



Application Package

Applicant's Name: _____



License #: _____ Application date: _____

Address: _____

City, St, ZC: _____

Phone: _____ Cel: _____ Bp: _____

Specialty (if any): _____

SS #: _____ Driver Lic. #: _____

Employee Signature: _____

Date: _____

EMPLOYEE'S LOG

| | | | | | | |
|---|---------------|------------------------------------|---|------------------|------------------|------------------|
| Employee's Name: _____ Street Address: _____ City/State/Zip Code: _____ Job Title: _____ | | | Bp: _____ Cell: _____ Soc. No: _____ Telephone: _____ Date of Hire: _____ | | | |
| DESCRIPTION | YES | DESCRIPTION | | | | YES |
| IRS from W-4 or W-9 | | SIGNED EMPLOYMENT APPLICATION | | | | |
| INS Form I-9 | | SIGNED JOB DESCRIPTION | | | | |
| HIPAA/Confidential Form | | PROBATIONARY PERIOD | | | | |
| COPY OF CHECK | | EMPLOYMENT REFERENCES | | | | |
| REVIEW-PERSONNEL POLICY [signed] | | COMPLETED ORIENTATION [date] | | | | |
| TRANSPORTATION RESPONSIBILITY | | PROFESSIONAL LIABILITY SHEET | | | | |
| TAX EXEMPT FORM | | CONFIDENTIALITY STATEMENT [sig.] | | | | |
| INDEPENDENT or CONTRACT AGREEMENT | | HIV - AIDS Certificate [Mandatory] | | | | |
| AFFIDAVIT OF GOOD MORAL CHARACTER | | C.P.R. CARD [Mandatory] | | | | |
| STATEMENT OF COMMITMENT | | INFECTION CONTROL [Signed] | | | | |
| DESCRIPTION | NUMBER | EXP. DATE | EXP. DATE | EXP. DATE | EXP. DATE | EXP. DATE |
| Professional License | | | | | | |
| Certificate [CNA] | | | | | | |
| Driver's License | | | | | | |
| Prof. Liability Insurance [1 and 3 millions] | | | | | | |
| Physical Exam, Free of Com. Disease, PPD/Mantoux test or X-Ray | | | | | | |
| Automobile Liability Insurance [PIP and PD] | | | | | | |
| H.H.A., 40 hours / C.N.A. 20 hrs. | | | | | | |
| Form of Verification: RN/LPN/PT | | | | | | |
| O.S.H.A. (Mandatory) | | YES () | | NO () | | |
| Comments: | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

APPLICATION FOR EMPLOYMENT

PRINT CLEARLY AND LEGIBLY

SECTION I - Name/Address

| | | |
|--------------------|--------|-----------------|
| Last: | First: | MI: |
| Address: | | |
| City: | State: | Zip: Telephone: |
| Social Security #- | DOB: | |

SECTION 2- Desired Employment

| | |
|---|---------------------|
| Position: | Date you can start: |
| Are you currently employed?: <input type="checkbox"/> yes <input type="checkbox"/> no If employed, may we inquire of your current employer?: <input type="checkbox"/> yes <input type="checkbox"/> no | |
| Have you applied to this agency before?: <input type="checkbox"/> yes <input type="checkbox"/> no If so, when: | |

SECTION 3 - Education

| | |
|---|---|
| HIGH SCHOOL | Name & Location of School: |
| | Years Attended: Date Graduated: Degree: |
| UNIVERSITY/ COLLEGE UNDERGRADUATE | Name & Location of School: |
| | Years Attended: Date Graduated: Degree: |
| UNIVERSITY/ COLLEGE GRADUATE | Name & Location of School: |
| | Years Attended: Date Graduated: Degree: |
| TRADE, BUSINESS OR CORRESPONDENCE SCHOOL | Name & Location of School: |
| | Years Attended: Date Graduated: Course study: |

SECTION 4- Employment History

| | |
|------------|------------------------------|
| Employer: | Job Title: |
| Address: | Duties: |
| Phone: | Salary: |
| Date From: | Date To: Reason for Leaving: |

| | |
|------------|------------------------------|
| Employer: | Job Title: |
| Address: | Duties: |
| Phone: | Salary: |
| Date From: | Date To: Reason for Leaving: |

| | |
|------------|------------------------------|
| Employer: | Job Title: |
| Address: | Duties: |
| Phone: | Salary: |
| Date From: | Date To: Reason for Leaving: |

MarcialEd Healthcare, Corp.

