FIND-A-STAFF
RELIABLE STAFFING SOLUTIONS

SECTION 1 **EMPLOYMENT APPLICATION CHECK OFF LIST**

Date: _____/_____/_____ Badge #: _______________

NAME:_______________________________________ PHONE: (_______)______________________

RN / LPN / CNA / HHA / HMK / COM / PCA EMAIL: ________________________@____________

HHA Exchange #: __________________ ATN #: _____________ NPI #: ______________________

- ✓ COVID-19 Questionnaire
- ✓ Independent contractor Data Sheet
- ✓ Employment Application
- ✓ Independent Contractors Agreement
- ✓ License/Certificate
- ✓ Licensure/Certification Verification Form / MQA
- ✓ Job Description(s)
  - Administrator/Director of Operations
  - RN/LPN
  - CNA/HHA
  - Homemaker/Companion
  - Personal Care Assistant
- ✓ FL DOEA Direct Service Provider Attestation Form
- ✓ Acknowledgement of Review of Independent contractor/Contractor Handbook
- ✓ Hepatitis B Declaration Form
- ✓ Annual Screen
- ✓ Infection Control / Standard Precautions
- ✓ HIV-AIDS 4 Hour Sworn Statement / Independent contractor Certification of HIPAA Privacy Training
- ✓ Tax Exempt Form
- ✓ Hurricane Preparedness Information Form
- ✓ Independent contractor Certification of HIPAA Privacy Training
- ✓ 2 References _____YES _____NO
- ✓ Professional Liability Insurance _____/_____/_____ _____/_____/_____
- ✓ Auto Insurance - (ANNUALLY) _____/_____/_____ _____/_____/_____
- ✓ Auto Registration - (ANNUALLY) _____/_____/_____ _____/_____/_____
- ✓ Direct Deposit _____YES _____NO

Missing Signatures? ____YES _____NO Where?: ____

COMMENTS?____
____
____

INDEPENDENT CONTRACTOR COVID-19 SCREENING QUESTIONNAIRE

The safety of our independent contractors and clients is our overriding priority. As the coronavirus (COVID-19) pandemic continues, we are monitoring the situation closely and following the guidance from the Centers for Disease Control and Prevention and local health authorities.

In order to prevent the spread of the coronavirus and reduce the potential risk of exposure to our workforce, we are asking everyone to complete and submit this questionnaire prior to entering the client's home / facility.

Please do not enter the client's home / facility until your responses have been reviewed and your entry has been approved.
Please respond to each of the following questions truthfully and to the best of your ability.
Your participation is important to help us take precautionary measures to protect you and our other clients.

Name: ___________________________________ Phone Number: (_____)_______________________

Discipline: _______________________

REPRESENTATIONS

1) Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms? *(Please take your temperature before you answer this question.)*

Yes ☐ No ☐ Fever (100.4° F/37.8° C or greater measured by an oral thermometer) Yes ☐ No ☐ Chills
Yes ☐ No ☐ Cough Yes ☐ No ☐ Shortness of breath or difficulty breathing
Yes ☐ No ☐ Sore throat Yes ☐ No ☐ New loss of taste or smell
Yes ☐ No ☐ Head or muscle aches Yes ☐ No ☐ Nausea, diarrhea, vomiting

2) In the past 14 days, have you been in close proximity to anyone who was experiencing any of the above symptoms or has experienced any of the above symptoms since your contact? Yes ☐ No ☐

3) In the past 14 days, have you been in the proximity to anyone who has tested positive for COVID-19? Yes ☐ No ☐

4) Have you been tested for COVID-19 and are waiting to receive test results? Yes ☐ No ☐

5) Have you have tested positive for COVID-19, or are you presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms? Yes ☐ No ☐

NOTE: *If you have tested positive for COVID-19 or have been presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms, please contact the agency when: (1) you have had no fever for at least 72 hours (3 full days), without the use of fever-reducing medications; (2) your other symptoms have improved; and at least 7 days have elapsed since your symptoms first appeared.*

6) In the past 14 days, have you been on a commercial flight or traveled outside of the United States? Yes ☐ No ☐

7) In the past 14 days, have you been in close proximity to anyone who has been on a commercial flight or traveled outside of the United States? Yes ☐ No ☐

8) Is there any reason why you feel you are at higher risk of contracting COVID-19 or experiencing complications from COVID-19 by entering the facility? If "yes", please provide a brief explanation. Yes ☐ No ☐

Explanation: ____.

CERTIFICATION: I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Signature: ____________________________________ Date: ______/______/______

Note: *The information collected on this form will be used to determine only whether you may be infected with COVID-19. The information on this form will be maintained as confidential. Any questions should be directed to your manager or your human resources representative.*

Access to client' home/facility: ___ Approved ___ Denied

INDEPENDENT CONTRACTOR DATA UPDATE

Independent contractor's Name: ___________________________________ Date of Birth: ______/______/______

Discipline: ____________

Professional License # ________________________________ Date of Birth: ______/______/______

Social Security # _________________________ Driver's License # ___________________________________

Address ______________________________________ City, State, Zip _______________________________________

NEXT OF KIN: ____ Relationship: __________________

Address ______________________________________ City, State, Zip _______________________________________

1. Home Phone: (__________)__________________________

2. Cell Phone: (__________)__________________________

3. Other Phone: (__________)__________________________

Comments: ____

____

____

____

____

APPLICATION FOR EMPLOYMENT

Company Name ______________________________________ Date: ______/______/______

We are an equal opportunity employer. Applicants are considered for positions without regard to veteran status, uniformed servicemember status, race, color, religion, sex, national origin, age, physical or mental disability, genetic information or any other category protected by applicable federal, state, or local laws.

THIS COMPANY IS AN AT-WILL EMPLOYER AS ALLOWED BY APPLICABLE STATE LAW. THIS MEANS THAT REGARDLESS OF ANY PROVISION IN THIS APPLICATION, IF HIRED, THE COMPANY OR I MAY TERMINATE THE EMPLOYMENT RELATIONSHIP AT ANY TIME, FOR ANY REASON, WITH OR WITHOUT CAUSE OR NOTICE.

Applicant Name ______________________________ Position Applied For ________ Phone Number (_____) _________________

SS#: ________________________ DOB: _____/_____/_____ Email Address: ___________________________________

Present Address ___________________________________ City, State, Zip: ____

How long have you lived there _____/_____ Years/Months

Type of employment desired? ___ Full-time ___ Part-time (Specify Hours)__________________________________

Are you willing to work overtime? ___Yes ___ No Date on which you can start work if hired: _____/_____/_____

Have you previously applied for employment with this Company? ___Yes ___ No
If Yes, when and where did you apply? ____
Have you ever been employed by this Company? ___Yes ___ No
If Yes, provide dates of employment, location and reason for separation from employment. ___________________________________
____

If applicable, below list any other names by which you have been known which may be necessary to allow us to confirm your work and educational record. For example, change of name, use of an assumed name, nickname, etc.: ____

Education Received	School Name/Location	Course of Study/Major	Graduated? Y or N	# of Years Completed	HONORS
High School					
College					
Graduate/Professional					
Trade or Correspondence					

WORK EXPERIENCE

Please list the names of your present and/or previous employers in chronological order with present or most recent employer listed first. Provide information for at least the most recent ten (10) year period. Attach additional sheets if needed. If self-employed, supply firm name and business references. You may include any verifiable work performed on a volunteer basis, internships, or military service. Your failure to completely respond to each inquiry may disqualify you for consideration from employment. Do not answer "see résumé."

EMPLOYER

Name: ____ Phone: (______)____________________
Address: ______________________________________ City, State, Zip: ____________________________________
Job Title _________________________ Dates Employed From: ______/______/______ to ______/______/______
Supervisor's Name: __________________________ May we contact? ___ Yes ____ No If No, why not? __________
Duties: ____
____
Reason for Leaving: ____
What will this employer say was the reason your employment terminated? ____
Were you ever disciplined? ___ Yes ____ No If So, for what: ____
How much notice did you give when resigning? _______________ If none, explain: _______________________________

Name: _______________________________________ Phone: (______)___________________
Address: _____________________________________ City, State, Zip: ___________________________________
Job Title _________________________ Dates Employed From: ______/______/______ to ______/______/______
Supervisor's Name: __________________________ May we contact? ___ Yes ____ No If No, why not? __________
Duties: ____
____
Reason for Leaving: ____
What will this employer say was the reason your employment terminated? ____
Were you ever disciplined? ___ Yes ____ No If So, for what: ____
How much notice did you give when resigning? _______________ If none, explain: _________________________________

Have you ever been terminated or asked to resign from any job? ___Yes ___ No If Yes, how many times? ______
Has your employment ever been terminated by mutual agreement? ___Yes ___ No If Yes, how many times? ______
Have you ever been given the choice to resign rather than be terminated? ___Yes ___ No If Yes, how many times? ______
If you answered Yes to any of the above three questions, please explain the circumstances of each occasion.
____
____

REFERENCES *[Optional]*

Please list the names of additional work-related references we may contact. Individuals with no prior work experience may list school or volunteer-related references.

