JMAKE HEALTHCARE SERVICES LLC.

JMAKE HEALTHCARE SERVICES LLC. APPLICATION CHECKLIST

TO: ALL HHA's, CNA's, LPN's, RN's

THE FOLLOWING DOCUMENTS ARE REQUIRED TO REGISTER WITH OUR COMPANY AND MUST BE CURRENT AND UP TO DATE:

/___/ RESUME

/___/ FLORIDA DRIVER'S LICENSE OR FLORIDA IDENTIFICATION CARD – **EXPIRATION DATE** _____

/___/ SOCIAL SECURITY CARD

/___/ EMPLOYMENT AUTHORIZATION (IF APPLICABLE)

/___/ PROFESSIONAL LICENSES (RN, LPN, CNA/HHA)

/___/ CPR CARD (RED CROSS, AMERICAN HEART ASSOCIATION, OTHERS) – **EXPIRATION DATE** _____

/___/ AUTO INSURANCE CARD/PROOF – **EXPIRATION DATE** _____

/___/ LIABILITY INSURANCE (CAN BE APPLIED DATE OF HIRE) – **EXPIRATION DATE** _____

/___/ PHYSICAL – DONE WITHIN THE LAST TWO TO THREE MONTHS (NOT BY A CHIROPRACTOR AND MUST STATE "FREE AND CLEAR FROM ALL COMMUNICABLE DISEASES". MUST BE PROVIDED BY A M.D. OR NURSE PRACTITIONER.

/___/ TB OR CHEST X-RAY – **EXPIRATION DATE** _____

/___/ LEVEL 2 BACKGROUND SCREENING

/___/ CERTIFICATE FROM SCHOOL STATING HOURS (CNA AND HHA ONLY) – **EXPIRATION DATE** _____

CEUS (12 HOURS IN-SERVICE REQUIRED ANNUALLY) – **EXPIRATION DATE** _____

/___/ ORIGINAL 4-HR HIV CERTIFICATE

/___/ ALZHEIMER'S/DEMENTIA

/___/ HIV UPDATE

/___/ OSHA UPDATE

/___/ HIPPA UPDATE

/___/ DOMESTIC VIOLENCE UPDATE

/___/ MEDICAL ERRORS UPDATE (LPN, RN ONLY)

IF NOT ABLE TO PROVIDE EMPLOYMENT FOR THE LAST 3 MONTHS – LEVEL 2 MUST BE REPEATED.

IF YOU ARE REGISTERING WITH OUR REGISTRY, PLEASE BE AWARE THAT WE CALL YOU UP TO THREE TIMES AND IF YOU ARE NOT AVAILABLE WE SHRED YOUR INFORMATION.

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

APPLICATION FOR EMPLOYMENT

Date: _____

SECTION 1: Name/ Address

Last Name:	First Name:		Middle:	
Address:				
City:	State:	Zip:	Telephone:	Cell:
Social Security #:				

SECTION 2: Desired Employment

Position: Hourly [ ] Visits [ ] Live-In [ ] other: Date you can start:
Are you currently employed? Yes [ ] No [ ]
If employed, may we inquire of your current employer? Yes [ ] No [ ]
Have you applied to this registry before? Yes [ ] No [ ]
Salary desired: Years of experience:

SECTION 3: General Information

Do you own a car? Yes [ ] No [ ]	Registration#:	Driver's License:
Car Insurance Company:	Car Model:	Year:
Have you ever been convicted of a crime? Yes [ ] No [ ]		

SECTION 4: Education

High School	Name & Location of School:		
	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:	Degree:

SECTION 5: Employment History

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

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

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

SECTION 6: Personal References

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

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

SECTION 7: Physical Record

Do you have any Physical disabilities that would prevent you from performing the work for which you are applying? Yes [ ] No [ ] If so, please describe:
Have you ever been injured? Yes [ ] No [ ] Provide Details:

SECTION 8: License/ Certification

TYPE	LICENSE/CERT.#	EXPIRATION DATE	STATE ISSUED

SECTION 9: Additional Areas of Expertise

Areas of specialized study, research or additional experience:		
List the foreign languages you speak fluently:	Read:	Write:
U.S. Military Services:	Separation Rank:	
Present Membership in National Guard or Reserve Yes [ ] No [ ]		

I voluntarily give JMAKE HEALTHCARE SERVICES LLC. 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 and for no definite period of time.

Applicant Signature_____ Date _____

REGISTRY AUTHORIZED REPRESENTATIVE INTERVIEWER	
HIRED? YES [ ] NO [ ]	SIGNATURE:

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

REFERENCE CHECK FORM

ATTN: _____ DATE: _____

ORGANIZATION: _____

ADDRESS: _____

PHONE NUMBER: _____ FAX: _____

To whom it may concern,

The applicant listed below is applying for a position as _____and has provided your name as an employment reference. As we place great importance on the thorough screening of our applicants, we would appreciate a prompt and thoughtful response.

Thank you in advance,

Section 1 – To be completed by the applicant

I, _____, owner of the Social Security #_____, hereby authorize JMAKE HEALTHCARE SERVICES LLC. to contact you as my previous employer.

_____
APLICANT'S SIGNATURE

Section 2 – To be completed by the previous employer

1. **Length of employment from _____ to _____.**
2. **Functioned in the capacity of RN_____LVN/LPN_____HHA/CNA_____**
3. **Reason for leaving_____**
4. **Is the applicant eligible for rehire? Yes____ No____**

PLEASE COMMENT ON THE APPLICANT'S ATTTRIBUTES USING THE FOLLOWING SCALE:

POOR FAIR GOOD VERY GOOD EXCELLENT

_____ Ability to follow instructions
_____ Professional dress and grooming
_____ Willingness to assume responsibility
_____ Skills / Proficiency
_____ Overall Job Performance
_____ Reliability and Attendance
_____ Ability to work with others
_____ Quality of work
_____ Job Knowledge

Additional Comments: _____
_____

Name (please print) _____
Signature _____ Position/Title _____
Date: _____

Thank you!

