Healthcare Solutions, Inc.

Independent Contractor Checklist.

Documents:

- Alien Card/Passport
- Reference x 2
- Drivers License
- Auto Insurance
- Social Security
- Professional License/Certificate
- CPR (Duplex)
- Current Physical (Must be 6 months from date of application)
- Current PPD/CXR (Must be 6 months from date of application)

CEUs:

- Infection Control
- Iv Therapy Certificate
- HIV/Aids Update
- HIV 4 Hour Initial Certificate
- OSHA/TB
- Domestic Violence
- Medical Errors
- HIPPA
- Alzheimer's (4 Hours Initial)
- Level 2 Background Screening
- Recognizing Impairment
- Florida Laws & Rules
- Human Trafficking

HEALTHCARE SOLUTIONS, INC.

Licensed Practical Nurse

APPLICATION FOR EMPLOYMENT

CWG HEALTHCARE SOLUTIONS
(954) 581-9968

Equal access to programs, services and employment is available to all persons. Those applicants requiring reasonable accommodation to the application and/or interview process should notify a representative of the Human Resources Department.

Position(s) applied for _____ Date of application _____

Name _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP CODE

Telephone # ( )_____ Cell/Beeper/other # ( )_____

Social Security # _____-_____-_____

If you are under 18, and it is required, can you furnish a work permit? ..... ☐Yes ☐No

If no, please explain _____

Have you ever been employed here before? ..... ☐Yes ☐No

Are you legally eligible for employment in this country? ..... ☐Yes ☐No

Date available for work _____

Type of employment desired ☐Full-Time ☐Part-Time ☐Temporary ☐Seasonal ☐Other

Are you able to meet the attendance requirements of this position? ..... ☐Yes ☐No

Have you been convicted of a crime in the last seven (7) years? ..... ☐Yes ☐No

If yes, please explain _____
Conviction will not necessarily be a bar to employment. Each instance and explanation will be considered in relation to the position for which you are applying.

Driver's license number if driving is an essential job function _____ State _____

Skills and Qualifications

Summarize any training, skills, licenses, and/or certificates that may qualify you as being able to perform job-related functions in the position for which you are applying. _____

_____

_____

Employment History

Provide the information for your past three (3) employers, assignments or volunteer activities, starting with the most recent.

From To Employer Telephone

Job Title Address

Immediate Supervisor and title Summarize the nature of work performed and job responsibilities

Reason for leaving Hourly rate/salary

Start $ Final $

From To Employer Telephone

Job Title Address

Immediate Supervisor and title Summarize the nature of work performed and job responsibilities

Reason for leaving Hourly rate/salary Start $ Final $

From To Employer Telephone

Job Title Address

Immediate Supervisor and title Summarize the nature of work performed and job responsibilities

Reason for leaving Hourly rate/salary Start $ Final $

Educational Background IF JOB RELATED

Name and Location	Years Completed	Did You Graduate		Course of Study
High School				
College		Major	Degree	
Other				

References

Name	Telephone #	Years Known

I UNDERSTAND THAT IF I AM EMPLOYED, ANY MISREPRESENTATION OR MATERIAL OMISSION MADE BY ME ON THIS APPLICATION WILL BE SUFFICENT CAUSE FOR CANCELLATION OF THIS APPLICATION OR IMMEDIATE DISCHARGE FROM THE EMPLOYER SERVICE, WHENEVER IT IS DISCOVERED.

I GIVE THE EMPLOYER THE RIGHT TO CONTACT AND OBTAIN INFORMATION FROM ALL REFERENCES, EMPLOYERS, EDUCATIONAL INSTITUTIONS AND TO OTHERWISE VERIFY THE ACCURACY OF THE INFORMATION CONTAINED IN THES APPLICATION. I HERBY RELEASE FROM LIABILITY THE EMPLOYER AND ITS REPRESENTATIVES FOR SEEKING, GATHERINGAND USING SUCH INFORMATION AND ALL OTHER PERSONS, ORGANIZATIONS OR CORPORATIONS FOR FURNISHING SUCH INFORMATION.

THE EMPLOYER DOES NOT UNLAWFULLY DISCRIMINATE IN EMPLOYMENT AND NO QUESTION ON THIS APPLICATION IS USED FOR THE PURPOSE OF LIMITING OR EXCUSEING AND APPLICANT FROM CONSIDERATION FOR EMPLOYMENT ON A BASIS PROHIBITED BY LOCAL, STATE, OR FEDERAL LAW.

THIS APPLICATION IS CURRENT FOR ONLY 60 DAYS. AT THE CONCLUSION OF THIS TIME, IF I HAVE NOT HEARD FROM THE EMPLOYER AND STILL WISH TO BE CONSIDERED FOR EMPLOYMENT, IT MAY BE NECESSARY TO FILL OUT A NEW APPLICATION.

IF I AM HIRED, I UNDERSTAND THAT I AM FREE TO RESIGN AT ANY TIME, WITH OR WITHOUT CAUSE AND WITHOUT PRIOR NOTICE, AND THE EMPLOYER RESERVES THE SAME RIGHT TO TERMINATE MY EMPLOYMENT AT ANY TIME, WITH OR WITHOUT CAUSE AND WITHOUT PRIOR NOTICE, EXCEPT AS MAY BE REQUIRED BY LAW. THIS APPLICATION DOES NOT CONSTITUTE AN AGREEMENT OR CONTRACT FOR EMPLOYMENT FOR ANY SPECIFIED PERIOD OR DEFINITE DURATION. I UNDERSTAND THA TNO REPRESENTATIVE OF THE EMPLOYER OTHER THAN AN AUTHORIZED OFFICER, HAS THE AUTHORITY TO MAKE ANY ASSURANCES TO THE CONTRARY. I FURTHER UNDERSTAND THAT ANY SUCH ASSURANCES MUST BE IN WRITING AND SIGNED BY AN AUTHORIZED OFFICER.

I UNDERSTAND IT IS THIS COMPANY'S POLICY NOT TO REFUSE TO HIRE A QUALIFIED INDIVIDUAL WITH A DISABILITY BECAUSE OF THAT PERSON'S NEED FOR A REASONABLE ACCOMODATION AS REQUIRED BY THE ADA.

I ALSO UNDERSTAND IF I AM HIRED, I WILL BE REQUIRED TO PROVIDE PROOF OF IDENTITY AND LEGAL WORK AUTHORIZATION.

I represent and warrant that I have read and fully understand the foregoing and seek employment under these conditions.

