ALL COUNTY STAFFING, INC.
LICENSED NURSE REGISTRY

INDEPENDENT CONTRACTOR HR FOLDER CHECKLIST

Contractor's Name: _____ SS#: ____- ____- ____ DOB: __/__/____ Phone # _____

☐ **RN** ☐ **LPN** ☐ **CNA** ☐ **HHA** ☐ **Homemaker/Companion**

Documents

☐ Signed Contract:	Completed On: ____/____/_____
☐ W-9 Form	Completed On: ____/____/_____
☐ I-9 Form	Completed On: ____/____/_____
☐ Liability Insurance	Exp. Date: ____/____/_____
☐ Reference Letter Sent _____	Received: ____/____/_____
☐ Orientation:	Completed On: ____/____/_____
☐ RN/ LPN License	Expiration Date: ____/____/_____
☐ Verification of License/Certificate	Completed On: ___/__/___ Annual Reconf. ____/____/___
☐ CNA/ HHA Certification:	Exp. Date: ____/____/_____
☐ Social Security Card:	Received On: ____/____/_____
☐ Driver's License	Exp. Date: ____/____/_____
☐ Car Insurance	Exp. Date: ____/____/_____
☐ Proof of Citizenship/Alien Card	Exp. Date: ____/____/_____
☐ CPR Card	Exp. Date: ____/____/_____
☐ Health Certificate /Physical	Exp. Date: ____/____/_____
☐ PPD/ Chest X-Ray	Exp. Date: ____/____/_____
☐ Level 2 Background Check	Exp. Date: ____/____/_____
☐ Registration Policies /Contractor Description	Completed On: ____/____/____

In-Services

☐ Domestic Violence	Exp. Date: ____/____/_____
☐ Alzheimer's/Dementia Update	Exp. Date: ____/____/_____
☐ HIV Update	Exp. Date: ____/____/_____
☐ HIPPA Update	Exp. Date: ____/____/_____
☐ OSHA, Infection Control	Exp. Date: ____/____/_____
☐ Self-Administered Medication	Exp. Date: ____/____/_____
☐ Communications cognitively impaired patients (CNAs)	Exp. Date: ____/____/_____
☐ Resident Rights (CNAs)	Exp. Date: ____/____/_____
☐ Medical Records Documentation (CNAs)	Exp. Date: ____/____/_____
☐ Medical Errors Update (CNA, LPN, RN)	Exp. Date: ____/____/_____
☐ Florida laws and rules (LPN, RN)	Exp. Date: ____/____/_____
☐ Human Trafficking (LPN, RN)	Exp. Date: ____/____/_____
☐ Recognizing Impairment in the Workplace (LPN, RN)	Exp. Date: ____/____/_____

Revised 6/2/2017

ALL COUNTY STAFFING, INC.
INDEPENDENT CONTRACTOR EMPLOYMENT APPLICATION - PAGE 1 OF 2

1. PERSONAL INFORMATION:

LAST NAME:	FIRST NAME:	DOB:	SSN:
ADDRESS:	CITY:	STATE:	ZIP:
EMAIL:	COUNTRY OF ORIGIN:	RACE:	RELIGION:
HOME PHONE:	CELL #:	OTHER#:	REFERRED BY:

2. CONTRACT POSITION DESIRED:

☐ RN	☐ LPN	☐ CNA	☐ HHA	☐ COMPANION/ HOMEMAKER	DATE YOU CAN START:	CONTRACT COMPENSATION DESIRED:
OTHER:				LICENSE/ CERTIFICATE #:		LICENSE EXPIRATION DATE:

ARE YOU EMPLOYED/ CONTRACTED NOW? ☐YES ☐ NO	IF SO, MAY WE INQUIRE OF YOUR PRESENT POSITION? ☐YES ☐ NO
ARE YOU A VETERAN? ☐YES ☐ NO	DID YOU CONTRACT WITH THIS REGISTRY BEFORE? ☐YES ☐ NO
ARE YOU GOING TO SCHOOL? ☐YES ☐ NO	WHEN?

WHAT LANGUAGES CAN YOU SPEAK FLUENTLY: ☐ ENGLISH ☐ SPANISH ☐ OTHER:

3. IN CASE OF EMERGENCY, PLEASE NOTIFY:	NAME:	RELATIONSHIP:
ADDRESS:	PHONE:	ALT. PHONE #:

4. EXPERIENCE: (CHECK ALL THAT APPLY)

☐ ALZHEIMERS	☐ LIFTING PATIENTS	☐ DIABETIC DIET
☐ STROKE	☐ BROKEN HIP	☐ KOSHER DIET
☐ CATHETER	☐ BYPASS SURGERY	☐ LOW SALT DIET
☐ DEMENTIA	☐ FEEDING TUBES	☐ DEHYDRATION
☐ HIV	☐ BREATHING TREATMENTS	☐ CONSTIPATION
☐ WHEELCHAIR	☐ HEARING/ VISION PROBLEMS	☐ INCONTINENCE
☐ BED RIDDEN	☐ CANCER	☐ HEART PROBLEMS

5. WORK AVAILABILITY: (CHECK ALL THAT APPLY)

☐ LIVE IN/ OUT	☐ WEEKDAYS	☐ LIVE IN/ OUT	☐ WEEKENDS	DO YOU HAVE ANY PHYSICAL DISABILITIES THAT WILL PREVENT YOU FROM PERFOMING THE JOB YOU ARE APPLYING FOR?
DRIVER'S LICENSE NUMBER:				☐ YES ☐ NO
OWN CAR? ☐ YES ☐ NO	MAKE:	MODEL:	YEAR:	HAVE YOU EVER BEEN INJURED? ☐ YES ☐ NO
☐ F/T	☐ P/T	☐ DAYS	☐ NIGHTS	AVAILABILITY SCHEDULE:

6. REFERENCES – PERSONAL (LIST 2 PERSONS NOT RELATED TO YOU THAT YOU HAVE KNOWN AT LEAST ONE YEAR)

NAME:	ADDRESS:	PHONE:	BUSINESS:	YRS KNOWN:

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ALL COUNTY STAFFING, INC.
INDEPENDENT CONTRACTOR EMPLOYMENT APPLICATION - PAGE 2 OF 2

7. EDUCATION:

SCHOOL NAME:	LOCATION:	YRS ATTENDED	GRADUATED?	SUBJECTS STUDIED/ DIPLOMA:
GRAMMER SCHOOL:				
HIGH SCHOOL:				
COLLEGE:				

8. ADDITIONAL EDUCATION: SUBJECTS OF SPECIAL STUDY OR SPECIAL TRAINING/ SKILLS

1.

