



Name of Company: \_\_\_\_\_

Address: \_\_\_\_\_

City / State / Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date Worked From: \_\_\_\_\_ To: \_\_\_\_\_

Position / Duties: \_\_\_\_\_

**Education**

High School: \_\_\_\_\_ Yr. Grad: \_\_\_\_\_

City / State: \_\_\_\_\_ Degree: \_\_\_\_\_

College: \_\_\_\_\_ Yr. Grad: \_\_\_\_\_

City / State: \_\_\_\_\_ Degree: \_\_\_\_\_

I agree to hold harmless *Encore Medical Staffing*, if injured on the job as an Independent Contractor.

I assume the risk and understand that I am not covered under workers compensation or general and professional liability with *Encore Medical Staffing* insurances.

**Licensure**

State: \_\_\_\_\_ License #: \_\_\_\_\_ Expires: \_\_\_\_\_

State: \_\_\_\_\_ License #: \_\_\_\_\_ Expires: \_\_\_\_\_

Malpractice Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

\_\_\_\_\_  
Independent Contractor

\_\_\_\_\_  
Date



## **HOME HEALTH AIDE JOB DESCRIPTION**

The basic function of this position is to care for the patient through in-home assistance with activities of daily living.

### **RESPONSIBILITIES**

Participates in following the orders of the patient's physician or nurse.

Accepts responsibilities to make sure that medication is taken on-time and in the right dosage.

Ability to change surgical dressings.

Monitors vital statistics such as temperature and blood pressure.

Assists the patient with normal activities, such as getting in and out of bed, using a bedpan or toilet, planning and cooking meals, bathing and dressing, changing linen, and cleaning.

\_\_\_\_\_  
Independent Home Health Aide

\_\_\_\_\_  
Date



# **Current Licensure, CPR Certification Card, and Drivers License**

**Please be sure to include a copy of  
your Current Licensure, CPR  
Certification Information, and  
Drivers License.**

**[www.encoremedicalstaffing.com](http://www.encoremedicalstaffing.com)**



## ***DRIVERS LICENSE VERIFICATION***

**INDEPENDENT CONTRACTOR** \_\_\_\_\_

**LICENSE #** \_\_\_\_\_

**EXPIRATION DATE** \_\_\_\_\_

**DATE VERIFIED** \_\_\_\_\_

**BY** \_\_\_\_\_



## CONSENT FOR CRIMINAL BACKGROUND CHECK WITH INVOICE PAYMENT REDUCTION

This authorization will allow you to release to Encore Medical Staffing or its representatives, all information you may have regarding any criminal **convictions** of any nature whatsoever regarding the individual named below. This also gives approval to reduce my first invoice by \$ \_\_\_\_\_ dollars to cover the cost of my background check. I also have the right to have a copy of this background check.

### PLEASE PRINT CLEARLY

Full Legal Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Country: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

(Very Clear Numbers)

X

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Authorized Independent Contractor

Driver's License Verified: \_\_\_\_\_

Date

Encore Initials

Social Security Card Verified: \_\_\_\_\_

Date

Encore Initials



## ***PAYMENT INSTRUCTION FORM***

I, the undersigned, do hereby instruct and direct EMS to pay all sums due to me for services rendered as an Independent Contractor on the following basis:

Daily \_\_\_\_\_  
Weekly \_\_\_\_\_  
Bi-Weekly \_\_\_\_\_  
Monthly \_\_\_\_\_

I understand that I am an Independent Contractor and not an employee of EMS and that it is my desire that EMS regard the information signed by me on the daily time slip as accurate. I understand that I have the complete authority and power to elect to be paid on a basis purely of my own control and direction. I further understand that EMS will issue a check to me for sums due within two working days after the end of the period elected above.

I understand that I am self-employed and am responsible for filing and paying my own federal, Social Security, and F.I.C.A. taxes. I further understand that EMS is not responsible for my tax liability for fees received while sub-contracting my services through EMS.

I authorize EMS to release my check to the following named persons:

1. \_\_\_\_\_
2. \_\_\_\_\_

I understand and agree that this release will remain valid until I notify EMS in writing, either by mail or personally hand deliver to EMS a written statement canceling this release. I further agree that I will hold EMS harmless for the monies due me if misappropriated by the above named individuals.