Signature of Applicant _____ Date _____

HEALTHCARE SOLUTIONS

INFORMATION SHEET/NEXT-OF-KIN

Employee Name:_____

Title:_____ **Hire Date:** _____ **Rate of Pay:**_____

Company Name (If Incorporated): _____

Mailing Address: _____

_____

Home#: _____ **Cell:**_____

Email: _____

Social Security Number:_____

Employee: YES NO **Independent Contractor:** YES NO

. . . . . .

In accordance with Florida Statues, we must have on file a Next of Kin and an Emergency Telephone Number in the event that either is needed.

Next-Of-Kin: _____

Relationship to you: _____

Telephone Number: _____

Other Phone Number: _____

Address: _____

_____

4850 N State Rd 7, Suite G 101 Lauderdale Lakes, FL 33319
Tel: 954-581-9968 Fax: 954-581-9642

HEALTHCARE SOLUTIONS

INDEPENDENT CONTRACTOR AGREEMENT

This Agreement dated _____, _____ is executed by CWG Healthcare Solutions, Inc., a Florida corporation whose address is 4850 N State Road 7, Bldg G, Suite 101, Lauderdale Lakes, FL 33319 ("Company") and _____ whose address is _____("Contractor")

The Contractor seeks to engage Company to solicit positions such as Licensed Practical Nurse, Registered Nurses and Certified Nursing Assistants.

The Company seeks to engage Contractor to perform there services, based on the skills, training and experience of the Contractor, for clients solicited by Company.

Based on the nature of the relationship between each party, each party engages the other as an independent contractor.

Therefore, in consideration of the mutual promises and covenants of the parties contained in the agreement, the parties agree and contract as follows:

1. Contractor engages Company to solicit client engagements involving the performance of services set forth above, and Company engages Contractor to perform these services for the Company's clients.
2. This agreement begins on _____, _____ and shall automatically be renewed annually unless either party advises the other in writing at least 30 days before the renewal date that does not want to renew this agreement.
3. Contractor has the absolute right to accept or refuse any engagement offered by Company. Company has the absolute right to determine which contractor the Company will use for a particular client engagement.
4. No Contractor will be placed unless that Contractor has complied with all Federal, State and Local Laws and has completed an orientation course with the Company. The Contractor must continue to comply with all Laws during the term of this agreement.
5. None of the benefits, if any, that are provide by Company to its employees shall be available to Contractor and to the extent that Contractor may, now or hereafter and for any reason, become eligible for any benefit programs maintained by Company, Contractor waives its right to participate in such programs.
6. For all purposes, including, but not limited to the Federal Insurance Contributions Act ("FICA"), the Social Security Act, the Federal Unemployment Tax Act ("FUTA"), income tax withholding and any and all other Federal, State and Local Laws, rules and regulations, each party (and it's respective employees if any) shall be treated as independent contractor and not as an employee with respect to the other.
7. Contractor shall not be entitled to Worker's Compensation benefits.
8. Contractor acknowledges and agrees that Contractor shall be responsible (as a self-employed individual) for filing all tax returns, tax declarations and tax schedules and for the payment of all taxes required, when due, regarding any and all compensation earned by Contractor under

this Agreement. Neither party will withhold any employment taxes from compensation paid the other. Each party will report the amount of compensation it pays the other party, if any, or IRS Forms 1099, when required to do so under applicable Internal Revenue Code provisions.

9. Contractor's compensations for services it provides under this Agreement shall be on a job-by-job basis, and be paid by the client from whom the services are provided. Company has no liability for the payment of any compensation to the Contractor for services performed under this Agreement.

10. If Contractor wishes to receive compensation for the services it provides before payment is made by the client, the Company may at its option advance funds in the amount owed by the client to the Contractor, less a discount of 2% as consideration to the Company for the advance. The Company shall then advise the Client to make payment directly to the Contractor for the amount due from the client.

11. If the Company advances funds to the Contractor and the client does not pay any or all of the amount owed within three months after the amount owed becomes due, then the amount not received shall be repaid by the Contractor to the Company in equal monthly installments over a period of 5 years, payable on the first day of each month beginning on the first day of the months after the amount became due by the Contractor, together with interest at the rate of 8% per year. Any amounts subsequently collected by Company from the Client shall be returned to the Contractor. However, Company shall retain any and all interest received from Contractor.

12. Company's compensation for the services it performs in obtaining client referrals for Contractor shall be a referral fee the Contractor receives from the client that was referred by the Company to the Contractor, which shall be payable a s long as Contractor provides services to client.

13. Because the services that will be performed by the Contractor are unique and requires specialized training, the Contractor must obtain the approval of both the Company and the client before it can engage others to assist in the performance of services under this Agreement.

14. Contractor reserves the right to perform services for others, as long as the performance of these services does not interfere with the performance of services under this Agreement. Contractor agrees, however, that it shall not perform services for a client that was referred by Company for a period of one year after no longer performing services for the client, unless the Company either refers the Contractor again to the client or gives the Contractor written permission to perform the services.

15. Contractor and Company mutually agree not to discriminate because of race, color, religion, sex, national origin, age, handicap or marital status. Each party will be responsible for their own actions and neither shall be responsible or liable for the others.

16. Either party may terminate this Agreement by giving the other party 30 days written notice.

17. If the Contractor breaches any of the terms of this Agreement, the Company has the right to terminate this Agreement immediately and to immediately remove the Contractor from any client engagement for which the Contractor is providing services, The Company also has the right to proceed against the Contractor in law or in equity for any damages caused to Company by the breach and if the breach constitutes a criminal act against the Company to file a criminal actions against the Contractor.

18. This Agreement is the entire Agreement between the parties and shall replace any other agreements if effect between the parties. This Agreement may not be modified expect by written agreement executed by both parties.

19. If any provision of this Agreement is found, held or deemed to be void, unlawful or unenforceable under any applicable statute or other controlling laws, the rest of the Agreement shall continue in full force and effect.

20. No breach of any provision of this Agreement can be waived unless in writing. Wavier of any breach of any provision of the Agreement shall not be considered to be waiver of any other breach nor any other provision.
21. This Agreement shall be governed and enforced in accordance with the laws of the State of Florida.
22. Any notice required or permitted under this Agreement shall be in writing and sent to the other party by first class mail to the address shown at the beginning of this Agreement unless either has notified the other, in writing, of any change of address, in which case notice will be sent to the new address.

I have read and accept the above terms, conditions and agreements.