Employee:

SECTION 5- Personal References

| | |
|----------|---------------|
| Name: | Occupation: |
| Address: | Relationship: |
| Phone: | Years Known: |

| | |
|----------|---------------|
| Name: | Occupation: |
| Address: | Relationship: |
| Phone: | Years Known: |

| | |
|----------|---------------|
| Name: | Occupation: |
| Address: | Relationship: |
| Phone: | Years Known: |

SECTION 6- Physical Record

| |
|---|
| Do you have any physical disabilities that would prevent you from performing the work for which you are applying?: <input type="checkbox"/> yes <input type="checkbox"/> no If so, please describe: |
| Have you ever been injured? <input type="checkbox"/> yes <input type="checkbox"/> no Provide Details: |

SECTION 7- Licenses/Certification

| TYPE | LICENSE / CERT. # | EXPIRATION DATE | STATE ISSUED |
|------|-------------------|-----------------|--------------|
| | | | |
| | | | |
| | | | |

SECTION 8- Additional Areas of Expertise

| |
|--|
| Areas of specialized study, research or additional experience: |
| List the foreign languages you speak fluently: Read: Write: |
| U.S. Military Service: Separation Rank: |
| Present Membership in National Guard or Reserves: [] YES [] NO |

SECTION 9- Emergency Contact Information

| | |
|----------|------------|
| Name: | Relation: |
| Address: | Telephone: |
| Name: | Relation: |
| Address: | Telephone: |

I voluntarily give to the Agency the right to make a thorough investigation of my past employment. I agree to cooperate in such an investigation. I understand that my employment will be based in part on the accuracy of the information provided on this application.

Signature: _____ Date: _____

| | | |
|---|------------|-------|
| AGENCY AUTHORIZED REPRESENTATIVE INTERVIEWER | | |
| HIRED? YES [] NO [] | SIGNATURE: | DATE: |

MarcialEd Healthcare, Corp.

Employee Name: _____ Position: _____

| ITEM | DESCRIPTION | INITIALS |
|--|---|----------|
| <p>EMPLOYEE ACKNOWLEDGMENT OF PROBATION</p> | <p>I UNDERSTAND THAT I AM ON PROBATION AS AN EMPLOYEE FOR THE FIRST NINETY DAYS OF MY EMPLOYMENT WHICH STARTED ON _____ FOR THE PURPOSE OF THE FLORIDA "UNEMPLOYMENT COMPENSATION LAW". I UNDERSTAND IF MY EMPLOYER DISCHARGES ME FOR UNSATISFACTORY WORK PERFORMANCE UNDER THE FLORIDA "UNEMPLOYMENT COMPENSATION LAW" HE WILL NOT HAVE HIS ACCOUNT CHARGED FOR ANY UNEMPLOYMENT BENEFITS I MIGHT BE DETERMINED FOR IN THE FUTURE. I ACKNOWLEDGE THAT I SIGNED THIS FORM WITHIN SEVEN (7) DAYS OF MY EMPLOYMENT.</p> | |
| <p>NOTICE TO APPLICANTS</p> | <p>We comply with the Americans with Disabilities Act of 1990. During the interview process, you may be asked questions concerning your ability, to perform job-related functions. If you are given a conditional offer of employment, you may be required to complete a post-job offer medical history questionnaire and/or undergo a medical examination. If required, all entering employees in the same job category will be subjected to the same medical questionnaire and/or examination and all information will be kept confidential and in separate files. We are an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, sex, religion, national origin, handicap, or marital status. We assure you that your opportunity for employment with us depends solely upon your qualifications. PLEASE READ AND SIGN STATEMENTS BELOW I understand that in accordance with Florida Statute 443.131 (3) (a) (2), if hired, I will be placed on a 90 day probationary period. I further understand that if I am terminated for unsatisfactory work performance within the 90 day probationary period, my employer may seek to contest any unemployment benefit I might attempt to obtain as a result of my termination. I understand and agree that all policies, procedures, and the Employee Handbook may be modified, amended, or deleted by my employer with or without notice to me of such amendment, modification or deletion; that the policies and procedures are not intended to be a contract of employment nor do they give me a right of continued employment, and that my employment may be terminated at my option or that the option of my employer with agreements, or understandings regarding the terms of employment. There may be no amendments or exceptions to this statement unless they are in writing and signed by the president. I understand that I may be required to undergo blood and/or urinalysis screening for drug or alcohol use as part of the pre-employment process. In addition, all employees are subject to blood and/or urinalysis screening for drug or alcohol use. I certify that all information given on this employment application, any resume that I submit to the company, and any related papers and answers given during oral interviews are true and correct. I understand that my employer will make a thorough investigation of my work and personal history. I authorize the giving and receiving of any such information requested by my employer during the course of such investigation. I understand that falsification of any information given by others during the course of this investigation of any derogatory information discovered as a result of this investigation may-subject-me-to-immediate-dismissal. I hereby release from liability all persons who provide information to my employer during the course of any such investigation.</p> | |
| <p>CONSENT FORM TO RELEASE PHYSICAL-MEDICAL EXAMINATION CRIMINAL BACKGROUND SCREENING DATA FORM</p> | <p>I have been formally instructed that any medical and/or Criminal Background screening data is maintaining confidentially and understand that the medical information regarding my health status may not be discussed with anyone, either inside or outside the agency (except an needed to conduct the business of the day). I understand that no medical/criminal data are to be removed from the home health agency unless a "Release of Information" form has been completed and signed for me. It is my understanding that such Release of Information (THIS FORM), authorize the Agency to release my Physical/Background Information data to State/Federal surveyors at their request if needed for conduct the annual survey or any necessary investigation. I have been formally instructed in the Personnel Policies and Regulations, and I have read and signed a job description for my specific classification.</p> | |

