IPPC PHARMACY

EMPLOYEE PACKET

2024

DRA

RETURN ONLY THE PAGES

THAT NEED TO BE

FILLED OUT AND/OR SIGNED

(HIGHLIGHTED IN GRAY)

****

THE REST OF THE INFORMATION IS

FOR YOU TO KEEP AND REVIEW

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

Signature of Employee	Today's Date (mm/dd/yyyy)

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)			**Additional Information**		
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.		

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.	First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**8.** Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

IPPC PHARMACY

EMPLOYEE DATA FORM

LAST NAME: _____ **FIRST NAME:** _____

STREET ADDRESS: _____

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

TELEPHONE NO: _____ **CELL NO.:** _____

DATE OF BIRTH: _____ **EMAIL:** _____

S.S.#: _____ **DATE OF HIRE:** _____

POSITION/TITLE: _____

LICENSE #: _____ **EXP. DATE:** _____

CERTIFICATE #: _____ **EXP. DATE:** _____

EMERGENCY CONTACT INFORMATION

NAME: _____ **RELATIONSHIP:** _____

EMERGENCY TELEPHONE NUMBER: _____

SCHEDULE

MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
SATURDAY		
SUNDAY		

STATION NO. (THIS WILL BE ASSIGNED TO YOU): _____

IPPC PHARMACY

STANDARDS OF PROFESSIONAL PRACTICE

TRAINING ACKNOWLEDGEMENT RECEIPT

_____ _____

Pharmacy Personnel Printed Name Title

Training conducted on _____ (Date)

Training

- ☐ Pharmacy Code of Ethics ☐ Date Revised _____
- ☐ Patient Bill of Rights and Responsibilities ☐ Date Revised _____
- ☐ Pharmacy Mission Statement ☐ Date Revised _____
- ☐ Pharmacy Scope of Services ☐ Date Revised _____
- ☐ Job Description ☐ Date Revised _____
- ☐ Employee Handbook ☐ Date Revised _____
- ☐ Pharmacy Work Environment ☐ Date Revised _____
- ☐ Cultural Awareness ☐ Date Revised _____
- ☐ Fire and Safety ☐ Date Revised _____
- ☐ OTHER (describe below)

_____

_____

I acknowledge that I have received the training as described above. It has been communicated to me in terms whereby I understand its content. I have been given ample opportunity to ask questions. By signing this, I commit to following the standards and protocols as presented in the training.

_____ _____

Pharmacy Personnel Signature Date

_____ _____

Trainer's Signature Date

IPPC PHARMACY

PHARMACY CODE OF ETHICS

Pharmacists have an overall responsibility for all aspects of the Pharmacy care and for all Pharmacy personnel who provide pharmacy services to the public. This necessitates Pharmacists interacting with the other health care professionals, physicians, nurses, and therapists in a multi-disciplinary team approach to ensure the patient's safety and welfare.

In accordance with their roles, pharmacists must uphold the following code when providing pharmacy services. They are also ultimately responsible for the pharmacy personnel to do likewise. All pharmacy personnel should:

1. Maintain in the utmost regard and sustain the trust bestowed by the patient.
2. Establish and continually protect the confidential nature of every pharmacist-patient relationship, while concurrently expressing compassion and caring in every interaction.
3. Encourage and educate each patient to actively participate in decision-making about their health care, while balancing cultural sensitivity and respect.
4. Allow integrity, honest and nondiscriminatory practices to govern all aspects of the pharmacist's role to not compromise actions taken in the best interests of the patient.
5. Continually educate and advance one's abilities to knowledge of new medications, devices, and technologies, as health care information becomes available.
6. Consult with fellow colleagues, when appropriate, or encourage the patient to seek further consultation to safeguard the patients' own health.
7. As the opportunities evolve, respond to the needs of the broader community in a responsible, ethical fashion.
8. Strive for balance and equity in the distribution of health care resources between each patient and community needs.

Effective Date: 9/19/2008
Reviewed: 1/15/2013

IPPC PHARMACY

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

To ensure the finest care possible, as a Patient receiving Durable Medical Equipment (DME) and our Pharmacy services, you should understand your role, rights and responsibilities involved in your own plan of care.

Patient Rights

- To select those who provide you with DME and Pharmacy services.
- To receive the appropriate or prescribed services in a professional manner without discrimination relative to your age, sex, race, religion, ethnic origin, or sexual preference or physical or mental handicap.
- To be treated with friendliness, courtesy and respect by each and every individual representing our Pharmacy, who provided treatment or services for you and be free from neglect and abuse, be it mental or physical.
- To assist in the development and preparation of your plan of care that is designed to satisfy, as best as possible, your current needs, including management of pain.
- To be provided with adequate information from which you can give your informed consent for commencement of services, the continuation of services, the transfer of services to another healthcare provider, or the termination of services.
- To express concerns, grievances, or recommend modifications to your DME and pharmacy services, without fear of discrimination or reprisal.
- To request and receive complete up-to-date information relative to your condition, treatment, alternative treatments, risk of treatment or care plans.
- To receive treatment and services within the scope of your plan of care, promptly and professionally, while being fully informed as to our Pharmacy's policies and procedures and charges.
- To request and receive data regarding treatment, services or costs thereof, privately and confidentially.
- To be given information as it relates to the uses and disclosures of your plan of care.
- To have your plan of care remain private and confidential, except as required and permitted by law.

Patient Responsibilities

- To provide accurate and complete information regarding your past and present medical history.
- To agree to schedule of services and report any cancellation of scheduled appointments and/or treatments.
- To participate in the development and updating of a plan of care.
- To communicate whether you clearly comprehend the course of treatment and plan of care.
- To comply with the plan of care and clinical instructions.
- To accept responsibility for your actions, if refusing treatment or not complying with the prescribed treatment and services.
- To respect the rights of Pharmacy personnel.
- To notify your Physician and the Pharmacy with any potential side effects and/or complications.

IPPC PHARMACY

MISSION STATEMENT

IPPC Pharmacy is a long-term care pharmaceutical provider dedicated to servicing our customers with pharmaceuticals, medical equipment, nutritionals, and incontinence supplies to ensure the highest quality of care and compliance.

We offer many different forms of packaging to aid in patient compliance and ease of administration for the nursing staff. Our objective is to save your staff time and assure accuracy.

IPPC Pharmacy will provide the perfect medication administration solution for patient safety and compliance in long term care, assisted living, residential health care and independent living settings, as well as correctional institutions.

Designing pharmaceutical programs of administration specifically aimed at the target population has become our specialty.

Result: You spend more time where it's needed most, patient care.