WHEN COMPLETED PLEASE FAX IT BACK TO (954) 284-6508 OR EMAIL TO JMAKEHCS_LLC.COM.COM

JMAKE HEALTHCARE SERVICES LLC.

REFERENCE CHECK FORM

ATTN: _____ DATE: _____

ORGANIZATION: _____

ADDRESS: _____

PHONE NUMBER: _____ FAX: _____

To whom it may concern,

The applicant listed below is applying for a position as _____and has provided your name as an employment reference. As we place great importance on the thorough screening of our applicants, we would appreciate a prompt and thoughtful response.

Thank you in advance,

Section 1 – To be completed by the applicant

I, _____, owner of the Social Security #_____, hereby authorize JMAKE HEALTHCARE SERVICES LLC. to contact you as my previous employer.

_____
APLICANT'S SIGNATURE

Section 2 – To be completed by the previous employer

1. **Length of employment from _____ to _____.**
2. **Functioned in the capacity of RN_____LVN/LPN_____HHA/CNA_____**
3. **Reason for leaving_____**
4. **Is the applicant eligible for rehire? Yes____ No____**

PLEASE COMMENT ON THE APPLICANT'S ATTTRIBUTES USING THE FOLLOWING SCALE:

POOR FAIR GOOD VERY GOOD EXCELLENT

_____ Ability to follow instructions
_____ Professional dress and grooming
_____ Willingness to assume responsibility
_____ Skills / Proficiency
_____ Overall Job Performance
_____ Reliability and Attendance
_____ Ability to work with others
_____ Quality of work
_____ Job Knowledge

Additional Comments: _____
_____

Name (please print) _____
Signature _____ Position/Title _____
Date: _____

Thank you!

WHEN COMPLETED PLEASE FAX IT BACK TO (954) 284-6508) OR EMAIL TO JMAKEHCS_LLC.COM .COM

JMAKE HEALTHCARE SERVICES LLC.

PER DIEM INDEPENDENT CONTRACTOR AGREEMENT

On this _____day of _____, 20___ ("Effective Date"), an agreement is made between JMAKE HEALTHCARE SERVICES LLC. a nurse registry licensed under Florida Statues 400.506 , located at 3800 Inverrary Blvd Suite 400 C Lauderhill FL 33319 hereinafter referred to as "the Registry" and _____, a Registered Nurse, Licensed Practical Nurse, Certified Nurse Assistant, Home Health Aide, Homemaker or Companion (circle one) herein after referred to as "Per Diem Independent Contractor" to engage in health and/ or maintenance services. I hereby state that I am a Per Diem Independent Contractor and meet all qualifications as such contained in the law.

PURPOSE

The purpose of this Agreement is to provide health care services in the home or health care facility where there are ill or disabled person and/or people in need of specialized home health care and/or staff relief for local health institution. Per Diem Independent Contractor acknowledges and represents that he/she is a self-employed care provider.

1. PAYMENT FOR SERVICES

I agree that I only received compensation for the work or services performed on a Per Diem Basis; as a (position) _____ at a defined rate per hour agreed between both parties in the Agreement variable to each Client. This contract does not prohibit the Per Diem independent Contractor from working with other organizations or on his/her own assignments.

I agree that for Clients that elect to pay me through an escrow account ("Escrow Account") that Registry maintains for the convenience of Clients, I hereby authorize that each such Client payment by the Client and/or its third party payer be reduced by the amount of fees I owe the Registry with respect to such payment. Furthermore, I assign to Registry all my right, title and interest to collect and receive for its own account such payment from the respective Client and/or third party payer on my behalf.

I acknowledge that I bear the entire risk of non-payment by any Client, an in the event that Registry were to advance me a Client payment, and the Client and/or its third party payer fail to pay such amount within a reasonable time determines solely by Registry, I will be liable to repay such amount to Registry and such amount may be deducted from any subsequent payment to me through the Escrow account by and Client.

I acknowledge and represent that I retain sole responsibility for all federal, state and local tax obligations that pertain to all compensation I receive from clients referred hereunder, including but not limited to Social Security, Medicare, self-employment and Income tax. I also understand that I will not be eligible for unemployment compensation. Registry will report on a Form 1099 for each year the amount of fees I received from clients referred by Registry.

2. LICENSES

The Per Diem Independent Contractor is responsible for ensuring that his or her own license or certification remains current and valid during the period of contract. Failure to maintain valid license or remains current status will cause suspension of assignments and may be the basis for termination of this agreement with the Registry. Per Diem Independent Contractor understands and acknowledges that he/she is responsible for fulfilling all continuing education requirements and all other requirements to maintain such license or certification.

INITIALS: _____

3. BACKGROUND SCREENING

Per Diem Independent Contractor agrees that as a condition of this Agreement that he/she must clear a Level II Criminal Background screening by the Registry through the Agency for Health Care Administration, as well as a national Sex Offender Registry Screening. Per Diem Independent Contractor agrees to bear the cost associated with any Background Screening.

4. DRUG SCREENING

Per Diem Independent Contractor agrees that his/her acceptance of this agreement is contingent upon the submission of a negative 10 panel drug screen result. Such panel shall be designated by the Registry. Per Diem Independent Contractor further agrees and consents to submit to random drug screening with the results being provided to the Registry. Per Diem Independent Contractor agrees to pay for the expense of such drug screenings. A positive result for illegal use of controlled substances or failure to submit to such drug screening shall be grounds for termination of the Agreement.