MarcialEd Healthcare, Corp.

Employee/Contractor Signature: _____ Date: _____

Employee Name: _____ Position: _____

| ITEM | DESCRIPTION | INITIALS |
|--|---|----------|
| CONFIDENTIALITY STATEMENT | <p>I HAVE BEEN FORMALLY INSTRUCTED IN MAINTAINING THE CONFIDENTIALITY OF THE MEDICAL RECORDS AND UNDERSTAND THAT THE MEDICAL INFORMATION REGARDING THE PATIENT MAY NOT BE DISCUSSED WITH ANYONE, EITHER INSIDE OR OUTSIDE THE AGENCY (EXCEPT AN NEEDED TO CONDUCT THE BUSINESS OF THE DAY). I UNDERSTAND THAT NO MEDICAL RECORDS ARE TO BE REMOVED FROM THE HOME HEALTH AGENCY UNLESS A "RELEASE OF INFORMATION" FORM HAS BEEN COMPLETED AND SIGNED BY THE PATIENT. IT IN MY UNDERSTANDING THAT SUCH DISCUSSION OR RELEASE OF INFORMATION IS CAUSE FOR DISMISSAL. I HAVE BEEN FORMALLY INSTRUCTED IN THE POLICIES AND PROCEDURES OF THIS HOME HEALTH AGENCY, ALSO INFORMED REGARDING THE AGENCY'S POLICY FOR HIPAA COMPLIANCE, AND I HAVE READ AND SIGNED A JOB DESCRIPTION FOR MY SPECIFIC CLASSIFICATION.</p> | |
| <p>PERSONAL HEALTH INFORMATION PLEDGE OF CONFIDENTIALITY</p> <hr/> <p>SIGNATURE OF INDIVIDUAL MAKING PLEDGE</p> <hr/> <p>SIGNATURE OF INDIVIDUAL ADMINISTERING PLEDGE</p> | <p>I, the undersigned, have read and understand the This Home Health Agency, (hereinafter "This Home Health Agency") policy on confidentiality of personal health information (PHI) as described in the Confidentiality Policy which is in accordance with relevant state and federal legislation.</p> <p>I also acknowledge that I am aware of and understand the Policies of the This Home Health Agency, regarding the security of personal health information including the policies relating to the use, collection, disclosure, storage and destruction of personal health information.</p> <p>In consideration of my employment or association with This Home Health Agency, 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 This Home Health Agency, or after my employment or association ends, access or use personal health information, or reveal or disclose to any persons within or outside This Home Health Agency, any personal health information except as may be required in the course of my duties and responsibilities and in accordance with applicable Legislation, and This Home Health Agency, policies governing proper release of information.</p> <p>I understand that my obligations outlined above will continue after my employment/contract/association/ appointment with This Home Health Agency, ends.</p> <p>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 This Home Health Agency, or with any of the entities, which have an association with This Home Health Agency</p> <p>I also understand that unauthorized use or disclosure of such information will 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 professional regulatory body.</p> | |
| POLICY ON JOBS | <p>As an employee of This Home Health Agency, I understand that the job I am being hired to perform belongs to This Home Health Agency, Inc. I also understand that it is illegal for me to transfer or attempt to transfer any case to another Agency or take ownership of any job that I am employed in.</p> <p>Should I act underhandedly and take over such a job so that I may be paid directly by the client, to the exclusion of my employer, or transfer any case to another Agency. I will be in violation of State, Federal and agency rules and will accordingly pay \$10,000.00 to This Home Health Agency</p> | |

MarcialEd Healthcare, Corp.