IPPC PHARMACY
703 GINESI DRIVE
MORGANVILLE, NJ 07751

SCOPE OF SERVICES

Following is information on the quality products and services offered by IPPC PHARMACY. If you should have any questions, please contact the Pharmacy for more information.

PHARMACY HOURS *	
Monday	24 Hours
Tuesday	24 Hours
Wednesday	24 Hours
Thursday	24 Hours
Friday	24 Hours
Saturday	9AM - 2AM
Sunday	9AM – 5PM
Holidays	9AM – 6PM

PHARMACY PHONE NUMBERS:

During Regular Business Hours — TEL: 732-617-8686; 1-866-809-4772
FAX: 732-617-8321

After-Hours Emergency Needs — Call IPPC and leave a message in the emergency mailbox. If you do not receive a call back within ten minutes, please dial 732-618-0749 or 908-692-8526.

PRODUCTS

PRESCRIPTION MEDICATIONS, OVER-THE-COUNTER MEDICATIONS, CREAMS, LOTIONS, SELECT HEALTH and BEAUTY AIDES, FIRST AID ITEMS, VITAMINS, HOME MEDICAL EQUIPMENT (SMALL EQUIPMENT AND SUPPLIES), DIABETIC SUPPLIES.

SERVICES

Training and education for all nursing and support staff in all facilities. On-site staff supports observation and education for med passes; provide pharmacy consultant when needed. Supply and repair med carts as needed.

*THESE HOURS DO NOT REFLECT EMPLOYEE SHIFT HOURS. CLOSING SHIFT LEAVES WITH THE LAST PHARMACIST.

IPPC PHARMACY

RECIEPT AND ACKNOWLEDGEMENT OF
IPPC PHARMACY'S EMPLOYEE HANDBOOK

Please read the following statements, sign below and return to Management.

Acknowledgement and Receipt of Employee Handbook:

I have received and read a copy of IPPC Pharmacy's Employee Handbook. I understand that the policies and benefits described in it are subject to change at the sole discretion of IPPC PHARMACY at any time.

At-Will Employment:

I understand that my employment is at will and neither I nor IPPC PHARMACY has entered into a contract regarding the duration of my employment. I am free to terminate my employment with IPPC PHARMACY at any time, with or without reason. Likewise, IPPC PHARMACY has the right to terminate my employment, or otherwise discipline, transfer, or demote me at any time, without reason, at the discretion of IPPC PHARMACY. No employee of IPPC PHARMACY can enter into an employment contract for a specified period of time or make any agreement contrary to this policy without the written approval from management.

_____ _____

Employee's Printed Name Position

_____ _____

Employee's Signature Date

IPPC PHARMACY

PERMISSION TO CONDUCT BACKGROUND INVESTIGATION

The information requested below is for the sole purpose of conducting a background investigation which includes, among other things, a criminal conviction check. The existence of a prior criminal conviction will not necessarily make you ineligible for employment, it is IPPC Pharmacy's Policy to evaluate any adverse information obtained in the background investigation based on a range of factors including, but not limited to, employment history and time, nature and job-relatedness of the offense. This form along with the final report will be placed in a separate file and will not be part of your personnel file should you be hired.

This information will be used for purposes of identification and pre-employment only and will not be used for discriminatory purposes. General Law prohibits discrimination in employment on the basis of age, race, color, creed, religion, sexual orientation, disability, or national origin. Many states also prohibit some or all the above types of discrimination and may also include marital status or other categories.

I acknowledge that consideration for employment is contingent on the results of a reference check, credit check, criminal record check, background check, negative drug screen result, my ability to establish employment eligibility under the Immigration Reform and control act of 1986 and upon verification of the information provided by me in my application, my resume or in other parts of the application process.

I understand that in making this application for employment, IPPC PHARMACY or any agent acting on its behalf may request an investigative consumer report, or other such information obtained through personal interviews with third parties such as neighbors, friends, business associates, financial sources and acquaintances. I authorize IPPC PHARMACY, its affiliates and representatives to verify all information provided by me in the application process and to inquire into my character, general reputation, personal characteristics and mode of living. I expressly authorize all employers, personnel, schools, companies, corporations, and law enforcement agencies to supply any and all information concerning my qualifications for employment and to verify the information given by me herein or elsewhere in the application process. In consideration for being a candidate for employment, I release IPPC PHARMACY, related entities, as well as any individual or entity providing information from any and all liability in connection with inquiries and investigations, information given, decisions made, or action taken concerning my employment based on such information.

I understand that employee screening or other tests, including drug screening, may be a condition of employment and refusal to take such tests when asked will subject me to termination. I also understand that no person is authorized to enter into written employment contracts on behalf of IPPC PHARMACY. I hereby acknowledge that no verbal promises or contracts are authorized by IPPC PHARMACY and upon my acceptance of employment; I expressly acknowledge that no such verbal promise, inducements, or verbal contracts have been made.

I hereby authorize IPPC PHARMACY or its agents to investigate my background to determine all information of concern to my record, whether same is of record or not, and I release employers and persons named in my application from all liability for any damages on account of his/her furnishing said information.

Additionally, you are hereby authorized to make any investigation of my personal history, educational background, military record and criminal records through an investigative or credit agency or bureau of your choice. I authorize the release of this information by the appropriate agencies to the investigating service.

Name of Applicant (Print) _____ Other Name(s) Used During Education/Career _____

Current Address _____ City / State _____ ZIP _____

Social Security Number _____ Date of Birth _____

Professional License / Certification # and State (current and inactive) _____

Applicant Signature _____ Date _____ Witness Signature _____ Date _____

Addresses for the past seven years: (If different from above)

Address _____ Address _____

City _____ State _____ ZIP _____ City _____ State _____ ZIP _____

Address _____ Address _____

City _____ State _____ ZIP _____ City _____ State _____ ZIP _____

IPPC PHARMACY

CERTIFICATION

I hereby certify that the information provided on this form is true and complete. I understand that any omission or false or misleading statement information provided on this form, my resume or in other aspects of the employment process may result in termination of my employment and / or personal liability for any damages caused by the submission of false information. A copy of this authorization shall have the same authority as the original.

_____ _____

Date Signature

IPPC PHARMACY

PHARMACY WORK ENVIRONMENT

POLICY

Pharmacy Ownership and Management shall maintain a safe, clean tobacco-free environment for all patients and Pharmacy personnel. Additionally, the Pharmacy does not engage in discriminatory practices regarding hiring eligible individuals with disabilities.