NAME	POSITION	COMPANY	WORK RELATIONSHIP	TELEPHONE

Please list the names of personal references. (not previous employers or relatives) who you know that we may contact.

NAME	OCCUPATION	ADDRESS	TELEPHONE	# OF YEARS KNOWN

DRIVING INFORMATION *[Optional]* *(Complete only if driving is an essential function of the job for which you are applying).*
Do you have a current valid driver's license? ___Yes ___ No
If yes, License #.: ________________________________ State: _____ Expiration Date: _____/_____/_____

If NO, do you have a current valid government issued Identification Card? ___Yes ___ No
If yes, ID Card #.: ________________________________ State: _____ Expiration Date: _____/_____/_____
Has your license ever been suspended or revoked? ___Yes ___ No
If yes, explain: ____

Do you have personal automobile insurance? ___Yes ___ No
If no, explain: ____

Have you ever been denied personal automobile insurance or has it ever been terminated or suspended? ___Yes ___ No
If yes, explain: ____

Please list all moving traffic violations in the last five (5) years:

OFFENSE	DATE	LOCATION	COMMENTS

APPLICATION CERTIFICATION

I understand and agree that if driving is a requirement of the job for which I am applying, my employment and/or continued employment is contingent on possessing a valid driver's license for the state in which I reside and automobile liability insurance in an amount equal to the minimum required by the state where I reside.

I understand that the Company may now have, or may establish, a drug-free workplace or drug and/or alcohol testing program consistent with applicable federal, state, and local law. If the Company has such a program and I am offered a conditional offer of employment, I understand that if a pre-employment (post-offer) drug and/or alcohol test is positive, the employment offer may be withdrawn. I agree to work under the conditions requiring a drug-free workplace, consistent with applicable federal, state, and local law. I also understand that all employees of the location, pursuant to the Company's policy and federal, state, and local law, may be subject to urinalysis and/or blood screening or other medically recognized tests designed to detect the presence of alcohol or illegal or controlled drugs. If employed, I understand that the taking of alcohol and/or drug tests is a condition of continual employment and I agree to undergo alcohol and drug testing consistent with the Company's policies and applicable federal, state, and local law.

If employed by the Company, I understand and agree that the Company, to the extent permitted by federal, state, and local law, may exercise its right, without prior warning or notice, to conduct investigations of property (including, but not limited to, files, lockers, desks, vehicles, and computers) and, in certain circumstances, my personal property.

I understand and agree that as a condition of employment and to the extent permitted by federal, state, and local law, I may be required to sign a confidentiality, restrictive covenant, and/or conflict of interest statement.

I certify that all the information on this application, my résumé, or any supporting documents I may present during any interview is and will be complete and accurate to the best of my knowledge. I understand that any falsification, misrepresentation, or omission of any information may result in disqualification from consideration for employment or, if employed, disciplinary action, up to and including immediate dismissal.

THIS COMPANY IS AN AT-WILL EMPLOYER AS ALLOWED BY APPLICABLE STATE LAW. THIS MEANS THAT REGARDLESS OF ANY PROVISION IN THIS APPLICATION, IF HIRED, THE COMPANY OR I MAY TERMINATE THE EMPLOYMENT RELATIONSHIP AT ANY TIME, FOR ANY REASON, WITH OR WITHOUT CAUSE OR NOTICE. NOTHING IN THIS APPLICATION OR IN ANY DOCUMENT OR STATEMENT, WRITTEN OR ORAL, SHALL LIMIT THE RIGHT TO TERMINATE EMPLOYMENT AT-WILL. NO OFFICER, EMPLOYEE OR REPRESENTATIVE OF THE COMPANY IS AUTHORIZED TO ENTER INTO AN AGREEMENT—EXPRESS OR IMPLIED—WITH ME OR ANY APPLICANT FOR EMPLOYMENT FOR A SPECIFIED PERIOD OF TIME UNLESS SUCH AN AGREEMENT IS IN A WRITTEN CONTRACT SIGNED BY THE PRESIDENT OF THE COMPANY.IF HIRED, I AGREE TO CONFORM TO THE RULES AND REGULATIONS OF THE COMPANY, AND I UNDERSTAND THAT THE COMPANY HAS COMPLETE DISCRETION TO MODIFY SUCH RULES AND REGULATIONS AT ANY TIME, EXCEPT THAT IT WILL NOT MODIFY ITS POLICY OF EMPLOYMENT AT-WILL.

I authorize the Company or its agents to confirm all statements contained in this application and/or résumé as it relates to the position I am seeking to the extent permitted by federal, state, or local law. I agree to complete any requisite authorization forms for the background investigation which may be permitted by federal, state and/or local law. If applicable and allowed by law, I will receive separate written notification regarding the Company's intent to obtain "consumer reports."

I authorize and consent to, without reservation, any party or agency contacted by this employer to furnish the above-mentioned information. I hereby release, discharge, and hold harmless, to the extent permitted by federal, state, and local law, any party delivering information to the Company or its duly authorized representative pursuant to this authorization from any liability, claims, charges, or causes of action which I may have as a result of the delivery or disclosure of the above requested information. I hereby release from liability the Company and its representative for seeking such information and all other persons, corporations, or organizations furnishing such information. Further, if hired, I authorize the company to provide truthful information concerning my employment to future employers and hold the company harmless for providing such information.

If hired by this Company, I understand that I will be required to provide genuine documentation establishing my identity and eligibility to be legally employed in the United States by this Company. I also understand this Company employs only individuals who are legally eligible to work in the United States.

THIS APPLICATION WILL BE CONSIDERED ACTIVE FOR A MAXIMUM OF SIXTY (60) DAYS. IF YOU WISH TO BE CONSIDERED FOR EMPLOYMENT AFTER THAT TIME, YOU MUST REAPPLY.

I CERTIFY THAT ALL OF THE INFORMATION THAT I HAVE PROVIDED ON THIS APPLICATION IS TRUE, ACCURATE, AND COMPLETE.

DO NOT SIGN UNTIL YOU HAVE READ ALL OF THE INFORMATION CONTAINED IN THE APPLICATION.

Applicant Signature ____ Date: _____/_____/_____

FEDERAL AND/OR STATE LAW MAY PROHIBIT THE USE OF LIE DETECTOR, POLYGRAPH OR SIMILAR TEST AS WELL.

THIS APPLICATION MAY NOT BE SUFFICIENT FOR ALL INDUSTRIES OR APPROPRIATE FOR USE IN ALL LOCALITIES.

LICENSURE/CERTIFICATION VERIFICATION FORM

Applicant's Name: ________________________________ Phone: (______)________________

Address: ____ City/State/Zip Code: ____________________________

Social Security #: _________________________________ D.O.B.: ______/______/______

License Or Certification #: ______ CNA ______ HHA

School Attended: ____

Address: ____ City/State/Zip Code: ____________________________

Dates Attended: ______/______/______ to ______/______/______

Still Attending? _______ YES ______ NO

Issuing Board or Department: _______________________________________

Person Spoke To: ____

Agency Representative: ____

Date of Inquiry: ______/______/______

Communication: Verbal ( ) By Mail ( ) Internet Search ( )

Verification Findings: ____

____

____

____

INDEPENDENT CONTRACTOR'S AGREEMENT

THIS AGREEMENT entered into at Miami, Florida, this ________ day of __________________, 20_____ , between **FIND A STAFF LLC** a Florida Corporation (hereinafter the "Agency") with its principal place of business located at: **1031 Ives Dairy Road,, Ste 228, Miami, FL 33179** and ____ (hereinafter the "Independent Contractor").

WITNESSETH

WHEREAS, the Agency is in the business of providing home care services to clients/clients.

