



The Medical Staffing Source

5830 Coral Ridge Drive, Suite 120
Coral Springs, FL 33076
Phone 866.425.5768/Fax 888.308.1147

TAX HOME QUESTIONNAIRE

Candidate Name:

What is the address of your primary (permanent) residence?

Address: _____ Apt _____

City: _____ State: _____ Zip _____

On this current assignment, Start Date: _____ End Date: _____ with Ardor Health do you work in the vicinity of your primary residence and live in that residence while on this assignment?

Yes No

If you are working away from your primary residence on this current assignment, do you pay for expenses to support your primary residence (for example: rent, mortgage, utilities, etc.)?

Yes No

After completion of this assignment with Ardor Health will you return to your primary residence?

Yes No

Signature _____ **Date** _____

PERSONAL INFORMATION

Name of Emergency Contact:

_____ Phone: _____

Relationship: _____



November 1, 2010

Dear Employee,

One of the benefits offered by Ardor Health Solutions is access to a great 401k plan. All new hires are eligible for the plan after 90 days of employment.

As an employee you have the option to join the plan, but it is not mandatory. Should you choose to enroll, just follow the steps below:

- Complete 90 days of fulltime employment
- Complete the 401k application online at www.mykplan.com or call 1-800-695-7526 and an ADP representative will enroll you.
- After enrolling, call us so we may activate your account for payroll deductions: Our 401k internal administrator is Greg Brusey at 866-425-5768 x 301.
- For investment advice only, you may call our Smith Barney Advisor, Mario Ponczek. He can be reached at 800-624-0263 or by email: mario.ponczek@mssb.com. Prior to calling him, please have the following information with you: birth date, planned year of retirement, most recent investment statements, current paycheck information, etc.

We would like to welcome you to Ardor Health Solutions and look forward to assisting you.

Sincerely,

Greg Brusey
401k Administrator
Ardor Health Solutions

Ardor Health

SOLUTIONS©

The Medical Staffing Source.

Travel Confirmation Form

I _____ hereby confirm the mileage from my current location (start point) in the city of _____, state of _____ to my appointed place of employment (end point) located in the city of _____, state of _____.

One way mileage is: _____. Approximate date of arrival: _____

Signed: _____

Date: _____

Please refer to your contract for specifics on Maximum allowances and other requirements.



AUTHORIZATION FOR RELEASE OF INFORMATION FORM

ARDOR HEALTH SOLUTIONS

Please Print in Black Ink or Type:

Social Security #:																				
Date of Birth:																				

I do not have a SSN.

First Name (No Nicknames)	Middle Initial
Last Name	Title
Maiden or Other Names Formerly Used	
Date Last Used (Month/Year)	
Maiden or Other Names Formerly Used	
Date Last Used (Month/Year)	

Gender: Male Female Choose not to disclose.

APPLICANT'S EMAIL ADDRESS

ADDRESS - CURRENT

Street:																				
City:											State:									
Country:																				
Zip Code:																				
Dates Lived in Residence	FROM:																			
	TO:																			

ADDRESS - PERMANENT (enter if different than current address):

Street:																				
City:											State:									
Country:																				
Zip Code:																				
Dates Lived in Residence	FROM:																			
	TO:																			

ADDRESS - PREVIOUS (List all other cities/counties where you have lived in the last 7 years starting with the most recent):

Street:																				
City:											State:									
Country:																				
Zip Code:																				
Dates Lived in Residence	FROM:																			
	TO:																			

ADDRESS - PREVIOUS (List all other cities/counties where you have lived in the last 7 years starting with the most recent):

Street:																
City:											State:					
Country:																
Zip Code:																
Dates Lived in Residence	FROM:									TO:						

DRIVER'S LICENSE INFORMATION - CURRENT

For Valid OR Non-Valid Driver's License Complete the Following:

Name as Appeared on License:																	
Issuing County:															Issuing State:		
License Number:																	

DRIVER'S LICENSE INFORMATION - PREVIOUS

For Valid OR Non-Valid Driver's License Complete the Following:

Name as Appeared on License:																	
Issuing County:															Issuing State:		
License Number:																	

EDUCATION INFORMATION (High School / Secondary Information)

School Name:																	
Street:																	
City:											State:						
Country:											GPA:				Level:		
Diploma Earned:	YES				NO					GED Earned:	YES				NO		
Dates Attended:	FROM:									TO:							

EDUCATION INFORMATION (University / Post Secondary Information)