5. COMMUNICABLE DISEASE

Per Diem Independent Contractor agrees to provide documentation of a health screening which verifies that he/she is free of communicable disease prior to or upon contract and prior to assignment of direct patient care.

Also, Per Diem Independent Contractor understands and agrees that pursuant to Florida Chapter 59A-18 (Nurse Registries Standards and Licensing) he/she must:

A. Prior to contact with Clients, Per Diem Independent Contractor has to provide a statement from a physician based on an examinations within the last six (6) months stating that he/she is free of communicable diseases and has been tested at his/her own expense and was found to be free of tuberculosis;

B. Obtain and keep active, at own expense, current CPR certificate;

C. Obtain all continuing education under their license;

D. Review and become familiar with the applicable rules and statutes attached hereto.

6. INSURANCE

Per Diem Independent Contractor shall maintain all required insurances including but not limited to:

E. Professional Liability Insurance in an amount specified by the Registry at Per Diem Independent Contractor own expense. Furthermore, hereby indemnifies and hold harmless Registry and any of its officers against any liability that might arise as a result of the failure to maintain Professional Liability Insurance coverage and against any liability arising out of service.

F. Automobile insurance, in the minimum amount required by state law.

G. Workman's Compensation coverage at Per Diem Independent Contractor expense for all injuries sustained while working with Registry Clients, including the related expense and loss of income. Furthermore, hereby indemnifies and hold harmless Registry and any of its officers against any liability that might arise as a result of the failure to maintain Workman's Compensation Coverage.

Per Diem Independent Contractor agrees to provide Registry with copies of all required insurance policies prior to or upon execution of this agreement and annually thereafter or upon renewal or substitution.

7. TRANSPORTATION

Per Diem Independent Contractor agrees to provide and maintain his/her reliable transportation.

INITIALS: _____

8. SELF EMPLOYEMENT

I hereby represent and affirm that I have established myself as a self-employed independent contractor and not an employee of Registry, which I maintain own business and that Registry and I intend to contract with each other's as independent contractors. Neither Registry nor shall I provide the other as any (i) tools, supplies or equipment (ii) reimbursement for any expenses, or (iii) training or instruction of any kind or nature other than as required by law. I always shall; retain the right, at my sole discretion, to accept or decline a client referral offered by Registry.

9. TOOLS AND SUPPLIES

Per Diem Independent Contractor agrees to provide his/her own equipment such as blood pressure cuff, stethoscope, uniforms, gloves etc.

10. CONFIDENTIALITY

Per Diem Independent Contractor shall maintain and preserve the confidentiality of all patient health related information in accordance with all State and Federal privacy laws and Registry Policy. Per Diem Independent Contractor acknowledges that it is within the terms and conditions of his work to respect at all times the privacy of clients and their families, students, volunteers and employees, and the confidential nature of the business of the Registry.

11. PATIENT VISIT NOTES AND WEEKLY INVOICE

Per Diem Independent Contractor shall be responsible for creating, updating, maintaining and submitting to the Registry clinical record and service notes for each patient or client. Per Diem Independent Contractor shall submit clinical records, service notes and weekly invoices for each patient/ client to the office of the Registry by close of business each **Monday** for all care or service provided during the previous week.

12. TERM, RENEWAL AND TERMINATION

A. This Agreement shall begin at the time both parties signatures are affixed on Effective Date

B. Any limitations set forth in this Agreement, including but not limited to the "Non-Compete" portion of the Agreement, shall remain in force and effect until the expiration of that limitation by its term.

C. The initial term of this engagement shall be the 12 month period commencing on the Effective Date hereof. This Agreement shall be automatically extended for successive additional one year terms provided that neither party hereto advises the other in writing at least thirty (30) days prior to the end of the current term of intent not to extent the Agreement. In addition, Registry may terminate this agreement (i) without cause upon thirty (30) days prior written notice or (ii) immediately if provider fails to maintain any required certifications, violates the term and provision of this agreement or (iii) if Registry determines, in its sole discretion, that there is a threat to the well-being of Client.

13. PER DIEM INDEPENDENT CONTRACTOR GUIDELINES

Per Diem Independent Contractor acknowledges receipt of and agrees to abide by all of the terms and conditions as set out in the "Per Diem Independent Contractor Guidelines" document and the "Per Diem Independent Contractor Guidelines" is made a part of the Agreement as if fully set out herein.

INITIALS: _____

14. NON- COMPETE

Except as referred by and through the Registry, Per Diem Independent Contractor agrees to refrain from accepting any employment from or providing any service that the Registry provides to a Registry client, as defined below, or from accepting anything of value in exchange for any service provided, that the Registry provides to a Registry client by the Per Diem Independent Contractor. During the period of time from the date of contract until the expiration of (1) one year after the date that Contractor relationship, whichever is last. Client is defined as an individual that the Registry has provided service or care to or has discussed with the client, caregiver, responsible party or guardian, the possibility of providing care or service through the Registry.

15. FINAL AGREEMENT & NOTICE

The Agreement constitutes the final understanding and Agreement between the parties with respect to the subject matter hereof and supersedes all prior negotiations, understandings and agreements between the parties, whether written or oral. This Agreement may be amended, supplemented or changed only by an agreement, either an agreement, either hereon with both parties' initials, or separately in writing signed by both parties. Any notice given under this Agreement shall be sufficient if it is in writing and if sent by certified or registered mail.

IN WITNESS WHEREOF, the parties hereto have set their hands and seals in execution of this Agreement as of the Effective Date first above written.