PROCEDURE

- Pharmacy personnel shall maintain clean work areas in both patient and business or administrative areas.
- The Pharmacy has posted Occupational Safety and Health Administration (OSHA) contacts and all mandatory posters.
- Designated smoking areas, where applicable, shall be located in such a manner as to eliminate the exposure of second-hand smoke to the patient and/or Pharmacy personnel. Said areas shall be positioned so as to minimize potential fire hazards in regard to the Pharmacy work environment.
- Trash shall be collected on a daily basis and properly disposed.
- If needed, a ladder shall be available to access products on shelving.
- Should the Pharmacy employ 15 or more people, individual(s) with disabilities shall be provided with reasonable workplace accommodations.

NOTE: Please click the following link to access the Americans with Disabilities Act of 1990 for full details.

Hazardous Supplies and Chemicals

The pharmacy has an OSHA Right to Know Training Program (Hazardous Communication). This training is documented in the employees' Personnel File. The program is reviewed annually with all employees. OSHA information posters are displayed near the employee time clock. All information, documentation and forms are kept in the DMEPOS coordinator's office in a separate binder.

- The pharmacy staff is required to wear gloves when counting oral solids or mixing any compounds.
- Protective gear (safety goggles and gloves) is worn for the handling of hazardous liquids.
- Proper use and cleaning of all medication packaging equipment is taught to appropriate staff that will be using this equipment. Equipment is cleaned on a daily basis.
- All slabs and spatulas are cleaned immediately after compounding.
- Hazardous Waste Materials are picked up as needed by Stericycle Services.
- OSHA standards are reviewed at the annual employees' meeting.

Material Safety Data Sheets (MSDS) shall be maintained for all hazardous supplies and chemicals maintained and used in the Pharmacy or any of its facilities (including warehouses). All employees are to be trained in its use and location.

Pharmacy Owner(s) and Management shall ensure appropriate documentation is available for all hazardous supplies and chemicals to include MSDS and instructions on the use and storage of materials.

Storage:
All Pharmacy personnel shall ensure that supplies and chemicals are properly stored.

Use:
Supplies and chemicals shall be used according to their intended purpose.

Review:
Pharmacy Owner(s) and Management shall work with Pharmacy personnel to ensure any potentially hazardous conditions in the work environments are mitigated.

Hazardous Work Environments

Pharmacy personnel shall notify Pharmacy Owner(s) and Management of any potentially hazardous conditions in the work environment.

Pharmacy Owner(s) and Management shall work with Pharmacy personnel to ensure any potentially hazardous conditions in the work environments are mitigated.

When applicable, Personal Protective Gear shall be provided for Pharmacy personnel. Its proper use is considered mandatory.

Facility's Physical Environment

The Pharmacy and other areas shall be well lit.

Temperature and ventilation shall be maintained as appropriate for Pharmacy personnel, patients, visitors, prescription drugs and DMEPOS products.

Fire Safety Protocols

The Pharmacy adheres to following Fire Safety Protocols:

- Fire Extinguishers shall be tested every two years (or as required by state or local laws).
- All employees shall be trained regarding the current operation of the Pharmacy's fire extinguishers.
- Local fire departments may be contacted to assist in the Pharmacy's fire and safety training.
- All exits are clearly marked with "Exit" signs.

EFFECTIVE DATE: 3/15/2011

IPPC PHARMACY

CULTURAL AWARENESS

POLICY

The Pharmacy values diversity and believes that diversity of backgrounds brings a variety of ideas, perspectives and experiences that will create a productive work environment in which talents are fully utilized. All Pharmacy policies, renumeration opportunities hours of work, performance reviews, corrective or other procedures are designed to promote equal opportunity and protection for all Pharmacy personnel. Religious or cultural beliefs and background, or other issues of diversity are recognized, respected and are considered when providing services, supplies and care to beneficiaries. All pharmacy personnel, regardless of position, are expected to comply with this policy and take appropriate measures to ensure that improper conduct with co-workers and beneficiaries does not occur. Appropriate corrective action will be taken against any Pharmacy personnel who violate this policy.

DEFINITION

Diversity is a collection of individuals bringing together varied demographic, cultural, human, intellectual and philosophical differences in a safe and supportive environment. Most characteristics of diversity are interdependent and may even seem to overlap. Diversity describes people, which is an inexact science. Strict characterization, differences and separations, as well as the degree to which some aspects are more valued than others, are the result of cultural influences and an individual's fixed point-of-view; they are not a part of the definition of diversity, which is naturally all-inclusive.

CHARACTERISTICS

Visible Diversity

- Characteristics over which a person has little or no control, but that contribute to assumptions, expectation, opportunities and identities.
- Includes race, ethnicity, gender, age, sexual orientation and disability.

Cultural Diversity

- Characteristics, over which a person has more control, can impact behaviors, communication, attitudes and identities.
- Includes geographic location, socio/economic status, education, relationship status, parental status, values, beliefs and faith/religion.

Diversity of Thought or Behavior

- Unique characteristics that emerge from visible and environmental diversity and manifest as thoughts, ideas and behaviors, directly impacts view of self and others and the ability to successfully interact with others.
- Includes talents, skills, knowledge, strengths, capabilities, intellect, and emotions, thinking styles, learning styles, communication styles, work styles, habits, hobbies and appearance.

Organizational Diversity

- Characteristics that describe a person's place within an organization.
- Includes length of service, role, position, team, department, business unit, hierarchy and work location.

EFFECTIVE DATE: 3/25/2012

IPPC PHARMACY

FIRE SAFETY PLAN DESIGN

In the event of a fire and/or the alarms sound, all personnel are to evacuate the building. First floor offices and the first-row tech filling stations will utilize the front entrance to evacuate. The rear of the pharmacy from the Pharmacists' station back will use the side entrance to evacuate. All employees are to proceed through the parking lot to the designated meeting spot.

Personnel working in the OPUS and AUTOMED section in the rear of the pharmacy are to exit through the fire door leading to the adjacent building and exit to the parking lot and proceed to designated meeting spot.

Second floor personnel are to use the stairs to the side entrance for evacuation and proceed through the parking lot to the designated area.

In the event that the fire is located in the front of the building, all staff should proceed to the side entrance in an orderly fashion and evacuate.

Once all personnel have left the building, they are to proceed to the end of Ginesi Drive at the Cul de Sac and wait there until Fire Officials give the "ALL CLEAR".

IPPC PHARMACY

CELL PHONE POLICY

- The use of cell phones in the workplace is strictly prohibited by Pharmacy Employees. (Exempt Listed in HR)
- Pharmacy Phones are not for personnel calls either; however, if someone needs to reach you in the event of an emergency, they should contact you through the pharmacy phone.
- Employees are paid to work, not to make personal phone calls, even if the phone calls are made on their personal cell phone.
- Violation of this policy will result in disciplinary action, up to and including termination.

As part of my employment, I _____
Understand that there will be no cell phones, Bluetooth, or any other similar devices, i.e., earpieces or IPODs used while I am working. Use of any devices will lead to immediate dismissal due to my negligence.