School Name:																	
College Name:																	
Street:																	
City:											State:						
Country:											GPA:				Level:		
Degree Earned:	YES				NO					Field of Study:							
Dates Attended:	FROM:									TO:							

EDUCATION INFORMATION (University / Post Secondary Information)

School Name:																	
College Name:																	
Street:																	
City:											State:						
Country:											GPA:				Level:		
Degree Earned:	YES				NO					Field of Study:							
Dates Attended:	FROM:									TO:							

PLEASE CHECK THE APPROPRIATE RESPONSE TO THE FOLLOWING QUESTIONS:

1. Within the last seven (7) years have you been convicted of, plead guilty to, or plead “no contest” to a crime that has not been expunged from your record? (crime means felonies and misdemeanors, including vehicular misdemeanors and felonies) or been released from prison? (Examples of vehicular misdemeanors and felonies include reckless driving, driving while license has been suspended, driving without insurance, DUI’s involuntary manslaughter, damage to property, etc. Prison includes time spent in city and county jails as well as local, state, and federal prisons.) Applicants for employment in Hawaii should not answer this question at this time. Applicants in California should not answer this question as it relates to marijuana-related convictions more than 2 years old under California Health and Safety Code Sections 11357 (b) and (c), 11360 (c) 11364, 11365 or 11550 YES* NO *If yes fill in below:

Date:		City:		State:	
Details:					

2. Are you currently on probation or parole for a criminal offense or have you received an alternative disposition sentence for a criminal act? YES NO

Date:		City:		State:	
Details:					

3. Name the specific court that adjudicated the admitted hit:

Court Name:					
Date:		State:			

NOTE: A conviction does not automatically mean you cannot be employed. Factors such as your age at the time of conviction, how long ago it occurred, the reason for the conviction and the rehabilitation you received will all be considered.

AUTHORIZATION FOR RELEASE

I certify that the information contained herein is true and understand that any falsification will result in the rejection of my application or termination of my employment. I also understand that the requested information is for the sole purpose of conducting a background investigation which may include a check of my identity, work history, education history, credit history, driving records, any criminal history which may be in the files of any federal, state or local criminal agency, and a post offer search of workers' compensation claim history. Information regarding age, sex, or race will not be used as part of any employment decision. A telephone facsimile of this authorization shall be valid as the original.

I hereby authorize this company, its corporate affiliates, its employees, its authorized agents, and representatives (including **American Background**) to verify all information contained in this form or in my application and to inquire into my character, general reputation, personal characteristics, and mode of living. I hereby release this company, its corporate affiliates, its employees, its authorized agents and representatives and all others involved in this background investigation from any liability in connection with any information they give or gather and any decisions made concerning my employment based on such information. I understand that any offer of employment I may receive is contingent upon the successful completion of the background investigation. I further understand that I have a right, under Section 606(b) of the Fair Credit Reporting Act, to make a written request to this company within a reasonable period of time for a complete and accurate disclosure of the nature and scope of the investigation requested, and for a written summary of rights pursuant to section 609(c) of the FCRA.

I further agree that should I accept an offer of employment, the company may need to update this information or conduct subsequent investigations from time to time during my employment and I expressly authorize such acts. (Not Applicable for CA Residents)

By signing this background authorization form and pursuant to section 1786.16 of California Civil Code, you are hereby notified that we have ordered an investigative consumer report for employment purposes. This Investigative Consumer Report is being prepared by American Background Information Services, Inc., 629 Cedar Creek Grade, Suite C; Winchester, VA 22601, (800) 669-2247. (CA Residents only – You may contact American Background to review your file and receive all applicable disclosures pursuant to section 1786.10 of the California Civil Code.)

Please Check here to receive a copy of the Background Report (CA, OK, and MN Residents only)

Please sign and date:	
Applicant Signature:	
Print Name:	
Date:	

Authorization for Direct Deposit

This authorizes All Source Recruiting, dba ARDOR HEALTH SOLUTIONS to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my account indicated below ("Account"). This authorizes the financial institution holding the Account to post all such entries.