WHEREAS, the Agency from time to time will secure the services of Independent Contractors to help carry out the Agency's business, and,

WHEREAS, the Agency will give orientation to the Independent Contractor in the nature of the Agency's business.

NOW, THEREFORE for and in consideration of the mutual promises contained herein, and other good and valuable consideration, the parties agree as follows:

1. **Engagement**. The Agency hereby engages Independent Contractor to perform the following services:
RN / LPN / CNA / HHA / HOMEMAKER / COMPANION / PCA.

2. **Duration**. The services to be performed by Independent Contractor pursuant to this Agreement shall commence on the date first written above and terminate pursuant to Section 12 herein.

3. **Compensation**. As compensation for providing the services described in paragraph one, above, Independent Contractor shall receive payment commensurate based on assignment or $__________ / (hour/visit/day/week/month). The Independent Contractor understands that assignment of clients are subject to a number of factors which include but are not limited to geographic area, skill level and qualifications, diagnosis and complexity of patient care and other criteria. The Independent Contractor understands that the Agency makes no assurance or guarantee that any patient will be assigned to him/her. Within the limitations herein stated, the Independent Contractor will render such services within the score of his/her practice and shall maintain at all times the necessary required professional liability and workmen's compensation at his/her expense.

4. **Independent Contractor's Employment Relationship**. Any other provision of this Agreement to the contrary, notwithstanding, this Agreement does not constitute a hiring by either party nor does it constitute an Agreement of employment. The Agency shall employ the Independent Contractor on an as needed basis to provide services to its clients/clients. The Independent Contractor is aware that the Agency maintains compliance with all non-discriminatory laws and does not discriminate. The Agency's hiring practices are not based on race, sex, age, national origin, handicap, religious practices or political affiliations. The parties' intention is that Independent Contractor is an Independent Contractor and not the employee of the Agency and that Independent Contractor retain sole and absolute discretion in the manner and means of carrying out the services described in paragraph one, above. This Agreement shall not be construed as a partnership or joint venture and neither party hereto shall be liable for any obligations incurred by the other party except as expressly provided herein. Independent Contractor recognizes that it is his/her legal responsibility to pay all applicable federal and state income taxes (included estimated taxes), social security, Medicare and all applicable federal and state self-employment taxes. The Agency does not guarantee the Independent Contractor any work and the employment is based on an as needed basis only. The Independent Contractor further understands that he/she is to be available to the Agency in the event his/her services are required on an "as needed" basis. The Agency employs a multi-disciplinary team of individuals capable of meeting the assessed needs of its clients/clients. The Independent Contractor is required to provide to the Agency a completed application for employment and documented evidence of all licenses, certifications, physician exam and required State, Federal and local documents prior to the Agency assigning work. The Agency will provide an orientation of the Agency's policies and procedures to the Independent Contractor. The Independent Contractor will be required to provide services following the Agency's policies and procedures.

5. **Expenses**. Independent Contractor shall be responsible for all expenses incurred as a result of performing the services described in paragraph one herein.

6. **Materials & Tools**. Any tools and materials required by the Independent Contractor to perform the services described in paragraph one, above, shall be furnished by the Independent Contractor.

7. **Indemnification**. The Independent Contractor shall indemnify and hold harmless the Agency, its officers, and directors against all claims, obligations or liabilities including court costs and attorney's fees, arising out of the Contractor's tortuous or unauthorized acts, misrepresentations, omissions, failure to perform his/her obligations hereunder, or any acts not expressly authorized in writing, related to or beyond the scope of this Agreement.

8. **Non-Disclosure of Confidential Information**. Independent Contractor recognizes and acknowledges that confidential information may exist from time to time, with respect to the business of the Agency. Accordingly, Independent Contractor shall not, during or after the term of this Agreement, disclose to any individual or entity any confidential information relating to the business of the Company. Furthermore, Independent Contractor shall not, without prior written consent of the Agency disclose to any person, firm or company, whether or not a competitor of the Company, and shall during or after the term of this Agreement, use his or her best efforts to prevent the publication or disclosure of, any information concerning the business, business practices, method of sales, training, assets, accounts or finances of the Agency's business or any of the secrets, dealings, transactions or affairs of the Agency, including, but not limited to, trade secrets, costs, pricing practices, customer lists, financial data, employee information or information as to the organization structure, which have or may come to his/ her knowledge during or after the term of this Agreement, or previously or otherwise. Independent Contractor shall use his/ her best efforts to cause his/her representatives, attorneys, accountants and advisors to whom information is disclosed to comply with the provisions of this paragraph eight. At any time the Agency may reasonably request that the Independent Contractor shall forthwith surrender to the Agency all documents and copies of documents in their possession relating to the foregoing, including, but not limited to, internal and external business forms, manuals, correspondence, notes, customer lists and computer programs, and the Independent Contractor shall not make or retain any copy or extract of any of the foregoing.

9. **Non-Impairment of Goodwill**. During and after the term of this Agreement, Independent Contractor shall not disparage, in any manner or respect, the Agency or the financial soundness and responsibility, personnel or practices of the Company's business.

10. **Non-Competition**. During and after the term of this Agreement, and for a period of (five) 5 years after the termination of this Agreement; Independent Contractor shall not:

10.1 directly or indirectly, with or without compensation, engage in, be employed by or have any interest (whether as Contractor, shareholder, director, officer, employee, subcontractor, partner, consultant, proprietor, agent or otherwise) in any business, Agency or firm engaged in a business similar to the Company's within a radius of fifty miles of any premises of the Agency at or from which the Agency business is carried on at the date of the termination of this Agreement; or

10.2 directly or indirectly, with or without compensation, engage in, be employed by or have any interest (whether as shareholder, director, officer, employee, subcontractor, partner, consultant, proprietor, agent or otherwise) in any business, Agency or firm carrying on a business which is or is likely to be in competition with any business carried on at the date of the termination of this Agreement by the Agency and with which Independent Contractor at any time within the year preceding the date of such termination of this Agreement was engaged on behalf of the Company.

11. **Non-Solicitation**. During or after the term of this Agreement and for a period of (five) 5 years thereafter Independent Contractor shall not either personally or by his agent or by letters, circular or advertisements and whether for himself or herself or on behalf of any other persons, Agency or firm;

11.1 canvas or solicit business (for any business similar to those being provided by the Agency at the time of the termination of this Agreement) from any person, Agency or firm who is at the time of such termination of this Agreement or has been at any time within two years prior to such termination of this Agreement, a customer of the Agency with which Independent Contractor had communications at any time when two years preceding the date of such Agreement; or

11.2 arrange or assist in the employment of any employee or Independent Contractor of the Agency or otherwise induce any employee or Independent Contractor of the Agency to leave or stop rendering service to the Company's employment.

12. **Termination**. This Agreement and the relationship created hereby may be terminated by either party at any time without cause upon one week notice given to the other. The Agency shall have the additional right to terminate this Agreement immediately by notice to Independent Contractor when such termination is for cause including, without limitation, dishonesty, fraud, misrepresentation to the Agency or any third person or breach of this Agreement. The Agency may terminate this agreement without written notice and such termination date will be determined in its sole discretion.

13. **Other Activities**. The Independent Contractor may engage in other activities for compensation during the term of this Agreement so long as those activities do not conflict with the responsibilities or limitations agreed to by Independent Contractor herein.

14. **Insurance**. The Independent Contractor shall also maintain in full force and effect insurance coverage consisting of comprehensive general public liability insurance, automobile, bodily injury, property damage, worker's compensation, with coverage in amounts and form satisfactory to Company. Upon Agency's request, Independent Contractor shall deliver to Agency, certificates of such insurance which stipulate that no less than ten days written notice via Certified Mail shall be given to Company, prior to termination or changes in the coverage or amounts thereof.

15. **Meditation and Arbitration**. Any disputes between the parties hereto, whether arising under this agreement or otherwise, which the parties cannot resolve between themselves using good faith shall be:

15.1 Referral to a court certified mediator of the Circuit Court in the County of the principal office of the Agency, and any mediation shall be held in the County of the principal office of the Agency. The parties shall share equally in the cost of said mediation.