_____

Contractor's Signature

CWG HEALTHCARE SOLUTIONS, INC.

By: _____

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

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

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.*

CWG HEALTHCARE SOLUTIONS
4850 N STATE ROAD 7, BLDG #G, SUITE 101
LAUDERDALE LAKES, FL 33319
TEL. (954) 581-9968 FAX. (954) 581-9642

REFERENCE REQUEST

To:_____ Date:_____

_____

_____ is being considered for employment with CWG HEALTHCARE for the position of _____. We would appreciate your reply to the following inquires and assure you that your reply will be held in strict confidence. A postage paid envelope has been included for your convenience. Thank you for your attention to this matter.

_____
Human Resources

Position Held _____ From:___/___/___ To:___/___/___

1. Please comment on applicant's quality of work:
   ___Excellent ___Very Good ___Average ___Poor
2. Please comment on the applicant's ability to get along with others:
   ___Excellent ___Very Good ___Average ___Poor
3. Please comment on the applicant's reliability and attendance:
   ___Excellent ___Very Good ___Average ___Poor
4. Would you re-employ? ____If no, why_____

_____

5. Additional remarks (if any)_____

_____

Name:_____ Title:_____

Signature:_____ Date:_____

I hereby authorize release of the above information and waive all rights to see or review comments that are furnished to CWG HEALTHCARE.

Applicant:_____ S.S. #:_____

CWG HEALTHCARE SOLUTIONS
4850 N STATE ROAD 7, BLDG #G, SUITE 101
LAUDERDALE LAKES, FL 33319
TEL. (954) 581-9968 FAX. (954) 581-9642

REFERENCE REQUEST

To:_____ Date:_____

_____

_____ is being considered for employment with CWG HEALTHCARE for the position of _____. We would appreciate your reply to the following inquires and assure you that your reply will be held in strict confidence. A postage paid envelope has been included for your convenience. Thank you for your attention to this matter.

_____
Human Resources

Position Held _____ From:___/___/___ To:___/___/___

1. Please comment on applicant's quality of work:
   ___Excellent ___Very Good ___Average ___Poor
2. Please comment on the applicant's ability to get along with others:
   ___Excellent ___Very Good ___Average ___Poor
3. Please comment on the applicant's reliability and attendance:
   ___Excellent ___Very Good ___Average ___Poor
4. Would you re-employ? ____If no, why_____

_____

5. Additional remarks (if any)_____

_____

Name:_____ Title:_____

Signature:_____ Date:_____

I hereby authorize release of the above information and waive all rights to see or review comments that are furnished to CWG HEALTHCARE.

Applicant:_____ S.S. #:_____

HEALTHCARE SOLUTIONS

LICENSE VERIFICATION

I, _____, HEREBY AUTHORIZE THE STATE OF FLORIDA, BOARD OF NURSING TO RELEASE ANY INFORMATION, WHICH MAY BE PERTINENT.

_____
SIGNATURE

_____
LICENSE NUMBER

_____ _____
EXPIRATON DATE SOCIAL SECURITY NUMBER

TO: VERIFICATION DEPARTMENT
FLORIDA BOARD OF HEALTHCARE
1940 NORTH MONROE STREET
TALLAHASSEE, FLORIDA 32399-0770

IS THE ABOVE INFORMATION CORRECT? _____ YES _____NO
IS THE ABOVE LICENSE IN GOOD STANDING? _____ YES _____ NO

ANY COMMENTS? _____

_____

_____ _____
SIGNATURE TITLE

_____
DATE

HEPATITIS B VIRUS VACCINE CONSENT/DECLINATION

BLOODBORNE PATHOGENS

I have been informed of the symptoms and modes of transmission of blood borne pathogens including hepatitis B virus (HBV). I know about the facilities of infection control program and understand the procedure to follow if an exposure incident occurs.

I understand that the hepatitis B vaccine is available, at not cost, to employees whose jobs involve the risk of directly contacting blood or other potentially infectious material. I understand that vaccinations shall be given according to recommendations for standard medical practice in the community.

HEPATITIS B VACCINE CONSENT

I consent to administration of the hepatitis B vaccine. I have been informed of the method of administration, the risks, complications, and expected benefits of the vaccine. I understand that the facility is not responsible for any reactions caused by this vaccine. NOTE: Failure to take your first shot within thirty (30) days will void this option.

_____ _____

Signature of Employee Date

_____

Print Employee's Name

HEPATITIS B VACCINE DECLINATION

Appendix A to Section 1910.1030

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

_____ _____

Signature of Employee Date

_____

Print Employee's Name

AFFIDAVIT OF GOOD MORAL CHARACTER FOR PURPOSES RELEVANT TO CHAPTER 400.512 F.S
STATE OF FLORIDA

COUNTY OF BROWARD

Before me this day personally appeared _____, who, being duly sworn, deposes and says:

As an applicant for employment with **CWG Healthcare Solutions, Inc**;

I hereby attest to meeting the requirements for employment, that I am of good moral character that I have not been found guilty of, regardless of adjudication, or entered a plea of nolo contender, or guilty to any offense prohibited under any of the following provisions of the Florida statutes or under any statutes of another jurisdiction:

(a) Section 415.111 relating to adult abuse, neglect, or exploitation of aged persons, or Disabled adults.

(b) Section 782.04 relating to murder.

(c) Section 782.07 relating to manslaughter.

(d) Section 782.071 relating to vehicular manslaughter.

(e) Section 782.09 relating to killing an unborn child by injury to the mother.

(f) Section 784.011 relating to assault if the victim was a minor.

(g) Section 784.021 related to aggravated assault.

(h) Section 784.03 relating to battery if victim was a minor.

(i) Section 784.045 relating to aggravated battery.

(j) Section 784.01 relating to kidnapping.

(k) Section 787.02 relating to false imprisonment.

(l) Section 749.011 relating to sexual battery.

(m) Section 794.041 relating to prohibited acts of Persons in familial or custodial authority.

(n) Chapter 796 relating to prostitution.

(o) Section 798.02 relating to lewd and lascivious behavior.

(p) Chapter 800 relating to lewdness and indecent exposure.

(q) Section 806.01 relating to arson.

(r) Chapter 812 relating to theft, robbery, and related crimes, if the offense is a felony. (See 812.014, 812.016, 812.019, 812.052, 812.081, 812.13, 812.14, 812.16).

(s) Section 817.5463 relating to fraudulent Sale of controlled substances only if the offense was a felony.

(t) Section 826.04 relating to incest.