Please **ATTACH a voided check(s)** to ensure accurate reading of your routing and account numbers. Do NOT attach deposit slips—these may not indicate correct routing numbers

Employee Name _____

Account #1

Type: Checking Savings

Amount: Entire Check or \$ _____

EMPLOYEE BANK NAME

BRANCH

CITY

STATE

BANK ROUTING # (ABA#)

ACCOUNT #

Account #2

Type Checking Savings

REMAINDER of funds will be deposited into this account

EMPLOYEE BANK NAME

BRANCH

CITY

STATE

BANK ROUTING # (ABA#)

ACCOUNT #

This authorization will be in effect until the Company receives written termination notice from me and has a reasonable opportunity to act on it, or upon termination of my employment.

SIGNATURE

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.

February 8, 2010

Dear Associate:

We are pleased to announce **portal.adp.com**, a new benefit for all associates. Through ADP, our payroll provider, we are able to offer you access to your earnings statements and W2 forms 24, hours per day, 7 days a week.

Upon registration you may elect to have an automatic email notification sent to you when your current earnings statement is available. Included in the email is a direct link to the **portal.adp.com** site.

How to Access portal.adp.com

1. Go to <http://portal.adp.com>
2. Click on "First Time Users Register Here".
3. Click Register now.
4. Enter your Self Service Registration Pass Code which is MEDSOURCE-MedsourceGrp click NEXT.
5. Enclosed you will find printed screen shots of the steps required to complete your registration

We hope you will enjoy this new feature. We appreciate the opportunity to provide you with this exciting new way of viewing your pay information.

Sincerely yours,

Payroll/Human Resources Department

Instructions**Please read all instructions carefully before completing this form.**

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination.

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and non-citizen) hired after November 6, 1986 is authorized to work in the United States.

When Should the Form I-9 Be Used?

All employees, citizens and noncitizens, hired after November 6, 1986 and working in the United States must complete a Form I-9.

Filling Out the Form I-9

Section 1, Employee: This part of the form must be completed at the time of hire, which is the actual beginning of employment. Providing the Social Security number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Preparer/Translator Certification. The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his/her own. However, the employee must still sign **Section 1** personally.

Section 2, Employer: For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors. Employers must complete **Section 2** by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required

document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, **Section 2** must be completed at the time employment begins. **Employers must record:**

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the Form I-9. **However, employers are still responsible for completing and retaining the Form I-9.**

Section 3, Updating and Reverification: Employers must complete **Section 3** when updating and/or reverifying the Form I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in **Section 1**. Employers **CANNOT** specify which document(s) they will accept from an employee.

- A. If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- B. If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- C. If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B and:
 1. Examine any document that reflects that the employee is authorized to work in the U.S. (see List A **or** C);
 2. Record the document title, document number and expiration date (if any) in Block C, and
 3. Complete the signature block.

What Is the Filing Fee?

There is no associated filing fee for completing the Form I-9. This form is not filed with USCIS or any government agency. The Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

USCIS Forms and Information

To order USCIS forms, call our toll-free number at **1-800-870-3676**. Individuals can also get USCIS forms and information on immigration laws, regulations and procedures by telephoning our National Customer Service Center at **1-800-375-5283** or visiting our internet website at **www.uscis.gov**.

Photocopying and Retaining the Form I-9

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Forms I-9 for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

The Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR § 274a.2.

Privacy Act Notice

The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of U.S. Immigration and Customs Enforcement, Department of Labor and Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Paperwork Reduction Act

We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: **1)** learning about this form, and completing the form, 9 minutes; **2)** assembling and filing (recordkeeping) the form, 3 minutes, for an average of 12 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529. OMB No. 1615-0047.

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

Form I-9, Employment Eligibility Verification

Please 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 eligible 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 or national of the United States
- A lawful permanent resident (Alien #) A _____
- An alien authorized to work until _____
(Alien # or Admission #) _____

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 eligible 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 eligibility.

Document Title: _____ Document #: _____ Expiration Date (if any): _____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible 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)
--	-----------------------