_____ _____

Signature Date

_____

Print Name

Revised 1/10/2018.

IPPC PHARMACY

Reprinted from pp 58-59 of the Medicare of the Medicare Prescription Drug Manual – Chapter 9 – Part D Program to Control Fraud, Waste and Abuse.

MEDICARE PART D COMPLIANCE
TRAINING ACKNOWLEDGEMENT RECEIPT

I acknowledge that I have received Medicare Part D Compliance training. Said training has been communicated to me in terms whereby I understand its content. I have been given ample opportunity to ask questions. By signing this acknowledgement receipt, I commit to following the standards and protocols as presented within the Medicare Part D Compliance program.

_____ _____

Pharmacy Personnel Signature Date

_____

Pharmacy Personnel Printed Name

_____ _____

Pharmacy Manager / Owner Signature Date

Eli Korn

_____

Pharmacy Manager / Owner Printed Name

IPPC PHARMACY

STATE AND FEDERAL LAW REQUIREMENTS

PHARMACY FRAUD, WASTE AND ABUSE

The following section describes examples of Pharmacy fraud, waste and abuse. Examples of potential fraud, waste and abuse include but are not limited to:

- INAPPROPRIATE BILLING PRACTICES: Inappropriate billing practices at the Pharmacy level occur when pharmacies engage in the following types of billing practices:
    - Incorrect billing for secondary payers to receive increased reimbursement.
    - Billing for non-existent prescriptions.
    - Billing multiple payers for the same prescriptions, except as required for coordination or benefit transactions.
    - Billing for brand when generics are dispensed.
    - Billing for non-covered prescriptions as covered items.
    - Billing for prescriptions that are never picked up (i.e., not reversing claims that are processed when prescriptions are filled but never picked up).
    - Billing based on "gang visits," e.g., a pharmacist visits a nursing home and bills for numerous pharmaceutical prescriptions without furnishing any specific service to individual patients.
    - Inappropriate use of dispense as written ("DAW") codes.
    - Prescription splitting to receive additional dispensing fees.
    - Drug diversion.
- PRESCRIPTION DRUG SHORTING: Pharmacist provides less than the prescribed quantity and intentionally does not inform the patient or make arrangements to provide the balance but bills for the full-prescribed amount.
- BAIT AND SWITCH PRICING: Bait and switch pricing occurs when a beneficiary is led to believe that a drug will cost one price, but at the point of sale the beneficiary is charged a higher amount.
- PRESCRIPTION FORGIN OR ALTERING: Where existing prescriptions are altered, by an individual without the prescriber's permission to increase quantity or number of refills.
- DISPENSING EXPIRED OR ADULTERATED PRESCRIPTION DRUGS: Pharmacies dispense drugs that are expired or have not been stored or handled in accordance with manufacturer and FDA requirements.
- PRESCRIPTION REFILL ERRORS: A pharmacist provides the incorrect number of refills prescribed by the provider.
- ILLEGAL REMUNERATION SCHEMES: Pharmacy is offered, or paid, or solicits, or receives unlawful remuneration to induce or reward the Pharmacy to switch patients to different drugs, influence prescribers to prescribe different drugs, or steer patients to plans.
- TrOOP MANIPULATION: When a Pharmacy manipulates TrOOP to either push a beneficiary through the coverage gap, so the beneficiary can reach catastrophic coverage gap so that catastrophic coverage is never realized.
- FAILURE TO OFFER NEGOTIATED PRICES: Occurs when a Pharmacy does not offer a beneficiary the negotiated price of a Part D drug.

IPPC PHARMACY

Prescription Drug Fraud, Waste and
Abuse Training Affidavit

I completed the IPPC Pharmacy Prescription Drug Fraud, Waste and Abuse Training on _____ (**Date**). I understand the importance of abiding by the requirements presented in the training related to CMS Part D Prescription Drug Program and the Federal False Claims Act. I also understand assistance is available to address any questions about the presentation.

_____ _____

Name (Please Print) Signature

_____

Title

IPPC PHARMACY

_____

Company Name (Please Print)

732-617-8686

_____

Telephone Number

AGREEMENT NOT TO COMPETE

IN CONSIDERATION OF I.P.P.C. PHARMACY (hereinafter referred to as the "Corporation") employing me at this time, I _____ hereby covenant and agree with the Corporation as follows:

1. Non-Compete. I will not do or attempt to do any of the following, either directly or indirectly, during my employment or during the period of {2} years after employment terminates, within {30} miles of any business of the Corporation or within the radio, cable or television marketing range of any business of the Corporation: (a) compete against the Corporation; (b) carry on a business similar to the Corporation's business; (c) engage in a business similar to the Corporation's business; (d) solicit old customers of the Corporation; (e) or own, manage, be employed by, work for, consult for, be an officer or director or, advise, represent, engage in, or carry on any business engaged in the practice of long term care pharmacy services or any other business similar to the type of business engaged in by the Corporation at that time.

2. Injunction and Damages. I agree that this Agreement is important, material, confidential, and gravely affects the effective and successful conduct of the business of the Corporation and affects its reputation and good will. The Corporation is entitled to obtain an injunction and damages for any breach of this Agreement, including but not limited to compensatory, incidental, consequential, exemplary, and lost-profits damages. I agree to pay the Corporation's attorneys' fees, litigation expenses and costs for enforcement of this Agreement if I breach this Agreement.

3. Miscellaneous. Wherever used in this agreement, the phrase "directly or indirectly" includes, but is not limited to, acting through my wife, children, parents, brothers, sisters, or any other relatives, friends, trustees, agents, or associates. The Corporation may waive a provision of this Agreement only in a writing signed by the President of the Corporation and specifically stating what is waived. The rights of the Corporation under this Agreement may be assigned, but I may not assign my rights or obligations under this Agreement. The title of this Agreement and the paragraph headings of this Agreement are not substantive parts of this Agreement and shall not limit or restrict this Agreement in any way. This Agreement is not a contract for future employment and does not change the fact that my employment may be terminated at any time by either me or the Corporation. This Agreement survives after my employment terminates. No change, addition, deletion or amendment of this Agreement shall be valid or binding upon me or the Corporation unless in writing and signed by me and the Corporation. This agreement is in addition to any other jurisdiction finally determines this agreement to be unreasonable, then said court may reduce the term or years or the geographical range, or both, so as to be reasonable.