2.

3.

4.

5.

9. FORMER CONTRACT EMPLOYERS (LIST YOUR LAST FOUR EMPLOYERS WITH CURRENT ONE FIRST)

FROM: DD/MM/YY	TO: DD/MM/YY	EMPLOYER'S NAME/ADDRESS	EARNINGS	POSITION	REASON YOU LEFT

10. AUTHORIZATION STATEMENT:

I CERTIFY THAT THE FACTS CONTAINED IN THIS APPLICATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT, IF CONTRACTED, FALSIFIED STATEMENTS ON THIS APPLICATION SHALL BE GROUND FOR TERMINATION OF THIS CONTRACT.

I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED HEREIN AND THE REFERENCES AND EMPLOYERS/CONTRACTORS LISTED ABOVE MAY GIVE YOU ANY AND ALL INFORMATION CONCERNING MY PREVIOUS WORK HISTORY AND ANY PERTINENT INFORMATION THEY MAY HAVE, PERSONAL OR OTHERWISE, AND RELEASE THE COMPANY FROM ALL LIABILITY FOR ANY DAMAGE THAT MAY RESULT FROM UTILIZATION OF SUCH INFORMATION.

I ALSO UNDERSTAND AND AGREE THAT NO REPRESENTATIVE OF THE COMPANY HAS THE AUTHORITY TO ENTER INTO ANY AGREEMENT FOR EMPLOYMENT. IF CONTRACT IS OFFERED, WORK SHALL BE PERFORMED AS AN INDEPENDENT CONTRACTOR ONLY.

DATE:	SIGNATURE:	PRINT NAME:

>> DO NOT WRITE BELOW THIS LINE <<

INTERVIEWED BY:	INTERVIEW DATE:

INTERVIEWER REMARKS:

PER DIEM INDEPENDENT CONTRACTOR AGREEMENT

ALL COUNTY STAFFING, INC.
LICENSED NURSE REGISTRY

On this _____day of _____, 20___ ("Effective Date"), an agreement is made between All County Staffing Inc. a nurse registry licensed under Florida Statues 400.506 , located at 4850 N. State Road 7, Bldg G Suite 101 Lauderdale Lakes, FL 33319 hereinafter referred to as "the Registry" and _____, a Registered Nurse, Licensed Practical Nurse, Certified Nurse Assistant, Home Health Aide, Homemaker or Companion (circle one) herein after referred to as "Per Diem Independent Contractor" to engage in health and/ or maintenance services. I hereby state that I am a Per Diem Independent Contractor and meet all qualifications as such contained in the law.

PURPOSE

The purpose of this Agreement is to provide health care services in the home or health care facility where there are ill or disabled person and/or people in need of specialized home health care and/or staff relief for local health institution. Per Diem Independent Contractor acknowledges and represents that he/she is a self-employed care provider.

1. **PAYMENT FOR SERVICES**

I agree that I only received compensation for the work or services performed on a Per Diem Basis; as a (position) _____ at a defined rate per hour agreed between both parties in the Agreement variable to each Client. This contract does not prohibit the Per Diem Independent Contractor from working with other organizations or on his/her own assignments.

I agree that for Clients that elect to pay me through an escrow account ("Escrow Account") that Registry maintains for the convenience of Clients, I hereby authorize that each such Client payment by the Client and/or its third party payer be reduced by the amount of fees I owe the Registry with respect to such payment. Furthermore, I assign to Registry all my right, title and interest to collect and receive for its own account such payment from the respective Client and/or third party payer on my behalf.

I acknowledge that I bear the entire risk of non-payment by any Client, an in the event that Registry were to advance me a Client payment, and the Client and/or its third party payer fail to pay such amount within a reasonable time determines solely by Registry, I will be liable to repay such amount to Registry and such amount may be deducted from any subsequent payment to me through the Escrow account by and Client.

I acknowledge and represent that I retain sole responsibility for all federal, state and local tax obligations that pertain to all compensation I receive from clients referred hereunder, including but not limited to Social Security, Medicare, self-employment and Income tax. I also understand that I will not be eligible for unemployment compensation and work's compensation. Registry will report on a Form 1099 for each year the amount of fees I received from clients referred by Registry.

2. **LICENSES**

The Per Diem Independent Contractor is responsible for ensuring that his or her own license or certification remains current and valid during the period of contract. Failure to maintain valid license or remains current status will cause suspension of assignments and may be the basis for termination of this agreement with the Registry. Per Diem Independent Contractor understands and acknowledges that he/she is responsible for fulfilling all continuing education requirements and all other requirements to maintain such license or certification.

3. **BACKGROUND SCREENING**

Per Diem Independent Contractor agrees that as a condition of this Agreement that he/she must clear a Level II Criminal Background screening by the Registry through the Agency for Health Care Administration, as well as a national Sex Offender Registry Screening. Per Diem Independent Contractor agrees to bear the cost associated with any Background Screening.

4. DRUG SCREENING

Per Diem Independent Contractor agrees that his/her acceptance of this agreement is contingent upon the submission of a negative 10 panel drug screen result. Such panel shall be designated by the Registry. Per Diem Independent Contractor further agrees and consents to submit to random drug screening with the results being provided to the Registry. Per Diem Independent Contractor agrees to pay for the expense of such drug screenings. A positive result for illegal use of controlled substances or failure to submit to such drug screening shall be grounds for termination of the Agreement.

5. COMMUNICABLE DISEASE

Per Diem Independent Contractor agrees to provide documentation of a health screening which verifies that he/she is free of communicable disease prior to or upon contract and prior to assignment of direct patient care. Also, Per Diem Independent Contractor understands and agrees that pursuant to Florida Chapter 59A-18 (Nurse Registries Standards and Licensing) he/she must:

A. Prior to contact with Clients, Per Diem Independent Contractor has to provide a statement from a physician based on an examination within the last six (6) months stating that he/she is free of communicable diseases and has been tested at his/her own expense and was found to be free of tuberculosis;
B. Obtain and keep active, at own expense, current CPR certificate;
C. Obtain all continuing education under their license;
D. Review and become familiar with the applicable rules and statutes attached hereto.