LISTS OF ACCEPTABLE DOCUMENTS

LIST A Documents that Establish Both Identity and Employment Eligibility	LIST B Documents that Establish Identity	LIST C Documents that Establish Employment Eligibility
OR		AND
1. U.S. Passport (unexpired or expired)	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. U.S. Social Security card issued by the Social Security Administration <i>(other than a card stating it is not valid for employment)</i>
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)	2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address	2. Certification of Birth Abroad issued by the Department of State <i>(Form FS-545 or Form DS-1350)</i>
3. An unexpired foreign passport with a temporary I-551 stamp	3. School ID card with a photograph	3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal
4. An unexpired Employment Authorization Document that contains a photograph (Form I-766, I-688, I-688A, I-688B)	4. Voter's registration card	4. Native American tribal document
5. An unexpired foreign passport with an unexpired Arrival-Departure Record, Form I-94, bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, if that status authorizes the alien to work for the employer	5. U.S. Military card or draft record	5. U.S. Citizen ID Card <i>(Form I-197)</i>
5. An unexpired foreign passport with an unexpired Arrival-Departure Record, Form I-94, bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, if that status authorizes the alien to work for the employer	6. Military dependent's ID card	6. ID Card for use of Resident Citizen in the United States <i>(Form I-179)</i>
	7. U.S. Coast Guard Merchant Mariner Card	7. Unexpired employment authorization document issued by DHS <i>(other than those listed under List A)</i>
	8. Native American tribal document	
	9. Driver's license issued by a Canadian government authority	
	For persons under age 18 who are unable to present a document listed above:	
	10. School record or report card	
	11. Clinic, doctor or hospital record	
	12. Day-care or nursery school record	

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

Employee Emergency Information

Date last updated:

Personal Information	
Employee ID	
First name	
Middle name	
Last name	
Nickname	
Gender	
Citizenship	
Place of birth (country/region)	
Home address	
District/County	
Home phone	
Cellular phone	
Home fax	
Home e-mail address	
Birthday (MM/DD/YYYY)	
Government ID or SSN	
Passport number	
Driver's license/state ID number	
Medical Information	
Doctor's name	
Address	
Phone number	
Blood type	
Medical conditions	
Allergies	
Current medications	
Emergency Information	
Emergency contact's name	
Relationship	
Address	
Phone number(s)	



The Medical Staffing Source.

OT/COTA Skills Checklist

Page 1 of 2

Name: _____ Date: _____
Last First Middle Initial

Profession: OT COTA NBCOT ID #: _____ Exam Date: _____

Please Mark Your Level of Experience

1 - No Experience

2 - Limited Experience (Assistance Needed)

3 - Some Experience (Needs Resource for Backup)

4 - Very Experienced (Requires No Supervision)

Work Settings

- | | ① | ② | ③ | ④ |
|--------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| General Acute Care | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Home Health | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Outpatient Clinic | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Pediatric Rehab | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Psychiatric Hospital | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Acute Rehab Hospital | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Rehab Unit in Hospital | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| School System | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Skilled Nursing Facility | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Industrial Medicine | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Orthopedics

- | | ① | ② | ③ | ④ |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| Arthritis Program | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| General Ortho (Knee, Shoulder, Ankle) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Hand Injury | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Hip Fractures | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Mobilization Techniques | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Total Hip / Total Knee | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Total Joint Replacement (Upper Extremities) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Neuro

- | | ① | ② | ③ | ④ |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| Cerebral Vascular Accident (CVA) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Cognitive Retraining | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Head Trauma | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Spinal Cord Injury | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Parkinson's Disease | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Traumatic Brain Injury | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Pediatrics

- | | ① | ② | ③ | ④ |
|-----------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Cerebral Palsy | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Developmental Screening | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Early Intervention | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Learning Disabilities | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Neurodevelopment Testing | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Sensory Integrative Testing | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Spina Bifida | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Visual Perception Testing | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Autism | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Down's Syndrome | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Mental Retardation | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Modalities

- | | ① | ② | ③ | ④ |
|-------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Biofeedback | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Edema Massage | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Feeding Techniques | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Fluidotherapy | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Oral Motor Facilitation | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Muscle Stimulation | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Paraffin Bath | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| TENS | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Therapeutic Massage | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Therapeutic Pool | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Prosthetics/Orthotics

- | | ① | ② | ③ | ④ |
|-----------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Prosthetics/Orthotics | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Dynamic Splints | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Functional Splinting | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Orthotics | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| LE Prosthetics | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Serial / Inhibitory Casting | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Static Splints | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| UE Prosthetics | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |



The Medical Staffing Source.