I would like my check mailed to me. (Initial if applicable.) \_\_\_\_\_

Independent Contractor: \_\_\_\_\_

Date: \_\_\_\_\_



***CURRENT TB / PPD VERIFICATION***

**Independent Contractor Name:** \_\_\_\_\_

**Date of Injection:** \_\_\_\_\_

**Site of Injection:** \_\_\_\_\_

**Given By:** \_\_\_\_\_

**TO BE READ BY DESIGNATED MEDICAL PERSONNEL 48 – 72 HOURS AFTER INJECTION!**

**Date Read:** \_\_\_\_\_

**Read By:** \_\_\_\_\_

**Results:** \_\_\_\_\_

**NOTE: IF “POSITIVE”...INCLUDE MM INDURATION.**

**IF SKIN TEST IS POSITIVE ( 10 MM OR LARGER ), REFER TO FAMILY PHYSICIAN FOR CHEST X-RAY.**

**Comments:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## ***HEPATITIS B VACCINE VERIFICATION***

I understand that due to my occupational exposure to blood and other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine from a physician or other facility of my choice and at my own expense. If I have already received the Hepatitis B vaccine or receive the vaccine in the future, I agree to provide the written documentation to verify the same to Encore Medical Staffing if I will continue to contract my services through EMS as an Independent Contractor.

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 from a physician or other facility of my choice and at my own expense.

With my signature in the appropriate space below, I hereby agree that I decline the Hepatitis B vaccine or have or will provide the written documentation to verify that I have received the Hepatitis B vaccination series.

***I decline the Hepatitis B vaccine.***

\_\_\_\_\_

**I have received the Hepatitis B vaccine.** \_\_\_\_\_

**I will provide verification of the Hepatitis B vaccine.** \_\_\_\_\_

**I will take the Hepatitis B vaccine and provide that info to EMSI.** \_\_\_\_\_

\_\_\_\_\_  
**Independent Contractor Signature**

\_\_\_\_\_  
**Date**



## ***OSHA FORM***

***Encore Medical Staffing*** has in place an education program to train healthcare workers to be knowledgeable and understand the OSHA standards CFR 1910:1030 and JCAHO requirements of safety.

I have demonstrated competency in the following areas as evidence by competency exams on file and available in my personnel record:

- A. Fire Safety
- B. Body Mechanics
- C. Chemical Hazards/MSDS
- D. CDC Guidelines & Infection Control
- E. Bloodborne Pathogens, Universal Precautions, Aids, & TB
- F. Venipuncture Assessment
- G. Pharmacology Exam
- H. HIPAA COMPLIANCE

Independent Contractor: \_\_\_\_\_ Date: \_\_\_\_\_



## *HIPAA FORM*

I have been formally instructed regarding the policies and procedures of *Encore Medical Staffing* and HIPAA regulations.

I understand that from time to time, I may be required to handle material of a confidential nature. I will treat as confidential anything that is not common knowledge, or has not been published, which includes patient's personal health information. I will respect the trust *Encore Medical Staffing* has placed in me by handling all such information in a careful and discrete manner. I will never divulge protected patient information, or company information to outsiders, including the media and/or government representatives without prior approval from my supervisor. I will contact my supervisor when I have any doubt about any matters relating to confidentiality of materials.

I understand that confidential information included, but not limited to the following examples:

- Compensation Data
- Computer Processes
- Computer Programs & Codes
- Customer List
- Customer Preferences
- Financial Information
- Marketing Strategies
- Technological Data
- Patient Information

I also certify that I am aware of all OSHA and HIPPA guidelines and will be asked to sign a non-disclosure agreement as a condition of my employment.