6. INSURANCE

Per Diem Independent Contractor shall maintain all required insurances including but not limited to:

A. Professional Liability Insurance in an amount specified by the Registry at Per Diem Independent Contractor own expense. Furthermore, hereby indemnifies and hold harmless Registry and any of its officers against any liability that might arise as a result of the failure to maintain Professional Liability Insurance coverage and against any liability arising out of service.
B. Automobile insurance, in the minimum amount required by state law.
C. Workman's Compensation coverage at Per Diem Independent Contractor expense for all injuries sustained while working with Registry Clients, including the related expense and loss of income. Furthermore, hereby indemnifies and hold harmless Registry and any of its officers against any liability that might arise as a result of the failure to maintain Workman's Compensation Coverage.

Per Diem Independent Contractor agrees to provide Registry with copies of all required insurance policies prior to or upon execution of this agreement and annually thereafter or upon renewal or substitution.

7. TRANSPORTATION

Per Diem Independent Contractor agrees to provide and maintain his/her reliable transportation at all times with automobile liability insurance coverage at or above the minimum levels required by the state for: Bodily injury and Property Damage. Furthermore, Per Diem Independent Contractor, agrees that he/she is fully responsible for any and all costs, expenses, and assessments arising from or in connection with the use of his/her automobile or the rendering of his/her services outlines in this agreement.

8. SELF EMPLOYEMENT

I hereby represent and affirm that I have established myself as a self-employed independent contractor and not an employee of Registry, which I maintain own business and that Registry and I intend to contract with each other's as independent contractors. Neither Registry nor shall I provide the other as any (i) tools, supplies or equipment (ii) reimbursement for any expenses, or (iii) training or instruction of any kind or nature other than as

required by law. I always shall; retain the right, at my sole discretion, to accept or decline a client referral offered by Registry.

9. TOOLS AND SUPPLIES

Per Diem Independent Contractor agrees to provide his/her own equipment such as blood pressure cuff, stethoscope, uniforms, gloves etc.

10. CONFIDENTIALITY

Per Diem Independent Contractor shall maintain and preserve the confidentiality of all patient health related information in accordance with all State and Federal privacy laws and Registry Policy. Per Diem Independent Contractor acknowledges that it is within the terms and conditions of his work to respect at all times the privacy of clients and their families, students, volunteers and employees, and the confidential nature of the business of the Registry.

11. PATIENT VISIT NOTES AND WEEKLY INVOICE

Per Diem Independent Contractor shall be responsible for creating, updating, maintaining and submitting to the Registry clinical record and service notes for each patient or client. Per Diem Independent Contractor shall submit clinical records, service notes and weekly invoices for each patient/ client to the office of the Registry by close of business each Monday for all care or service provided during the previous week.
Per Diem Independent Contractor shall maintain a written daily summary of his/her patient visits and the home health services provided. Each patient (or an authorized member of the patient's household) must sign the daily summary, thereby confirming that the home health services were rendered on the date specified therein.

12. TERM, RENEWAL AND TERMINATION

A. This Agreement shall begin at the time both parties' signatures are affixed on Effective Date
B. Any limitations set forth in this Agreement, including but not limited to the "Non-Compete" portion of the Agreement, shall remain in force and effect until the expiration of that limitation by its term.
C. The initial term of this engagement shall be the 12-month period commencing on the Effective Date hereof. This Agreement shall be automatically extended for successive additional one year terms provided that neither party hereto advises the other in writing at least thirty (30) days prior to the end of the current term of intent not to extent the Agreement. In addition, Registry may terminate this agreement (i) without cause upon thirty (30) days prior written notice or (ii) immediately if provider fails to maintain any required certifications, violates the term and provision of this agreement or (iii) if Registry determines, in its sole discretion, that there is a threat to the well-being of Client.

13. PER DIEM INDEPENDENT CONTRACTOR GUIDELINES

Per Diem Independent Contractor acknowledges receipt of and agrees to abide by all of the terms and conditions as set out in the "Per Diem Independent Contractor Guidelines" document and the "Per Diem Independent Contractor Guidelines" is made a part of the Agreement as if fully set out herein.

14. NON- COMPETE

Except as referred by and through the Registry, Per Diem Independent Contractor agrees to refrain from accepting any employment from or providing any service that the Registry provides to a Registry client, as defined below, or from accepting anything of value in exchange for any service provided, that the Registry provides to a Registry client by the Per Diem Independent Contractor. During the period of time from the date of contract until the expiration of (1) one year after the date that Contractor relationship, whichever is last. Client is defined as an individual that the Registry has provided service or care to or has discussed with the client, caregiver, responsible party or guardian, the possibility of providing care or service through the Registry.

In the event of violation the above conditions, Per Diem Independent Contractor agrees to pay Registry upon demand the sum of $3,000 plus attorney's fees as liquidation damage.

15. FINAL AGREEMENT & NOTICE

The Agreement constitutes the final understanding and Agreement between the parties with respect to the subject matter hereof and supersedes all prior negotiations, understandings and agreements between the parties, whether written or oral. This Agreement may be amended, supplemented or changed only by an agreement, either an agreement, either hereon with both parties' initials, or separately in writing signed by both parties. Any notice given under this Agreement shall be sufficient if it is in writing and if sent by certified or registered mail.

IN WITNESS WHEREOF, the parties hereto have set their hands and seals in execution of this Agreement as of the Effective Date first above written.

Per Diem Independent Contractor:

Printed Name: _____ Title: _____

Signature: _____ Date: _____

All County Staffing, Inc.:

Printed Name: _____ Title: _____

Signature: _____ Date: _____

ALL COUNTY STAFFING, INC.
LICENSED NURSE REGISTRY

EMPLOYMENT HEALTH RELEASE
DENIAL OF T.B. SIGNS AND SYMPTOMS

Printed Name: _____

Have you ever had tuberculosis? Yes ☐ No ☐
If yes, please explain, including date of positive test, circumstances and treatment involved:

_____
_____
_____

Have you ever had the BCG vaccine? Yes ☐ No ☐ Year received: _____
Have you ever had a positive TB skin test? Yes ☐ No ☐ Date of positive test: _____
Date of last Chest X-ray: _____

If you were treated, please include the dates treated and type of treatment:

_____
_____
_____

THE EARLY SIGNS AND SYMPTOMS OF TUBERCULOSIS ARE: Cough, Night Sweats, Fever, Loss of Weight, Loss of Appetite, Coughing Blood.

