UNIVERSAL MEDICAL RECORDS

NEW HIRE FORM/TERMINATION FORM

From: hrdepartment@universalmedicalrecord.com

Fax: 914-940-6860

ALL INFORMATION MUST BE COMPLETED PRIOR TO PAYROLL RECEIVING THIS FACE SHEET

EFFECTIVE DATE: __ __/__ __/__2019__ __

EMPLOYEE NAME: _____

SOCIAL SECURITY #: ___-___-_____

PHONE (H) (___)-___-_____ **PHONE (C)** (___)-___-_____

EMAIL ADDRESS: _____

D.O.B. __ __/__ __/_____

RACE: _____ **SEX: Circle One: Male Female**

STREET ADDRESS: _____

CITY OR TOWN: _____ **STATE:** __ __ **ZIP CODE:**_____

JOB TITLE/POSITION: _____

LICENSE/CERTIFICATION NUMBER _____

EXPIRATION DATE: __ __/__ __/_____

TERMINATION DATE: __ __/__ __/_____

AUTHORIZED BY:_____ **DATE:** __ __/__ __/__2019__ __

FACILITY NAME: _____

UMR Staffing

22 The Cross Road
Cortlandt Manor, NY 10567
(914) 737-7499

Employment Application

Applicant Information

Full Name: _____ Date: _____

Last *First* *M.I.*

Address: _____

Street Address *Apartment/Unit #*

_____

City *State* *ZIP Code*

Phone: **( )** E-mail Address:

Date Available: Social Security No.: Desired Salary: **$**

Position Applied for:

Are you a citizen of the United States? YES ☐ NO ☐ If no, are you authorized to work in the U.S.? YES ☐ NO ☐

Have you ever worked for this company? YES ☐ NO ☐ If yes, when?

Have you ever been convicted of a felony? YES ☐ NO ☐

If yes, explain:

Education

High School: Address:

From: To: Did you graduate? YES ☐ NO ☐ Degree:

College: Address:

From: To: Did you graduate? YES ☐ NO ☐ Degree:

Other: Address:

From: To: Did you graduate? YES ☐ NO ☐ Degree:

References

Please list three professional references.

Full Name: Relationship:

Company: Phone: **( )**

Address:

Full Name: Relationship:

Company: Phone: **( )**

Address:

Full Name: Relationship:

Company: Phone: ( )

Address:

Previous Employment

Company: Phone: ( )

Address: Supervisor:

Job Title: Starting Salary: $ Ending Salary: $

Responsibilities:

From: To: Reason for Leaving:

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company: Phone: ( )

Address: Supervisor:

Job Title: Starting Salary: $ Ending Salary: $

Responsibilities:

From: To: Reason for Leaving:

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company: Phone: ( )

Address: Supervisor:

Job Title: Starting Salary: $ Ending Salary: $

Responsibilities:

From: To: Reason for Leaving:

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Military Service

Branch: From: To:

Rank at Discharge: Type of Discharge:

If other than honorable, explain:

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

Signature: _____ Date: _____

Employee Name_____

Universal Medical Records

22 The Cross Road Cortlandt Manor, NY 10567
Tel: 914 737-7499 Fax: 516 977-3006

Pre-Employment Physical Examination and Screen

Name: _____ Date of Exam: _____

Address: _____ Date of Birth: _____

Sex: ☐Male ☐Female

Blood Pressure: _____/_____ **Pulse:** _____ **Respirations:** _____ **Temp:** _____ **Height:** _____

Weight: _____

PERSONAL HEALTH HISTORY

Past Illnesses / Injuries: _____

_____

Current illnesses / Injuries: _____

_____

Allergies: _____

_____

List all medications taken frequently or regularly:

_____

_____

IMMUNIZATIONS: *(Please attach lab report)*

Tetanus/Diphtheria *(every 10 years):* _____//_____
Hepatitis B: _____/_____/_____ _____/_____/_____ _____/_____/_____
Flu Shot: _____/_____/_____
Other *(specify)* _____

