



EMPLOYEE TRAINING CHECKLIST

Employee Name		
First:	<input type="text"/>	Last: <input type="text"/> PPL ID: <input type="text"/>
Consumer Name		
First:	<input type="text"/>	Last: <input type="text"/> PPL ID: <input type="text"/>
Employer Name (this must be completed)		
First:	<input type="text"/>	Last: <input type="text"/>

Training Checklist
<p>As an Employee in the Indiana FSSA Health & Wellness Program, I confirm that I understand:</p> <ul style="list-style-type: none"> • My role in the program • How the program will work and what my duties are • Worker’s Compensation will not be provided by: <ul style="list-style-type: none"> • Employer • PPL • The State <p>I will:</p> <ul style="list-style-type: none"> • Complete all the required paperwork to become an Employee • Be responsible for my own negligent acts and will not take on tasks and services that are outside the range of the job description, including medically-related services • Submit my time accurately per program’s timekeeping procedures • Be treated with dignity and respect, which includes respect of my privacy and confidentiality, and I will extend this respect to my Employer • Report abuse or fraud to the specified authorities as soon as I can

Agree and Sign
<p>My signature below confirms that I have read and understood these duties and will do my best to perform them.</p> <p>Employee Signature: <input type="text"/> Date: <input type="text"/></p>