Employee/Contractor Signature: _____ Date: _____

Employee Name: _____ Position: _____

| ITEM | DESCRIPTION | INITIALS |
|---|--|----------|
| EMPLOYEE STATEMENT OF COMMITMENT | <p>I have read and understand This Home Health Agency, Personnel Policy Manual. In compliance with those policies I agree to conform to the following:</p> <ul style="list-style-type: none"> -I have read and understand the This Home Health Agency, job description appropriate to my level of performance. I will not accept assignments beyond my designated performance level as determined by This Home Health Agency -I will abide with the This Home Health Agency Standard Code of Dress as described in the Personnel Policy Manual. -I will arrive in time for the assignments I have accepted. In the event of an emergency which may cause me to be late, I will notify the This Home Health Agency, office of the situation and expected arrival time. -I will not accept any money or gifts from This Home Health Agency's Clients. I will receive payment for services rendered directly from This Home Health Agency | |
| VOLUNTARY SUBSTANCE TESTING | <p>In order to protect myself and my employer, I _____ voluntarily authorize blood and urine testing for alcohol and/or drug use. I agree to allow such samples and testing to be completed at a time and place to be chosen by my employer. I understand should such samples and testing be requested it is either due to the company's Drug Free Workplace Program, suspicion that I am under the influence of alcohol/drugs which could result in an on-the-job injury, or may affect the quality of my work. I further authorize the results of samples/testing to be released to my employer.</p> | |
| POLICY AND PROCEDURE STATEMENT OF ORIENTATION COMPLETION | <p>(Non-Nursing Staff Personnel)</p> <p>This is to testify that _____ (employee name) has successfully completed the 8-hour required orientation and is now qualified to proceed with his/her routine job functions.</p> <p>The orientation was conducted on the ____ day of _____, _____.</p> <p>Signed: _____ Administrator or DON Employee</p> <p>I HAVE READ AND UNDERSTAND THE POLICIES AND PROCEDURES OF THE AGENCY AND HAVE HAD THE OPPORTUNITY TO HAVE ALL OF MY QUESTIONS/CONCERNS ADDRESSED TO MY COMPLETE SATISFACTION. I AGREE TO ABIDE AND UPHOLD ALL POLICIES AND PROCEDURE, AND HAVE BEEN ADVISE THAT FAILURE TO DO SO MAY RESULT IN TERMINATION OF EMPLOYMENT.</p> <p>I ALSO AGREE THAT AS A CONDITION OF EMPLOYMENT THAT I WILL PROVIDE THE AGENCY WITH A FOURTEEN (14) DAY WRITTEN NOTICE OF INTENT TO TERMINATE EMPLOYMENT.</p> | |

MarcialEd Healthcare, Corp.

Employee/Contractor Signature: _____ Date: _____

DATE: _____

TO: _____

Dear Sir or Madam,

_____ SS#: _____ is applying to our office as _____. Until we have thoroughly checked her/his references and tested her/his ability we cannot permit her/him to work. Please lend us your cooperation in completing the information requested.

I authorize This Home Health Agency, to gather any information concerning my qualification 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 _____ Date 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 & Attendance _____

Appearance (Grooming) _____

Judgement _____

Performance _____

Ability to Perform _____

Organization of Time _____

Compatibility _____

Accepts Direction _____

Signed _____ Title _____ Ph _____

Print Name: _____ Thank you for your courtesy

DATE: _____

TO: _____

Dear Sir or Madam,

_____ SS#: _____ is applying to our office as _____. Until we have thoroughly checked her/his references and tested her/his ability we cannot permit her/him to work. Please lend us your cooperation in completing the information requested.

I authorize This Home Health Agency, to gather any information concerning my qualification 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 _____ Date 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 & Attendance _____

Appearance (Grooming) _____

Judgement _____

Performance _____

Ability to Perform _____

Organization of Time _____

Compatibility _____

Accepts Direction _____

Signed _____ Title _____ Ph _____

Print Name: _____ Thank you for your courtesy

Employee Name: _____

OFFICE CLERK JOB DESCRIPTION

POSITION SCOPE:

To ensure effective Office Filling/Secretarial needs for the services working with the company's personnel, and through liaison with other organizations and individuals also providing care to the patient/client

POSITION QUALIFICATIONS:

Graduate of high school with a high school diploma or equivalent.