Contractor:	**Registry:**
By: _____	By: _____
Print Name: _____	Name & Title: _____
Date: _____	Date: _____

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

EMPLOYMENT HEALTH RELEASE
DENIAL OF T.B. SIGNS AND SYMPTOMS

Name: _____ Date: _____

Have you ever had tuberculosis? Yes [ ] No [ ]
If yes, please explain, including date of positive test, circumstances and treatment involved:
_____
_____
_____

Have you ever had the BCG vaccine? Yes [ ] No [ ] Year received: _____
Have you ever had a positive TB skin test? Yes [ ] No [ ] Date of positive test: _____
Date of last Chest X-ray:_____
If you were treated please include the dates treated and type of treatment:
_____
_____
_____

THE EARLY SIGNS AND SYMPTOMS OF TUBERCULOSIS ARE: Cough, Night Sweats, Fever, Loss of Weight, Loss of Appetite, Coughing Blood.

Do you currently have any of the symptoms mentioned above? If yes which one:
_____
_____

I have read the above information and do not have any of these signs or symptoms at this time. If any of these signs or symptoms develops I will contact my supervisor immediately for follow up.

*Please include any Annual TB Screening Forms.

_____ _____
Applicant Name (Please Print) Title

_____ _____
Applicant Signature Date

_____ _____
Witness Date

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

APPLICANT NOTICE

This is a notice to all potential Per Diem Independent Contractors of **JMAKE HEALTHCARE SERVICES LLC.** that to inform that the Registry does not provide full time employment and cannot guarantee 40 hours of employment per week to any of our Per Diem Independent Contractors. Placement staggers and working hours vary day-to-day and week-to-week

When service begins between a Client and Per Diem Independent Contractor, and the assignment has been accepted, the Registry expects the Per Diem Independent Contractor to show up for the case and complete the accepted hours. If a situation should arise that does not allow the Per Diem Independent Contractor to fulfill the commitment, the Registry expects a prompt notice to the office staff with sufficient time for it to provide a replacement. A no show or failure to notify the office of an absence is a reason for immediate termination.

SAFETY POLICY

It is the policy of **JMAKE HEALTHCARE SERVICES LLC,** to provide a safe and healthful environment for all employees/caregivers/ contractors and visitors who are associated with our company.

Safety and health programs dedicated to the elimination of accidents causes, will be emphasized and sponsored throughout the facility and department work safety rules, the investigation of accidents and the inspection of work procedures and facilities. These on-going programs eliminate unsafe work practices/conditions and to reduce the potential for accidents and personal injury.

The success of our safety and health programs will only be achieved by the active leadership, direct participation, and enthusiastic support from all department heads, and case managers.

Each member of **JMAKE HEALTHCARE SERVICES LLC,** is obligated to observe safe practices and obey all safety rules, this direct personal involvement is the only way we can attain our goal of accident reduction and elimination.

I have read and fully understand and agree to the above statements.

_____ _____

Applicant Signature Interviewer

_____

Date

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

TRANSPORATION RESPONSIBILITY POLICY

It has been explained to me that I am being offered employment with the understanding that I have personal transportation at my disposal to be used for travel to and from patient assignments.

I further understand that I am responsible for maintaining automobile liability to include bodily injury and property damage.

Should I be unable to make patient visits assigned to be because of transportation problems, I will give **JMAKE HEALTHCARE SERVICES LLC**, a minimum of one working day or eight hours' notice.

Failure to comply with the above may result in the immediate termination of my employment contract without further notice.

HOURS OF OPERATIONS POLICY

Office hours are from 9:00 am to 5:00 pm, Monday through Friday. Should an incident occur which requires immediate attention Per Diem Independent Contractor is required to notify the Registry as soon as possible. A 24-hour / 7-days a week answering systems is provided for this purpose.

By signing this agreement you are stating that you understand that any incident involving you or the client must be reported to **JMAKE HEALTHCARE SERVICES LLC.**, immediately.

You also understand that proper documentation must be completed and submitted to the office in a timely manner. Nursing Notes are due Every Thursday.

Any other matter you are wishing to discuss with the Registry personnel, the calls should be placed during office hours.

PATIENT ABANDONMENT POLICY

It is the policy of this Registry that if a caregiver abandons a patient, the Per Diem Independent Contractor/caregiver will be immediately dismissed. The patient will be assigned another caregiver to continue care. The supervisor must contact the case manager to inform of the situation.

Leaving a patient before your shift is completed without the knowledge and approval of **JMAKE HEALTHCARE SERVICES LLC.** is considered patient abandonment. The above mentioned actions will be taken.

_____
Applicant Signature

_____
Date

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

DRESS CODE POLICY

To present a professional health care individual image to the public at large and specifically to our clients and their family members.

PROCEDURE

Dress Code for All Personnel:

1. Good personal hygiene
2. Minimal jewelry – accessories simple and uncluttered
3. Clean, well-groomed fingernails
4. Neat, clean hair – no extreme non-professional styles
5. Appropriate undergarments
6. Hemlines no more than 2 inches above the knee or 2 inches below the knee
7. Make-up natural – no extreme colorings, lashes or sparkles

Dress Code for All Direct Care Personnel:

1. All of the above plus:
2. Clean, wrinkle-free uniforms (may be scrub-type)
3. Clean, closed-toe, flat shoes
4. Clean, short-trimmed and groomed fingernails
5. Avoid heavy perfumes and colognes
6. Office RN's must wear white lab coat if not in uniform and visiting patients, hospital, physician's offices, etc.