MEASLES- *ATTACH LAB REPORT*
MUMPS- *ATTACH LAB REPORT*
RUBELLA- *ATTACH LAB REPORT*
VARICELLA-*ATTACH LAB REPORT*

Tuberculosis (TB) SCREENING: *((If Annual PPD is needed, a 2-step procedure must be done: First, Initial PPD is done, If negative PPD test, a repeat booster PPD test must be done 1-3 weeks apart.)*

Date given _____ Date read _____ Results _____
Booster PPD (2nd PPD)
Date Given: _____ Date Read: _____ Result (in mm):_____
Chest x-ray (date) _____ Results: **Attach report**

Employee Name_____

EVALUATION OF SYSTEMS

System Name	Normal findings?	Comments/Description
Eyes	☐ Yes ☐ No	
Ears	☐ Yes ☐ No	
Nose	☐ Yes ☐ No	
Mouth/Throat	☐ Yes ☐ No	
Head/Face/Neck	☐ Yes ☐ No	
Breasts	☐ Yes ☐ No	
Lungs	☐ Yes ☐ No	
Cardiovascular	☐ Yes ☐ No	
Extremities	☐ Yes ☐ No	
Abdomen	☐ Yes ☐ No	
Gastrointestinal	☐ Yes ☐ No	
Endocrine	☐ Yes ☐ No	
Musculoskeletal	☐ Yes ☐ No	

Physician Certification

Based on the above information, the employee_____ does _____ do not have a communicable disease or other health impairment (such as habituation or addiction to drugs or alcohol) that might present a risk to a resident or otherwise interfere with the performance on his/her duties as an employee of this facility.

Name of physician *(please print)* _____

Physician's Signature_____

Date_____

Physician's Office Stamp _____

NYS Department of Health

CHRC Unit
P. O. Box 2607
Albany, NY 12220-0607
Phone: 518.402.5549
Fax: 518.474.7477
www.nyhealth.gov/chrc
chrc@health.state.ny.us

REQUEST FOR CRIMINAL HISTORY RECORD CHECK
PAGE 1
INSTRUCTIONS

CRIMINAL HISTORY RECORD CHECK (CHRC) PROGRAM

For Department use only
Leave blank

This form is to be used to request a criminal history record check (CHRC) for a subject individual from the DOH CHRC Unit.

For purposes of this form, the term **"Agency"** means residential health care facility, certified home health agency, licensed home care services agency or long term home health care programs that are authorized by law to request a check of criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.
"Authorized Person" is the individual that is allowed to request, on behalf of the Agency, fingerprints and criminal history record checks.
"Subject individual" is an "employee" as defined by Public Health Law Section 2899(3).

INSTRUCTIONS:

1. This form is to be completed by the Authorized Person, who will sign and date where indicated in Section 3.
2. Please obtain subject individual information and complete all sections on page 2 of this form prior to or at the time of fingerprinting. This information will be used to conduct both a Federal and State criminal history record check pursuant to State law.
3. If subject individual is employed by a staffing organization with an Agency work location, the Agency is responsible for completing this form and the staffing agency may complete Section 4 if that staffing agency fingerprints the subject individual.
4. Subject individual is required to present two (2) forms of identification (ID) when fingerprinted. One must be a government-issued ID with subject individual's signature. At least one of the two forms of ID must contain a current photograph. Acceptable forms of government-issued IDs are: valid driver's license or Department of Motor Vehicles (DMV) ID, valid passport, valid military identification or valid school identification document. The type of government-issued ID presented is recorded in Section 2 of this form. Refer to the Employment Eligibility Verification Form I-9 for examples of other forms of identification. The second ID must be produced but not recorded in Section 2 of this form.
5. If subject applicant is fingerprinted by other than the Authorized Person, provide this instructional page to that individual for assistance in completing Section 4 of this form.
6. Authorized Person is to ensure that all fields in all sections must be completed for accurate and timely submissions.
7. Authorized Person will forward Page 2 of this Form to the DOH CHRC Unit at the address indicated above.