\_\_\_\_\_  
Independent Contractor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Encore Representative

\_\_\_\_\_  
Date



## ***BODY MECHANICS TEST***

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**1. WHEN LIFTING:**

- A. hold load away      B. hold load close      C. does not matter

**2. BASIC TRANSFER PROCEDURES ARE:**

- A. always do the same way      B. adapt to the conditions      C. none are necessary

**3. TO TRANSFER TO SIDE OF BED:**

- A. push      B. reach under patient and pull      C. Pull patient's arm

**4. TO TRANSFER TO HEAD OF BEAD:**

- A. keep patient's knees flat      B. raise patient's knees      C. doesn't matter about knees

**5. TO TURN PATIENT ON SIDE:**

- A. push      B. reach over; pull shoulder-hip      C. tilt bed

**6. TO ASSIST FOR SIT-UP:**

- A. pull patient's arm      B. patient hugs your neck      C. raise their body while lowering their legs

**7. TO ASSIST FOR STAND-UP:**

- A. get back, then reach out      B. get close with knees bent      C. either way you want

**8. TO ASSIST WITH SITTING:**

A. patient hugs your neck    B. patient leans on chair arms    C. either way you want

**9. TO ASSIST WITH WALKING, YOU STAND AT:**

A. patient's weak side    B. patient's strong side    C. either way you want

**10. TO ASSIST WITH A HEAVY PATIENT:**

A. get help or and mechanical aid    B. try very hard    C. don't do anything



## ***INDEMNITY / HOLD HARMLESS AGREEMENT***

This is an agreement between Encore Medical Staffing, (hereafter “EMS”) and the personnel (hereafter referred to as the “undersigned” or “personnel”) it places as contract workers in healthcare / provider facilities. EMS’s mission is to place needed personnel into various healthcare facilities. At all times, when personnel is traveling to, performing work at, and / or traveling away from the healthcare facility, the undersigned person is an Independent Contractor as defined under SC R.S. 23: 1021 (7).

EMS does not exercise any control or supervision whatsoever over said personnel when they are performing their employment duties at the healthcare facility. Personnel are under the supervision and control of the healthcare facility where he or she is working at all times.

EMS suggests that Independent Contractors should maintain their own medical and disability insurance at all times.

As such, EMS and \_\_\_\_\_, the undersigned, agree that in the event of an accident of any kind or cause, EMS will not be held responsible or liable for damages by the undersigned in tort, workers’ compensation, or under any other avenue of compensation. The undersigned agrees to indemnify EMS against liability and assume all risks associated his or her duties while working as an Independent Contractor in any healthcare facility where he or she is placed.

This agreement will remain in effect unless the undersigned notifies EMS in writing that he or she wishes to terminate the agreement, at which time the undersigned will be ineligible for placement services from EMS.

\_\_\_\_\_  
Independent Contractor / Undersigned

\_\_\_\_\_  
Witness



***STATEMENT OF INDEPENDENT CONTRACTOR  
HEALTH STATUS AND INJURY HISTORY***

**Please circle all the following that apply or have applied:**

- 1. Reactions to medications**
- 2. Skin rashes or eczema**
- 3. Back trouble**
- 4. Back injury**
- 5. Back surgery**
- 6. Back pain on lifting**
- 7. Knee surgery**
- 8. Swollen joints**
- 9. Rheumatism or arthritis**
- 10. Dislocated shoulder**
- 11. Fracture of a bone**
- 12. Any other type of injury**

**Work related injury claim within the past five years?** \_\_\_\_\_

\_\_\_\_\_

**Allergies** \_\_\_\_\_

**Comments** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

\_\_\_\_\_  
**Independent Contractor Signature**

\_\_\_\_\_  
**Date**

## Request for Taxpayer Identification Number and Certification

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

|   |   |   |
|---|---|---|
| Print or type<br>See Specific Instructions on page 2. | Name (as shown on your income tax return)   |   |
|   | Business name, if different from above  |   |
|   | Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶ ..... |   |
|   | <input type="checkbox"/> Exempt from backup withholding   |   |
|   | Address (number, street, and apt. or suite no.)   | Requestor'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 Line 1 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         |
| +                              |
| OR                             |
| Employer identification number |
| +                              |

### Part II Certification

Under penalties of perjury, I certify that:

- 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
- 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
- I am a U.S. person (including a U.S. resident alien).

**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.)

|                  |                            |        |
|------------------|----------------------------|--------|
| <b>Sign Here</b> | Signature of U.S. person ▶ | Date ▶ |
|------------------|----------------------------|--------|

### 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.

**U.S. person.** 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:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, 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.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

**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.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,