INDEPENDENT CONTRACTOR APPLICATION

PLEASE COMPLETE ALL SECTIONS SIGN AND DATE.

BRING ORIGINAL DOCUMENTS AS FOLLOWS:

PROFESSIONAL LICENSE

PROFESSIONAL INSURANCE

SOCIAL SECURITY CARD

IMMIGRATION STATUS VERIFICATION

DRIVER'S LICENSE

CAR INSURANCE

CPR CARD

OSHA

DOMESTIC VIOLENCE

HIV/AIDS

ALZHEIMER'S DISEASE AND RELATED DEMENTIA DISORDERS 2HR COURSE

PHYSICAL EXAM/PPD/CHEST X-RAY LESS THAN 6 MONTHS OLD

ANY AND ALL OTHER RECENT EDUCATION CERTIFICATES

APPLICATION FOR EMPLOYMENT

PERSONAL INFORMATION

NAME	SOCIAL SECURITY NUMBER
PRESENT ADDRESS	PERMANENT ADDRESS (IF DIFFERENT)
PHONE:	REFERRED BY:

EDUCATION HISTORY

LEVEL	NAME & LOCATION OF SCHOOL	YEARS ATTENDED	SUBJECT STUDIED
GRAMMAR SCHOOL			
HIGH SCHOOL			
COLLEGE			
TRADE, OTHER SCHOOL			

GENERAL INFORMATION

SUBJECTS OF SPECIAL STUDY, SPECIAL TRAINING, U.S. MILITARY OR NAVAL SERVICE

EMPLOYMENT HISTORY (IF YOU HAVE A RESUME DO NOT COMPLETE)

FROM: TO:	NAME & LOCATION OF EMPLOYER	POSITION	REASON FOR LEAVING

AUTHORIZATION: I CERTIFY THAT THE FACTS CONTAINED IN THIS APPLICATION ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND I UNDERSTAND THAT, IF EMPLOYED, FALSIFIED STATEMENTS ON THIS APPLICATION SHALL BE GROUNDS FOR DISMISSAL. I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED HEREIN AND THE EMPLOYERS LISTED ABOVE. I UNDERSTAND THAT I MUST PROVIDE A WRITTEN PERSONAL REFERENCE AND A BUSINESS REFERENCE BEFORE MY APPLICATION CAN BE CONSIDERED.

DATE: _____ SIGNATURE:_____

INTERVIEWED BY: _____ DATE: _____

EMPLOYEE NAME:_____**DA TE:**_____

EMPLOYEE EMERGENCY NOTIFICATION

AS PER AGENCY POLICY. EVERY EMPLOYEE MUST COMPLETE AT LEAST TWO EMERGENCY NOTIFICA TION AS WELL AS UPDATE THE FORM AS NECESSARY.

IN CASE OF EMERGENCY NOTIFY NEXT OF KIN:

NAME:_____ RELATIONSHIP:_____

ADDRESS:_____

CITY :_____STATE:_____ ZIP CODE:_____

AREA CODE AND TELEPHONE: (_____)_____

SECOND EMERGENCY CONTACT (FRIEND OR RELATIVE NOT LEAVING WITH YOU)

NAME:_____ RELATIONSHIP:_____

ADDRESS:_____

CITY :_____STATE:_____ ZIP CODE:_____

AREA CODE AND TELEPHONE: (_____)_____

NOTIFICATION OF PROBATIONARY PERIOD

I,_____ ACCEPT AND UNDERSTAND THAT THE FIRST 90 DAYS OF EMPLOYMENT WILL BE CONSIDERED MY PROBATIONARY PERIOD. IF FOR ANY REASON MY EMPLOYMENT IS TERMINATED DURING THIS PERIOD, I UNDERSTAND AND ACCEPT THAT THIS ACCOUNT WILL NOT BE CHARGED WITH ANY UNEMPLOYMENT BENEFITS THAT I MAYBE ELIGIDLE TO RECEIVE UNDER THE STATE OF FLORIDA UNEMPLOYMENT COMPENSA TION LAW.

I ALSO UNDERSTAND AND ACCEPT THAT AT THE END OF THE 90 DAY PERIOD, I WILL RECEIVE A WRITTEN EV ALUA TION OF MY WORK PERFORMANCE. SHOULD THE AGENCY FAIL TO PROVIDE THIS WRITTEN EV ALUA TION, IT SHALL BE UNDERSTOOD AND ACCEPTED BY ALL INVOLVED THAT THE PROBATIONARY PERIOD WILL HAVE BEEN COMPLETED SATISFACTORILY.

