in the employee's placement on the "Attendance Assistance Program", which has been designed to assist our employees to achieve regular attendance at work.

☐ I have reviewed the above and am aware of my responsibilities regarding regular and punctual attendance at work.

Print Name Signature Date

PHOTO/VIDEO CONSENT FORM

The undersigned does hereby authorize Headwaters Health Care Centre, Headwaters Health Care Centre Foundation and Headwaters Health Care Centre Orangeville Auxiliary to photograph/videotape:

_____

Name *(please print*)

The undersigned authorizes Headwaters Health Care Centre, Headwaters Health Care Centre Foundation and Headwaters Health Care Centre Orangeville Auxiliary to permit the use and display of said photographs/video footage in any publication, multimedia production, display, advertisement, fundraising material or online social media pages and our corresponding websites.

The undersigned agrees that Headwaters Health Care Centre, Headwaters Health Care Centre Foundation and Headwaters Health Care Centre Orangeville Auxiliary may use name, likeness, or biological information supplied by the undersigned.

The undersigned releases and forever discharges Headwaters Health Care Centre, Headwaters Health Care Centre Foundation and Headwaters Health Care Centre Orangeville Auxiliary, its agents, officers and employees from any and all claims and demands arising out of or in connection with the use of said photographs/images, including but not limited to, any claims for invasion of privacy or defamation.

Accepted and Agreed:

_____

Signature of Subject

_____

Signature of Guardian
/ Substitute Decision Maker

_____

Date