Evidence of knowledge of home care environment; Ability to work under stress, and to take rapid actions.

Verbal and written communication skills

Good organizational skills.

Computer skills/typing/filing.

PHYSICAL REQUIREMENTS:

No physical requirement

Ability to deal effectively with stress and a great work load at times

PERFORMANCE, ABILITIES AND STANDARDS:

Medical Records filling.

Basic Computer Data Entry/typing.

Institutes a set of check points to make sure that the services were provided/Customer Satisfaction Surveys.

Participates in facility activities directed to implementation of safety management program, security plan, utility plan, emergency preparedness plan, etc.

Is responsible for confidentiality issues. Ensure HIPAA guidelines and procedures are maintained.

Understands the nature and type of the patient/client population serviced,

The Office clerk will be aware of the responsibilities of all organizations and individuals involved in patient's/client's care/service including the coverage For the services rendered.

The Office clerk will participate in education conferences, meetings, in-services and training for policy and procedures modifications, emergency response and preparedness plan, organization planning, quality assurance and company activities improvement, etc.

The Office clerk gives accurate information to clients, clients' families, and other professionals involved in patient's care/service,

Complies with all applicable Policies and Procedures, Federal and State rules, regulations, and laws in effect.

Participates in personal growth and development.

Documents all communications in the Communication Notes from the patient's charts.

Employee

Date

Employee:

STAFF CODE OF CONDUCT/ETHIC

To outline a standard of conduct for all employees, contractors and members of the Board of Directors. To establish and retain the highest possible level of public confidence.

CODE OF ETHICS:

- The Code of Ethics contains standards of ethical behavior and practices that impact all dealings with colleagues, patients, the community and society as a whole.
- The Code of Ethics also incorporates standards governing personal behavior particularly when that conduct directly relates to the role and identity of the organization.
- The Code of Ethics outlines principles focused on maintaining and enhancing excellence within OUR AGENCY
- The Code of Ethics serves as notice to government officials that OUR AGENCY expects its personnel to abide by all applicable laws and regulations.
- OUR AGENCY has an ethical responsibility to the patients and the community it serves, and fulfills this responsibility through ethical care, treatment, services and business practices.
- Whenever possible, patients/families/legal guardians are included in decisions about the patients' care, treatment and services, including ethical issues.
- Should the patient require or request care, treatment or services not available or inconsistent with the organization's mission, an offer to refer/transfer the patient to an organization that can fulfill this need will be made and if in agreement, the patient will be referred/transferred appropriately.
- The patient/family will be notified of any financial benefit, if any, to OUR AGENCY as a result of the referral/transfer process.
- Contracted providers/staff of healthcare services must meet and adhere to the quality and ethical standards of this organization.
- Billing practices of OUR AGENCY shall adhere to and be compliant with usual and acceptable standard ethical and legal business billing practices.
- The effectiveness and safety of care, treatment and services provided by OUR AGENCY is consistent for all patients and is not dependent on the patient's ability to pay.

STAFF MEMBERS' AND BOARD OF DIRECTORS' RESPONSIBILITY TO THE ORGANIZATION:

- Uphold the values, ethics and mission of the organization.
- Conduct all personal and professional activities with honesty, integrity, respect, fairness and good faith in a manner that will reflect positively upon the organization and in the best interest of the patient population and community served.
- Comply with all applicable local, state and federal laws and regulations in the conduct of organizational or personal activities.
- Respect confidences including confidential business information.
- Assure that no conflict of interest exists in any dealings involving the organization.
- Provide healthcare services consistent with available resources and assure the existence of a resource allocation process that considers ethical ramifications.
- Respect of the customs and practices of those served, consistent with the organization's philosophy.
- Be truthful in all forms of communication, including receivables and avoid information that would create unreasonable expectations.
- Assure the existence of a process to evaluate the quality of care or services rendered.
- Avoid practicing or facilitating discrimination and institute safeguards to prevent discriminatory organizational practices.
- Advise patient of rights, responsibilities and risks regarding care and services provided.

VIOLATIONS: Employees, Administrators and volunteers who violate this code shall be subject to disciplinary action, up to and including termination of employment.