Do you currently have any of the symptoms mentioned above? If yes which one:

_____
_____

I have read the above information and do not have any of these signs or symptoms at this time. If any of these signs or symptoms develops I will contact my supervisor immediately for follow up.

*Please include any Annual TB Screening Forms.

APPLICANT NOTICE

This is a notice to all potential Per Diem Independent Contractors of ALL COUNTY STAFFING, INC. that to inform that the Registry does not provide full time employment and cannot guarantee 40 hours of employment per week to any of our Per Diem Independent Contractors. Placement staggers and working hours vary day-to-day and week-to-week

When service begins between a Client and Per Diem Independent Contractor, and the assignment has been accepted, the Registry expects the Per Diem Independent Contractor to show up for the case and complete the accepted hours. If a situation should arise that does not allow the Per Diem Independent Contractor to fulfill the commitment, the Registry expects a prompt notice to the office staff with sufficient time for it to provide a replacement. A no show or failure to notify the office of an absence is a reason for immediate termination.

Signature: _____ Title: _____ Date: _____

ALL COUNTY STAFFING, INC.
LICENSED NURSE REGISTRY

SAFETY POLICY

It is the policy of ALL COUNTY STAFFING, INC. to provide a safe and healthful environment for all employees/caregivers/ contractors and visitors who are associated with our company.

Safety and health programs dedicated to the elimination of accidents causes, will be emphasized and sponsored throughout the facility and department work safety rules, the investigation of accidents and the inspection of work procedures and facilities. These on-going programs eliminate unsafe work practices/conditions and to reduce the potential for accidents and personal injury.

The success of our safety and health programs will only be achieved by the active leadership, direct participation, and enthusiastic support from all department heads, and case managers.

Each member of ALL COUNTY STAFFING, INC. is obligated to observe safe practices and obey all safety rules, this direct personal involvement is the only way we can attain our goal of accident reduction and elimination.

TRANSPORATION RESPONSIBILITY POLICY

It has been explained to me that I am being offered employment with the understanding that I have personal transportation at my disposal to be used for travel to and from patient assignments.

I further understand that I am responsible for maintaining automobile liability to include bodily injury and property damage.

Should I be unable to make patient visits assigned to be because of transportation problems, I will give ALL COUNTY STAFFING, INC., a minimum of one working day or eight hours' notice.

Failure to comply with the above may result in the immediate termination of my employment contract without further notice.

HOURS OF OPERATIONS POLICY

Office hours are from 9:00 am to 5:00 pm, Monday through Friday. Should an incident occur which requires immediate attention Per Diem Independent Contractor is required to notify the Registry as soon as possible. A 24/7 on-call service is provided for this purpose.

By signing this agreement, you are stating that you understand that any incident involving you or the client must be reported to ALL COUNTY STAFFING, INC., immediately. You also understand that proper documentation must be completed and submitted to the office in a timely manner. Nursing Notes are due every Monday. Any other matter you are wishing to discuss with the Registry personnel, the calls should be placed during office hours.

I have read and fully understand and agree to the above statements.

Signature: _____ Title: _____ Date: _____

ALL COUNTY STAFFING, INC.
LICENSED NURSE REGISTRY

PATIENT ABANDONMENT POLICY

It is the policy of this Registry that if Per Diem Independent Contractor abandons a patient, the Per Diem Independent Contractor will be immediately dismissed. The patient will be assigned another Per Diem Independent Contractor to continue care. The supervisor must contact the case manager to inform of the situation.

Leaving a patient before your shift is completed without the knowledge and approval of ALL COUNTY STAFFING, INC. is considered patient abandonment. The above mentioned actions will be taken.

DRESS CODE POLICY

To present a professional health care individual image to the public at large and specifically to our clients and their family members.

PROCEDURE

Dress Code for All Personnel:

1. Good personal hygiene
2. Minimal jewelry – accessories simple and uncluttered
3. Clean, well-groomed fingernails
4. Neat, clean hair – no extreme non-professional styles
5. Appropriate undergarments
6. Hemlines no more than 2 inches above the knee or 2 inches below the knee
7. Make-up natural – no extreme colorings, lashes or sparkles

Dress Code for All Direct Care Personnel:

1. All of the above plus:
2. Clean, wrinkle-free uniforms (may be scrub-type)
3. Clean, closed-toe, flat shoes
4. Clean, short-trimmed and groomed fingernails
5. Avoid heavy perfumes and colognes
6. Office RN's must wear white lab coat if not in uniform and visiting patients, hospital, physician's offices, etc.

Items Not Acceptable (All Staff):

1. Glitter or sequin-covered clothing
2. Jean-type clothing
3. Tight pants or leggings
4. Shorts
5. Beach-type sandals
6. Long, dangling or hoop earrings
8. See-through fabrics
9. Tank tops
10. Open-back tops or plunging necklines
11. No exposed body piercing except ears
12. Long dresses/skirts due to safety hazard

Signature: _____ Title: _____ Date: _____

CONFIDENTIALITY STATEMENT

I acknowledge that I have read and understood ALL COUNTY STAFFING, INC., here in referred to as Registry, Confidentiality Policy, HIPAA regulations and the Privacy Statement. I acknowledge that during my employment/placement/volunteer/project work with Registry I may have access to confidential information. I acknowledge that it is a term and condition of my work with Registry that I will at all times respect the privacy of clients and their families, students, volunteers and employees, and the confidential nature of the business of Registry. I will closely protect confidential information to prevent it being inappropriately accessed, used or disclosed either directly by me, or by virtue of my password to systems, or by permitting breaches in physical security to occur. If I become aware of any violation of confidentiality, or lose any record containing confidential information or any key or other item that could be used to violate confidentiality, I will notify my supervisor or another responsible Registry supervisor at the first reasonable opportunity. I understand that violations to confidentiality may include, but are not limited to:

- Accessing personal or organizational information that I do not require in order to properly carry out my duties;
- Using or disclosing personal/organizational information (verbally, through the computer system, or in hard copy) without proper authorization;
- Inappropriately sharing passwords, keys, codes or other identification devices without proper authorization.

