EMPLOYEE TRAINING CHECKLIST

Employee Name

First: **Last:** **PPL ID:**

Consumer Name

First: **Last:** **PPL ID:**

Employer Name (this must be completed)

First: **Last:**

Training Checklist

As an Employee in the Indiana FSSA Pathways For Aging Program, I confirm that I understand:

- My role in the program
- How the program will work and what my duties are
- Worker's Compensation will not be provided by:
  - Employer
  - PPL
  - The State

I will:

- 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

My signature below confirms that I have read and understood these duties and will do my best to perform them.

Employee Signature: **Date:**