15.2 In the event that said dispute is not resolved in mediation, the parties shall submit the dispute to a neutral arbitrator residing in the County of the principal address of the Agency. The arbitration shall be held in the County of the principal office of the Agency. The Agency shall recover all fees and costs of said arbitration. In the event that the parties are unable to agree upon an arbitrator within 15 days of the date on which either party requests arbitration of a matter, the arbitrator shall be provided by the American Arbitration Association. The parties further agree that full discovery shall be allowed to each party to the arbitration and a written award shall be entered forthwith. Any and all types of relief that would otherwise be available in Court shall be available to both parties in the arbitration. The decision of the arbitrator shall be final and binding. Arbitration shall be the exclusive legal remedy of the parties. Judgment upon the award may be entered in any court of competent jurisdiction pursuant to Florida Statutes Chapter 682, as amended, The Arbitration Code.

15.3 If either party refuses to comply with a ruling or decision of the arbitrator and a lawsuit is brought to enforce said ruling or decision, it is agreed that the party not complying with the ruling or decision of the arbitrator shall pay the court costs and reasonable attorney's fees (including Trail and Appellate attorney's fees) incurred in enforcing the ruling or decision of the arbitrator.

15.4 Any rights of injunctive relief shall be in addition to and not in derogation or limitation of any other legal rights.

16. **Interpretation of this Agreement**. The parties acknowledge that this Agreement is the product of mutual efforts by the parties and their respective agents. This Agreement shall be interpreted neither more favorable in favor of one party, nor less favorably in favor of another party.

17. **Entire Agreement**. This Agreement constitutes the entire understanding of the parties and supersedes all prior discussions, negotiations, Agreements and understandings, whether oral or written, with respect to its subject matter.

18. **Modification**. No change, modification or waiver of this Agreement shall be valid unless it is in writing and signed by all the parties who are bound by terms of this Agreement.

19. **Severability**. If any provision of this Agreement is held invalid, unenforceable, or void by a court of competent jurisdiction, this Agreement shall be considered divisible as to such provision, and the remainder of the Agreement shall be valid and binding as though such provision were not included in this Agreement.

20. **Benefits; Binding Effects**. This Agreement shall be binding upon and shall operate for the benefit of the parties hereto and their respective executors, administrators, successors, and assigns.

21. **Venue and Jurisdiction**. Should a lawsuit be necessary to enforce this Agreement the parties agree that jurisdiction and venue are waived and suit shall be brought in the county of the principal office of the Company.

22. **Notices**. Any notice, demand or other communication required or permitted by this Agreement must be in writing and shall be deemed to have been given and received:

22.1 if delivered by overnight delivery service or messenger, when delivered or

22.2 if mailed, on the third business day after deposit in the United States mail, certified or registered postage prepaid, return receipt requested, or

22.3 if faxed, telexed or telegraphed, twenty-four hours after being dispatched by fax, telegram or telex; in every case addressed to the party to be notified as follows:

If to Company:

FIND A STAFF LLC
Attn: Martine J. Miller, Manager
1031 Ives Dairy Road – Ste 228, Miami, FL 33179
Phone: (______________________________
Fax: (754) 202-0545
Email: findastaff1@gmail.com

If to Contractor:

____
____
____
Telephone: ________________________
Attention: _________________________

23. **No-Waivers**. The written waiver by any party of any other party's breach of any provision of this Agreement shall not operate nor be construed as a waiver of any subsequent breach, and the written waiver by any party to exercise any right or remedy shall not operate nor be construed as a waiver or bar to the exercise of such right or remedy upon the occurrence of any subsequent breach. All waivers under this Agreement must be in writing and signed by the parties hereto.

24. **Headings**. Headings in this Agreement are for convenience only and shall not be used to interpret or construe its provisions.

25. **Governing Law**. This Agreement shall be governed by the laws of the State of Florida (without regard to the laws that might be applicable under principles of conflicts of law) as to all matters, including, but not limited to, matters of validity, construction, effect and performance.

26. **Counterparts**. This Agreement may be executed in two or more parts, each of which shall be deemed an original but all of which together shall be one the same instrument.

27. **Facsimile Copy**. A facsimile copy of this Agreement and any signatures affixed hereto shall be considered for all purposes as originals.

IN WITNESS WHEREOF the parties have executed this Independent Contractor's Agreement as of the day and year first above written.

COMPANY: FIND A STAFF LLC

___________________________________	_____________________________
Managerr/Designee	Printed Name of Contractor
___________________________________	______________________________
Witness	Signature of Contractor
_______/_______/_______	_______/_______/_______
Date	Date

HOME HEALTH AIDE/CNA JOB DESCRIPTION

Must complete at least forty hours of training in: communication skills, observation, reporting, documentation of patient status and the care provided, reading and recording temperature, pulse and respiration, basic infection control procedures, basic elements of body functions, that must be reported to the Registered Nurse Supervisor, maintenance of a clean, safe, and healthy environment, recognition of emergencies and knowledge of emergency procedures, physical, emotional, and developmental characteristics of population served. Appropriate and safe techniques in personal hygiene, grooming, including bed bath, sponge, tub, or shower bath, shampoo, tub or bed, nail and skin care, oral hygiene. Safe transfer techniques and ambulation, normal range of motion and positioning, adequate nutrition and fluid intake, the role of the aide in the home, differences in families, food and household management.

Home Health Aide/CNAs assisting with self-administered medication, must receive a minimum of 2 hours of training (which can be part of the 40-hour home health training), prior to assuming responsibility. Training must cover state law and rule requirements with respect to the assistance with self-administration of medications in the home, procedures for assisting the resident with self-administration of medication, common medications, recognition of side effects and adverse reactions and procedures to follow residents appear to be experiencing side effects and adverse reactions.

Training must be performed by or under the supervision of a registered nurse. The HIV and AIDS educational requirements also must meet a minimum of 2 hours of initial training and 1 hour biennially of in-service training in HIV and AIDS. The training should include universal precautions and infection control procedures to ensure proper practices are followed. Training must be provided to obtain and maintain a certificate in cardiopulmonary resuscitation.
Each home health aide must be able to read the prescription label and any instructions. Individuals who cannot read must not be permitted to assist with prescription medications.

The Home Health Aide/CNA shall perform the follow duties:
All the personal care activities contained in a written assignment by a licensed health professional independent contractor, or contractor, and which include activities such as:

- Assisting the patient with personal hygiene
- Assisting the patient with ambulation/physical transfer
- Assisting the patient with eating
- Assisting the patient with dressing
- Assisting the patient with shaving

Maintenance of a clean, safe and healthy environment, which may include light cleaning and straightening of the bathroom, sleeping and living areas, washing the patient's or client's dishes or laundry, and such tasks to maintain cleanliness and safety for the patient or client. Patient related activities as taught to the HHA/CNA by a Licensed Health Professional for specific patient.

Such activities include:
A) Assisting with change of colostomy bag, reinforcement of dressing
B) Measuring temperature, pulse, respiration, or blood pressure
C) Measuring intake and output of fluids
D) Assisting with the use of devices for aid to daily living example, a walker or wheelchair.
E) Assisting with prescribed range of motion exercise (such exercise are limited to those taught to the Home Health Aide/CNA and the patient by a professional independent contractor)
F) Assisting with prescribed ice cap or collar.

G) Doing simple urine tests for sugar, acetone, and albumin
H) Measuring and preparing special diets.
I) Keeping records of personal health care activities.
J) Observing appearance and gross behavioral changes in the patient and reporting to the Registered Nurse.

5. Supervision of self-administered medication in the home limited to:
obtaining medication container from the storage area for the patient, ensuring that the medication is prescribed for the patient, remind the patient self-administering the medication.
6. The Home Health Aide/CNA may also provide the following assistance with self-administered medication, as needed by the patient, in accordance with 400.488.F.S.:

- Prepare necessary items such as juice, water, cups, or spoons to assist the patient in the self-administration of medication.
- Open and close the medication container or tear the foil of prepackaged medications
- Assist the resident in the self-administration process, such as steadying of the arm, hand or other parts of the patient's body so as to allow the self-administration of medication.
- Assist the patient by placing unused doses of solid medication back into the medication container.

THE HOME HEALTH AIDE/CNA SHALL NOT PERFORM THE FOLLOWING TASKS:

- Changing of sterile dressings
- Irrigating body cavities such as giving an enema
- Irrigating a colostomy or wound
- Performing a gastric irrigation or enteral feeding
- Catheterizing a patient
- Administering medication
- Applying heat by any method
- Caring for a tracheostomy tube
- Any personal health service which has not been included by the Registered Nurse in the patient care plan

In cases where a Home Health Aide/CNA will provide assistance with self-administered medications, an assessment of the medication for which assistance is to be provided shall be conducted by a licensed health care professional to ensure the unlicensed independent contractor provides assistance in accordance with their training and with the medication prescription. A licensed health care professional shall inform the patient/independent contractor, that the patient may receive assistance with self-administration medication by unlicensed person. The patient/independent contractor must given written consent for this arrangement.