I will only access, use, transfer or disclose private and confidential information as required by the duties of my position. I agree to cooperate with Registry in any audit or investigation relating to confidential information and to provide any records requested in connection with such audits or investigations. I understand and agree to abide by the conditions outlined in this agreement both during and after my employment or association with Registry. I understand that a violation of this agreement may result in disciplinary action that may include termination/dismissal from employment or association with Registry, or that I may be subject to civil or criminal liability.

I understand that no information is to be released without the written “Release of Information” consent signed by the patient or patient’s legal representative.

It is understood that breaks in the policies and procedures of Registry concerning confidentiality may result in immediate terminate without put further notice.

Signature: _____ Title: _____ Date: _____

ALL COUNTY STAFFING, INC.
LICENSED NURSE REGISTRY

BACKGROUND CHECK AUTHORIZATION

I voluntarily consent to and authorize ALL COUNTY STAFFING, INC., here in referred to as Registry, and or their assigned agents, associates, or consumer reporting agencies to request and receive any criminal background reports, consumer reports, investigative consumer reports containing information as to my character, general reputation, personal characteristics and mode of living, or information concerning me as part of the pre-employment background review process. Reports requested may include any of the following: Law Enforcement Records, Criminal Records, Civil Records, Motor Vehicle/ Driving Records, Credential Verification, Employment Verifications, Past Employment Verifications, Education Verifications, Reference Checks, Military Service Verifications, and Consumer Credit Reports in accordance with the provisions of the Fair Credit Reporting Act and similar State laws.

I authorize any persons, organizations, companies, corporations, consumer reporting agencies, courts of law, licensing agencies, schools, and any current or past employer to furnish Registry and or their assigned agents, associates or consumer reporting agencies with any and all information concerning me. I further agree to release Registry and or their assigned agents, associates, or consumer reporting agencies and all persons and organizations providing information from any and all claims, liability and responsibility arising out of the release of such information in connection with this research.

This authorization shall remain on file and shall serve as an ongoing authorization for Registry to procure criminal records, consumer reports, including investigative consumer reports, at any time during the contracting period. By signing below, I hereby release Registry, its employees, agents, and all persons, agencies and entities providing information or reports about me from any and all liability arising out of the release of any such information or reports.

I understand that if an adverse decision on my application for employment is made, based in whole or in part on information contained in any consumer report, I will be so informed. I will also be provided an opportunity to obtain a copy of that consumer report and to dispute any inaccurate or incomplete information.

I agree that a photocopy, facsimile, or other electronic forms of this information can be furnished to Registry, and that it will have the same authority and authenticity as the original. I also understand that any misrepresentation, falsification or omission of facts herein may be considered cause for rescinding and offer of employment, termination of employment, or denial of consideration for future employment.

Printed Name: _____ SSN: ___-___-_____ DOB: ____/____/_____

Signature: _____ Title: _____ Date: _____

Other names under which previously employed (Print Name): _____

COMPANY DISCIPLINARY ACTION FOR A POSITIVE CONFIRMED DRUG AND / ALCOHOL SCREEN

This company hereby state its policy relating to those individuals who test positive on a drug and/or alcohol screen to be as followed;

Any Per Diem Independent Contractor/Employee who tests positive on a Drug and/or Alcohol screening will be terminated from their contract. If he/she is able to successfully obtain substance abuse treatment, at their own expense, and their contract is still available, he/she will be given one (1) chance to be retired, upon a negative return-to-work Drug and/or Alcohol screen he/she will then undergo random Drug and/or Alcohol screens for a period of (2) years as follow-up treatment. If he/she tests positive on any of their follow-up Drug and/or Alcohol screens, he/she will be terminated from their employment.

If a Per Diem Independent Contractor/Employee refuses to take a periodic, random, post-accident, routine fitness for duty or reasonable suspicion Drug and/or Alcohol screen, he/she will be terminated from employment.

Any Per Diem Independent Contractor/Employee using, selling, purchasing, possessing, soliciting or distributing drugs and/or alcohol on duty or at company's property, it will be terminated from the contract.

PAYCHECK POLICY

Disbursement of Funds and Pay Check Policy

ALL COUNTY STAFFING INC. will issue paychecks every Friday after 2:00 pm. Checks must be picked up by you at the office with a valid ID. If a check needs to be re-issued, you will be required to pay the $50.00 bank fee, which will be deducted from your re-issued check.

I, _____have read and fully understand the above policy set forth by ALL COUNTY STAFFING INC.

Signature: _____ Title: _____ Date: _____

ALL COUNTY STAFFING, INC.
LICENSED NURSE REGISTRY

INFECTION CONTROL
UNIVERSAL ISOLATION

POLICY: The procedures of "University Isolation" as recommended by the Center for Disease Control will be carried out.

"UNIVERSAL ISOLATION" precautions means that blood and body fluids precautions should be consistently used for all patients.

PROCEDURE: 1) Gloves should be worn for touching blood and body fluids, mucous membranes, or non-intact skin for all patients, for handling items or surfaces soiled with blood or body fluids, and for performing venipuncture and other vascular access procedure.

2) Masks and protective eyewear or face shields should be worn during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure of mucous membranes of the mouth, nose, and eyes.

3) Gowns or aprons should be worn during procedures that are likely to generate splashes of blood or other body fluids.

4) Hands and other skin surfaces should be washed immediately and thoroughly if contaminated. Hands should be washed immediately after removing gloves.

5) Needles should not be recapped, bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand.

6) Mouthpieces, resuscitation bags, or other ventilation devices should be available for use in areas in which the need for resuscitation is Predictable

7) Health-care workers who have exudative lesion or weeping dermatitis should refrain from direct patient care and from handling patient-care equipment until the condition is resolved.

Signature: _____ Title: _____ Date: _____

ALL COUNTY STAFFING, INC.
LICENSED NURSE REGISTRY

MEDICAL QUESTIONNAIRE

State of Purpose:

The purpose of this questionnaire is to provide ALL COUNTY STAFFING INC. with information regarding preexisting conditions or disabilities that the employee/contractor might suffer.
The intent if this questionnaire is not to discriminate against any qualified individual in regards to the procedure of this job application

Name of Employer: ALL COUNTY STAFFING INC.