OT/COTA Skills Checklist

Page 2 of 2

Name: _____ Date: _____
Last First Middle Initial

Profession: OT COTA NBCOT ID #: _____ Exam Date: _____

Please Mark Your Level of Experience

- 1 - No Experience
- 2 - Limited Experience (Assistance Needed)
- 3 - Some Experience (Needs Resource for Backup)
- 4 - Very Experienced (Requires No Supervision)

Other

	①	②	③	④
Activities of Daily Living (ADL)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Adaptive Equipment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Amputees	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Burn Management	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving Evaluation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dysphagia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Energy Conservation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Family Education	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gait Analysis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Geriatrics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Group Dynamics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Home Accessibility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Job Task Analysis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Oncology	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain Management	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Perceptual Motor Testing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pulmonary Rehab	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Range of Motion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sensation Testing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wheelchair Evaluation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wheelchair Ordering	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wheelchair Position Testing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Work Capacity Evaluation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Work Hardening (BTB)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Work Hardening (Valpar)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other Skills/Credentials

Please list any additional experience or skills that have not been included above:

Signature

Date



Age Specific Practice Criteria

Please print clearly in black ink

Please check the boxes for each age group for which you have expertise in providing age-appropriate.

- | | |
|---------------------|------------------|
| 1. Birth - 30 Days | 5. 12 - 18 Years |
| 2. 30 Days - 1 Year | 6. 18 - 39 Years |
| 3. 3 - 5 Years | 7. 39 - 64 Years |
| 4. 5 - 12 Years | 8. 64 + Years |

Experience with Age Groups

	1	2	3	4	5	6	7	8
Evaluate for age-appropriate behavior motor skills and physiological norms.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Able to communicate and instruct patients according to their age maturity and comprehension level.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Able to assure a safe environment for the specific needs of various age groups	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Which Medication Administration Systems are you familiar with? _____

Which Computerized Charting Systems are you familiar with? _____

Print Name: _____ Date _____

Signature _____



Patient Bill of Rights

Please print clearly in black ink

Patient Bill of Rights

1. The patient has the right to considerate and respectful care.
2. The patient has the right to know the names and roles of people treating them.
3. The patient has the right to be well informed about their illness, treatment and possible outcomes.
4. The patient has the right to consent to, or refuse, a treatment.
5. The patient has the right to have an advance directive, such as a living will.
6. The patient has the right to privacy.
7. The patient has the right to expect confidentiality.
8. The patient has the right to review their medical records.
9. The patient has the right to expect that the hospital will give them necessary health services to the best of its ability.
10. The patient has the right to know if this hospital has relationships with outside parties that may influence their treatment and care. These relationships may be with educational institutions, or other healthcare providers, or insurers.
11. The patient has the right to consent to, or decline, to take part in research affecting their care.
12. The patient has the right to be told of realistic care alternatives when hospital care is no longer appropriate.
13. The patient has the right to know about hospital rules that affect them and their treatment and about charges and payment methods. The patient has the right to know about hospital resources, such as patient representatives or ethics committees, that can help them resolve a problems and questions about their hospital stay and care.

I have read and understand the Patient Bill of Rights above.

Applicant's Signature

Date



The Medical Staffing Source.

Authorization Release

Please print clearly in black ink

This form should be completed by the applicant.

I, _____ authorize my employers, school, law enforcement agencies and/or persons who may aide Ardor Health Solutions in determining my suitability for employment, to provide reference information to Ardor Health Solutions. I hereby release all such employees, individuals and/or organizations contacted from all liabilities for issuing this information to Ardor Health Solutions. I also authorize Ardor Health Solutions to disclose this information to a client facility ONLY after receiving my consent on each job opportunity.

Applicant's Signature

Social Security Number

Ardor Health Solutions Representative



The Medical Staffing Source.

Physician's Statement

Please print clearly in black ink

This Physician's Statement must be completed before you can begin an assignment. If this cannot be completed immediately, this statement may be sent at a later date, but must be sent prior to the start of your employment.

Personal Data

Patient Name _____ Today's Date _____
 Address _____
 City _____ State / Province _____ Zip _____
 Social Security Number _____

Physician's Statement*

The above patient has been examined by me and found to be in good physical and mental health, free from communicable diseases, and able to function at full capacity.

Date of Exam _____

Tests Performed	Results Positive	Negative	MM	Date Performed
TB Skin Test **	_____	_____	_____	_____
Step 1	_____	_____	_____	_____
Step 2	_____	_____	_____	_____
Chest X-Ray (only if pos. ppd)	_____	_____	_____	_____

Immunization Records***	Date Performed	Immune Status	Non-Immune Status
Hepatitis Titer	_____	<input type="radio"/>	<input type="radio"/>
Hepatitis Vaccine 1	_____		
Hepatitis Vaccine 2	_____		
Hepatitis Vaccine 3	_____		
Rubella Titer/or Vaccine	_____	<input type="radio"/>	<input type="radio"/>
Rubeola Titer/or Vaccine	_____	<input type="radio"/>	<input type="radio"/>
Mumps Titer	_____	<input type="radio"/>	<input type="radio"/>
Varicella Titer	_____	<input type="radio"/>	<input type="radio"/>
MMR Vaccine	_____		
Tetanus/Diphtheria Vaccine	_____		
Polio Vaccine	_____		

* Please Note: Some hospitals require complete physical with full system review. Your recruiter will advise you if this is necessary.