Employee/Contractor Signature: _____

Date: _____

Employee:

STAFF CONFLICT OF INTEREST

PURPOSE:

To ensure employees avoid any personal interest that may conflict with the interests of the agency.

POLICY:

The Agency expects all of its employees to understand and be aware of potential situations where their personal interests may conflict with the business interests of the Agency.

PROCEDURE:

1. All employees will report to their immediate supervisor any interests in or employment with an entity that interacts with the Agency including, but not limited to:
 - A. employee participation in any business transactions where there might appear to be a conflict between the employee's personal interest and that of the Agency.
 - B. employee participation in any entity which buys services from or provides services/products to the Agency.
 - C. outside employment that interferes with satisfactory performance of an employees duties and responsibilities for the Agency.
 - D. any outside relationship, financial interest, or participation in a business transaction which might appear to influence the performance of an employee's duties and responsibilities for the Agency.
 - E. acceptance/giving of gifts, including cash payments, fees, services, discounts, valuables, privileges or other favors which would or might appear to improperly influence an employee in the performance of the employee's duties and responsibilities for the Agency.
2. If a conflict of interest is discovered or suspected the supervisor/manager and employee will discuss its impact with the Administrator.
3. After the above discussion, a recommendation may be made for the employee to end his/her association with the entity or the Agency within a specified period of time.
4. The failure of an employee to cease activity that management determines to be a conflict interest will subject the employee to disciplinary action up to and including termination.
5. Upon hire, agency staff will sign a Conflict of Interest Statement.

Staff Signature

Date

**Form 1-9, Employment
Eligibility Verification**

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification (To be completed and signed by employee at the time employment begins.)

| | | | |
|----------------------------------|-------|----------------|--------------------------------|
| Print Name: Last | First | Middle Initial | Maiden Name |
| Address (Street Name and Number) | | Apt. # | Date of Birth (month/day/year) |
| City | State | Zip Code | Social Security # |

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):

- A citizen of the United States
- A noncitizen national of the United States (see instructions)
- A lawful permanent resident (Alien #) _____
- An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - month/day/year)

| | |
|----------------------|-----------------------|
| Employee's Signature | Date (month/day/year) |
|----------------------|-----------------------|

Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

| | |
|---|------------|
| Preparer's/Translator's Signature | Print Name |
| Address (Street Name and Number, City, State, Zip Code) | |
| Date (month/day/year) | |

Section 2. Employer Review and Verification (To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)

| | List A | OR | List B | AND | List C |
|---------------------------|--------|----|--------|-----|--------|
| Document title: | _____ | | _____ | | _____ |
| Issuing authority: | _____ | | _____ | | _____ |
| Document #- | _____ | | _____ | | _____ |
| Expiration Date (if any): | _____ | | _____ | | _____ |
| Document # | _____ | | _____ | | _____ |
| Expiration Date (if any): | _____ | | _____ | | _____ |

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

| | | |
|---|------------|-----------------------|
| Signature of Employer or Authorized Representative | Print Name | Title |
| Business or Organization Name and Address (Street Name and Number, City, State, Zip Code) | | Date (month/day/year) |

Section 3. Updating and Reverification (To be completed and signed by employer.)

| | | |
|--|--|---------------------------------|
| A. New Name (if applicable) | B. Date of Rehire (month/day/year) (if applicable) | |
| C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization. | | |
| Document Title: _____ | Document # _____ | Expiration Date (if any): _____ |

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 | Date (month/day/year) |
|--|-----------------------|

MarcialEd Healthcare, Corp.

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A

**Documents that Establish Both
Identity and Employment
Authorization**

LIST B

**Documents that Establish
Identity**

LIST C

**Documents that Establish
Employment Authorization**

OR

AND

| | | |
|--|---|---|
| 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. Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States |
| 2. Permanent Resident Card or Alien Registration Receipt Card (Form 1-551) | | 2. Certification of Birth Abroad issued by the Department of State (Form FS-545) |
| 3. Foreign passport that contains a temporary 1-551 stamp or temporary 1-551 printed notation on a machine-readable immigrant visa | 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 | 3. Certification of Report of Birth issued by the Department of State (Form DS-1350) |
| 4. Employment Authorization Document that contains a photograph (Form 1-766) | 3. School ID card with a photograph | 4. 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. Voter's registration card | |
| 5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form 1-94 or Form 1-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with an restrictions or limitations identified on the form | 5. U.S. Military card or draft record | 5. Native American tribal document |
| | 6. Military dependent's ID card | |
| | 7. U.S. Coast Guard Merchant Mariner Card | 6. U.S. Citizen ID Card (Form 1-197) |
| | 8. Native American tribal document | |
| | 9. Driver's license issued by a Canadian government authority | |
| 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form 1-94 or Form 1-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI | For persons under age 18 who are unable to present a document listed above: | 7. Identification Card for Use of Resident Citizen in the United States (Form I-179) |
| | 10. School record or report card | 8. Employment authorization document issued by the Department of Homeland Security |
| | 11. Clinic, doctor, or hospital record | |
| | 12. Day-care or nursery school record | |