Name of Contractor: _____

Contractor SSN Number: _____-____-_____ Height_____ Weight_____

1. Do you have any of the following

	YES	NO
Epilepsy (convulsions, seizures)	_____	_____
Diabetes (Medication?)	_____	_____
Marie-Strum Pell disease (inflammation of vertebrae)	_____	_____
Amputation of foot, leg, arm, or hand.		
Total loss of sight of one or both eyes, or partial loss		
Corrected vision of more than 75% bilaterally	_____	_____
Polio (poliomyelitis)	_____	_____
Cerebral palsy	_____	_____
Multiple Sclerosis	_____	_____
Parkinson's disease	_____	_____
Vascular (blood vessel) disorder	_____	_____
Psychoneurotic disability (emotional or nervous disability)	_____	_____
Hemophilia	_____	_____
Chronic osteomyelitis (infection in bone)	_____	_____
Ankylosis of major weight-bearing joint (frozen joint)	_____	_____
Hyperinsulinism	_____	_____
Muscular dystrophy	_____	_____
Thrombophlebitis	_____	_____
Herniated disk	_____	_____
Surgical removal of disk	_____	_____
Total deafness	_____	_____

Other: _____
_____

Signature: _____ Title: _____ Date: _____

ALL COUNTY STAFFING, INC.
LICENSED NURSE REGISTRY

HEPATITIS B VACCINATION INFORMED CONSENT

I understand that due to my risk of occupational exposure to blood or other potential infectious material, I may be at risk of acquiring Hepatitis B virus (HBV) infections. I have read the information concerning the Hepatitis B vaccine and I am aware of the availability and benefit that such vaccination provides in the preventions of infection with Hepatitis B virus.

I understand the benefits and risks of Hepatitis B vaccination and have had the opportunity to ask questions. I understand that:

1. The vaccination will be administered in a series of three (3) doses; the initial one, the second one a month later, and the third dose six (6) months after the first dose. I understand I must complete the series for full immunization at my own expense.

2. If I receive the vaccine, I have 90-95% chance of developing antibodies to the Hepatitis B surface antigen and therefore immunity to the infection of the Hepatitis B virus.

3. The vaccine may not be effective, if I am already incubating the Hepatitis B Virus.

4. The duration of the immunity is unknown at this time and I may require a booster in five (5) years.

5. The vaccine only protects against Hepatitis B virus and does not confer immunity against the Hepatitis A, Hepatitis C, or non-A/non-B agents.

6. After receiving the vaccine minor side effects, such as infections site soreness and redness, Low-grade fever, malaise and nausea have been reported.

I, _____, request vaccination with Hepatitis B vaccine.

Pregnant:	YES_____ NO _____	Date vaccinated	Lot No.
Allergies	YES_____NO_____	1._____	_____
		2._____	_____
		3._____	_____

HEPATITIS B VACCINE DECLINATION

I, _____, decline vaccination with the Hepatitis B vaccine. I have read the above information and realize that I am potentially at increased risk of exposure or Development of the Hepatitis B infection. I choose not to receive the Hepatitis B vaccine at this time.

Signature of person declining vaccine: _____ Date: _____

ALL COUNTY STAFFING, INC.
LICENSED NURSE REGISTRY

CONDITIONS OF EMPLOYMENT

APPLICATION:
Upon receipt of your references, your application and exam will be reviewed by our staff and your license will be verified by the State Board of Nursing. You will be notified approximately one week after your interview until your appreciation has been approved.

PROBATION: When references have cleared and you have been offered your first assignment, you are considered a probationary Per Diem Independent Contractor.

Probationary status is in effect for 90 days from the date of your first assignment. One or more incidents could cause us to discontinue offering you assignment, and will result in your termination.

Some examples are:

a. Infractions of the "Nurse Practice Act".

b. Reports from facilities or clients that your work is not accepted.

c. Not showing up for an assignment that you have accepted.

d. Too many sick or emergency cancellations.

e. Any serious misconduct while on or off duty that may reflect on All County Staffing, Inc.

f. Infractions of policies or procedure of facilities.

g. Violation of "Conditions of Employment".

REQUIREMENTS: When you work for ALL COUNTY STAFFING INC., it is your responsibility to call in your availability to our office on a weekly basis. If you fail to do so your file will be placed inactive and you will be considered resigned. If you change your telephone number, or it becomes disconnected, it is your responsibility to provide our office with an alternative phone number until this requirement is met. If our office cannot reach you due to the reason above, your file will be place inactive and you will be considered resigned. All employees/caregivers/contractors must comply with AHCA requirements within 30 days from the date of your first assignment. Any violation of AHCA requirements, either by not complying when hired or at renewal times, are grounds for termination

Signature: _____ Title: _____ Date: _____

ALL COUNTY STAFFING, INC.
LICENSED NURSE REGISTRY

POLICY STATEMENT

Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975.

ALL COUNTY STAFFING INC. agrees to comply with provisions of title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975, and all requirements imposed pursuant thereto, to the end that no person shall on the grounds of race, color, national origin, handicap or age, be excluded from participation in, be denied benefits of, or otherwise be subjected to discrimination in the provisions of any care of services.

Specifically, the above includes (but is not limited to) the following characteristics:

1. Care will be provided in a manner that is not discriminated against person on the basis of race, color, national origin, handicap, or age.

2. Employees will be assigned to clients' services without regard to the race, color, national origin, handicap, or age of either the client or employee.

3. Staff privileges will not be denied professionally qualified personnel on the basis of race, color, national origin, handicap or age.

4. All facilities of the Registry will be utilized without regard to race, color, national origin, handicap or age.

The non-discriminatory policy of this Registry applies to clients, physicians, independent contractors and all responsible employees.

BIOHAZARDOUS WASTE MANAGEMENT AKNOWLEDGEMENT

APPLICANT ACKNOWLEDGEMENT OF RECEIPT ON:
RECOMMENDED METHOD OF HANDLING BIOMEDICAL WASTE

- I have been verbally informed of the recommended method of handling biomedical Waste generated in the home care setting.