Items Not Acceptable (All Staff):

1. Glitter or sequin-covered clothing
2. Jean-type clothing
3. Tight pants or leggings
4. Shorts
5. Beach-type sandals
6. Long, dangling or hoop earrings
8. See-through fabrics
9. Tank tops
10. Open-back tops or plunging necklines
11. No exposed body piercing except ears
12. Long dresses/skirts due to safety hazard

DATE: _____ APPLICANT SIGNATURE: _____

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

CONFIDENTIALITY STATEMENT

I acknowledge that I have read and understood **JMAKE HEALTHCARE SERVICES LLC.**, here in referred to as Registry, Confidentiality Policy, HIPAA regulations and the Privacy Statement. I acknowledge that during my employment/placement/volunteer/project work with Registry I may have access to confidential information.
I acknowledge that it is a term and condition of my work with Registry that I will at all times respect the privacy of clients and their families, students, volunteers and employees, and the confidential nature of the business of Registry. I will closely protect confidential information to prevent it being inappropriately accessed, used or disclosed either directly by me, or by virtue of my password to systems, or by permitting breaches in physical security to occur. If I become aware of any violation of confidentiality, or lose any record containing confidential information or any key or other item that could be used to violate confidentiality, I will notify my supervisor or another responsible Registry supervisor at the first reasonable opportunity. I understand that violations to confidentiality may include, but are not limited to:

- Accessing personal or organizational information that I do not require in order to properly carry out my duties;
- Using or disclosing personal/organizational information (verbally, through the computer system, or in hard copy) without proper authorization;
- Inappropriately sharing passwords, keys, codes or other identification devices without proper authorization.

I will only access, use, transfer or disclose private and confidential information as required by the duties of my position. I agree to cooperate with Registry in any audit or investigation relating to confidential information and to provide any records requested in connection with such audits or investigations. I understand and agree to abide by the conditions outlined in this agreement both during and after my employment or association with Registry. I understand that a violation of this agreement may result in disciplinary action that may include termination/dismissal from employment or association with Registry, or that I may be subject to civil or criminal liability.

I understand that no information is to be released without the written “Release of Information” consent signed by the patient or patient’s legal representative.

It is understood that breaks in the policies and procedures of Registry concerning confidentiality may result in immediate terminate without put further notice.

_____
Name

_____
Applicant Signature

_____
Date

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

BACKGROUND CHECK AUTHORIZATION

I voluntarily consent to and authorize **JMAKE HEALTHCARE SERVICES LLC.**, here in referred to as Registry, and or their assigned agents, associates, or consumer reporting agencies to request and receive any criminal background reports, consumer reports, investigative consumer reports containing information as to my character, general reputation, personal characteristics and mode of living, or information concerning me as part of the pre-employment background review process. Reports requested may include any of the following: Law Enforcement Records, Criminal Records, Civil Records, Motor Vehicle/ Driving Records, Credential Verification, Employment Verifications, Past Employment Verifications, Education Verifications, Reference Checks, Military Service Verifications, and Consumer Credit Reports in accordance with the provisions of the Fair Credit Reporting Act and similar State laws.

I authorize any persons, organizations, companies, corporations, consumer reporting agencies, courts of law, licensing agencies, schools, and any current or past employer to furnish Registry and or their assigned agents, associates or consumer reporting agencies with any and all information concerning me. I further agree to release Registry and or their assigned agents, associates, or consumer reporting agencies and all persons and organizations providing information from any and all claims, liability and responsibility arising out of the release of such information in connection with this research.

This authorization shall remain on file and shall serve as an ongoing authorization for Registry to procure criminal records, consumer reports, including investigative consumer reports, at any time during the contracting period. By signing below, I hereby release Registry, its employees, agents, and all persons, agencies and entities providing information or reports about me from any and all liability arising out of the release of any such information or reports.

I understand that if an adverse decision on my application for employment is made, based in whole or in part on information contained in any consumer report, I will be so informed. I will also be provided an opportunity to obtain a copy of that consumer report and to dispute any inaccurate or incomplete information.

I agree that a photocopy, facsimile, or other electronic forms of this information can be furnished to Registry, and that it will have the same authority and authenticity as the original. I also understand that any misrepresentation, falsification or omission of facts herein may be considered cause for rescinding and offer of employment, termination of employment, or denial of consideration for future employment.

_____ _____ _____

Printed Name SSN DOB

_____ _____

Applicant Signature Date

_____

Other names under which previously employed (Print Name)

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

COMPANY DISCIPLINARY ACTION FOR A POSITIVE CONFIRMED DRUG AND / ALCOHOL SCREEN

This company hereby states its policy relating to those individuals who test positive on a drug and/or alcohol screen to be as followed;

Any Per Diem Independent Contractor/Employee who tests positive on a Drug and/or Alcohol screening will be terminated from their contract. If he/she is able to successfully obtain substance abuse treatment, at their own expense, and their contract is still available, he/she will be given one (1) chance to be retired, upon a negative return-to-work Drug and/or Alcohol screen he/she will then undergo random Drug and/or Alcohol screens for a period of (2) years as follow-up treatment. If he/she tests positive on any of their follow-up Drug and/or Alcohol screens, he/she will be terminated from their employment.

If a Per Diem Independent Contractor/Employee refuses to take a periodic, random, post-accident, routine fitness for duty or reasonable suspicion Drug and/or Alcohol screen, he/she will be terminated from employment.

Any Per Diem Independent Contractor/Employee using, selling, purchasing, possessing, soliciting or distributing drugs and/or alcohol on duty or at company's property, it will be terminated from the contract.

_____
Applicant Signature

_____
Date

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

INFECTION CONTROL
UNIVERSAL ISOLATION

POLICY: The procedures of "University Isolation" as recommended by the Center for Disease Control will be carried out.

"UNIVERSAL ISOLATION" precautions means that blood and body fluids precautions should be consistently used for all patients.

PROCEDURE:

1) Gloves should be worn for touching blood and body fluids, mucous membranes, or non-intact skin for all patients, for handling items or surfaces soiled with blood or body fluids, and for performing venipuncture and other vascular access procedure.

2) Masks and protective eyewear or face shields should be worn during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure of mucous membranes of the mouth, nose, and eyes.