FIELD DESCRIPTIONS:

SEX FIELD
M – Male
F – Female

RACE FIELD
A – Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan or any other Pacific Islander
B – African black racial groups
I – American Indian, Eskimo, or Alaskan native
U – Of indeterminable race
W – Caucasian, Mexican, Puerto Rican, Cuban, Central/South American or other Spanish origin

BIRTH COUNTRY/PLACE FIELD
Enter **United States of America** for those of American birth
Enter Country of Birth for those not of American birth

HEIGHT FIELD
To be completed as a three (3) character value. If reported in feet and inches, the first (leftmost) digit is used to show feet with the two rightmost digits are used to show the inches between 00 and 11. If reported in inches, the leftmost character is "N" followed by two digits. If height in unknown, 000 is entered.

The allowable range is 400 to 711. Heights shorter than 4 ft. will be recorded as 400 and taller than 7 ft. 11 in. will be recorded as 711.

WEIGHT FIELD
In this field, the subject applicant's weight in pounds is entered (000-499). If weight is unknown, 000 is entered.
All weight in excess of 499 pounds will be recorded as 499 lbs.

HAIR FIELD – COLOR CODES
BAL – Bald
BLK – Black
BLN – Blonde or Strawberry
BLU – Blue
BRO – Brown
GRN – Green
GRY – Gray or Partially Gray
ONG – Orange
PNK – Pink
PLE – Purple
RED – Red or Auburn
SDY – Sandy
WHI – White
XXX – Unknown

EYE FIELD – COLOR CODES
BLK – Black
BLU – Blue
BRO – Brown
GRY – Gray
GRN – Green
HAZ – Hazel
MAR – Maroon
MUL – Multicolored
PNK – Pink
XXX – Unknown

NYS Department of Health | CRIMINAL HISTORY RECORD CHECK

Resubmission ○

Type or print all information - USE CAPITAL LETTERS.
Inaccurate, incomplete or illegible information will delay processing.

DOH use only. Leave blank

SECTION 1 - SUBJECT INDIVIDUAL INFORMATION

Social Security Number* ___ - ___ - ____ Date of Birth mm/dd/yyyy __ / __ / ____

LAST Name _____ FIRST Name _____ M.I. _

Maiden Name _____ Alias (AKA) _____

Street Nmbr _____ Street Name _____ Apt # _____

City _____ St __ Zip _____ Home Phone ___ - ___ - ____

Sex _ Birth Country/Place _____ Cell Phone ___ - ___ - ____

Race _ Height (ft-inch) _ - __ Weight (lbs) ___ Hair ___ Eyes ___

SECTION 2 - SUBJECT INDIVIDUAL IDENTIFICATION

Please Select the Type of **PICTURE IDENTIFICATION** (select one):

○ Drivers License/ DMV ID ○ Passport ○ Miltary ○ School ○ Other Identify: _____

Issuing State/Country/Armed Force/School: _____ ID Number _____ ID Expire Date mm/dd/yy __ / __ / __

SECTION 3 - AGENCY IDENTIFICATION

○ Nursing Home ○ CHHA ○ LTHHCP PFI# ____ ○ LHCSA LICENSE # _____

Full name of Agency where applicant will be working _____ Telephone number with area code ___ - ___ - ____

Authorized Person LAST Name _____ FIRST Name _____

Agency's Street Nmbr _____ Street Name _____

City _____ State __ Zip _____

Authorized Party's e-mail: _____

The subject individual, whose identification I have confirmed, will provide direct care or supervision to individuals receiving care and/or services and is a subject individual concerning whom a criminal history record check is required by law (Article 28-E of the Public Health Law and Section 845-B of the Executive Law). I understand that the results of the criminal history record check will be used solely for purposes authorized by law and I will abide by the confidentiality requirements set forth in law. Informed consent (DOH CHRC Form 102) has been given by the subject individual and is on file.

Signature of Agency Authorized Person: _____ Date: __ / __ / __ (MM / DD / YY)

SECTION 4 - FINGERPRINTING METHOD/IDENTIFICATION

Fingerprint Method:
○ Ink & Roll
○ Live Scan

Name & Address of Location where fingerprint services were performed _____

City _____ State __ Zip _____

Identification verified before fingerprinting: (refer to Instruction #4)
○ Yes
○ No

The subject individual, whose identification I have confirmed, appeared before me for fingerprinting. I secured his/her fingerprints via the method indicated.