- I have been given written material on "Safe Sharps Disposal at Home"

- I have been given written material on "Cleaning up after Injury or Accident in Your Home"

- ALL COUNTY STAFFING INC. has given me the chance to discuss my concern regarding biomedical waste management in my home.

Signature: _____ Title: _____ Date: _____

ALL COUNTY STAFFING, INC.
LICENSED NURSE REGISTRY

NON-DISCRIMINATION POLICY

In accordance with Title VI of the Civil Rights Act of 1964 and its implementing regulation, ALL COUNTY STAFFING INC. is an EQUAL OPPORTUNITY EMPLOYER and WILL NOT DISCRIMINATE AGAINST RACE, COLOR, CREED, RELIGION, SEX, AGE, GENDER PREFERENCE, NATIONAL ORIGIN HANDICAP (MENTALOR PHYSICAL), ETHICAL/POLITICAL BELIEFS, DECISION REGARDING ADVANCE DIRECTIVES OR COMMUNICABLE DISEASE AS DEFINED IN SECTION 504 OF TITLE VI.

In accordance with Section 504 of Rehabilitation Act of 1973 and it's implementing regulation, ALL COUNTY STAFFING INC. WILL NOT, DIRECTLY OR THROUGH CONTRACTUAL OR OTHER ARRANGEMENTS, DISCRIMINATE ON THE BASIS OF HANDICAP.

In accordance with the Age Discrimination Act of 1975 and it's implementing regulation, ALL COUNTY STAFFING INC. WILL NOT, DIRECTLY OR THROUGH CONTRACTUAL OR OTHER ARRANGEMENTS, DISCRIMINATE ON THE BASIS OF AGE in the provision of services, unless age is a factor necessary to normal operation or the achievement of any statutory objective.

In accordance with the Americans with Disabilities Act of 1992 (42 USC & 12101) and it's implementing regulations, (private employers with more than 25 Registry personnel), ALL COUNTY STAFFING INC. WILL NOT, DIRECTLY OR THROUGHT CONTRACTUAL OR OTHER ARRANGEMENTS DISCRIMINATE ON THE BASIS OF DISABILITY. A disability is a physical or mental impairment that substantially limits a major life activity, or for which there is a record if impairment or which causes the individual to be regarded as impaired.

I hereby verify that have had all my questions answered by my satisfaction and that I understand all of the material covered.

Signature: _____ Title: _____ Date: _____

ALL COUNTY STAFFING, INC.
LICENSED NURSE REGISTRY

ORIENTATION

1. GENERAL ORIENTATION

- Facility Mission/Goals/Objective/Philosophy/Organizational Structure.
- Tour of Registry
  A) Location of administrative offices
  B) Location of fire extinguishers
  C) Location of Emergency lights/exits
  D) Location of first aid box
  E) Emergency evacuation routes
- Standards of Ethical Conducts
- Scope of Services
- Employment Policies/Job Descriptions/Competency
- Complaint Policy/Grievance Form
- Nondiscrimination
- Payroll
- Cultural Diversity and Sensitivity
- Professional Liability Insurance (Minimum coverage $500,000/$1,000,000)

2. CLINICAL ORIENTATION

- Client Rights and Responsibilities/Advance directives
- Assignments/Cancellations Policy
- Assessments/documentation
- Medical Emergencies
- Chart audits
- On-Call Policy
- Documentation Requirements/Time frames
- Client Referrals to Other Registry
- Clinical Records
- Abuse Reporting

3. CONFIDENTIALITY

- Client/Family/Significant Other
- Staff Information
- HIPPA Privacy Rule/Notice of Privacy Practices
- Nurse Registry Business Information

Signature: _____ Title: _____ Date: _____

ALL COUNTY STAFFING, INC.
LICENSED NURSE REGISTRY

REFERENCE CHECK FORM

ATTN: _____ **DATE:** _____

ORGANIZATION: _____

ADDRESS: _____

PHONE NUMBER: _____ **FAX:** _____

To whom it may concern,

The applicant listed below is applying for a position as _____and has provided your name as an employment reference. As we place great importance on the thorough screening of our applicants, we would appreciate a prompt and thoughtful response.

Thank you in advance,

Section 1 – To be completed by the applicant

I, _____, owner of the Social Security #____-_____-_____, hereby authorize ALL COUNTY STAFFING, INC. to contact you as my previous employer.

_____
APLICANT'S SIGNATURE

Section 2 – To be completed by the previous employer

1. **Length of employment from _____ to _____.**
2. **Functioned in the capacity of RN_____LVN/LPN_____HHA/CNA_____**
3. **Reason for leaving_____**
4. **Is the applicant eligible for rehire? Yes____ No____**

PLEASE COMMENT ON THE APPLICANT'S ATTTRIBUTES USING THE FOLLOWING SCALE:
POOR FAIR GOOD VERY GOOD EXCELLENT

_____ **Ability to follow instructions** _____ **Reliability and Attendance**
_____ **Professional dress and grooming** _____ **Ability to work with others**
_____ **Willingness to assume responsibility** _____ **Quality of work**
_____ **Skills / Proficiency** _____ **Job Knowledge**
_____ **Overall Job Performance**

Additional Comments: _____
_____

Name (please print): _____ **Date:** _____
Signature: _____ **Position/Title:** _____

Thank you!

WHEN COMPLETED PLEASE FAX IT BACK TO (954) 584-2274 OR EMAIL TO INFO@ALLCOUNTYSTAFFING.COM

Revised 6/2/2017

All County Staffing Dade, Inc

INDEPENDENT CONTRACTOR ORIENTATION

CERTIFIED NURSING ASSISTANT (CNA) AND HOME HEALTH AIDE (HHA)

REGISTRATION POLICIES

I have received the following applicable rules and Florida State Statutes of AHCA and the contractor description (summarized from regulations) and agree to follow them:

1. 59A-18.00081: Certified Nursing Assistant and Home Health Aide
2. 400.506: Licensure of nurse registries; requirements; penalties.
3. 400.512: Screening of nurse registry personnel.
4. 400.484: Right of inspection; deficiencies; fines.
5. 400.462: Definitions.
6. 400.495: Notice of toll-free telephone number for central abuse hotline.
7. 59A-18.017: Supplemental Staffing for Health Care Facilities.
8. Independent Contractor Description- Duties Summary from regulations.