3) Gowns or aprons should be worn during procedures that are likely to generate splashes of blood or other body fluids.

4) Hands and other skin surfaces should be washed immediately and thoroughly if contaminated. Hands should be washed immediately after removing gloves.

5) Needles should not be recapped, bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand.

6) Mouthpieces, resuscitation bags, or other ventilation devices should be available for use in areas in which the need for resuscitation is Predictable

7) Health-care workers who have exudative lesion or weeping dermatitis should refrain from direct patient care and from handling patient-care equipment until the condition is resolved.

DATE_____ APPLICANT SIGNATURE _____

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

EMERGENCY CONTACTS

EMPLOYEE/CONTRACTOR

NAME: _____

ADDRESS: _____

PHONE: _____

EMERGENCY CONTACT #1

NAME: _____

ADDRESS: _____

RELATIONSHIP TO YOU: _____

TELPHONE NUMBER AT HOME: _____

WORK: _____

EMERGENCY CONTACT #2

NAME: _____

ADDRESS: _____

RELATIONSHIP TO YOU: _____

TELPHONE NUMBER AT HOME: _____

WORK: _____

EMERGENCY CONTACT #3

NAME: _____

ADDRESS: _____

RELATIONSHIP TO YOU: _____

TELPHONE NUMBER AT HOME: _____

WORK: _____

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

MEDICAL QUESTIONNAIRE

State of Purpose:

The purpose of this questionnaire is to provide JMAKE HEALTHCARE SERVICES LLC. with information regarding preexisting conditions or disabilities that the employee/contractor might suffer.
The intent if this questionnaire is not to discriminate against any qualified individual in regards to the procedure of this job application

Name of Employer: **JMAKE HEALTHCARE SERVICES LLC.**

Name of Contractor: _____

Contractor SSN Number: _____-____-_____ Height_____ Weight_____

1. Do you have any of the following	YES	NO
Epilepsy (convulsions, seizures)	_____	_____
Diabetes (Medication?) Yes__ No___	_____	_____
Marie-Strum Pell disease (inflammation of vertebrae)	_____	_____
Amputation of foot, leg, arm, or hand.		
Total loss of sight of one or both eyes, or partial loss		
Corrected vision of more than 75% bilaterally	_____	_____
Polio (poliomyelitis)	_____	_____
Cerebral palsy	_____	_____
Multiple Sclerosis	_____	_____
Parkinson's disease	_____	_____
Vascular (blood vessel) disorder	_____	_____
Psychoneurotic disability (emotional or nervous disability)	_____	_____
Hemophilia	_____	_____
Chronic osteomyelitis (infection in bone)	_____	_____
Ankylosis of major weight-bearing joint (frozen joint)	_____	_____
Hyperinsulinism	_____	_____
Muscular dystrophy	_____	_____
Thrombophlebitis	_____	_____
Herniated disk	_____	_____
Surgical removal of disk	_____	_____
Total deafness	_____	_____

Other_____
_____

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

HEPATITIS B VACCINATION INFORMED CONSENT

I understand that due to my risk of occupational exposure to blood or other potential infectious material, I may be at risk of acquiring Hepatitis B virus (HBV) infections. I have read the information concerning the Hepatitis B vaccine and I am aware of the availability and benefit that such vaccination provides in the preventions of infection with Hepatitis B virus.

I understand the benefits and risks of Hepatitis B vaccination and have had the opportunity to ask questions. I understand that:

1. The vaccination will be administered in a series of three (3) doses; the initial one, the second one a month later, and the third dose six (6) months after the first dose. I understand I must complete the series for full immunization at my own expense.
2. If I receive the vaccine, I have 90-95% chance of developing antibodies to the Hepatitis B surface antigen and therefore immunity to the infection of the Hepatitis B virus.
3. The vaccine may not be effective, if I am already incubating the Hepatitis B Virus.
4. The duration of the immunity is unknown at this time and I may require a booster in five (5) years.
5. The vaccine only protects against Hepatitis B virus and does not confer immunity against the Hepatitis A, Hepatitis C, or non-A/non-B agents.
6. After receiving the vaccine minor side effects, such as infections site soreness and redness, Low-grade fever, malaise and nausea have been reported.

I, _____, request vaccination with Hepatitis B vaccine.

Pregnant:	YES_____ NO _____	Date vaccinated	Lot No.
Allergies	YES_____NO_____	1._____	_____
		2._____	_____
		3._____	_____

_____ _____
Signature of person receiving vaccine Date

_____ _____
Signature of registry witness Date

HEPATITIS B VACCINE DECLINATION

I, _____, decline vaccination with the Hepatitis B vaccine. I have read the above information and realize that I am potentially at increased risk of exposure or Development of the Hepatitis B infection. I choose not receive the Hepatitis B vaccine at this time.

_____ _____
Signature of person receiving vaccine Date

_____ _____
Signature of registry witness Date

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

CONDITIONS OF EMPLOYMENT

APPLICATION:
Upon receipt of your references, your application and exam will be reviewed by our staff and your license will be verified by the State Board of Nursing. You will be notified approximately one week after your interview until your appreciation has been approved.

PROBATION: When references have cleared and you have been offered your first assignment, you are considered a probationary caregiver.

Probationary status is in effect for 90 days from the date of your first assignment. One or more incidents could cause us to discontinue offering you assignment, and will result in your termination.

Some examples are:

a. Infractions of the "Nurse Practice Act".

b. Reports from facilities of clients that your work is not accepted.

c. Not showing up for an assignment that you have accepted.

d. Too many sick or emergency cancellations.

e. Any serious misconduct while on or off duty that may reflect on Royal Home Health Care Inc.

f. Infractions of policies or procedure of facilities.

g. Violation of "Conditions of Employment".