AGREEMENT NOT TO COMPETE:

EMPLOYEE	I.P.P.C. PHARMACY
	Eli Korn
_____	BY: _____
EMPLOYEE NAME	CORP. OFFICER'S NAME
DATE: _____	DATE: _____

CONSUMER REPORT AUTHORIZATION AND DISCLOSURE FORM

I authorize IPPC Pharmacy to request and procure an investigative consumer report concerning me for employment purposes. I understand that this investigative consumer report may include information concerning my character, general reputation, personal characteristics, and mode of living. I understand that investigative information may be obtained through personal interviews with my neighbors, friends, associates, or other acquaintances.

I also authorize IPPC Pharmacy to communicate the information in my investigative consumer reports to any of its divisions, departments, parents, and subsidiaries as may be necessary for legitimate business needs. I understand that if I do not wish such information to be communicated to such affiliates, I will notify IPPC Pharmacy's Management in writing within five (5) business days of signing this Authorization and Disclosure Form.

I understand that IPPC Pharmacy will provide me with a copy of the investigative report it may have procured if I request such a copy of such investigative report within thirty (30) days after signing this Authorization and Disclosure Form. I also understand that, if I make such a request, IPPC Pharmacy will mail or otherwise deliver me a copy of the investigative report within five (5) days of the date of my request or of the date on which IPPC Pharmacy receives the investigative report, whichever is later.

This authorization is continuing, and does not expire, so that IPPC Pharmacy may use this same authorization at some time(s) in the future to request and procure additional reports as may be necessary for employment purposes, including but not limited to future promotion or retention.

A Summary of Your Rights User the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) is designed to promote accuracy, fairness, and privacy of information in the files of every "consumer reporting agency" (CRA). Most CRAs are credit bureaus that gather and sell information about you – such as if you pay your bills on time or have filed bankruptcy – to creditors, employers, landlords, and other businesses. You can find the complete text of the FCRA, 15 U.S.C. 1681 – 1681 u. at the Federal Trade Commission's web site (http://ftc.gov). The FCRA gives you specific rights, as outlined below. You may have additional rights under state law. You may contact a state of local consumer protection agency or a state attorney general to learn those rights.

- **You must be told if information in your file has been used against you.** Anyone who uses information from a CRA to take action against you – such as denying an application for credit, insurance, or employment – must tell you,, and give you the name, address, and phone number of the CRA that provided the consumer report.
- **You can find out what is in your file.** At your request, a CRA must give you the information in your file, and a list of everyone who has requested if recently. There is no charge for the report if a person has taken action against you because of information supplied by CRA, if you request the report within 60 days of receiving notice of the action. You are also entitled to one free report every twelve months upon request if you certify that (1) you are unemployed and plan to seek employment within 60 days, (2) you are on welfare, or (3) your report is inaccurate due to fraud. Otherwise, a CRA may charge you up to eight dollars.
- **You can dispute inaccurate information with the CRA.** If you tell a CRA that your file contains inaccurate information, the CRA must investigate the items (usually within 30 days) by presenting to its information source all relevant evidence you submit, unless your dispute is frivolous. The source must review your evidence and report its

findings to the CRA. (The source also must advise national CRAs – to which it has provided the data – of any error.) The CRA must give you a written report of the investigation and a copy of your report if the investigation results in any change. If the CRA's investigation does not resolve the dispute, you must add a brief statement to your file. The CRA must normally include a summary of your statement in future reports. If an item is deleted or a dispute statement is filed, you may ask that anyone who has recently received your report be notified of the change.

- **Inaccurate information must be corrected or deleted.** A CRA must remove or correct inaccurate or unverified information from its files, usually within 30 days after you dispute it. However, the CRA is not required to remove accurate data from your file unless it is outdated (as described below) or cannot be verified. If your dispute results in any change to your report, the CRA cannot reinsert into your file a disputed item unless the information source verifies its accuracy and completeness. In addition, the CRA must give you a written notice telling you it has reinserted the item. The notice must include the name, address and phone number of the information source.
- **You can dispute inaccurate items with the source of the information.** If you tell anyone – such as a creditor who report to a CRA – that you dispute an item, they may not then report the information to a CRA without including a notice of your dispute. In addition, once you've notified the source of the error in writing, it may not continue to report the information if it is, in fact, an error.
- **Outdated information may not be reported.** In most cases, a CRA may not report negative information that is more than seven years old; ten years for bankruptcies.
- **Access to your file is limited.** A CRA may provide information about you only to people with a need recognized by the FCRA – usually to consider an application with a creditor, insurer, employer, landlord, or other business.
- **Your consent is required for reports that are provided to employers, or reports that contain medical information.** A CRA may not give information about you to your employer, or prospective employer, without your written consent. A CRA may not report medical information about you to creditors, insurers, or employers without your permission.
- **You may choose to exclude your name from CRA lists for unsolicited credit and insurance offers.** Creditors and insurers may use file information as the basis for sending you unsolicited offers of credit or insurance. Such offers must include a toll-free phone number for you to call if you want your name and address removed from future lists. If you call, you must be kept off the lists for two years. If you request, complete, and return the CRA form provided for this purpose, you must be taken off the lists indefinitely.
- **You may seek damages from violators.** If a CRA, a user or (in some cases) a provider of CRA data, violates the FCRA, you may sue them in state or federal court.

The FCRA gives several different federal agencies authority to enforce the FCRA:

FOR QUESTIONS OR CONCERNS REGARDING:	PLEASE CONTACT:
CRAs, creditors and others not listed below	Federal Trade Commission Consumer Response Center – FCRA Washington, DC 20580 202-326-3761
National banks, federal branches / agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)	Office of the Comptroller of the Currency Compliance Management, Mail Stop 6-6 Washinton, DC 20219 800-613-6743
Federal Reserve System member banks (except national banks, and federal branches / agencies of foreign banks)	Federal Reserve Board Division of Consumer & Community Affairs Washington, DC 20551 202-452-3693
Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institutions name)	Office of Thrift Supervision Consumer Programs Washington, DC 20552 800-842-6929
Federal credit unions (words "Federal Credit Union" appear in institutions name)	National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 703-518-6360
State-chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Division of Compliance & Consumer Affairs Washinton, DC 20429 800-934-FDIC
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission.	Department of Transportation Office of Financial Management Washinton, DC 20590 202-366-1306
Activities subject to the Packers and Stockyards Act. 1921	Department of Agriculture Office of Deputy Administrator – GIPSA Washinton, DC 20250 202-720-7051

_____ _____

Signature Date

IPPC PHARMACY

Employee Confidentiality and Non-Solicitation Agreement
(ADDENDUM)

Employee: _____ Date: _____, 20_____

WHEREAS Employee is or is about to be employed as an agent or employee of the Company; and serves at the will of the Company; and

WHEREAS the parties desire that the Employee enter into covenants with the Company.

NOW THEREFORE, in consideration of Company employing Employee at this time, which employment may be terminated at will by either party at any time. Employee hereby agrees to the terms as follows in addition to the previous agreement that I have signed.