I have signed an independent contractor agreement and understand and agree that I will be responsible for my own payroll taxes and will not be covered for workers compensation, social security and unemployment benefits per the contract.

_____ _____

INDEPENDENT CONTRACTOR WITNESS

_____ _____

DATE DATE

Form **W-9**
(Rev. November 2017)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here **Signature of U.S. person** ► **Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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	Other Last Names Used *(if any)*

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

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

Employer Completes Next Page


Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

ATTESTATION OF COMPLIANCE
with Background Screening Requirements

Authority: This form shall be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**

- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes,** which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:
Health Care Provider/ Employer Name:
Address of Health Care Provider:

You must attest to meeting the requirements for employment and you may not have been arrested for and awaiting final disposition of, have been found guilty of, regardless of adjudication, or have entered a plea of nolo contendere (no contest) or guilty to, or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under *any* of the following provisions of state law or similar law of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

(a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

(b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

(c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.

(d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(e) Section 782.04, relating to murder.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

(bb) Section 810.145, relating to video voyeurism, if the offense is a felony.

(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S.

(a) Any authorizing statutes, if the offense was a felony.

(b) This chapter, if the offense was a felony.

(c) Section 409.920, relating to Medicaid provider fraud.

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

(f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.

(g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(h) Section 817.234, relating to false and fraudulent insurance claims.

(i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.

(j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.

(k) Section 817.505, relating to patient brokering.

(l) Section 817.568, relating to criminal use of personal identification information.

(m) Section 817.60, relating to obtaining a credit card through fraudulent means.

(n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(o) Section 831.01, relating to forgery.

(p) Section 831.02, relating to uttering forged instruments.

(q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

(s) Section 831.30, relating to fraud in obtaining medicinal drugs.

(t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony

(u) Section 895.03, relating to racketeering and collection of unlawful debts.

(v) Section 896.101, relating to the Florida Money Laundering Act.

☐ **I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).**

Date of Decision: _____

☐ **I have been granted an Exemption from Disqualification through the Florida Department of Health.**

Date of Decision: _____

A copy of the Exemption from Disqualification decision letter must be attached*

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening:_____

Screening conducted by: Date of Prior Screening: _____

☐ Agency for Healthcare Administration
☐ Department of Health
☐ Agency for Persons with Disabilities
☐ Department of Elder Affairs
☐ Department of Financial Services
☐ Department of Children and Families

Attestation

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

_____	_____	_____
Employee/Contractor Signature	Title	Date

BBP Test

1. Which of the following are the two most prevalent Bloodborne diseases in the United States?
    a) Hepatitis B and Mononucleosis
    b) HIV and Tuberculosis
    c) Tuberculosis and Mononucleosis
    d) HIV and Hepatitis B

2. Vaccines do exist that can prevent infection from Hepatitis C and HIV?
    a) True
    b) False

3. You may not eat, drink, apply cosmetics, lip balm nor handle contact lenses where there is a potential for exposure?
    a) True
    b) False

4. All types of gloves can be reused after an exposure incident if they are decontaminated?
    a) False
    b) True

5. Used needles or sharps should never be bent, sheared, or broken; they should be disposed of in?
    a) Waste basket
    b) Puncture resistant container
    c) Garbage bags

6. Personal Protective Equipment can help guard against infection by Bloodborne Pathogens?
    a) True
    b) False

7. What is the most important personal hygiene practice for preventing infection from Bloodborne disease?
    a) Gargling with disinfectant
    b) Hand washing
    c) Cleaning fingernails nails

8. What color must be used as the "background" on Biohazard Warning Labels?
    a) Yellow
    b) Red/Orange
    c) Black

_____ _____

Signature Date

_____

Print Name

HIPAA QUIZ

1. Telling your husband about a client's condition along with her name and other identifying information is not a HIPAA violation.
    a) True
    b) False

2. PHI includes all health information that is used or disclosed, except in oral form.
    a) True
    b) False

3. The patient's telephone number is an example of PHI.
    a) True
    b) False

4. You are permitted to discuss the client's condition with a coworker during the change of a shift.
    a) True
    b) False

5. The HIPAA Privacy Rule protects a client's fundamental right to privacy and confidentiality
    a) True
    b) False

6. Protected Health Information is anything that connects a patient to his or her health information.
    a) True
    b) False

7. It is permissible to disclose PHI without authorization in the case of reporting abuse, neglect, or domestic violence.
    a) True
    b) False

8. An authorization to disclose PHI (Protected Health Information) must contain an expiration date.
    a) True
    b) False

9. PHI is disclosed when it is shared, examined applied or analyzed.
    a) True
    b) False

10. You can receive personal fines for disclosing information about an individual.
    a) True
    b) False

_____ _____

Signature Date

_____

Print Name

Hand Hygiene Quiz

1. What is the minimum time I wash my hands?
   (A) 5 to 10 seconds
   (B) 15 to 20 seconds
   (C) 30 to 40 seconds
   (D) 60 seconds or more

2. Hand washing is the most important means for preventing the spread of infection.
   (A) True
   (B) False

3. Alcohol hand sanitizers should be at least 60 percent alcohol.
   (A) True
   (B) False

4. I should wash my hands:
   (A) before and after giving care to my patient
   (B) after taking care of my patient and before preparing food
   (C) after I remove my gloves
   (D) all of the above
   (E) none of the above

5. I should turn of the water lever with my elbow or a disposable paper towel.
   (A) True
   (B) False

6. Artificial nails or extenders should not be worn when I am providing care to my patients.
   (A) True
   (B) False

7. When using alcohol-based hand sanitizers, I should
   (A) apply at least ½ teaspoon on the palm of my hand
   (B) rub my hands together covering all surfaces of my hand until they're dry.
   (C) both (A) and (B)
   (D) none of the above

8. I should wash my hands after assisting my client into bed.
   (A) True
   (B) False

9. I don't need to wash my hands after I blow my nose.
   (A) True
   (B) False

10. I should wash my hands after I take my client's temperature.
    (A) True
    (B) False

_____ _____

Signature Date

_____

Print Name

PRIVACY POLICY ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, which describe the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

I understand and agree that I will read and comply with the guidelines contained in the privacy policies.

_____

Employee/Contractor Name (Printed)

_____

Employee/Contractor Signature

_____

Date