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

(XIV) This contract is subject to automatic annual renewal, if not canceled for any party.

(XV) Our Agency has full responsibility over all contracted services.

(XVI) Our Agency has full responsibility to retain and maintain all clinical records of patients served by this Contract.

(XVII) The second party must submit evidence of liability and insurance, evidence of current licensure, education or certification, if applicable.

PROFESSIONAL RESPONSIBILITY

Nothing in this Agreement shall construed to interfere with or otherwise affect the rendering of services by the Employee/Contractor in accordance with his independent and professional judgment. This Agreement shall be subject to our Policies and Procedures, the rules and regulations of any and all professional organizations or associations to which Employee/Contractor may from time to time belong and the laws and regulations governing said practice in this State.

Our Agency has full responsibility to retain and maintain all clinical records of patients served by this Contract.

Both parties agree that the Employee/Contractor shall submit clinical notes and progress reports to the Director of Nursing once every one week or more often if requested, and shall conform with prescribed scheduling of visits and, periodic patient evaluation. Both parties agree that this Agency shall coordinate all job-related activities of the Employee/Contractor, and control all job-related activities of the Employee/Contractor.

Both parties agree that the Employee/Contractor participate in our Performance Improvement Program, by suggest according they daily practices, ways to improve our services, treatment, relationship with patients/family/physicians, report needs and expectations of patients and families.

Both parties agree that patients are accepted for care, the service will be controlled, coordinated, and evaluated, only by our Agency, the Employee/Contractor must comply with all scheduling of visits according Physician order and initial admission assessment, and report any need of schedule change to the Agency immediately identified the need. Participate in periodic patient evaluation to improve our services and the goals of the Patient Plan of Care compliance, including but no limited to Participate in Case Conference, create progress/deterioration reports, periodic communication with the Agency's Supervisor and Care Managers. Participate in the Developing of the Plan of Care, suggest any change needed to achieve the treatment goals, make suggestion for improving services and patient care and safety.

SIGNATURES

Our Agency. (Employer):
Administrator or Director of Nursing

Employee/Contractor: _____
Title: _____

Date: _____

Date: _____

Form W-4 (2011)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2011 expires February 16, 2012. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using

Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

| | | | |
|----------|--|----------|---------------|
| A | Enter "1" for yourself if no one else can claim you as a dependent | A | <u> </u> |
| B | Enter "1" if: { <ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. } | B | <u> </u> |
| C | Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) | C | <u> </u> |
| D | Enter number of dependents (other than your spouse or yourself) you will claim on your tax return | D | <u> </u> |
| E | Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) | E | <u> </u> |
| F | Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.) | F | <u> </u> |
| G | Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children | G | <u> </u> |
| H | Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶ | H | <u> </u> |
| | For accuracy, complete all worksheets that apply. { <ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. } | | |

----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

| | | |
|--|---|---|
| Form W-4 Department of the Treasury Internal Revenue Service | <h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p> | OMB No. 1545-0074 2011 |
| 1 Type or print your first name and middle initial. | Last name | 2 Your social security number |
| Home address (number and street or rural route) | | 3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. |
| City or town, state, and ZIP code | | 4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/> |
| 5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) | 5 <u> </u> | |
| 6 Additional amount, if any, you want withheld from each paycheck | 6 \$ <u> </u> | |
| 7 I claim exemption from withholding for 2011, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶ | | 7 <u> </u> |
| Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete. | | |
| Employee's signature (This form is not valid unless you sign it.) ▶ | | Date ▶ |
| 8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) | 9 Office code (optional) | 10 Employer identification number (EIN) |