____ _______/________/_________

Signature Date

COMPANION/HOMEMAKER
JOB DESCRIPTION

COMPANION

Adult Companion services are non-medical care, supervision and socialization provided to a functionally impaired adult. “Companion” or “sitter” means a person who spends time with or cares for an elderly, handicapped, or convalescent individual and accompanies such individual on trips and outings and may prepare and serve meals to such individual.

- A companion may not provide hands-on personal care to a client.
- The services may be provided at the recipient’s residence or anywhere in the community where care is necessary.
- Companions may not drive the recipients in their car or the recipient’s car but may accompany the recipient on public transportation, by taxi or on Medicaid transportation.
- Companion Services may not be provided or received in the Companion Service provider’s home.

DUTIES MAY INCLUDE:

- Listening, reading to patient, verbal communication.
- Supervising environment
- Recognizes life threatening situations, acts accordingly to protocol.
- Offers emotional support.
- Accompanies patient to outside appointments.
- Provides light housekeeping task, such as preparation of meals, laundering the patient’s personal garments.
- Stabilizes the clients when walking as needed.
- Maintains a chronological written record of services.

HOMEMAKER

Homemaker services consist of general household activities (meals preparation and routine household care) provided by a homemaker, when the individual who is regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.

DUTIES MAY INCLUDE:

- Meal planning and preparation.
- Housekeeping—when the client occupies only a portion of the residence, the homemaker must maintain this area only.
- Laundry—only the client’s laundry is the responsibility of the homemaker.
- Clothing Repair—repair is restricted to the Waiver recipients clothing.
- Minor home repair such as changing light bulbs or tightening screws on a loose rail.
- Shopping assistance—this assistance is limited to the client’s needs
- Reporting changes in the recipient’s condition to the Case Manager/Coordinator.
- The services must be provided at the recipient’s residence.

I have read and understand the requirements and duties described in this job description and agree to accept the position and perform the duties as described in this job description. I also agree to maintain confidentiality of clients and agency matters.

____   _______/________/_________

Signature   Date

PERSONAL CARE ASSISTANT JOB DESCRIPTION

DEFINITION:

The Personal Care Assistant is a person who assists the client to maintain the home, and assumes the duties undertaken by the customary homemaker. Personal care assistance is a service that assists a recipient with eating and meal preparation, bathing, dressing, personal hygiene, and other self care activities of daily living. The service also includes activities such as assistance with meal preparation, bed making and vacuuming when these activities are essential to the health, safety and welfare of the recipient and when no one else is available to perform them. This service is provided on a one-on-one basis. Personal care assistance may not be used solely for supervision. Personal care assistance may not be used as a substitute for a meaningful day activity.

LINE OF AUTHORITY:

Reports directly to the Administrator.

QUALIFICATIONS:

- Documentation on file of having received, training in topics related to human development and interpersonal relationships, nutrition, marketing, food storage, use of equipment and supplies, planning and organizing of household tasks and principles of cleanliness and safety.
- Minimum of 18 years of age.
- Demonstrates maturity and a sincere interest in the patient.
- Demonstrates good personal grooming and home habits.
- Must have reliable transportation.
- Demonstrate mental acuity high enough to write, read and adequately communicate with clients.

DUTIES:

1. Renders home making services to clients in the home setting as follows:
   - maintain the home in an optimum state of cleanliness and safety depending upon the patient's and the independent contractor's resources;
   - perform the functions generally undertaken by the customary homemaker including such duties as preparation of meals, laundry, shopping and care of children;
   - stabilize the client when walking, as needed, by holding the client's arm or hand;
   - report to the appropriate supervisor any incidents or problems related to his or her work or to the independent contractor
   - report any unusual incidents or changes in the patient's behavior to the registered nurse;
   - All services provided to the client are coordinated, appropriate, adequate and consistent with the plan of care
   - Maintain appropriate work records.

1. Maintains confidentiality of clients and agency matters.

Personal Care Assistance Provider Qualifications

Providers of personal care assistance may be home health or hospice agencies, licensed in accordance with Chapter 400, parts III or IV, F.S. Providers may also be independent vendors. Independent vendors are not required to be licensed, certified, or registered. Independent vendors and employees of agencies shall be at least 18 years of age and have at least one year of experience working in a medical, psychiatric, nursing or Developmental Disabilities Waiver Services Coverage and Limitations Handbook May 2010 1-23 childcare setting or working with recipients who have a developmental disability. College, vocational or technical training equal to 30 semester hours, 45 quarter hours or 720 classroom hours may substitute for the required experience.

Training Requirements
Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), HIV/AIDS and infection control is required within 30 days of initially providing personal care assistance. Proof of annual or required updated training shall be maintained on file for review.
The provider is responsible for all training requirements outlined in the Core Assurances.

Limitations
Personal care assistance is limited to the amount, duration and scope of the services in the recipient's support plan and current approved cost plan. A recipient shall receive no more than 180 hours a month, or 720 quarter hour units of this service per month. A recipient having intensive physical, medical, or adaptive needs meeting the requirements for the intense level of personal care assistance, who needs additional hours over 180 to maintain their health and medical status, may request additional hours of personal care assistance services. The requested additional units must have prior authorization by APD.
This service cannot be provided concurrently (at the same time) with companion services or ADT services. Recipients who receive in-home support services are not eligible to receive personal care assistance.

Documentation Requirements
Reimbursement* and monitoring documentation to be maintained by the provider:

1. *Copy of claim(s) submitted for payment; and
2. *Copy of service log.

The provider must submit a copy of service log, monthly, to the waiver support coordinator.

If the provider plans to transport the recipient in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license, 2) car registration, and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date.

Place of Service
Personal care assistance shall be provided in the recipient's own home or family home or while the recipient who lives in one of those arrangements is engaged in a community activity. No service may be provided or received in the provider's home, a hospital, an ICF/DD or other institutional environment.

Special Considerations
Personal care assistance for persons under the age of 21 may be provided through Medicaid Home Health State Plan Program services. Recipients who live in their own home or adults that live in a family home may require personal care assistance to assist them with meeting their own personal care needs.

I have read and understand the requirements and duties described in this job description and agree to accept the position and perform the duties as described in this job description. I also agree to maintain confidentiality of clients and agency matters.

____ ________/_________/__________

Independent contractor's Signature Date

ACKNOWLEDGMENT OF REVIEW OF
INDEPENDENT CONTRACTOR/CONTRACTOR HANDBOOK/F.S.

This is to acknowledge that I have reviewed a copy of the independent contractor/Contractor Handbook and understand that it sets forth the terms and conditions of my employment as well as the duties, responsibilities, and obligations of employment with the company. I understand and agree that it is my responsibility to read the independent contractor/Contractor Handbook and abide by the rules, policies, and standards set forth in the Independent contractor/Contractor Handbook.

I also acknowledge that my employment with our agency is not for a specified period of time and can be terminated at any time for any reason, with or without cause or notice, by me or by the company. I acknowledge that no oral or written statements or representations regarding my employment can alter the foregoing. I also acknowledge that no Manager or Independent contractor has the authority to enter into an employment agreement-express or implied-providing for employment other than at-will.

I also acknowledge that, except for the policy of at-will employment, the company reserves the right to revise, delete, and add to the provisions of this independent contractor/Contractor Handbook. All such revisions, deletions, or additions must be in writing and must be signed by the President of the company. No oral statements or representations can change the provisions of this independent contractor/Contractor Handbook. I also acknowledge that, except for the policy of at-will employment, terms and conditions of employment with the company may be modified at the sole discretion of the company with or without cause or notice at any time. No implied contract concerning any employment-related decision, term of employment, or condition of employment can be established by any other statement, conduct, policy, or practice.

I understand that the foregoing agreement concerning my at-will employment status and the company's right to determine and modify the terms and conditions of employment is the sole and entire agreement between me and our Agency concerning the duration of my employment, the circumstances under which my employment may be terminated, and the circumstances under which the terms and conditions of my employment may change. I further understand that this agreement supersedes all prior agreements, understandings, and representations concerning my employment with the nurse registry.