REQUIREMENTS: When you work for JMAKE HEALTHCARE SERVICES LLC., it is you're responsibility to call in your availability to our office on a weekly basis. If you fail to do so your file will be placed inactive and you will be considered resigned. If you change your telephone number, or it becomes disconnected, it is your responsibility to provide our office with an alternative phone number until this requirement is met. If our office cannot reach you due to the reason above, your file will be place inactive and you will be considered resigned. All employees/caregivers/contractors must comply with AHCA requirements within 30 days from the date of your first assignment. Any violation of AHCA requirements, either by not complying when hired or at renewal times, are grounds for termination

Applicant Signature: _____ Date: _____

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

POLICY STATEMENT

Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975.

JMAKE HEALTHCARE SERVICES LLC agrees to comply with provisions of title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975, and all requirements imposed pursuant thereto, to the end that no person shall on the grounds of race, color, national origin, handicap or age, be excluded from participation in, be denied benefits of, or otherwise be subjected to discrimination in the provisions of any care of services.

Specifically, the above includes (but is not limited to) the following characteristics:

1. Care will be provided in a manner that is not discriminated against person on the basis of race, color, national origin, handicap, or age.

2. Employees will be assigned to clients services without regard to the race, color, national origin, handicap, or age of either the client or employee.

3. Staff privileges will not be denied professionally qualified personnel on the basis of race, color, national origin, handicap or age.

4. All facilities of the Registry will be utilized without regard to race, color, national origin, handicap or age.

The non-discriminatory policy of this Registry applies to clients, physicians, independent contractors and all responsible employees.

Name of Nurse Registry: _____

Applicant Signature: _____

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

PAYCHECK POLICY

Disbursement of Funds and Pay Check Policy

JMAKE HEALTHCARE SERVICES LLC will issue paychecks every other Friday after 2:00 pm. Once a check is mailed, it is your responsibility. If a check needs to be re-issued, you will be required to pay the **$50.00** bank fee, which will be deducted from your re-issued check.

Would you prefer?

(a) Pick you check up in the office_____
(b) Have your check mailed to you_____

If would like your check mailed, please confirm the address:

Name: _____

Address: _____

City: _____

I, _____have read and fully understand the above policy set forth by JMAKE HEALTHCARE SERVICES LLC.

Applicant Signature Date

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

BIOHARZADOUS WASTE MANAGEMENT AKNOWLEDGEMENT

APPLICANT ACKNOWLEDGEMENT OF RECEIPT ON:
RECOMMENDED METHOD OF HANDLING BIOMEDICAL WASTE

Applicant Name: _____

Date: _____

Please check all that are true:

____ I have been verbally informed of the recommended method of handling biomedical Waste generated in the home care setting.

____ I have been given written material on “Safe Sharps Disposal at Home”

____ I have been given written material on “Cleaning up after Injury or Accident in Your Home”

____ JMAKE HEALTHCARE SERVICES LLC has given me the chance to discuss my concern regarding biomedical waste management in my home.

_____ _____
Applicant Signature Date

_____ _____
Witness Signature Date

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

NON-DISCRIMINATION POLICY

In accordance with Title VI of the Civil Rights Act of 1964 and its implementing regulation, **JMAKE HEALTHCARE SERVICES LLC** is an EQUAL OPPORTUNITY EMPLOYER and WILL NOT DISCRIMINATE AGAINST RACE, COLOR, CREED, RELIGION, SEX, AGE, GENDER PREFERENCE, NATIONAL ORIGIN HANDICAP (MENTALOR PHYSICAL), ETHICAL/POLITICAL BELIEFS, DECISION REGARDING ADVANCE DIRECTIVES OR COMMUNICABLE DISEASE AS DEFINED IN SECTION 504 OF TITLE VI.

In accordance with Section 504 of Rehabilitation Act of 1973 and it's implementing regulation, **JMAKE HEALTHCARE SERVICES LLC** WILL NOT, DIRECTLY OR THROUGH CONTRACTUAL OR OTHER ARRANGEMENTS, DISCRIMINATE ON THE BASIS OF HANDICAP.

In accordance with the Age Discrimination Act of 1975 and it's implementing regulation, **JMAKE HEALTHCARE SERVICES LLC** WILL NOT, DIRECTLY OR THROUGH CONTRACTUAL OR OTHER ARRANGEMENTS, DISCRIMINATE ON THE BASIS OF AGE in the provision of services, unless age is a factor necessary to normal operation or the achievement of any statutory objective.

In accordance with the Americans with Disabilities Act of 1992 (42 USC & 12101) and it's implementing regulations, (private employers with more than 25 Registry personnel), **JMAKE HEALTHCARE SERVICES LLC** WILL NOT, DIRECTLY OR THROUGHT CONTRACTUAL OR OTHER ARRANGEMENTS DISCRIMINATE ON THE BASIS OF DISABILITY. A disability is a physical or mental impairment that substantially limits a major life activity, or for which there is a record if impairment or which causes the individual to be regarded as impaired.

I hereby verify that have had all my questions answered by my satisfaction and that I understand all of the material covered.