(u) Section 827.03 relating to aggravated Child abuse.

(v) Section 827.04 relating to child abuse.

(w) Section 827.05 relating to negligent treatment of children.

(x) Section 827.071 relating to sexual performance of a child.

(y) Chapter 847 relating to obscene literature.

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

I further attest that I have not been judicially determined to have committed abuse or neglect against a child as defined in Section 39.01 (2) and (37), Florida Statutes; nor do I have a confirmed report of adult abuse, neglect, or exploitation as defined in Section 415.102 (5), or abuse or neglect as defined in Section 415.503 (6), which has been uncontested or upheld under Section 415.103 or Section 415.504, Florida Statutes; nor have I committed an act which constituents domestic violence as Defined in Section 741.30.

Under the penalties of perjury I declare that I have read the foregoing, and the facts alleged are true to the best of my Knowledge and belief.

_____
Affiant

To the best of my knowledge and belief, my record may contain one of the foregoing disqualifying acts of offenses.

_____
Affiant

Sworn to and subscribed before me this _____ day of _____, _____.

_____
Notary Public, State of Florida

ANNUAL SCREEN

The T.B organism is different from other lung infections in that it is very small and light weight and can stay suspended in the air for a long period of time; Caregivers 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? (Circle the appropriate answer)

Blood in sputum when I cough	Yes	No	Don't Know
Increased sweating at night time	Yes	No	Don't Know
Low Grade temperature (above 99F)	Yes	No	Don't Know
Fatigue, unusual tiredness	Yes	No	Don't Know
Bad cough that lasts longer then 2 chest	Yes	No	Don't Know
Unplanned weight loss	Yes	No	Don't Know
Chills	Yes	No	Don't Know
Cold symptoms that don't go away	Yes	No	Don't Know

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.

Signature:_____ Date:_____

APPENDIX A-1

CWG HEALTHCARE SOLUTIONS

PERSONAL HEALTH INFORMATION PLEADGE OF CONFIDENTIALITY

I, the undersigned, have read and understand the CWG Healthcare Solutions, (Hereinafter stated as "CWG") policy on confidentiality of personal health information (PHI) as described in the Confidentiality Policy which is in accordance with relevant state and federal legislation.

I also acknowledge that I am aware of and understand the Policies of the CWG regarding the security of personal health information including the policies relating to the use, collection, disclosure, storage and destruction of personal health information.

In consideration of my employment or association with CWG, and as an integral part of the terms and conditions of my employment or association, I hereby agree, pledge and undertake that I will not at any time, during my employment or association with CWG, or after my employment or association ends, access or use of personal information, or reveal or disclose to any persons within or outside CWG, any personal health information except as may be required in the course of my duties and responsibilities and in accordance with applicable Legislation, and CWG policies governing proper release of information.

I understand that my obligations outlined above will continue after my employment/contract/association/appointment with CWG ends.

I further understand that my obligations concerning the protection of the confidentiality of PHI relate to all personal health information whether I acquired the information through my employment or contract or association or appointment with CWG or with any of the entities, which have an association with CWG.

I also understand that unauthorized use or disclosure of such information with result in a disciplinary action up to and including termination of employment or contract or association or appointment, the imposition of fines pursuant to relevant state and federal legislation, and a report to my personal regulatory body.

DATE SIGNED	X_____ SIGNATURE OF INDIVIDUAL MAKING PLEDGE I have been informed of the contents of CWG's Personal Health Information Confidentiality Policy and the consequences.
Employee ID# of Individual Making Pledge (if applicable)	_____ Name of Individual Making Pledge (Please Print)
DATE SIGNED	X_____ SIGNATURE OF INDIVIDUAL ADMINISTERING PLEDGE I have discussed the Personal Health Information Confidentiality Policy and the consequences of a breach with the above named.

HIPAA:

Privacy & Protection of Personal Health Information

Post Test

Name: _____ Date: _____

1. **Ms. Aide is a CWG aide who did a bath visit for Mr. Patient. While on the elevator, a neighbor of Mr. Patient asked "What is wrong with him now?" Ms. Aide's answer should be which of the following:**
   a. Pneumonia, He is getting old you know.
   b. I told him to stop smoking, but he won't quit.
   c. My agency policy does not allow me to discuss that, I'm sorry.
   d. Go ask his Wife.

2. **Ms. Aide is driving home and gets a page from the coordinator. She calls back from the grocery store and the coordinator wants to get a report on Mr. Patient. Which of the following is Ms. Aide's best action:**
   a. Tell the coordinator she will call her back at a more private, convenient time and location.
   b. Go ahead and give the report, also tell her how she handled Mr. Patient's neighbor.
   c. Do not respond to the coordinator.

3. **Ms. Aide was taken off Mr. Patient's case. She has an information sheet for Mr. Patient in her possession. Which of the following should Ms. Aide do:**
   a. Place the information sheet into her home garbage for pick up.
   b. Rip the information sheet in several pieces and dispose in the kitchen trash.
   c. Use white out over the name, address, social and phone number.
   d. Return the information sheet to the office for shredding.

4. **Ms. Coordinator is a supervisor at CWG. She is giving a field nurse information on a new patient to be admitted. Which of the following is Ms. Coordinator's best action:**
   a. Sit at the general meeting table and give the nurse the information so that everyone can witness to what she tells this nurse.
   b. Do not give the nurse any information at all since HIPAA rules says so.
   c. Give the nurse the minimum necessary information from a private area with reasonable voice control.

5. **An office employee forgot her computer password. She asks another employee to allow her to use her password. What should the other employee do:**
   a. Give her the password and tell her to return it as soon as she is done.
   b. Give her the password and tell her to try and remember hers.
   c. Tell her to notify the person in Technical Support at CWG because passwords are <u>private</u>.

6. **Ms. Nurse is a nurse with CWG. She was in a Sandwich shop and overheard another employee (Ms. Aide) giving personal health information for a patient (Mr. Client) over her cell phone. Ms. Nurse should do which of the following:**
    a. Tell the employee you heard everything she said and she owes you a favor not to tell on her.
    b. Ignore the situation, after all this happens everyday.
    c. Notify Ms. Aide's supervisor, a member of the compliance committee or any office staff about the breach.

7. **Ms. Assistant is responsible for sorting and filing notes in a patient's files. Tuesday was rushed and the filing was incomplete. Ms. Assistant should do which of the following:**
    a. Leave the notes at the reception area so she can find it easily the next day.
    b. Leave the notes at the reception area but cover them so that visitors do not see them.
    c. Store the notes in a locked room and/or a locked cabinet to maintain privacy and security.
8. **HIPAA means which of the following:**
    a. An HMO insurance approved by the government.
    b. A large animal.
    c. Health Information Portability and Accountability Act.