I also acknowledge that I have been given a copy of the Florida Statutes as it pertains to my discipline, and I agree to abide by these rules.

If I have questions regarding the content or interpretation of this handbook, I will bring them to the attention of my supervisor.

____	______/______/______
Independent Contractor’s Signature	Date

HEPATITIS B DECLARATION FORM

Hepatitis B is a major infectious occupational health hazard in the health care industry. The critical risk for the Health Personnel is contact with blood or other body fluids. Persons previously infected with Hepatitis B Virus (HBV) are immune to the disease. For persons who have not had the disease, Hepatitis B Vaccine will provide immunity. The vaccines are given in three (3) separate doses and failure to receive all doses may cause the vaccine to be ineffective and not result in immunity. Clinical studies have shown that 85% to 96% of those vaccinated evidence immunity. Periodic testing of vaccinated persons for an antibody to Hepatitis B will confirm immune status.

I understand that due to my risk of occupational exposure to blood or other potentially infectious material, I may require a booster in five (5) years. The vaccine only protects against the Hepatitis B Virus and does not confer immunity against the Hepatitis A or Non-A/Non-B agents. After receiving the vaccination minor side effects such as vaccination site soreness and redness, low grade fever, malaise, and nausea have been reported.

____

I, _________________________________ have read the above information and have received verbal and written instructions regarding the efficacy, risk and complications of receiving the vaccine. I acknowledge that I am aware of the availability of the Hepatitis B Vaccine and the benefit that such vaccination provides in the prevention of the infection with Hepatitis B Virus.

[ ] I DECLINE Hepatitis B Vaccination at this time because I have completed the Three (3) Doses of the Hepatitis B Vaccine. I have attached a copy of the Hepatitis B Vaccination Record.

[ ] 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. If in the future I continue to have occupational exposure to blood or other potentially infectious material, I will want be vaccinated with Hepatitis B Vaccine. I can receive the vaccination series at no charge to me.

[ ] I ACCEPT the Hepatitis B Vaccine. I have read the above information concerning the Hepatitis B Vaccine.
I understand that I must complete the three (3) doses series for full immunization. I can receive the vaccination series at NO CHARGE.

_____________________________________ ______/______/______

Independent Contractor's Signature Date

_____________________________________ ______/______/______

Witness Date

ANNUAL SCREEN

The T.B. organism is different from other lung infections in that it is very small and lightweight and can stay suspended in the air for a long period of time; Independent contractors must wear what is called an N-95 mask when providing care for someone with T.B. These masks require additional training in their use.

Health care workers need to be tested or screened at least every year for T.B. infection.

Have you experienced any of the following symptoms within the past year? *(Please circle answer)*

Persistent productive cough?	Y / N
Coughing up blood?	Y / N
Chest pain?	Y / N
Shortness of breath/difficulty breathing?	Y / N
Unexplained fever lasting more then 3 days?	Y / N
Unexplained night sweats?	Y / N
Unexplained sudden weight loss?	Y / N
Unexplained fatigue/run down feeling?	Y / N
Have you sought medical care for chest symptoms within the past year?	Y / N
Have you lived with/been in close contact with someone who had TB disease?	Y / N

I have read the above information on Tuberculosis and understand the importance of seeking medical attention immediately if I develop any of the symptoms of T.B.

I have understood the questions and have answered them truthfully.

I certify that the information contained on this form is true and correct. I understand that if any of the above responses are "Yes" that I may be re-evaluated to rule out the presence of active tuberculosis.

If you answered yes to any of the above questions, please explain: ____
____
____

____ ______/______/______

Independent Contractor's Signature Date

____ ______/______/______

Witness Date

INFECTION CONTROL / STANDARD PRECAUTIONS

STANDARD PRECAUTIONS MEAN THAT BLOOD AND BODY FLUID PRECAUTIONS SHOULD BE CONSISTENTLY USED FOR ALL CLIENTS.
Home care providers will adhere to the following when delivering care to all clients. By adhering to the following CA precautionary measures, the risk of transmission of disease, is decreased when the infection status of the patient is unknown.

Gloves should be worn for touching blood and body fluids, mucous membranes, or non-intact skin of all clients for handling items or surfaces soiled with blood fluids, and for performing vascular access procedures.
Gloves must be worn when delivering patient care, handling specimens, doing domestic cleaning, handling items that may be soiled with blood or body fluids.

Gloves or aprons must be worn during procedures or while managing a patient situation when there will be exposure to body fluids, blood, draining wounds or mucous membranes.

Mask and protective eyewear or face shield must be worn during procedures that are likely to generate droplets of body fluids, blood or when the patient is coughing excessively.

Gloves are to be worn when handling specimens to prevent contamination from body specimen fluids or blood.

Hand washing:
Hands must be washed before gloving and after gloves are removed. Hands and other skin surfaces must be washed immediately and thoroughly if contaminated with body fluids or blood and after all patient care activities.

Homecare providers, who have open cuts, sores, or dermatitis on their hands must wear gloves for all patient contact.

____	______/______/______
Independent Contractor’s Signature	Date
____	______/______/______
Witness	Date

HIV/AIDS 4-HOUR SWORN STATEMENT

This is a sworn statement that I, ______________________________________, have completed the initial HIV/AIDS 4-Hour education course, which is a requirement for any type of licensure or certification, as mandated in the regulations, by the State of Florida.

INDEPENDENT CONTRACTOR CERTIFICATION OF HIPAA PRIVACY TRAINING

By my signature, I, _______________________________________ certify that I have received training regarding the HIPAA Privacy Rule.
I have had an opportunity to have all of my questions/concerns addressed to my total satisfaction.
I understand that I have an obligation to abide by all of the Agency's Privacy Policies and Procedures as well as to abide by Federal and State laws relating to the Privacy Rule, and that failure to do so will result in disciplinary action up to including termination of employment.

I agree to report any breaches of privacy that I discover or become aware of to the Agency Privacy Official.

______________________________________ ______/______/______

Independent Contractor's Signature Date

____ ______/______/______

Administrator Signature Date

PHYSICAL EXAM FORM

Name ____ Date : _______/_______/_______

I HAVE EXAMINED__________________________________ ON THE ABOVE DATE AND HAVE FOUND HIM/HER TO BE FREE FROM COMMUNICABLE DISEASE IN THE COMMUNICABLE STATE, FROM SKIN LESSONS, AND FROM HEALTH HANDICAPS WHICH MIGHT DISQUALIFY HIM/HER FROM THE POSITION FOR WHICH HE/SHE IS SEEKING EMPLOYMENT.

MANTOUX METHOD TUBERCULIN TEST

Test Date: _____/_____/_____

Date Read: _____/_____/_____

Results: _____/_____/_____

CHEST X-RAY

Date: _____/_____/_____

Results: _____/_____/_____

Physician Name ____

Address ____

Phone No. (________)_________________

____ _______/_______/________

Physician Signature Date

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 for the preceding year by February 1st, of each year which will also be sent to the Internal Revenue Service. As an Independent Contractor, I am not eligible for any benefits such as vacations, disability or unemployment and will not be covered by Workmen's Compensation.

Independent contractor Signature _______________________________________

Date _____/_____/_____

Social Security # _________________________

Position ________________________________

HURRICANE PREPAREDNESS INFORMATION FORM

As you are aware, the summer months in South Florida are Hurricane Season. It is imperative that we all take precautions now to prepare for a storm. Please take a few moments to fill out this information form and return it to us. It is extremely important that we know what your plans are so that we will be able to contact you in the event of a storm. Hopefully we will not have a hurricane, but we must be prepared for the worst-case scenario.

Name: ____ Title: _______________

Address: _______________________________ City, State, Zip: _________________________

Phone: (______)____________________ Alt Phone: (______)____________________

Name, Address, Phone number of nearest relative:

Name: ____ Title: _______________

Address: _______________________________ City, State, Zip: _________________________

Phone: (______)____________________ Alt Phone: (______)____________________

Do you live in an Evacuation Zone? _____Yes _____ No

If you do need to evacuate, where will you go?

Address: _______________________________ City, State, Zip: _________________________

Are you available to work?

Before a storm? _____Yes _____ No

During a storm? _____Yes _____ No

After a storm? _____Yes _____ No

If you are an HHA, do you plan to stay with your patient during a disaster? _____Yes _____ No

THANK YOU FOR YOUR TIME AND ASSISTANCE IN THIS MATTER

DIRECT DEPOSIT AUTHORIZATION FORM

Please print and complete ALL the information below.

