U.S. Department of Labor
Office of Labor-Management Standards
Washington, DC 20210

# FORM LM-20
# AGREEMENT AND ACTIVITIES REPORT

Form approved
Office of Management and Budget
No. 1245-0003
Expires 08-31-2016


This report is mandatory under P.L. 86-257, as amended. Failure to comply may result in criminal prosecution, fines, or civil penalties as provided by 29 U.S.C. 439 or 440. Required of persons, including Labor Relations Consultants and Other Individuals and Organizations, Under Section 203(b) of the Labor-Management Reporting and Disclosure Act of 1959, as amended. (LMRDA)

**READ THE INSTRUCTIONS CAREFULLY BEFORE PREPARING THIS REPORT.**

650124

1. File Number: C- 00755

**Person Filing**

2. Name and mailing address (include ZIP Code):

Name Robert Long

Title President

Organization Healthcare Labor Solutions

P.O. Box, Bldg., Room No., if any Suite 251-151

Street 4843 Colleyville Blvd.

City Colleyville

State Texas ZIP Code + 4 76034

3. Any other address where records necessary to verify this report are kept:

Name

Title

Organization

P.O. Box, Bldg., Room No., if any

Street

City

State ZIP Code + 4

4. Date fiscal year ends: Dec / 31

5. Type of person: a. ☐ Individual b. ☐ Partnership c. ☒ Corporation d. ☐ Other (Specify):

**Nature of Agreement or Arrangement**

6. Full name and address of employer with whom made (include ZIP Code):

Name Sabrina Granville

Organization Lowell General Hospital

Trade Name, if any

P.O. Box, Bldg., Room No., if any

Street 295 Varnum Avenue

City Lowell

State Massachusetts ZIP Code + 4 01854

7. Date entered into: 5 / 15 / 2017

8. Name of person(s) through whom made:

Name Robert Long

Name Sabrina Granville

Name

Name

Name

**Signatures**

Each of the undersigned declares, under penalty of perjury and other applicable penalties of law, that all of the information submitted in this report (including the information contained in any accompanying documents) has been examined by the signatory and is, to the best of the undersigned's knowledge and belief, true, correct, and complete. (See *Section VII* on penalties in the instructions.)

13. Signed _____ President (If other title, see instructions)

Title President

On 06/14/2017 (Date) 877-424-9799 (Telephone Number)

14. Signed _____ Treasurer (If other title, see instructions)

Title Treasurer

On 06/14/2017 (Date) 877-424-9799 (Telephone Number)

| Filer: Robert Long Healthcare Labor Solutions | File Number C- 00755 |
|---|---|

9. Check the appropriate box to indicate whether an object of the activities undertaken, is directly or indirectly:

a. [X] To persuade employees to exercise or not to exercise, or persuade employees as to the manner of exercising, the right to organize and bargain collectively through representatives of their own choosing.

b. [ ] To supply an employer with information concerning the activities of employees or a labor organization in connection with a labor dispute involving such employer, except information for use solely in conjunction with an administrative or arbitral proceeding or a criminal or civil judicial proceeding.

10. Terms and conditions (Explain in detail; see instructions. Written agreements must be attached.):

All services described in Section 11a below shall be performed on an hourly fee basis. Expenses in connection with the performance of such services as accomodations, meals, copies, travel, etc. will be reimbursed to Healthcare Labor Solutions.

**Specific Activities to be Performed**

11. For each activity, separately list in detail the information required (See instructions):

a. Nature of activity:

Healthcare Labor Solutions has been retained to assist the employer named above in communications with its employees with regard to the manner in which they exercise their rights to organize and bargain collectively under the National Labor Relations Act. We will assist in communicating and conducting meetings with employees during this period.

| 11.b. Period during which performed: | 11.c. Extent performed: |
|---|---|
| 06/08/2017 | ongoing |

| 11.d. Name and address through whom performed: | Additional Name and address through whom performed, if any: |
|---|---|
| Name Jim Misercola | Name |
| Organization Healthcare Labor Solutions | Organization |
| P.O. Box, Bldg., Room No., if any Suite 251-151 | P.O. Box, Bldg., Room No., if any |
| Street 4843 Colleyville Blvd. | Street |
| City Colleyville | City |
| State Texas ZIP Code + 4 76034 | State ZIP Code + 4 |

| 12.a. Identify subject groups of employees: | 12.b. Identify subject labor organizations: |
|---|---|
| RNs | MNA |