9. **The three basic guiding rules for HIPAA are:**
    1. NEED TO KNOW.
    2. MINIMUM NECESSARY.
    3. REASONABLE CONTROLS.

    Which of the following best explains "minimum necessary":

    a. The supervisor tells the nurse on the phone all past infections the new patient had.
    b. The coordinator gave the aide basic information such as name, address, phone, number age, sex, and the patient's present problems that relate to the care required.
    c. The supervisor gives the therapist a report on past illness, hospitalizations, treatments and results for a new patient so that the therapist could do a proper evaluation of the <u>fractured ankle</u>.

10. **<u>True or False</u>**

    As a part of CWG Healthcare Solutions' ongoing compliance inspection, the inspector or committee member can do visual checks of employees' cars to see how confidential information is transported and protected.

    a. True _____ b. False _____

HEALTHCARE SOLUTIONS

APPLICANT: _____

LPN SKILLS SELF-ASSESSMENT

Please rate your current proficiency in each area (include only work experience, not school).

1 – No experience 2 – Little experience 3 – Moderate experience 4 – Experienced

SKILL	RATE	SKILL	RATE
Admission		Peritoneal Dialysis	
Discharge		AIDS/HIV Patient Care	
PEG Tube		Enemas	
N/G Feedings		Hickman Catheter	
Douche		Swan-Ganz	
Aseptic Technique		IV Starts	
Catheterization-Male		Hypothermia Blanket	
Catheterization-Female		Pre-op Care	
Foley Irrigation		Burn Care	
Sterile Dressings		N/G Insertion	
Biohazardous Waste		*Assist with Thoracentesis*	
C.P.R.		Healthy History	
Heimlich Maneuver		Blood Transfusion	
Eye Irrigation		Roto-rest Bed	
Postural Drainage		IV Pumps	
Suctioning		Cardiac Monitor	
Suprapubic Catheter Care		*Pediatric Care*	
Cast Care		Psychiatric Care	
Tracheostomy Care		Critical Care	
TPN Peripheral		Ostomy Care	
TPN Central		Hospice Care	
Groshong Catheter		Paraplegic Care	
IV Medications		Patient Teaching	
Central Line Dressings		PICC Lines	

It is the obligation of any (practitioner) which lacks knowledge or capability in any care/service to refuse acceptance of any assignment where she/he is unable to properly and safely provide care required. I UNDERSTAND AND AGREE TO THIS RESPONSIBILITY.

_____ _____

Signature Date

HEALTHCARE SOLUTIONS

PROFILE SHEET

PERSONAL:

Name: _____ Social Security #_____
LAST FIRST MI.

Home Address: _____
STREET APT.# CITY/STATE ZIP

Home Telephone: _____ Cell: _____ Email_____

Emergency Contact: _____ Tel: _____ Relationship _____

SKILLS:

Circle your Classification: RN LPN CNA Other License # _____

Circle your Certifications: PICC Chemo IV Arrhythmia Critical Care Heartsavers BLS ACLS PALS

Circle your Specialties: M/S CCU/ICU TELE ER PICU NICU PSYCH PEDS VENT

Circle if you do: Staff Relief Private Duty Hospice Care

Circle if you will work: HIV/AIDS Geriatrics Quads

Circle if you are: IV Certified

Circle if you know: Kosher cooking

Circle Days Available: MON TUE WED THU FRI SAT SUN M-F W/E

Circle Shifts Available: 8a-4p / 4p-12p / 12a-8a / 7a-7p / 7p-7a / 3p-11p / 11p-7a ANY

Circle Languages spoken: English Spanish French Other _____

Circle where you will work: Dade Broward Palm Beach

Do you have (circle): Drivers License Car

List Hospitals/Hospice where you are oriented: _____

_____

_____

In which Hospitals/Hospice have you previously worked and when:

_____

_____

HEALTHCARE SOLUTIONS

JOB DESCRIPTION

LICENSED PRACTICAL NURSE
STAFF RELIEF

JOB SUMMARY

- The Licensed Practical Nurse, who under the supervision of a charge nurse, gives nursing care to a private duty patient. This includes direct and indirect care. Responsibilities include planning, giving and evaluating nursing care. The functions performed require judgment based upon established policies of the institution.

JOB RELATIONSHIPS

- Accountable to the nurse in charge of the patient unit (Head Nurse/Assistant Head Nurse/Charge Nurse).
- Works closely with patient, visitors, hospital staff and volunteer workers.

MINIMUM QUALIFICATIONS

Education:

- Graduation of a State accredited nursing program and licensed to practice as a Licensed Practical Nurse in the State of Florida or possess an endorsement from the Florida State Board of Nursing while awaiting nursing license.
- Maintains current CEU's.
- Must have IV Therapy/Medication course or equivalent
- Must receive a passing grade on Agency's assessment test.

Experience:

- Must have at least one year of experience in a hospital/clinical setting.

Health:

- Evidence of good health as stated by a physician.
- Negative PPD or Chest X-Ray.
- Physically able to perform duties without limitations.
- Mentally and emotionally able to perform duties.

Abilities:

- Ability to identify problems, analyze nursing situations and plan a reasonable course of action in an organized manner consistent with standard nursing practices.

Performance Requirements

- Adherence to institution's policies and procedures
- Utilization of acquired knowledge and skills in giving safe nursing care.

HEALTHCARE SOLUTIONS

Performance Requirements

- Adherence to institution's policies and procedures
- Utilization of acquired knowledge and skills in giving safe nursing care.
- Knowledge of nursing services, treatments and preventative procedures requiring substantial, specialized skills and as ordered by the patient's physician.
- Maintains patient confidentiality.
- Participations in the inservice programs offered by the Agency.
- Follows dress code of the Agency and institution.
- Accepts direction, supervision and evaluation of performance.
- Economical use of time, efforts and material.

Special Demands

- Considerable walking, standing and lifting.
- Relieves the charge nurse when assigned.
- Excellent problem-solving skills.
- May be requested to work additional hours.
- Assignments may be revised at the discretion of the institution.