CONTRACTORS INFORMATION

Contractor's Name: ________________________________ Phone: (______)_________________

SS#: ________________________ D.O.B.: _____/_____/_____

Address: ____________________________________ City, State, Zip: _________________________________

Email: ____

BANK INFORMATION

Name of Bank: ____

9-Digit Routing #: ____

Account #: ____

Amount: ☐ Entire Paycheck or $ ___________

Type of Account: ____Checking ____Savings

ZELLE INFORMATION

Name of Bank: ____

Phone: (_________)_________________________ assigned to bank account

Email: (_________)_________________________ assigned to bank account

Please attach a voided check for each bank account to which funds should be deposited.

FIND A STAFF LLC is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Contractor's Signature: ____

Date: ______/______/______

AVAILABILITY FORM

NAME/TITLE:______________________________________ PHONE: (_______)______________________

RN / LPN / CNA / HHA / HMK / COM / PCA EMAIL: ________________________@____________

Schedule Availability

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
From (Time):							
To (Time):							
Overnight? (Yes / No?)							

Experience/Skills

[ ] Alzheimer [ ] Bedbound [ ] Dementia [ ] Heart Problems

[ ] Parkinson [ ] Transfer [ ] Respiratory [ ] Asthma

[ ] Catheter [ ] Walker [ ] Kosher [ ] Hoyer Lift

[ ] Diabetic [ ] Cancer [ ] Colostomy Bag [ ] Wheel Chair

[ ] Fractures [ ] Oxygen [ ] Blind [ ] Amputee

[ ] Deaf [ ] Pets [ ] Stroke [ ] Hospice

[ ] Smoking [ ] Back Rubs [ ] Body Alignment [ ] Body Mechanics

[ ] Change Linens [ ] Feed Patient [ ] ROM Exercises [ ] Isolation Techniques

[ ] Oral Hygiene [ ] Transfer Activities [ ] Blood Pressure [ ] Prepare Special Diet

[ ] CPR [ ] Pulse [ ] Intake & Output [ ] Universal Precautions

Additional Skills:

____

____

____

Contractor’s Signature: ____ Date: ______/______/______

REQUEST FOR REFERENCE

To ______________________________________
____
____
____

Dear Sir or Madam,

_________________________________, SS# xxx-xx-_______ is applying to our office as a RN / LPN / CNA / HHA / HMK COM / PCA. Until we have thoroughly checked his/her references and tested his/her ability, we cannot permit him/her to work. Please take a few minutes to complete the information requested.

I authorize FIND A STAFF LLC to gather information concerning my qualifications and past performances. Please reply to their questions. I hereby release you from any and all liability.

Applicant Signature: ____________________________________

To be completed by Previous Employer:

Position: ___________________________________ Dates from: _______________ to ________________

Reason for leaving: ____

Would you rehire? Yes _________ No ________

If no, please advise why: ____

PLEASE ADVISE IF: ABOVE AVERAGE, SATISFACTORY, BELOW AVERAGE, OR COMMENTS.

Punctuality and Attendance ____

Appearance (Grooming) ____

Judgement ____

Performance ____

Ability to Perform ____

Organization of Time ____

Compatibility ____

Accepts Direction ____

Signed ______________________________ Title _________ Phone (_______)____________________

Print Name ____

Thank you for your time and courtesy.

REQUEST FOR REFERENCE

To ______________________________________
____
____
____

Dear Sir or Madam,

_________________________________, SS# xxx-xx-_______ is applying to our office as a RN / LPN / CNA / HHA / HMK COM / PCA. Until we have thoroughly checked his/her references and tested his/her ability, we cannot permit him/her to work. Please take a few minutes to complete the information requested.

I authorize FIND A STAFF LLC to gather information concerning my qualifications and past performances. Please reply to their questions. I hereby release you from any and all liability.

Applicant Signature: ___________________________________

To be completed by Previous Employer:

Position: ___________________________________ Dates from: _______________ to ________________

Reason for leaving: ____

Would you rehire? Yes _________ No ________

If no, please advise why: ____

PLEASE ADVISE IF: ABOVE AVERAGE, SATISFACTORY, BELOW AVERAGE, OR COMMENTS.

Punctuality and Attendance ____

Appearance (Grooming) ____

Judgement ____

Performance ____

Ability to Perform ____

Organization of Time ____

Compatibility ____

Accepts Direction ____

Signed ______________________________ Title _________ Phone (_______)____________________

Print Name ____

Thank you for your time and courtesy.

SECTION 2

	ISSUE DATE	EXPIRATION DATE
E-Verified	____YES _____NO	
Level 2 Background Screening (5 YEARS)	_____/_____/_____	_____/_____/_____
Local Background - (ANNUALLY)	_____/_____/_____	_____/_____/_____
Group Membership / Non Institutional (FORMS)	____YES _____NO	
Affidavit of Compliance (FORM)	____YES _____NO	
Attestation of Good Moral Character (FORM)	____YES _____NO	
Affidavit of Good Moral Character (FORM)	____YES _____NO	
Attestation of Compliance with BGS (FORM)	____YES _____NO	
W-9 (FORM)	____YES _____NO	
I-9 (FORM)	____YES _____NO	
Privacy Policy Acknowledgement Form (FORM)	____YES _____NO	
License / Certificate: __________________	_____/_____/_____	_____/_____/_____
Resume	____YES _____NO	
CPR Card - (BI-ANNUALLY)	_____/_____/_____	_____/_____/_____
HIV/AIDS Certificate - (ANNUALLY)	_____/_____/_____	_____/_____/_____
Infection Control Certificate - (ANNUALLY)	_____/_____/_____	_____/_____/_____
HIPPA Certificate – (TRAIN) (ANNUALLY)	_____/_____/_____	_____/_____/_____
Alzheimer's Certificate - (ANNUALLY)	_____/_____/_____	_____/_____/_____
Domestic Violence Certificate - (ANNUALLY)	_____/_____/_____	_____/_____/_____
Medical Errors (RN/LPN Only) (ANNUALLY)	_____/_____/_____	_____/_____/_____
Assisting with Self Medication - (ANNUALLY)	_____/_____/_____	_____/_____/_____
Impairment in the workplace (RN/LPN Only)	_____/_____/_____	_____/_____/_____
Human Trafficking (RN/LPN Only) - (ANNUALLY)	_____/_____/_____	_____/_____/_____
Fl Board of Nursing Laws and Rules - (ANNUALLY)	_____/_____/_____	_____/_____/_____
Coronavirus Certificate - (ANNUALLY)	_____/_____/_____	_____/_____/_____
Driver's License #: _________________________	_____/_____/_____	_____/_____/_____
Social Security Card	____YES _____NO	
Passport /Alien Card #: ____________________	_____/_____/_____	_____/_____/_____
Voter's Registration	_____/_____/_____	
Certificate of Naturalization	_____/_____/_____	
Physical Less Than 6 Months – (ANNUALLY)	_____/_____/_____	_____/_____/_____

SECTION 2

	ISSUE DATE	EXPIRATION DATE
E-Verified	____YES _____NO	
Level 2 Background Screening (5 YEARS)	_____/_____/_____	_____/_____/_____
Local Background - (ANNUALLY)	_____/_____/_____	_____/_____/_____
Group Membership / Non Institutional (FORMS)	____YES _____NO	
Affidavit of Compliance with BGS (FORM)	____YES _____NO	
Attestation of Good Moral Character (FORM)	____YES _____NO	
Affidavit of Good Moral Character (FORM)	____YES _____NO	
W-9 (FORM)	____YES _____NO	
I-9 (FORM)	____YES _____NO	
Privacy Policy Acknowledgement Form (FORM)	____YES _____NO	
License / Certificate: __________________	_____/_____/_____	_____/_____/_____
Resume	____YES _____NO	
CPR Card - (BI-ANNUALLY)	_____/_____/_____	_____/_____/_____
HIV/AIDS Certificate - (ANNUALLY)	_____/_____/_____	_____/_____/_____
Infection Control Certificate - (ANNUALLY)	_____/_____/_____	_____/_____/_____
HIPPA Certificate – (TRAIN) (ANNUALLY)	_____/_____/_____	_____/_____/_____
Alzheimer's Certificate - (ANNUALLY)	_____/_____/_____	_____/_____/_____
Domestic Violence Certificate - (ANNUALLY)	_____/_____/_____	_____/_____/_____
Medical Errors (RN/LPN Only) (ANNUALLY)	_____/_____/_____	_____/_____/_____
Assisting with Self Medication - (ANNUALLY)	_____/_____/_____	_____/_____/_____
Impairment in the workplace (RN/LPN Only)	_____/_____/_____	_____/_____/_____
Human Trafficking (RN/LPN Only) - (ANNUALLY)	_____/_____/_____	_____/_____/_____
Fl Board of Nursing Laws and Rules - (ANNUALLY)	_____/_____/_____	_____/_____/_____
Coronavirus Certificate - (ANNUALLY)	_____/_____/_____	_____/_____/_____
Driver's License #: _________________________	_____/_____/_____	_____/_____/_____
Social Security Card	____YES _____NO	
Passport /Alien Card #: ____________________	_____/_____/_____	_____/_____/_____
Voter's Registration	_____/_____/_____	
Certificate of Naturalization	_____/_____/_____	
Physical Less Than 6 Months – (ANNUALLY)	_____/_____/_____	_____/_____/_____