Signature: _____

First Name: _____

Last Name: _____

Title: _____

Date Fingerprinted __ / __ / ____ (MM / DD / Y Y Y Y)

51289

*The Authorized Person shall inform the subject individual that disclosure of the Social Security Number (SSN) is voluntary and not mandatory and that it will be used to assist DOH-CHRC Unit in performing criminal history record checks.

DOH CHRC 102 (1/07)

NYS Department of Health
ACKNOWLEDGEMENT AND CONSENT FORM FOR FINGERPRINTING AND DISCLOSURE OF CRIMINAL HISTORY RECORD INFORMATION
THIS FORM IS TO BE RETAINED BY THE AGENCY- DO NOT FORWARD TO THE DOH CHRC UNIT.
chrc@health.state.ny.us

The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

LAST Name	FIRST Name	M.I.	
Date of Birth (mm/dd/yyyy)	Mother's Maiden Name	Alias: AKA	

Mailing Address (street)	City	State	Zip

SECTION 2 - ATTESTATION

1. I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).

2. I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.

3. I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary to be provided to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, as maintained by DCJS or the FBI, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. I have been advised that by law, DOH is authorized and may be required to provide the results of the criminal history record check through a criminal history record summary to the agency. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law.

4. I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.

5. I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI.

6. I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.

7. I certify to the best of my knowledge and belief that I (check as appropriate):
   - ☐ **Have** ☐ **Have not been convicted of a crime in New York State or any other jurisdiction**
   - ☐ **Do** ☐ **Do not have a final finding of patient or resident abuse**

   If you have checked either "Have" and/or "Do", please provide a brief explanation. (Optional)
   _____

8. My current mailing or home address is indicated in Section 1 of this form.

9. I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the redisclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own (not applicable for Expedited Review submitted pursuant to CHRC Form 104).

Applicant Signature: _____ Date: _____

Signature of Parent or Legal Guardian_____ Date: _____
(if subject individual is under 18 years of age)

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name:	PFI/Operating License Number:
Print Name of Authorized Person:	Title:
Signature of Authorized Person:	Date:

Declination of Influenza Vaccination

My employer or affiliated health facility, _____, has recommended that I receive influenza vaccination to protect the patients I serve.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including
  - all patients in this healthcare facility
  - my coworkers
  - my family
  - my community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons: _____

_____

_____

I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is still available.

I have read and fully understand the information on this declination form.

Signature: _____ Date: _____

Name (print): _____

Department: _____

Reference: CDC. Prevention and Control of Influenza with Vaccines—Recommendations of ACIP at www.cdc.gov/flu/professionals/acip/index.htm

Technical content reviewed by the Centers for Disease Control and Prevention, October 2011.

www.immunize.org/catg.d/p4068.pdf • Item #P4068 (10/11)

Emergency Contact Information Form

This information will be extremely important in the event of an accident or medical emergency.

Please be sure to sign and date this form

Name: _____
Last First MI

Phone:
Home: _____ **Cell:** _____

Home Email Address: _____

Address: _____
Street City State Zip Code

Primary Emergency Contact Name: _____
Last First

Relationship: _____

Phone:
Home: _____ **Cell:** _____ **Work:** _____

Secondary Emergency Contact Name: _____
Last First

Relationship: _____

Phone:
Home: _____ **Cell:** _____ **Work:** _____

Comments *(include any special medical or personal information you would want an emergency care provider to know – or special contact information:*

Signature: _____ **Date:** _____

Hepatitis B Immunization

Name: _____ Social Security No: _____

Employee Consent to Hepatitis B Vaccination

I understand that as a result of my position I may be exposed to the hepatitis B virus through exposure to blood or other potentially infectious materials. I hereby give my consent to receive the hepatitis B vaccination series and certify that:

- I have received a copy of the hepatitis B information sheet and understand the contents thereof.
- I received training relative to the hepatitis B virus prior to accepting the hepatitis B vaccination.
- I was examined by a licensed healthcare professional prior to receiving the hepatitis B vaccination.
- I received the hepatitis B vaccination at no cost to me: and
- I received training and information about the facility's hepatitis B immunization policies and procedures.