1. **Disclosure of Customers or Suppliers.** Employee will not at any time, either during employment or during the period of three (3) years after employment terminates, in any fashion, form or manner, either directly or indirectly, divulge, disclose or communicate to any person, firm or Company in any manner whatsoever, any confidential information regarding the operations of the Company, including, but not limited to, information concerning manufacturing processes, sales techniques, pricing and prices, supplies and suppliers, advertising and advertisements, and names of customers. The Employee agrees said confidential information is proprietary to the Company and constitutes a trade secret owned exclusively by the Company, the disclosure or which would be harmful and damaging to the Company's business.
2. **Not to Solicit Customers, Suppliers, or Advertisers.** Employee will not, either during employment or during the period of three (3) years after termination of employment, directly or indirectly, either for himself, herself, or for any other person, firm, or Company, take any action or perform any services which are similar to the actions taken or services performed by Employee for Company during said time which actions or services are designed to or in fact call upon, compete for, solicit, divert, or take away, or attempt to divert or take away, any of the customers, suppliers, endorsers or advertisers of the Company.
3. Company Ownership and Non-Disclosure of Trade Secrets
   Employee in connection with Employee's employment with the Company, Employee may become aware of or familiar with processes, formulae, procedures, information and materials which the Company has spent a great deal of time and money to develop, which are essential to the business of the Company, and which comprise confidential information and trade secrets of the Company (collectively called "Trade Secrets"). The term "Trade Secret" does not include any process, formula, procedure, information or material that is currently in the public domain or which hereafter becomes public knowledge in a way that does not involve a breach of an obligation of confidentiality. Notwithstanding the foregoing, employee acknowledges and agrees that any process, formula, procedure, information or material of which Employee becomes aware during Employee's employment with the Company is presumed to be a Trade Secret unless the Company advises Employee in writing that it is not a Trade Secret.

(a) In order to induce the company to employ Employee, and in consideration thereof, Employee agrees that Employee will not during the term of Employee's employment with the Company and at all times thereafter, either directly or indirectly, use or disclose to anyone any Trade Secrets, except what while Employee is employed by the Company. Employee may use Trade Secrets in the performance of Employee's services for the Company and Employee may disclose Trade Secrets to employees of the company who need to know them in the performance of their services for the Company and who are bound by confidentiality agreements. Employee also agrees that the Company will be entitled to and will own all the results and proceeds of Employee's services for the Company including, without limitation all rights throughout the world to any copyright, patent, trademark or other right to all ideas, inventions, products, programs, procedure, formats and other materials of any kind created, developed or worked on by Employee during Employee's employment with the Company.

(b) Without limiting the foregoing, it will be presumed that any copyright, patent, trademark or other right and any idea, invention, product, program, procedure, format or material created, developed or worked on by Employee's service for the Company. Employee will take such action and execute such documents as the Company may request to warrant and confirm the Company's title to and ownership of all such results and proceeds and to transfer and assign to the Company any rights which employee may have therein. Employees' right to compensation and other benefits will not constitute a lien or any such results or proceeds.

4. Employee's Compliance with HIPPA and Other Applicable Laws. Employee agrees that Employee shall comply with all other laws, statutes, codes, rules and regulations governing Employee in the performance of Employee's services to the Company, including but not limited to, The Health Insurance Portability and Accountability Act of 1966 (HIPPA).

(a) I have received a Policy and Procedure Manual, Volume Number _____. I understand that the information contained within is the property (intellectual property of) IPPC Pharmacy.

(b) I understand that this information is strictly confidential and in no form, (fax, photocopy, etc.) partial or whole, may be communicated with any other individual in any form outside of a current authorized employee of the Company.

(c) I understand that I cannot remove said manual in its original form or any other form, partial or whole, from the premises of 703 Ginesi Drive, Morganville, NJ 07751.

(d) I take full responsibility for this manual and will in no manner disclose any of its contents to any outside person.

(e) The term of this agreement is three (3) years after separation from IPPC Pharmacy.

(f) The information contained within is protected by HIPPA and can be prosecuted under such if a breach occurs.

EMPLOYEE: _____

Eli Koru, IPPC Pharmacy

EMPLOYER: _____

POLICY: WHISTLEBLOWER

Policy: Whistleblower

Manual: Corporate Compliance Chapter: Workplace Conduct and Employer-Employee Practices

Review responsibility: _____ of IPPC Pharmacy and IPPC Pharmacy, _____.

By: _____ Reviewed: _____ Revised: _____

Policy applies to: All (x) All clinical staff ( )

Committee Endorsement:

(If applicable)

Approval: _____, President

POLICY: The purpose of this policy is to state clearly and unequivocally that IPPC Pharmacy prohibits discrimination, harassment and/or retaliation against any employee who provides information or otherwise assists in an investigation or proceeding regarding any conduct which he or she reasonably believes to be a violation of any federal and/or state law, rule or regulation, including, but not limited to, the federal false claim act, the Anti-Kickback statute, federal or state Pharmacy self-referral laws (i.e. Stark and Codey), EMTALA, New Jersey Pharmacy Licensing Standards, the Social Security Act and/or state Medicaid Act, or federal and/or state laws regarding mail and wire fraud.

Everyone at IPPC Pharmacy is responsible for assuring that the workplace is free from all forms of discrimination, harassment and retaliation prohibited by this policy. However, this does not mean that an employee can avoid corrective action or other form of discipline for poor work or wrongful acts by reporting his or her own inadequate performance. It does mean that the consequence of poor performance may not be more severe because an employee has made the report on his or her own. No officer, employee, agent, contractor or subcontractor of IPPC Pharmacy has the authority to engage in any conduct prohibited by this policy. Therefore, it is the policy of IPPC Pharmacy that no retaliatory action (including termination, suspension, demotion, discrimination, or harassment) shall be taken against an employee because the employee undertakes any of the following:

(1) Discloses, or threatens to disclose to a supervisor or to a public body an activity, policy or practice of IPPC Pharmacy or another employer, with whom IPPC Pharmacy has a business relationship, that the employee reasonably believes is in violation of a law, or a rule or regulation promulgated pursuant to law.

(2) Provides information to, or testifies before, any public body conducting an investigation, hearing or inquiry into any violation of law, rule or regulation promulgated pursuant to law by IPPC Pharmacy or another employer, with whom IPPC Pharmacy has a business relationship, or in the case of an employee who is a licensed or certified health care professional, provides information to, or testifies before any public body conducting an investigation, hearing or inquiry into the quality of patient care; or

(3) Objects to, or refuses to participate in any activity, policy or practice which the employee reasonably believes:

a. Is in violation of a law, rule or regulation promulgated pursuant to law, or if the employee is a licensed or certified health care professional, constitutes improper quality of patient care.

b. Is incompatible with a clear mandate of public policy concerning public health, safety or welfare or protection of the environment.