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

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

Employee/Contractor Name:	
Health Care Provider/ Employer Name:	FIND A STAFF LLC
Address of Health Care Provider:	1031 IVES DAIRY ROAD - STE 228, MIAMI, FL 33179

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

(e) Section 782.04, relating to murder.

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

(g) Section 782.071, relating to vehicular homicide

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

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

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

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

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

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

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

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

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

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

(s) Section 794.011, relating to sexual battery.

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

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

(v) Chapter 796, relating to prostitution.

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

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

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

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

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

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

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

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

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

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

(hh) Section 826.04, relating to incest.

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

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

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

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

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

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

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

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

(qq) Chapter 847, relating to obscene literature.

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

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

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

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

(vv) Section 944.40, relating to escape.

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

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

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

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

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

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

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

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

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

(d) Section 409.9201, relating to Medicaid fraud.

(e) Section 741.28, relating to domestic violence.

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

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

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

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

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

(k) Section 817.505, relating to patient brokering.

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

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

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

(o) Section 831.01, relating to forgery.

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

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

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

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

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

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

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

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

Date of Decision: ____________________________

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

Date of Decision: ____________________________

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

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

Purpose of Prior Screening:________________________

Screening conducted by: Date of Prior Screening: ______

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

Attestation

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

______________________________	____________________	______________
Employee/Contractor Signature	Title	Date

ATTESTATION OF GOOD MORAL CHARACTER

State of Florida

County of: MIAMI-DADE

I, ____ who, as an applicant for employment with, an employee of, a volunteer for, or an applicant to volunteer with FIND A STAFF LLC, I affirm and attest under penalty of perjury that I meet the moral character requirements for employment, as required by Chapter 435 Florida Statutes in that:

I have not been arrested with disposition pending or found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction for any of the offenses listed below:

	Relating to:
Section 393.135	sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct
Section 394.4593	sexual misconduct with certain mental health patients and reporting of such sexual misconduct
Section 415.111	adult abuse, neglect, or exploitation of aged persons or disabled adults or failure to report of such abuse
Section 741.28	criminal offenses that constitute domestic violence, whether committed in Florida or another jurisdiction
Section 777.04	attempts, solicitation, and conspiracy
Section 782.04	murder
Section 782.07	manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child
Section 782.071	vehicular homicide
Section 782.09	killing an unborn quick child by injury to the mother
Chapter 784	assault, battery, and culpable negligence, if the offense was a felony
Section 784.011	assault, if the victim of offense was a minor
Section 784.03	battery, if the victim of offense was a minor
Section 787.01	kidnapping
Section 787.02	false imprisonment
Section 787.025	luring or enticing a child
Section 787.04(2)	taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceeding
Section 787.04(3)	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
Section 790.115(1)	exhibiting firearms or weapons within 1,000 feet of a school
Section 790.115(2) (b)	possessing an electric weapon or device, destructive device, or other weapon on school property
Section 794.011	sexual battery
Former Section 794.041	prohibited acts of persons in familial or custodial authority
Section 794.05	unlawful sexual activity with certain minors
Chapter 796	prostitution
Section 798.02	lewd and lascivious behavior
Chapter 800	lewdness and indecent exposure
Section 806.01	arson
Section 810.02	burglary
Section 810.14	voyeurism, if the offense is a felony
Section 810.145	video voyeurism, if the offense is a felony
Chapter 812	theft and/or robbery and related crimes, if a felony offense
Section 817.563	fraudulent sale of controlled substances, if the offense was a felony
Section 825.102	abuse, aggravated abuse, or neglect of an elderly person or disabled adult
Section 825.1025	lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult
Section 825.103	exploitation of disabled adults or elderly persons, if the offense was a felony
Section 826.04	incest
Section 827.03	child abuse, aggravated child abuse, or neglect of a child
Section 827.04	contributing to the delinquency or dependency of a child
Former Section 827.05	negligent treatment of children
Section 827.071	sexual performance by a child
Section 843.01	resisting arrest with violence
Section 843.025	depriving a law enforcement, correctional, or correctional probation officer means of protection or communication
Section 843.12	aiding in an escape
Section 843.13	aiding in the escape of juvenile inmates in correctional institution
Chapter 847	obscene literature
Section 874.05(1)	encouraging or recruiting another to join a criminal gang

Chapter 893	drug abuse prevention and control only if the offense was a felony or if any other person involved in the offense was a minor
Section 916.1075	sexual misconduct with certain forensic clients and reporting of such sexual conduct
Section 944.35(3)	inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm
Section 944.40	escape
Section 944.46	harboring, concealing, or aiding an escaped prisoner
Section 944.47	introduction of contraband into a correctional facility
Section 985.701	sexual misconduct in juvenile justice programs
Section 985.711	contraband introduced into detention facilities

I understand that I must acknowledge the existence of any applicable criminal record relating to the above lists of offenses including those under any similar statute of another jurisdiction, regardless of whether or not those records have been sealed or expunged. Further, I understand that, while employed or volunteering at ___________FIND A STAFF LLC_________________ in any position that requires background screening as a condition of employment, I must immediately notify my supervisor/employer of any arrest and any changes in my criminal record involving any of the above listed provisions of Florida Statutes or similar statutes of another jurisdiction whether a misdemeanor or felony. This notice must be made within one business day of such arrest or charge. Failure to do so could be grounds for termination.

I attest that I have read the above carefully and state that my attestation here is true and correct that **my record does not contain any of the above listed offenses.** I understand, under penalty of perjury, all employees in such positions of trust or responsibility shall attest to meeting the requirements for qualifying for employment and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses. I also understand that it is my responsibility to obtain clarification on anything contained in this affidavit which I do not understand prior to signing. I am aware that any omissions, falsifications, misstatements or misrepresentations may disqualify me from employment consideration and, if I am hired, may be grounds for termination or denial of an exemption at a later date.

SIGNATURE :____ Date:__________________

Sign Above OR Below, DO NOT Sign Both Lines

To the best of my knowledge and belief, **my record contains one or more of the applicable disqualifying acts or offenses listed above. I have placed a check mark by the offense(s) contained in my record.** (If you have previously been granted an exemption for this disqualifying offense, please attach a copy of the letter granting such exemption.) (Please circle the number which corresponds to the offense(s) contained in your record.)

SIGNATURE:____ Date: ___________________

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

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

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

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

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

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

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

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

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

☐ Other (see instructions) ▶

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

Exempt payee code (if any) ________

Exemption from FATCA reporting code (if any) ________

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

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number

☐☐☐ – ☐☐ – ☐☐☐☐

or

Employer identification number

☐☐ – ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

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

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

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

General Instructions

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

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

Purpose of Form

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

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

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

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

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

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

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

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

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

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

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

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

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States *(See instructions)*
- ☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): ____________
- ☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): ____________
  Some aliens may write "N/A" in the expiration date field. *(See instructions)*

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

1. Alien Registration Number/USCIS Number: ____________

OR

2. Form I-94 Admission Number: ____________

OR

3. Foreign Passport Number: ____________

Country of Issuance: ____________

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

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

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

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

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
		FIND A STAFF LLC

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code
1031 IVES DAIRY ROAD - STE 228	MIAMI	FL	33179

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

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

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

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

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

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

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

PRIVACY POLICY ACKNOWLEDGEMENT FORM

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

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

____

Employee Name (Printed)

____

Employee Signature

____

Date