EMPLOYEE SIGNATURE:

EMPLOYEE NAME:_____**DA TE:**_____

EMPLOYEE ORIENTATION

Introduction to the Organization:
- ☐ History
- ☐ Corporate structure
- ☐ Mission, vision, values, goals and customer service perspective
- ☐ Types of care or services provided

Organization's Policies and Procedures:
- ☐ Ethics
- ☐ Patient Rights and Responsibilities
- ☐ Advance Directives/Living Wills/Healthcare Surrogate
- ☐ Death and Dying
- ☐ Confidentiality of Patient, Staff and Organization Information
- ☐ Care or Service Responsibilities - Roles and Responsibilities of Interdisciplinary Healthcare Team Members

Personnel Policies:
- ☐ Hours of work/pay period
- ☐ Holidays, sick/personal time
- ☐ Insurance and other benefits

Infection/Exposure Control/Safety:
- ☐ Personal hygiene
- ☐ Aseptic procedures
- ☐ Communicable infections
- ☐ Precautions
- ☐ Cleaning, disinfection and sterilization of equipment and supplies
- ☐ Disposal of hazardous materials
- ☐ Provided Copy of the Infection Control Plan

- ☐ Personal Safety/Security on the Job, in the Automobile, in the Home
- ☐ Safety within the Patient's Place of Residence:
  - ☐ Bathroom
  - ☐ Fire
  - ☐ Environmental
  - ☐ Electrical
- ☐ Emergency Management
- ☐ Communication with Supervisors

Other topics that may be included:

Overview of:
- ☐ Discharge Planner Role
- ☐ Specialty Services
  - ☐ Diabetes Education
  - ☐ Pain Assessment/Management
  - ☐ Nutritional Counseling
  - ☐ Respiratory Therapy

- ☐ Alzheimer's Disease and Related Dementia Disorders
- ☐ Principles of Reimbursable Documentation
- ☐ Documentation Accuracy, Legibility
- ☐ OASIS Documentation

ADMINISTRATOR Signature: _____

EMPLOYEE SIGNATURE:

EMPLOYEE NAME:_____**DA TE:**_____

EMPLOYEE STATEMENT OF COMMITMENT

I have read and understand the agency's. , Personnel Policy Manual. In compliance with those policies I agree to conform to the following:

- I will always maintain professionalism in the home to which I am assigned.

- I will immediately contact the agency's regarding any areas of discrepancy between the client's assessment of the assignment requirements and my understanding of my specific performance level as designated by the agency's.

- I have read and understand the agency's job description appropriate to my level of performance. I will not accept assignments beyond my designated performance level as determined by the agency's.

- I will abide with the agency's. Standard Code of Dress as described in the Personnel Policy Manual.

- I will arrive on time for the assignments I have accepted. In the event of an emergency which may cause me to be late, I will notify the agency's office of the situation and expected arrival time.

- I will not accept any money of gifts from the agency's clients. I will receive payment for services rendered directly from the agency's.

- I will notify the agency's. immediately if I am unable to arrive for my assignment within my due time of if I am unable to meet my assignment commitment. I understand the agency's. office will then contact the client. I also understand that not calling the agency's. office when I am unable to meet my assignment commitment will be ground for termination immediately.

- I will not make or accept personal telephone calls on the client's home.

- I will not transport a patient of family member in my personal vehicle.

- I will not smoke in a patient's home.

TRANSPORTATION RESPONSIBILITY

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 the patient assignments. I further understand that I am responsible for auto liability insurance coverage.

EMPLOYEE SIGNATURE:

EMPLOYEE NAME:_____**DA TE:**_____

CONFIDENTIALITY STATEMENT

Disclosure of confidential information gained through your employment is stated as an act of prohibited conduct subject to formal disciplinary action. Any information concerning a patient's illness, family, financial condition or personal peculiarities is strictly confidential. When a patient's history or condition is reviewed, it must be done in privacy with only those persons involved with the care of the patient. Any other information coming to you in the course of your work concerning another person or employee is also considered confidential and may not become the topic of conversation with others.

EMPLOYEE SIGNATURE:

Standards of Conduct

The organization has zero tolerance for criminal or unethical conduct on the part of its employees and/or agents

Such conduct includes but is not limited to:

- Upcoding
- Unbundling
- Doubling billing
- Fraudulent manipulation of billing practices, cost reporting, time sheets, or patient care documentation

- The organization, its employees and/or agents will not offer or accept inducements to increase, decrease or provide services or care inappropriately.

- Each employee will be familiar with the rules and regulations impacting their job function and will sign an agreement, to be renewed each year on the anniversary date of hire, stating that he/she has read and understands the organization compliance plan and agrees to abide by the plan.

- All employees are required to attend a minimum of four (4) hours of compliance training annually. Refusal to attend such programs may result in disciplinary action up to and including termination of employment.

- A reporting system is in place for employees, agents of the organization, patients, caregivers, and any concerned individual to report improprieties that may constitute fraud, abuse, or waste.