Date_____

Comments:

Employee Declination to Receive Hepatitis B Vaccination

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be a risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____ _____

Date Signature – Employee

_____ _____

Date Signature – Witness

The original copy of this consent form must be filed in the employee's medical

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 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	E-mail Address	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):

☐ A citizen of the United States

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

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

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

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

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

Signature of Preparer or Translator:	Date *(mm/dd/yyyy):*

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

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

STOP ***Employer Completes Next Page*** STOP

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type
See **Specific Instructions** on page 2.

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; 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. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member 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.)

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 Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 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 on page 3.

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

General Instructions

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

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

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?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Universal Medical Records
22 The Cross Road Cortlandt Manor, NY 10567
Tel: 914 737-7499 Fax: 914-940-6860
email: hrdepartment@universalmedicalrecord.com

Direct Deposit Authorization Form

AUTHORIZATION AGREEMENT				
COMPANY NAME: Universal Medical Records		**DATE:**		
EMPLOYEE NAME:		**EMPLOYEE ID:**		
EMPLOYEE EMAIL ADDRESS:				
ACCOUNT INFORMATION				
Name of Financial Institution:				
Routing Number:		%	or	$
Account Number		Checking	or	Savings
SECOND ACCOUNT INFORMATION				
Name of Financial Institution:				
Routing Number:		%	or	$
Account Number		Checking	or	Savings

PLEASE ATTACH A MANDATORY VOIDED CHECK

I understand that Universal Medical Records provides (UMR) payroll service for my Employer. I hereby authorize and direct UMR to make deposits into my account(s) which is (are) designated on this authorization form. Furthermore, if UMR makes a deposit into my account in error or in an incorrect amount, I agree to return the funds to UMR and/or I authorize UMR to withdraw the funds from my account as may be appropriate. This authorization shall remain in effect until it is revoked by me by written notice of revocation received by UMR. You must specify by circling Checking or Savings Account. Any account information that is submitted incorrectly may result in an incurred banking fee of no less than $50

Employee Name (Print):

Employee Signature:

UNIVERSAL MEDICAL RECORDS INFORMATION NETWORK CORP.
22 The Cross Road Cortlandt Manor, New York 10567 Voice: 914-737-7499 Fax: 212-504-7956

AGREEMENT

This Independent Contractor Agreement [hereinafter "Agreement"], between [Name of Individual], located at [Address], [Town/City], [State], [Zip Code], (hereinafter "Contractor"), and Universal Medical Records Information Network Corp, located at 22 The Cross Road, Cortlandt Manor, New York 10567 [hereinafter "Agency''']

a. It is understood and agreed that Contractor is an Independent Contractor and will receive a 1099 at the end of the year. Contractor will be responsible for obtaining all Insurance such as Worker's Compensation and Disability Insurance. Additionally Contractor will be responsible for pay all taxes including; Social Security, Medicare and any and all Federal and Local State Taxes, etc.

b. Contractor shall defend, indemnify and hold harmless Agency, on behalf of itself, assigns, successors and affiliates and their respective directors, officers, members, employees, agents and representatives (collectively "Indemnitees") from and against any and all third party claims, demands, actions, suits and proceedings, whether civil, criminal or administrative, and all losses, liabilities, damages, costs, fines, penalties, interest and expenses, whether direct or indirect, (including without limitation, settlement costs and any legal, accounting and other expenses for investigation or defending any actions or threatened actions) (collectively "Losses"), which any Indemnitee may suffer or incur resulting from, arising from, or relating to any wrongful or negligent acts or omissions, breach, or willful or intentional misconduct of the Contractor or any of its directors, officers, officers, shareholders, members, managers, employees, Staff, agents and/or representatives The Contractor shall not enter into any settlement that imposes any obligation or liability or fault on Agency with Agency express approval.