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

| | | | |
|-----------|--|-----------|----------|
| 1 | Enter an estimate of your 2011 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions | 1 | \$ _____ |
| 2 | Enter: $\left\{ \begin{array}{l} \$11,600 \text{ if married filing jointly or qualifying widow(er)} \\ \$8,500 \text{ if head of household} \\ \$5,800 \text{ if single or married filing separately} \end{array} \right\}$ | 2 | \$ _____ |
| 3 | Subtract line 2 from line 1. If zero or less, enter “-0-” | 3 | \$ _____ |
| 4 | Enter an estimate of your 2011 adjustments to income and any additional standard deduction (see Pub. 919) | 4 | \$ _____ |
| 5 | Add lines 3 and 4 and enter the total. (Include any amount for credits from the <i>Converting Credits to Withholding Allowances for 2011 Form W-4 Worksheet</i> in Pub. 919.) | 5 | \$ _____ |
| 6 | Enter an estimate of your 2011 nonwage income (such as dividends or interest) | 6 | \$ _____ |
| 7 | Subtract line 6 from line 5. If zero or less, enter “-0-” | 7 | \$ _____ |
| 8 | Divide the amount on line 7 by \$3,700 and enter the result here. Drop any fraction | 8 | _____ |
| 9 | Enter the number from the Personal Allowances Worksheet , line H, page 1 | 9 | _____ |
| 10 | Add lines 8 and 9 and enter the total here. If you plan to use the Two-Earners/Multiple Jobs Worksheet , also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1 | 10 | _____ |

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

| | | | |
|--|---|----------|----------|
| 1 | Enter the number from line H, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet) | 1 | _____ |
| 2 | Find the number in Table 1 below that applies to the LOWEST paying job and enter it here. However , if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than “3” | 2 | _____ |
| 3 | If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter “-0-”) and on Form W-4, line 5, page 1. Do not use the rest of this worksheet | 3 | _____ |
| Note. If line 1 is less than line 2, enter “-0-” on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill. | | | |
| 4 | Enter the number from line 2 of this worksheet | 4 | _____ |
| 5 | Enter the number from line 1 of this worksheet | 5 | _____ |
| 6 | Subtract line 5 from line 4 | 6 | _____ |
| 7 | Find the amount in Table 2 below that applies to the HIGHEST paying job and enter it here | 7 | \$ _____ |
| 8 | Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed | 8 | \$ _____ |
| 9 | Divide line 8 by the number of pay periods remaining in 2011. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2010. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck | 9 | \$ _____ |

Table 1

Table 2

| Married Filing Jointly | | All Others | | Married Filing Jointly | | All Others | |
|---|-----------------------|---|-----------------------|--|-----------------------|--|-----------------------|
| If wages from LOWEST paying job are— | Enter on line 2 above | If wages from LOWEST paying job are— | Enter on line 2 above | If wages from HIGHEST paying job are— | Enter on line 7 above | If wages from HIGHEST paying job are— | Enter on line 7 above |
| \$0 - \$5,000 - | 0 | \$0 - \$8,000 - | 0 | \$0 - \$65,000 | \$560 | \$0 - \$35,000 | \$560 |
| 5,001 - 12,000 - | 1 | 8,001 - 15,000 - | 1 | 65,001 - 125,000 | 930 | 35,001 - 90,000 | 930 |
| 12,001 - 22,000 - | 2 | 15,001 - 25,000 - | 2 | 125,001 - 185,000 | 1,040 | 90,001 - 165,000 | 1,040 |
| 22,001 - 25,000 - | 3 | 25,001 - 30,000 - | 3 | 185,001 - 335,000 | 1,220 | 165,001 - 370,000 | 1,220 |
| 25,001 - 30,000 - | 4 | 30,001 - 40,000 - | 4 | 335,001 and over | 1,300 | 370,001 and over | 1,300 |
| 30,001 - 40,000 - | 5 | 40,001 - 50,000 - | 5 | | | | |
| 40,001 - 48,000 - | 6 | 50,001 - 65,000 - | 6 | | | | |
| 48,001 - 55,000 - | 7 | 65,001 - 80,000 - | 7 | | | | |
| 55,001 - 65,000 - | 8 | 80,001 - 95,000 - | 8 | | | | |
| 65,001 - 72,000 - | 9 | 95,001 -120,000 - | 9 | | | | |
| 72,001 - 85,000 - | 10 | 120,001 and over | 10 | | | | |
| 85,001 - 97,000 - | 11 | | | | | | |
| 97,001 -110,000 - | 12 | | | | | | |
| 110,001 -120,000 - | 13 | | | | | | |
| 120,001 -135,000 - | 14 | | | | | | |
| 135,001 and over | 15 | | | | | | |

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

MarcialEd Healthcare, Corp.