_____ _____

Applicant Signature Date

HEALTHCARE SOLUTIONS

JOB DESCRIPTION

LICENSED PRACTICAL NURSE
HOME HEALTH

JOB SUMMARY

- The Licensed Practical Nurse, who under the supervision of a charge nurse, gives nursing care to a private duty patient. This includes direct and indirect care. Responsibilities include planning, giving and evaluating nursing care. The functions performed require judgment based upon established policies of the institution.

JOB RELATIONSHIPS

- Accountable to the nurse in charge of the patient unit (Head Nurse/Assistant Head Nurse/Charge Nurse).
- Works closely with patient, visitors, hospital staff and volunteer workers.

MINIMUM QUALIFICATIONS

Education:

- Graduation of a State accredited nursing program and licensed to practice as a Licensed Practical Nurse in the State of Florida or possess an endorsement from the Florida State Board of Nursing while awaiting nursing license.
- Maintains current CEU's.
- Must have IV Therapy/Medication course or equivalent.
- Must receive a passing grade on Agency's assessment test.

Experience:

- Must have at least one year of experience in a hospital/clinical setting.

Health:

- Evidence of good health as stated by a physician.
- Negative PPD or Chest X-Ray.
- Physically able to perform duties without limitations.
- Mentally and emotionally able to perform duties.

Abilities:

- Ability to identify problems, analyze nursing situations and plan a reasonable course of action in an organized manner consistent with standard nursing practices.

PERFORMANCE REQUIREMENTS

-
- Assists in the development and implementation of the interdisciplinary patient care plan as it pertains to nursing.
- Provides skilled nursing care as outlined in the patient care plan to include the following:
    - Nursing services, treatments and preventive procedures requiring substantial, specialized skill as directed by the RN Case Manager.
    - Observing signs and symptoms and reporting to the RN Case Manager reactions to treatments, including drugs, and changes in the patient's physical or emotional condition.
    - Teaching, supervising and counseling the patient and family members regarding the nursing care needs and other related problems of the patient and family members regarding the nursing care needs and other related problems of the patient and family members regarding the nursing care needs and other related problems of the patient at home under the NR Case Manager's direction.
    - Orders from the physician must be sign by the RN Case Manager.
    - Maintains and submits written clinical and agency records as deemed necessary to include:
        - Care plan
        - Daily notes
        - Weekly schedules
        - Discharge summary
    - Discusses and plans with the RN Case Manager, at least weekly, the following:
        - Next week's schedule including necessary frequency of visits.
        - Patient's general condition and required care and necessary changes on the Plan of Treatment.
    - Communicates with other team members in order to provide comprehensive patient care.
    - Assumes responsibility for self-development by continually striving to improve his/her nursing knowledge through educational programs, attendance at workshops and conferences, active participation in professional and related organization meetings individual research and reading.

_____ _____

Applicant Signature Date

CWG HEALTHCARE SOLUTIONS

Pre-employment Medical Questionnaire

Have you had or been treated for any of the following conditions or diseases?

__ Epilepsy
__ Diabetes
__ Cardiac Diseases
__ High Blood Pressure
__ Arthritis
__ Blood Clots
__ Back problems
__ Herniated Disc
__ Hearing Disorders
__ Eye Disorders
__ Cancer
__ Kidney Disorders
__ Ulcers
__ Head Injury
__ Headaches
__ Dizziness
__ Respiratory Disorders
__ Alcoholism
__ Drug Addiction
__ Mental Illness
__ Nervous Disorders
__ _____
__ _____
__ _____

Have you been hospitalized in the last three years? If so, for what condition?

_____

_____

Have you been treated for any mental conditions? If so, for what condition?

_____

_____

Is there any health-related reason why you may not be able to perform the job duties for which you are applying?

_____

_____

List all medications that you are currently taking:

_____

_____

Have you ever filed a Workman's Compensation Claim? If so, please explain in detail:

_____

_____

Please list dates for the following:

_____ Varicella (chicken pox)
_____ Rubella (measles)
_____ MMR immunization
_____ Varicella (chicken pox) Titer
_____ Rubella (measles) Titer
_____ Last PPD/chest X-ray

I understand that CWG HEALTHCARE has offered me a job conditional upon my completing the medical questionnaire. It is my understanding that only those applicants who meet CWG HEALTHCARE's physical and psychological criteria for employment, with or without reasonable accommodations, will be qualified to receive confirmed offers of employment.

Print Name _____ Date _____

Signature _____ Date _____

HEALTHCARE SOLUTIONS

EMPLOYEE SAFE WORKING PRACTICES AGREEMENT

As a condition of employment, I _____ do hereby agree to comply with the following safe working practices:

1) I agree to follow established departmental safety procedures.

2) I agree to report any work related accident or injury to my supervisor as soon as it occurs, but no later than the end of my shift.

3) If I need treatment for a work related injury, I agree to:

    a. Notify my employer of the need for treatment.
    b. Only go to an employer directed physician(s) for necessary treatment.

4) If my job involves the handling of patients, I agree to always use proper body mechanics, have assistance and/or use mechanical lifting devices, for all patients who require any form of assistance in making a movement.

I understand that a failure on my part to follow the above procedures could result in disciplinary action, not to exclude termination.

I also understand that according to section 440.09 (4) of the Florida worker's compensation law, my compensation benefits could be reduced for any injury that occurs because of a failure to follow established safety procedures.

_____ _____

Employee Signature Date

_____

Witness

HEALTHCARE SOLUTIONS

EMPLOYEE AGREEMENT

I hereby acknowledge that I have been advised of and understand the following policies of the agency:

Job Description:	I have been furnished with a copy of the appropriate job description.
Assignments:	I may accept or reject any assignment offered, however, once an assignment has been accepted, I am obligated to fulfill the assignment.
Documentation:	Proper and accurate documentation pertaining to the service and care of the clients is of utmost importance to this agency. I understand that the agency may withhold payment to me if this documentation is not received in an accurate and timely manner.
Promptness:	Habitual tardiness will jeopardize employment.
Schedule Changes:	Any change in the assignment, as to time or date, must be made through the agency.
Cancellation:	Excessive cancellations will jeopardize employment.
No Show:	Not reporting to an assignment is cause for immediate termination.

I hereby agree not to accept employment from any client for a period of Ninety (90) days, without written approval from CWG Healthcare Solutions, and that failure to comply with this provision will result in termination and a fine in the amount of $2,500.