c. Notwithstanding anything herein to the contrary, Contractor shall defend, indemnify and hold Indemnitees harmless from any and all liabilities and damages incurred by an Indemnitee or Indemnitees, including, but not limited to, penalties and restitution paid to any payor, including, but not limited to, Transportation Insurance, Medicare or the state Medicaid program, as a result of penalties and restitution paid to any payor, including, but not limited to, Medicare or the state Medicaid program, as a result of any assigned Staff or the Contractor's owners or management level employees: (i) not being properly licensed, qualified and/or certified to provide services; or (ii) having been or being excluded from the Medicare program, the state Medicaid Program, and/or any other federal or state health program.

d. In the event that any investigation and/or litigation is commenced or threatened against Agency, on behalf of itself, assigns, successors and affiliates and their respective directors, officers, members, employees, agents and representatives (collectively "Indemnitees") is entitled to indemnification hereunder, Indemnitees shall be entitled to engage legal counsel of its own choosing at the Contractor's cost. The Contractor shall be entitled to participate in the response to any investigation and defense of any litigation and defensed of any litigation and maintain the right to approve or disapprove of any settlement thereof.

e. The provisions of this Section 10, and the Contractor's indemnification obligations shall survive the expiration or termination of the Agreement

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The Contractor has read and reviewed the entirety of these Policies and Procedure

Contractor's Name _____
Contractor's Signature _____
Dated: _____

UMR
HR Manager Name_____
HR Manager Signature _____
Dated: _____

TERMS AND CONDITIONS

INDEPENDENT CONTRACTOR

UNIVERSAL MEDICAL RECORD

EFFECTIVE DATE: __ __ /__ __/__ __ __ __

APPLICANT NAME: __
STREETADDRESS: __
CITY/TOWN STATE ZIP CODE: __
PHONE (H) (__ __ __) - __ __ __ - __ __ __ __ PHONE (C) (__ __ __) - __ __ __ - __ __ __ __

CONTRACTORS BUSINESS NAME: __
STREET ADDRESS: __
CITY/TOWN STATE ZIP CODE: __
OFFICE PHONE (__ __ __) - __ __ __ - __ __ __ __

NAME OF FACILITY NAME: __
STREETADDRESS: __
CITY/TOWN STATE ZIP CODE: __
OFFICE PHONE (__ __ __) - __ __ __ - __ __ __ __

JOB TITLE/POSITION: __
Rate of Pay or Compensation: __ __ __ __ __ __ __ __ __ __ Hours Per Week: __ __ Days Per Week: __ __
Check List: Must Have the Following Insurance
Name of General Liability Insurance __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Policy No:__ __ __ __ __ _
Name of Malpractice Insurance __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Policy No:__ __ __ __ __ _
Name of Workers Compensation Insurance __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Policy No:__ __ __ __ __ _
Name of Disability Insurance __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Policy No:__ __ __ __ __

INDEPENDENT CONTRACTOR UNDERSTANDS THE ABOVE CONDITIONS AND ALSO AGREES TO THE FOLLOWING:

- **Contractor understands their work as an independent contractor and receives a 1099**
- **There are NO BENEFITS – Contractor will obtain and maintain their own General Liability, Malpractice, Workers Compensation and Disability Insurances**
- **Contractor establishes their own work schedule, hours and days**
- **Contractor CANNOT file for unemployment or any other BENEFITS**
- **Contractor works for AGENCY on a nonexclusive basis**
- **Contractor is fully informed with UMR's mission statement, code of ethics and best practices.**
- **Contractor is fully informed with the facility's work policies, procedures and conduct and has duly executed their signature on same**
- **Contractor will formally notify in writing, email, or text of any issue(s) incurred when they are working at their current facility within 48 hours of any occurrence. This includes any policy and/or procedural issue(s) that may be compromised**

TERMS AND CONDITIONS

This Agreement constitutes the entire Agreement between Agency and Contractor with respect to the subject matter hereof and supersedes any and all other Agreements, either oral or in writing, between the parties hereto with respect to the subject matter thereof. This Agreement shall be binding upon the successors or assigns of the parties hereto In **WITNESS WHEREOF,** Contractor and Agency have hereunto caused this Agreement to be executed as by laws provided, the date and year first above written