- Supervisory staff is expected to educate and monitor staff in appropriate compliance activities/adherence to the compliance plan. Failure to exercise due diligence in overseeing the activities of the staff may result in disciplinary action up to and including termination of employment.

I have read and understand the above Standards of Conduct of the Home Health Organization, and agree to abide by these standards.

Employee Signature: _____ Date: _____

Employment Reference Request

Date: _____

Company Name: _____
Attention:_____
Address:_____
Phone;_____

or Fax No.:_____

I have applied for employment with _____ I authorize you to provide information regarding to my last employment with you. Thank you for your prompt reply.

Applicant's Signature:_____

Applicant's Name:_____

To be complete by Former Employer:

Job Skills	**Excellent**	**Very Good**	**Good**	**Poor**
Reliability and Attendance				
Ability to work with others				
Organizational Skills				
Honesty				
Ability to accept directions				
Supervisory ability capacity				
Patient Care Skills				

Date of Employment: _____ to _____

_____ _____ _____
Signature of Representative Title Date

In office use only:
Date sent: Via [ ] mailed [ ] Fax [ ] Phone: _____ By: _____

Employment Reference Request

Date: _____

Company Name: _____
Attention:_____
Address:_____
Phone;_____

or Fax No.:_____

I have applied for employment with _____ I authorize you to provide information regarding to my last employment with you. Thank you for your prompt reply.

Applicant's Signature:_____

Applicant's Name:_____

To be complete by Former Employer:

Job Skills	**Excellent**	**Very Good**	**Good**	**Poor**
Reliability and Attendance				
Ability to work with others				
Organizational Skills				
Honesty				
Ability to accept directions				
Supervisory ability capacity				
Patient Care Skills				

Date of Employment: _____ to _____

_____ _____ _____
Signature of Representative Title Date

In office use only:
Date sent: Via [ ] mailed [ ] Fax [ ] Phone: _____ By: _____

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

AFFIDAVIT OF COMPLIANCE WITH Background Screening Requirements

Authority: This form may 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 submitted within the previous 5 years to meet any provider or professional licensure requirements of the Agency, the Department of Health, the Agency for Persons with Disabilities, the Department of Children and Family Services, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651 if the person has not been unemployed for more than 90 days.

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:

I hereby attest to meeting the requirements for employment and that I have not been arrested for or been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense, or have an arrest awaiting a final disposition prohibited under any of the following provisions of the Florida Statutes or under any similar statute 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 782.04, relating to murder.

(e) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(f) Section 782.071, relating to vehicular homicide.

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

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

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

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

(k) Section 787.01, relating to kidnapping.

(l) Section 787.02, relating to false imprisonment.

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

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

(o) 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.

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

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

(r) Section 794.011, relating to sexual battery.

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

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

(u) Chapter 796, relating to prostitution.

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

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

(x) Section 806.01, relating to arson.

(y) Section 810.02, relating to burglary.

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

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

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

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

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

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

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

(gg) Section 826.04, relating to incest.

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

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

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

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

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

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

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

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

(pp) Chapter 847, relating to obscene literature.

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

(rr) 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.

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

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

(uu) Section 944.40, relating to escape.

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

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

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

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

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

(h) Section 817.505, relating to patient brokering.

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

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

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

(l) Section 831.01, relating to forgery.

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

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

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

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

(q) 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.

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:_____

Screened conducted by: Date of Prior Screening: _____

- ☐ Agency for Health Care Administration
- ☐ Department of Health
- ☐ Agency for Persons with Disabilities
- ☐ Department of Children and Family Services
- ☐ Department of Financial Services

Affidavit

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

INDEPENDENT CONTRACTOR AGREEMENT

This Agreement is made and entered into this day_____, by and between _____a Florida Corporation, (hereinafter referred to as 'Corporation'), and_____, S.S.# _____ a Florida resident at _____ _____ (hereinafter referred as 'Contractor'),

PARAGRAPH I

Whereas, corporation desires to hire contractor to perform work **in accordance with the terms of this Agreement (see attached Job Description)**. WHEREAS, contractor is willing to perform services in accordance with the terms hereinafter set forth, now therefore in consideration of the mutual covenants and agreements herein contained, it is hereby agreed as follows:

PARAGRAPH II

Corporation shall not be liable for any withholding tax, social security taxes, workmen's compensation or other expense or liability attributable to an employer/employee relationship,

PARAGRAPH III. RELATIONSHIP BETWEEN PARTIES.

Contractor is retained and employed by the Corporation only for the purposes and to the extent set forth in this agreement, and his relation to the Corporation and its subsidiary companies shall, during the period or periods of his employment and services hereunder, be that of an independent practitioner.
Contractor shall not be considered as being entitled to participate in any plans, arrangements, or distribution by the Corporation or its subsidiary companies pertaining to or in connection with any pension, stock, and bonus, profit-sharing or similar benefits for their regular employees.