NAME: _____

DATE_____ APPLICANT SIGNATURE: _____

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

ORIENTATION

APPLICANT: _____ TITLE: _____

Date Completed Orientation: _____

1. GENERAL ORIENTATION

____ Facility Mission/Goals/Objective/Philosophy/Organizational Structure.
____ Tour of Registry
A) Location of administrative offices
B) Location of fire extinguishers
C) Location of Emergency lights/exits
D) Location of first aid box
E) Emergency evacuation routes
____ Standards of Ethical Conducts
____ Scope of Services
____ Employment Policies/Job Descriptions/Competency
____ Complaint Policy/Grievance Form
____ Nondiscrimination
____ Payroll
____ Cultural Diversity and Sensitivity
____ Professional Liability Insurance (Minimum coverage $500,000)

2. CLINICAL ORIENTATION

____ Client Rights and Responsibilities/Advance directives
____ Assignments/Cancellations Policy
____ Assessments/documentation
____ Medical Emergencies
____ Chart audits
____ On-Call Policy
____ Documentation Requirements/Time frames
____ Client Referrals to Other Registry
____ Clinical Records
____ Abuse Reporting

3. CONFIDENTIALITY

____ Client/Family/Significant Other
____ Staff Information
____ HIPPA Privacy Rule/Notice of Privacy Practices
____ Nurse Registry Business Information

_____ _____
Applicant Signature Date

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

PHYSICIAN'S STATEMENT OF SATISFACTORY HEALTH

Date: _____

Applicant Name: _____ Job Title: _____

Physician Name: _____
Phone: _____
Address: _____
City State Zip

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

Additional Remarks: (BP, Hernia, Etc.)

DATE OFCHEST X-RAY_____
CHEST X RAY RESULTS _____

PPD INTERMEDIATE SKIN TEST_____DATE GIVEN_____

DATE READ_____ RESULTS _____READ BY_____

HEPATITIS B VACCINE: DATE GIVEN_____

Additional Comments:
_____
_____

Physical Examination Date Physician Signature

PLEASE FAX IT BACK TO (954) 284-6508 OR EMAIL TO JMAKEHCS_LLC.COM

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

RECEIPT FOR ALZHEIMER'S INFORMATION

I, _____, A NEWLY DIRECT CARE STAFF WITH _____ DO ACKNOWLEDGE THAT UPON DATE OF HIRE, _____ REGISTRY PROVIDED ME WITH AN INFORMATION SHEET REGARDING ALZHEIMER PATIENT AND HOME CARE.

I HAVE READ THIS INFORMATION AND UNDERSTAND ITS CONTENTS.

I HAVE HAD THE OPPORTUNITY TO HAVE ALL OF MY QUESTIONS/CONCERNS IN THIS MATTER ADDRESSED TO MY TOTAL SATISFACTIONS.

_____

APPLICANT SIGNATURE/TITLE/DATE

_____

WITNESS SIGNATURE/TITLE

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

WORK AVAILABILITY FORM

Print Name _____

Address: _____

Phone: _____ Position: _____

Schedule Availability

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

Experience/Skills

[ ] Alzheimer	[ ] Bedbound	[ ] Dementia	[ ] Heart Problems
[ ] Parkinson	[ ] Transfer	[ ] Respiratory	[ ] Asthma
[ ] Catheter	[ ] Walker	[ ] Kosher	[ ] Hoyer Lift
[ ] Diabetic	[ ] Cancer	[ ] Colostomy Bag	[ ] Wheel Chair
[ ] Fractures	[ ] Oxygen	[ ] Blind	[ ] Amputee
[ ] Deaf	[ ] Pets	[ ] Stroke	[ ] Hospice
[ ] Smoking	[ ] Back Rubs	[ ] Body Alignment	[ ] Body Mechanics
[ ] Change Linens	[ ] Feed Patient	[ ] ROM Exercises	[ ] Isolation Techniques
[ ] Oral Hygiene	[ ] Transfer Activities	[ ] Blood Pressure	[ ] Prepare Special Diet
[ ] CPR	[ ] Pulse	[ ] Intake & Output	[ ] Universal Precautions

Additional Skills:

_____

_____

Signature _____ Date _____

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

GUARANTEED COMPATIBILITY - CAREGIVERS

At **JMAKE HEALTHCARE SERVICES LLC.**, we guarantee our clients will be matched with a caregiver that not only precisely follows their unique plan of care, but they are also compatible on a social level so they have the best care experience possible. In addition, we want to provide a great match for our caregivers as well. By knowing your likes and dislikes, we will work to match you with a client where you can be most productive and effective.

Name: _____
Date: _____

	Like	Neutral	Dislike
Watching TV / Movies			
Cleaning			
Interacting with pets			
Playing card games			
Playing board games			
Cooking			
Baking			
Doing crafts			
Light outdoor activities (bird watching, sitting outside)			
Moderate outdoor activities (gardening, going for a walk)			
Reading			
Listening to music			
Watching or talking about sports			
Singing			
Smoking or being in a smoking environment			

JMAKE HEALTHCARE SERVICES LLC will make every attempt to place caregivers on assignments that minimize their "dislikes". However, based on the client's needs and plan of care, certain activities may be required. If there is a compelling reason why you are not able to perform them, please contact the Branch Manager to discuss.

Signature _____ Date _____

INITIALS: _____

JMAKE HEALTHCARE SERVICES LLC.

VOLUNTARY SELF-IDENTIFICATION

JMAKE HEALTHCARE SERVICES LLC is committed to equal employment opportunity for all employees. As a federal contractor, the Registry is required to take affirmative action to employ and advance in employment women and minorities, disabled individuals, disabled veterans and veterans of the Vietnam Era. To assist the Registry in properly identifying its employees and applicants, we request that you complete the following information. Completion of this form is strictly voluntary.

Please identify yourself as one of the following:

SEX

/___/ Male
/___/ Female

RACE

/___/ African American
/___/ Asian / Pacific Islander
/___/ Hispanic
/___/ White – Non Hispanic
/___/ Two or more races
/___/ Other: _____

RELIGION

/___/ Christian
/___/ Jewish
/___/ Muslim
/___/ Other: _____

DISABLED OR VETERAN STATUS

/___/ I am a Disabled Individual
/___/ I am a Disabled Veteran
/___/ I am a Vietnam Era Veteran
/___/ I am Other Eligible Veteran
/___/ None of the above

Name: _____ Date: _____

INITIALS: _____