_____ _____

Employee Signature Date

_____

Witness

HEALTHCARE SOLUTIONS

UNIVERSAL PRECAUTIONS

HEALTH CARE PROVIDERS WILL ADHERE TO THE FOLLOWING WHEN DELIVERING CARE TO ALL PATIENTS. BY ADHERING TO THE FOLLOWING PRECAUTIONARY MEASURES, THE RISK OF TRANSMISSION OF DISEASE IS DECREASED WHEN THE INFECTION STATUS OF THE PATIENT IS UNKNOWN.

GLOVES MUST BE WORN WHEN DELIVERING PATIENT CARE, HANDLING SPECIMENS, DOING DOMESTIC CLEANING, AND 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 EYE WEAR 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 ALL SPECIMENS TO PREVENT CONTAMINATION FROM BODY SPECIMENS, 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.

HEALTH CARE PROVIDERS WHO HAVE OPEN CUTS, SORES, OR DERMATITIS ON THEIR HANDS MUST WEAR GLOVES FOR ALL PATIENT CONTACT.

EMPLOYEE
SIGNATURE_____ DATE _____

HEALTHCARE SOLUTIONS

CONFIDENTIALITY STATEMENT

I HAVE BEEN FORMALLY INSTRUCTED IN MAINTAINING THE CONFIDENTIALITY OF MEDICAL RECORDS AND UNDERSTAND THAT EXCEPT AS NEEDED TO CONDUCT THE BUSINESS OF THE DAY, THE MEDICAL INFORMATION REGARDING THE PATIENT MAY NOT BE DISCUSSED WITH ANYONE EITHER INSIDE OR OUTSIDE THE COMPANY.

I UNDERSTAND THAT NO MEDICAL RECORDS ARE TO BE REMOVED FROM THE COMPANY UNLESS A RELEASE OF INFORMATION FORM HAS BEEN COMPLETED AND SIGNED BY THE PATIENT.

IT IS MY UNDERSTANDING THAT SUCH DISCUSSION OR RELEASE OF INFORMATION IS CAUSE FOR DISMISSAL.

I HAVE BEEN FORMALLY INSTRUCTED ON THE POLICIES AND PROCEDURES OF CWG HEALTHCARE. I HAVE ATTENDED A FORMAL ORIENTATION AND HAVE READ AND SIGNED A JOB DISCRIPTION FOR MY SPECIFIC CLASSIFICATION.

_____

EMPLOYEE SIGNATURE DATE

CWG HEALTHCARE SOLUTIONS

Confidentiality Attestation

I have been instructed on Florida State Public Health Law Statue 381.609 and Department of Health Regulations regarding the confidentiality of HIV information. I am aware that, when necessary for provision of care, HIV information will be disclosed to me from confidential records, which are protected by state law. Additionally, Psychiatric illness, drug or alcohol abuse, and Venereal Disease will also be handled with the same level of confidentiality. Any unauthorized disclosure may lead to disciplinary action, including suspension or dismissal from employment, a fine, jail sentence or both. I also understand that the aforementioned confidentiality policy pertains to all patients/clients.

CWG HEALTHCARE considers certain types of information about its services, processes, employees and customers as confidential data whose disclosure to competitors or other members of the public could significantly harm the organization's interest. Employees and independent contractors are forbidden to disclose any trade secrets or other confidential data learned over the course of individuals not employed or contracted by this agency. Trade secrets and other confidential information will be disclosed to employees only if their jobs, assignments, or duties require knowledge of sensitive information. In handling confidential documents and materials, employees/contractors must adhere to all procedure restrictions designed to safeguard such information.

Employee/contractor's who violate the agency's confidentiality rules will be subject to disciplinary action and possible termination. CWG HEALTHCARE also reserves the right to seek legal redress and remedies for breaches of its confidentiality policy by former employees and/or contractors.

I completely understand the above Fidelity Agreement and Confidentiality Agreement and agree to comply with these policies.

_____ _____

Signature of Employee Date

_____

Witness to Signature

HEALTHCARE SOLUTIONS

DISCLOSURE OF CONFLICT OF INTEREST
NON-COMPETE/ FIDELITY CONTRACT

By signing this agreement all staff and contractors agree to the following:

1. I will not work for any client of CWH Healthcare outside of agency time without the express written consent of the agency administrator.

2. I will report to the agency administrator any client that wishes to hire said employee to perform the duties that said agency employee is hired to do through the agency.

3. If employee or contractor is no longer with client they may not contact client to offer their services.

4. I may not solicit business from a client on behalf of other agencies.

5. If at any time while in the employ of CWG Healthcare I become engaged in other organizations by ownership or employment, which presents a conflict of interest, this information will be voluntarily submitted to the agency administrator.

6. I may not divulge any information concerning the operation and/or business strategies of CWG Healthcare or provide any of CWG's forms and/or documents to other organizations for modification and/or utilization.

I have reviewed and understand the above contract. Presently I am not engaged in any activity by ownership or employment that presents a conflict of interest with CWG Healthcare. If so I have voluntarily disclosed the information and have made CWG Healthcare aware of each instance.

Failure to adhere to this contract will result in immediate termination from CWG Healthcare, and will result in civil action and/or fine.

_____ _____

Employee Signature Date

_____

Witness Signature

HEALTHCARE SOLUTIONS

CONSENT TO SUBSTANCE ABUSE SCREENING

A. I understand that CWG HEALTHCARE absolutely prohibits the use, manufacture, distribution, and possession of narcotics, drugs, and alcoholic beverages in the workplace. This includes at the work site as well as at work functions.

I, _____, agree to abide by CWG HEALTHCARE's substance abuse policy.

B. **AUTHORIZATION**

I hereby consent and agree to submit to urinalysis testing, or any clinically accepted method of substance abuse screening, by CWG HEALTHCARE or CWG HEALTHCARE's agent. I understand the results of the screening will be used, in part, to determine my employment or continued employment. Failure or refusal to be tested terminates any further employment processing.

I hereby authorize CWG HEALTHCARE to release the results of my substance abuse test to the current, or prospective client where I am assigned to work.

C. DURATION

This authorization is effective immediately and shall remain in effect until revoked in writing by me.

D. **ADDITIONAL COPY**

I understand that I may obtain a copy of this authorization. Copy requested and received. Yes ___ No ___ Initial ___

E. SIGNATURES

Date _____ Signed _____
Employee

Date _____ Signed _____
Witness

HEALTHCARE SOLUTIONS

EQUAL OPPORTUNITY AND NON-DISCRIMINATION POLICY STATEMENT

IT IS THE POLICY OF CWG HEALTHCARE TO PROVIDE EQUAL EMPLOYMENT OPPORTUNITY FOR ALL APPLICANTS AND EMPLOYEES. CWG HEALTHCARE DOES NOT UNLAWFULLY DISCRIMINATE ON THE BASIS OF RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN, AGE, HANDICAP, VETERAN STATUS, OR MARITAL STATUS.