PURPOSE: To assure that no employees are subject to retaliation as a result of protected conduct occasioned by the honest and dutiful reporting of prohibited workplace conduct.

SCOPE: Corporate Compliance Manual

PROCEDURE:

Any employee who believes that they have been retaliated against for engaging in the protected conduct outlined above is strongly encouraged to immediately report the facts forming the basis of that belief or knowledge to his or her immediate supervisor, department director and/or the corporate compliance officer. An employee may also use the IPPC Pharmacy Confidential Message Reporting Line ("Helpline" at 832-617-8686 ext. 117) to report suspected wrong doings. Upon receiving a complaint, IPPC Pharmacy will promptly conduct a thorough investigation. Those responsible for the investigation will maintain the confidentiality of the allegations of the complaint and the identity of the persons involved, subject to the need to conduct a full and impartial investigation, remedy.

Any violations of the IPPC Pharmacy policies or monitor compliance with or administer IPPC Pharmacy policies. The investigation generally will include but will not be limited to, discussion with the complaining employee (unless the complaint was submitted on an anonymous basis), the party against whom allegations have been made, and witnesses, if appropriate, participates in IPPC Pharmacy investigation. In the event that an investigation establishes that an employee has engaged in conduct or actions constituting discrimination, harassment and/or retaliation in violation of this policy, IPPC Pharmacy will take immediate and appropriate corrective action up to and including termination of that employee's employment.

"Employee" means any individual who performs services or and under the control and direction of IPPC Pharmacy for wages or other renumeration.

"Public Body" means:

(1) The United States Congress, and State legislature, or any popularly elected local governmental body, or any member or employee thereof;

(2) Any federal, state, or local judiciary, or any member or employee thereof, or any grand or petit jury;

(3) Any federal, state or local regulatory, administrative, or public agency or authority or instrumentality thereof;

(4) Any federal, state or local law enforcement agency, prosecutorial office, or police or peace officer;

(5) Any federal, state or local department of an executive branch of government; or

(6) Any division, board, bureau, office, committee or commission of any of the public bodies described in the above paragraphs.

"Supervisor" means any individual with IPPC Pharmacy who has authority to direct and control the work performance of the affected employee, who has authority to take corrective action regarding the violation of the law, rule or regulation of which the employee complains, or who has been designated by the IPPC Pharmacy to do so.
"Retaliatory action" means the discharge, suspension or demotion of any employee, or other adverse employment action taken against an employee in the terms and conditions of employment.
"Improper quality of patient care" means with respect to patient care, any practice, procedure, action or failure to act of IPPC Pharmacy which violates any law, or any rule, regulation or declaratory ruling adopted pursuant to law, or any professional code of ethics.

EXAMPLE:
Pharmacist A criticizes the actions of Pharmacist B regarding the dispensing of Medications to patients. Pharmacist A claims that Pharmacist B was providing insufficient pain medications to the patients and that the patients were suffering as a result. Pharmacist B, an older but equal level Pharmacist to Pharmacist A, is offended and tells Pharmacist A to keep his opinion to himself. Pharmacist A communicated his belief to his supervisor. There is a great deal of tension between the two after this confrontation. Pharmacist A feels Pharmacist B is rude to him and refuses to listen or cooperate. Pharmacist A subsequently discloses to the Pharmacist supervisor that he believes Pharmacist B is stealing medication from patients to feed her own addiction to pain killers. The Pharmacist supervisor, who has worked with Pharmacist B for 20 years, dismisses the allegation without investigation and transfers Pharmacists A to a different position with less hours and less compensation. The Pharmacist supervisor contends that the tension caused by the criticism and allegation by Pharmacists A has "poisoned the atmosphere" to such a degree that someone must be transferred to preserve quality of patient care.

QUESTION:
In what ways has the Corporate Compliance-Whistleblower been implicated here?

ANSWER:
The action against Pharmacist A may be deemed to have violated the New Jersey Conscientious Employee Protection Act ("CEPA"). Pharmacist A may claim protection under the IPPC Pharmacy Whistleblower policy as well as the CEPA statute since he communicated to his supervisor what he reasonably believed to be a violation of the law by Pharmacist B due to the action by Pharmacist B which he reasonably believed constituted improper quality of patient care. The supervisor failed to investigate the claims of Pharmacist A and arguably retaliated against him by transferring him to a lesser position. The fact Pharmacist A was complaining about a co-worker still would likely deem him protected under the statute and policy.

EMPLOYMENT ARBITRATION CLAUSE

Should any dispute between Employee and IPPC arise at any time out of any aspect of the employment relationship, but not limited to, the hiring, performance or termination of employment and/or cessation of employment with IPPC and/or against any employee, officer, alleged agent, director, affiliate, subsidiary or sister company relationship, or relating to an application or candidacy for employment, Employee and Employer will confer in good faith to resolve promptly such dispute. In the event that Employer and Employee are unable to resolve their dispute and should either desire to pursue a claim against the other party, both Employer and Employee agree to have the dispute resolved by final and binding Arbitration. The Employee and Employer agree that the Arbitration shall be held in the county and state where Employee currently works for Employer or most recently worked for Employer.

The Arbitration shall be conducted by an Arbitrator(s) provided by an impartial third-party Arbitration provider, National Arbitration and Mediation ("NAM"), and be subject to NAM's Employment Rules and Procedures and the Fee Schedule in effect, or for general inquiries regarding the dispute resolution process, NAM can be contacted at 1-800-358-2550, Att: Employment Division.

All previously unasserted claims arising under federal, state, or local statutory or common law and all disputes relating to the validity of this contract, as well as this Arbitration provision, shall be decided by final and binding Arbitration. Any award of the Arbitrator(s) is final and binding and may be entered as a judgement in any court of competent jurisdiction. In the event a court having jurisdiction finds any portion of this agreement unenforceable, that portion shall not be effective, and the remainder of the agreement shall remain in effect.

_____

EMPLOYEE

_____

DATE

IPPC PHARMACY

By signing below, you attest that you have received and read a job description for your position and that you understand your duties and responsibilities.

_____	_____
PRINTED NAME	POSITION
_____	_____
SIGNATURE	DATE

IPPC PHARMACY

COVID-19 INFECTION PREVENTION PROGRAM

Employee Acknowledgement Form

IPPC, Inc. is committed to preventing workplace hazards that could result in employee injury and/or illness, and to complying with all applicable state and local occupational health and safety guidelines and regulations. This acknowledgement confirms that you have received, read and understand IPPC, Inc COVID-19 Infection Prevention Program and are willing to follow the expectations established by our COVID-19 Infection Prevention Program. Please initial and sign in the spaces provided.