Both parties agree that the Contractor shall be paid as per Attachment A. Payment is subject to the submission of all required documents in this agreement.

PARAGRAPH IV. PROFESSIONAL RESPONSIBILITY.

Nothing in this Agreement shall construe to interfere with or otherwise affect the rendering of services by Contractor In accordance with his independent and professional judgment. This Agreement shall be subject to the rules and regulations of any and all professional organizations or associations to which Contractor may from time to lime belong and the laws and regulations governing said practice in this State. **Our Agency has full responsibility over all contracted services. Our Agency has full responsibility to retain and maintain all clinical records of patients served by this Contract. The Contractor agrees to abide by the Corporations Policy and Procedures.**
The second party must submit evidence of all education and certification requirements, physical exams and insurance coverage. Both parties agree that the

Employee shall submit clinical notes and progress reports to the Director of Nursing once a week (on/or before 72 his of service rendered), and shall conform to prescribed scheduling of visits and, periodic patient evaluation. Both parties agree that this Agency shall coordinate all job-related activities of the Employee, control all job-related activities of the Employee, and shall evaluate the Employee's job performance just as we do that of other employees. The Contractor agrees to participate in the agency Performance Improvement Activities and Compliance Programs.

PARAGRAPH V. SUSPENSION AND TERMINATION.

The initial term of this Agreement shall be for a period of twelve (12) months, and shall automatically continue thereafter for successive terms of twelve (12) months unless or until terminated as hereinafter provided. Corporation shall have the right to terminate this agreement If Contractor fails to comply with all the rules and regulations provided to Contractor by the Corporation.

PARAGRAPH VI. ENTIRE AGREEMENT.

This Agreement (Including any attachments, exhibits, and amendments hereto) constitutes the entire understanding between the parties hereto and cancels and supersedes all prior negotiations representations, understandings and agreements either written or oral, with respect to the subject matter hereof.

Executed as of the day and year first above written.

Corporation:

BY: _____ _____
Signature Name/Title

Contractor:
BY: _____ _____
Signature Name/Title

Date: _____

Attachment A

Payment Schedule

Date:_____

Visit Type	Rate

TAX EXEMPT FORM

I, _____, hereby acknowledge that I am an independent contractor; therefore, I am responsible for my Social Security and taxes. I also acknowledge that I will receive an IRS 1099 form for the preceding year by February 1, of service. As an independent contractor, I am not eligible for any benefits such as vacations, disability or unemployment and will not be covered by Workman's Compensations.

DATE: _____

EMPLOYEE SIGNATURE: _____

POSITION: _____

Form **W-9**
(Rev. January 2011)
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.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification (required): ☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ Exempt payee

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

Requester's name and address (optional)

City, state, and ZIP code

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 the "Name" line to avoid backup withholding. For individuals, this is 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 chart on page 4 for guidelines on whose number to enter.

Social security number

			–		–				

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).

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 4.

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

General Instructions

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

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

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.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

PHYSICAL EXAMINATION FORM

IN MY OPINION, _____ IS PHYSICALLY
AND MENTALLY ABLE TO PERFORM THE DUTIES AND IS FREE OF COMUNICABLE DISEASE.

[ ] RN [ ] LPN [ ] HHA [ ] PT [ ] PTA [ ] OTHER:_____

.

_____ _____
PHYSICIAN SIGNATURE DATE

PPD OR CHEST X-RAY

NAME: _____

TEST DATE: _____ NEGATIVE [ ] POSITIVE [ ]

READING DATE: _____

READ BY: _____

RECOMENDATIONS:

SIGNATURE _____

INFORMED CONSENT FOR HEPATITIS B VACCINE

I have read the Hepatitis B Vaccine Information Sheets regarding hepatitis B and hepatitis B vaccine. I understand the benefits and risks of the vaccination. I understand that vaccination is not mandatory but highly recommended.

I understand that I must have three doses of the vaccine over the next 6 months to confer immunity. I know that there is no absolute guarantee that I will become immune or that I will not have adverse reaction from the vaccine.

I REQUEST THAT THE HEPATITIS B VACCINE BE GIVEN TO ME:

Employee Signature: _____ Date: _____

Department: _____

Witness: _____

	Date	***Site**	**Lot#**	**Given By**
1st Dose	_____	_____	_____	_____
2nd Dose	_____	_____	_____	_____
3rd Dose	_____	_____	_____	_____

*Site:#1 = Left deltoid
#2 = Right deltoid

DECLINATION:

I understand that, due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infections. I have been given the opportunity to be vaccinated with 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.

Name of Employee (printed): _____

Signature: _____ Date: _____