CWG HEALTHCARE PROVIDES REASONABLE ACCOMMODATION FOR WALIFIED INDIVIDUALS WITH DISALBITIES UNLESS DOING SO RESULTS IN AN UNDO HARDSHIP.

THIS POLICY GOVERNS ALL ASPECTS OF EMPLOYMENT, INCLUDING SELECTION, JOB ASSIGNMENT, COMPENSATION, DISCIPLINE, TERMINATION, AND ACCESS TO BENEFITS IN TRAINING. THIS EQUAL OPPORTUNITY AND NON-DISCRIMINATION POLICY INCLUDES, BUT IS NOT LIMITED TO, THE PROVISIONS OF CARE SERVICES TO CLIENTS, ALL PRIVILEGES AND USE OF FACILITES.

CWG HEALTHCARE HAS PROVIDED A COPY OF TIS POLICY STATEMENT TO YOU, WITHOUT ACKNOWLEDGING ANY LIABILITY TO THE EXTENT THAT ONE OF ITS EMPLOYEES AND/OR INDEPENDENT CONTRACTORS FAILS TO ABIDE BY THE POLICY SET FORTH HEREIN.

_____ _____

NAME OF AGENCY SIGNATURE

_____

PRINT NAME

HEALTHCARE SOLUTIONS

Orientation Acknowledgement

I have received orientation and been advised of all policies and procedures for CWG Healthcare Solutions.

Sign_____

Date_____

HEALTHCARE SOLUTIONS

Acknowledge To Have Received Memos

I hereby acknowledge and agree I have received the following memorandums and notices from CWG Healthcare Solutions, Inc and have been advised of their comments.

- Memorandums regarding nursing notes and payroll
- Notice to all nurses regarding nursing notes are due every Tuesday by 12:00 noon
- Rules for Hospice Care

Sign_____

Date_____

EMPLOYMENT ACKNOWLEDGMENT AGREEMENT

I hereby acknowledge that I have received this company's Drug Free Workplace Handbook, which includes the company Drug Free Workplace policy, employee assistance information, a listing of drugs being tested for, common over-the-counter medications which may alter a drug test and educational material on substance abuse. I have also been given the opportunity to voluntarily complete a Medication Disclosure Form.

I freely and voluntarily agree and realize that as part of my employment, I may be subjected to future drug and/or alcohol screens for post-accident, reasonable suspicion, routine fitness-for-duty, return to work, follow-up, and/or random testing at the company's discretion. I understand that a refusal to submit to a blood, urinalysis, hair and/or breath test will result in immediate termination from employment. I understand that a tampered or an adulterated drug and/or alcohol specimen will be considered a refusal to test, resulting in immediate termination. I understand that a confirmed positive drug and/or alcohol test will result in immediate termination of employment, but if I am able to successfully complete substance abuse treatment at my expense, and if a job is still available, I may be given one chance to be rehired, upon a negative return to work drug and/or alcohol test. I understand that I will be subject to the company rehabilitation agreement and I will undergo random follow-up drug and/or alcohol tests for a period of 2 years. I understand that a confirmed positive drug and/or alcohol follow-up test or any violation of the rehabilitation agreement will result in termination of employment.

I agree to voluntarily submit to a blood, urinalysis and/or breath test for drug or alcohol use as part of my ongoing employment, and I release my employer from any liability resulting from my participation in such a screening. I understand that if I am injured during the course and scope of my employment and I test positive for the presence of alcohol and/or drugs, I may forfeit my eligibility for medical and indemnity benefits under Florida's workers' compensation law (Florida Statutes 440.101, 440.102). I also understand that a refusal to test under this circumstance will automatically result in forfeiture of my eligibility for medical and indemnity benefits and immediate termination from employment. I understand that a confirmed positive drug and/or alcohol test, a tampered with or an adulterated specimen or a refusal to test may result in forfeiture of unemployment benefits under Florida law.

I hereby give my consent to release the results of my blood urinalysis and/or breath test to the person(s) or department(s) or the specified agent of my employer, including my employer's Workers' Compensation Insurance Company, for the purpose of determining the presence of alcohol and/or other drugs in my body for the duration of my employment. By signing this form, I hereby release to the Company and/or Company's Medical Review Officer the results of the test(s) to which I have consented. I further authorize the Company to discuss the results with medical personnel/physician collecting the specimen, the testing facility, its directors, officers, agents, and employees responsible for administrating the aforementioned test(s) or evaluating the results thereof and any of them herein. I also authorize the Company to discuss the results with its legal advisors and to use the test results as a defense to any legal action to which I am a party. I further release any testing facility or any physicians who have tested me from any liability arising from a release of any and all results, written reports, medical records, and data concerning my test(s) to the appropriate Employer officials. I agree to have the results released to the Company and/or the Company's Medical Review Officer.

I also understand that the Drug –Free Workplace policy and related documents are not intended to constitute a contract between this employer and myself.

As an employee, I understand and agree to abide by this company's Drug Free Workplace policy, under Florida statute 440.101 and 440.102, and have received a written 60-day notification of this program, if applicable.

Employee Signature	Print Name	Date / /

As a job applicant, I freely and voluntarily agree to a urinalysis drug screen as part of my application for employment and I understand that a refusal to test, a positive confirmed drug test or a tampered with or an adulterated specimen will disqualify me from employment, even if I have started work pending the results of the drug test. I understand I am still completing the application process and will not officially be an employee until the company receives a negative pre-employment drug test result. If I am employed by this company, I understand and agree to abide by this company's Drug Free Workplace policy, under Florida statute 440.101 and 440.102, as stated above.

Applicant Signature	Print Name	Date / /

DRUG FREE WORKPLACE ADDENDUM

ROUTINE FITNESS-FOR-DUTY DRUG TESTING

Due to the safety sensitive nature of certain job classifications or group, this company will be conducting unannounced, routine fitness-for-duty drug testing for all employees in these classifications or group. These job classifications or group include;

I hereby understand that due to the safety sensitive nature of my job and my job classification or group, I will be subject to unannounced routine fitness-for-duty drug testing as stated under Florida statute 440.102 and as outlined in the company Drug Free Workplace Policy.

_____

Employee Name (Print)

_____

Employee Signature

_____ / _____ / _____

Date