CONTRACTOR SIGNATURE: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ DATE: __ __/__ __/__ __ __ __

AUTHORIZED BY:__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ DATE: __ __/__ __/__ __ __ __

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Employee HIPPA Compliance Signature Form

Employee: _____
Date: _____

My Commitment to Compliance

I have been taught and understand fully our office's Employee Hipaa rules and regulations. I agree to do all that I can, within my area of responsibility to maintain up-to-date knowledge about federal and state laws and program requirements. I will comply with these requirements to the best of my ability, and to immediately let the Compliance Officer know if there is any area where I feel our office is not in compliance with these laws and program requirements. Our policy is a simple, yet powerful four-step process: Keep up-to-date, Educate, Comply, and Audit/Correct;

a) We seek to maintain **up-to-date** knowledge about federal and state laws pertaining to the protection of our patients Protected Health Information.

b) We **educate** our employees and keep them up-to-date about federal and state laws as it applies to Protected Health Information.

c) Our policy is to **comply** with all federal and state law governing Protected Health Information.

We desire that all our employees are particularly cognizant of the fact that protected chiropractic patient information must be treated with the upmost attention, accuracy, honesty, and integrity. We seek to educate and carry out these policies with all our employees, and where appropriate contractors and other agents.

I agree with our policy and will do all that I can to apply with all the regulatory laws pertaining to personal protected chiropractic patient information. I understand that our office has an open door policy and that I may discuss any problems I feel may occur with PHI without worry of recourse with my supervisor or supervisors.

_____
Signature of Employee

_____
Signature of Compliance Officer

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AGREEMENT

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b. Contractor shall defend, indemnify and hold harmless Agency, on behalf of itself, assigns, successors and affiliates and their respective directors, officer, members, employees, agents and representatives (collectively "Indemnitees") from and against any and all third party claims, demands, actions, suits and proceedings, whether civil, criminal or administrative, and all losses, liabilities, damages, costs, fines, penalties, interest and expenses, whether direct or indirect, (including without limitation, settlement costs and any legal, accounting and other expenses for investigation or defending any actions or threatened actions) (collectively "Losses"), which any Indemnitee may suffer or incur resulting from, arising from, or relating to any wrongful or negligent acts or omissions, breach, or willful or intentional misconduct of the Contractor or any of its directors, officers, shareholders, members, managers, employees, Staff, agents and/or representatives. The Contractor shall not enter into any settlement that imposes any obligation or liability or fault on Agency with Agency express approval.

c. Notwithstanding anything herein to the contrary, Contractor shall defend, indemnify and hold Indemnitees harmless from any and all liabilities and damages incurred by an Indemnitee or Indemnitees, including, but not limited to, penalties and restitution paid to any payor, including, but not limited to, Transportation Insurance, Medicare or the state Medicaid program, as a result of penalties and restitution paid to any payor, including, but not limited to, Medicare or the state Medicaid program, as a result of any assigned Staff or the Contractor's owners or management level employees: (i) not being properly licensed, qualified and/or certified to provide services; or (ii) having been or being excluded from the Medicare program, the state Medicaid Program, and/or any other federal or state health program.

d. In the event that any investigation and/or litigation is commenced or threatened against Agency, on behalf of itself, assigns, successors and affiliates and their respective directors, officers, members, employees, agents and representatives (collectively "Indemnitees") is entitled to indemnification hereunder, Indemnitees shall be entitled to engage legal counsel of its own choosing at the Contractor's cost. The Contractor shall be entitled to participate in the response to any investigation and defense of any litigation and defensed of any litigation and maintain the right to approve or disapprove of any settlement thereof.

e. The provisions of this Section 10, and the Contractor's indemnification obligations shall survive the expiration or termination of the Agreement

UNIVERSAL MEDICAL RECORD SERVICES CORP.

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The Employer and the Employee have each duly executed this Agreement as of the date set forth below.

Employer:
Universal Medical Record Services Corp

By:_____
STEVEN CHARLES COHN, M.D.
President/CEO
Date of Execution:

Employee
Signature:_____ **Notary**
Date of Execution