By initialing below, I _____, acknowledge that I have received training provided by IPPC, Inc. to help make sure I understand the dangers or COVID-19 including (initial):

_____ COVID-19 and how it is spread.
_____ Symptoms of COVID-19 infection and when to seek medical attention.
_____ Importance of not coming to work when ill.
_____ Steps to prevent the spread of COVID-19 infection.
_____ Coughing and sneezing etiquette.
_____ Importance of frequent hand washing/hand sanitizing.
_____ Importance of maintaining safe physical distancing.
_____ Safely using cleaners and disinfectants on surfaces and objects.
_____ COVID-19 Infection Prevention Program information and expectations.
_____ Method to report issues or suggest improvements to the COVID-19 Infection Prevention Program.

EMPLOYEE RESPONSIBILITIES

I, _____, also understand IPPC, Inc. has established a list of expectations. By initialing below, I acknowledge my responsibility to prevent the spread of COVID-19 in the workplace, including but not limited to:

_____ Self-monitor my health on a daily basis.
_____ Stay at home when sick and avoid close contact with others.
_____ Keep a minimum distance of 6 feet from others when possible.
_____ Refrain from shaking hands, hugging, or touching others.
_____ Avoid unnecessary interaction with others outside my immediate work area or work team.

_____ Clean surfaces in common areas and shared equipment before and after use.
_____ Wash hands with soap and water or use hand sanitizer.
_____ Wash/sanitize hands multiple times daily, including before/after work, breaks, eating, going to the restroom, and after coughing, sneezing, or blowing nose.
_____ Avoid touching mouth, nose, and eyes.
_____ Wear face covering, and other personal protective equipment as required by my company.
_____ Cover mouth and nose when coughing or sneezing and immediately wash hands.
_____ Avoid sharing personal items with coworkers (food, dishes, lunch boxes, gloves, etc.)
_____ Report any safety violations, issues, and suggestions regarding the COVID-19 Infection Prevention Program.

If I have tested positive for COVID-19, identify symptoms, or have interacted with someone infected with COVID-19, I will:

_____ Immediately communicate the presence of symptoms to my supervisor.
_____ Immediately communicate to my supervisor when I have interacted with someone with COVID-19 either at or outside of the workplace.
_____ Go home immediately after discovering symptoms or as instructed.
_____ Immediately contact a medical professional by phone before going to a medical facility.
_____ Provide my supervisor with names of people in the workplace I've interacted with.
_____ Notify HR when the doctor allows my safe return to work.

INFECTION PREVENTION PROGRAM RECEIPT

I have received a copy of IPPC, Inc. COVID-19 Infection Prevention Program on the date listed below. I understand I am expected to follow the program at all times and to report any issues or suggestions I may have to improve it.

Please sign two copies of this Acknowledgement of Receipt, retain one copy for yourself, and return one copy to Stephanie O'Rourke. A copy of the signed form will be retained in your personnel file.

_____

Employee Name (print)

_____

Employee Signature

_____

Date

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 3. Cat. No. 10220Q Form **W-4** (2023)

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $ _____

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $ _____

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $ _____

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $ _____

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . 3 _____

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . 4 $ _____

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $ _____

2 Enter:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 if you're single or married filing separately

. . . . . 2 $ _____

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $ _____

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . 4 $ _____

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $ _____

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

PAYCHEX

Direct Deposit Enrollment/Change Form*

Company Name and/or Client Number ____

Employee/Worker Name__________________________ **Employee/Worker Number** __________

Employee/Worker: Retain a copy of this form for your records. Return the original to your employer/company.

Employer/Company: Please retain a copy of this document for your records.

COMPLETE TO ENROLL / ADD / CHANGE BANK ACCOUNTS – *PLEASE PRINT CLEARLY IN BLACK/BLUE INK ONLY*

Add new	Update existing account	Replace existing account	Last 4 digits of the existing account number ☐☐☐☐
Type of Account Checking Savings	Account holder's Name:		
Routing/Transit Number ☐☐☐☐☐☐☐☐☐			
Checking/Savings Account Number** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐			
Financial Institution ("Bank") Name			
I wish to deposit (check one): _____% of Net	Specific Dollar Amount $ ____________ .00	Remainder of Net Pay	

Add new	Update existing account	Replace existing account	Last 4 digits of the existing account number ☐☐☐☐
Type of Account Checking Savings	Account holder's Name:		
Routing/Transit Number ☐☐☐☐☐☐☐☐☐			
Checking/Savings Account Number** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐			
Financial Institution ("Bank") Name			
I wish to deposit (check one): _____% of Net	Specific Dollar Amount $ ____________ .00	Remainder of Net Pay	

Add new	Update existing account	Replace existing account	Last 4 digits of the existing account number ☐☐☐☐
Type of Account Checking Savings	Account holder's Name:		
Routing/Transit Number ☐☐☐☐☐☐☐☐☐			
Checking/Savings Account Number** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐			
Financial Institution ("Bank") Name			
I wish to deposit (check one): _____% of Net	Specific Dollar Amount $ ____________ .00	Remainder of Net Pay	

CONFIRMATION STATEMENT – *PLEASE PRINT CLEARLY IN BLACK/BLUE INK ONLY*

I authorize my employer/company to deposit my earnings into the bank account(s) specified above and, if necessary, to electronically debit my account to correct erroneous entries. I certify my account(s) allow these transactions. Furthermore, I certify that the above listed account number accurately reflects my intended receiving account. I agree that direct deposit transactions I authorize comply with all applicable laws. My signature below indicates that I am agreeing that I am either the accountholder or have the authority of the accountholder to authorize my employer/company make direct deposits into the named account. I understand that this authorization will remain in full force and effect until I notify Company in writing that I wish to revoke my authorization.I understand that the Company requires at least 5 business days prior notice to cancel this authorization.

➡ **Employee/Worker Signature** ________________________________ **Date:** ____________ MM/DD/YY

I confirm that the above named employee/worker has added or changed a bank account for direct deposit transactions processed by Paychex, Inc. I have reviewed the information provided and it is accurate to the best of my knowledge. My signature below indicates that I have the authority to execute this document on behalf of the Client.

Employer/Company Representative Printed Name: ___________________________

➡ **Employer/Company Representative Signature:** ________________________________ **Date:** ____________ MM/DD/YY

* **All fields are required except Employee/Worker Number.**

** **Certain accounts may have restrictions on deposits and withdrawals. Check with your bank for more information specific to your account.**

Note: Digital or Electronic Signatures are not acceptable.

DP0002 10/20

Form Expires 10/31/23