** May be required more often. Your recruiter will advise you if this is necessary.

*** Documentation of vaccination is requested. Also please note that the hospital may require a titer to be drawn despite vaccination to ensure immunity status.

Additional Comments _____

Name of Physician _____

Physician Address _____

City _____ State / Province _____ Zip _____

Physician Signature _____ Date _____ Licence Number _____



The Medical Staffing Source.

Hepatitis B Vaccination Waiver Form

Please print clearly in black ink

Hepatitis B Declination Form

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease.

Signature _____ Date _____

Note: The statement of declination of Hepatitis B vaccinations is not intended to supersede or in any way affect any workmen's compensation law, common law, statutory rights, or duties or liabilities of employers and employees arising out of or in the course of employment.

Proof of Hepatitis B Series

I have received the vaccination series and/or have proof of immunity to Hepatitis B, please see my attached documentation.

Signature _____ Date _____



HIPAA Acknowledgement

Confidentiality of Patient Health Care Information

Print

Name: _____

I, _____, an employee of **Ardor Health Solutions**, acknowledge the confidentiality of patient health care information (“Confidential Patient Information”) that I may receive or have access to in the course of providing patient care services at any and all medical facilities to which I am assigned through **Ardor Health Solutions**.

I shall maintain the confidentiality of Confidential Patient Information and, in doing so, shall comply with all applicable state and federal laws and regulations, including without limitation the privacy provisions under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), and the policies and procedures of each participating medical facility where I am assigned.

My agreement to maintain the confidentiality of Confidential Patient Information shall survive the termination of my employment with **Ardor Health Solutions** and the conclusion of any assignment at any medical facility.

Signature

Profession

Date



The Medical Staffing Source.

In accordance with the OSHA Bloodborne Pathogens Standard, 29 CFR 1910.1030. Please sign below that you have received a copy of Ardor Health Solutions OSHA Bloodborne Pathogen exposure control plan. This will be part of your personnel file.

NAME: _____

SIGNATURE: _____

Please complete the below in its entirety (if applicable)

I certify that:

_____ I have previously received OSHA Bloodborne Pathogen
(Check here if true)

Training:

Date of Training ____/____/____

Location _____

Instructor _____

Name: _____

Signature

Date ____/____/____

Social Security #



The Medical Staffing Source.

EXPOSURE CONTROL PLAN: Bloodborne Pathogens means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, Hepatitis B virus (HBV) and human immunodeficiency virus (HIV).

1. The purpose of this exposure control plan is to eliminate or minimize employee occupational exposure to blood or certain other body fluids and comply with the OSHA Bloodborne Pathogens Standard, 29 CFR1910.1030.
2. Exposure Determination – In accordance with OSHA – Employers must perform an exposure determination for employees with occupational exposure to blood or other possible infectious materials. This exposure determination shall be made without regard to the use of personal protective equipment. This exposure determination shall contain the following, list of job classifications in which all employees in these job classifications have occupational exposure. Occupational Exposure means reasonably anticipated skin, eye, mucous membrane, or potential contact with blood or other potentially infectious materials that may result from the performance of an employee's duties. At Ardor Health Solutions the following job classifications are in these categories:

REGISTERED NURSES

REGISTERED RESPIRATORY THERAPISTS

CERTIFIED RESPIRATORY THERAPIST TECHNICIANS

POLYSONOGRAPHER

SURGICAL TECHNICIANS

CERTIFIED SURGICAL TECHNICIANS

NUCLEAR MEDICINE TECHNOLOGISTS

ULTRASOUND SONOGRAPHERS

VASCULAR TECHNOLOGISTS

RADIOLOGIC TECHNOLOGISTS

COMPUTERIZED TOMOGRAPHERS

MAGNETIC RESONANCE IMAGING TECHNOLOGISTS

RADIATION THERAPISTS

MAMMOGRAPHERS

MEDICAL DOSIMETRIST

ECHOCARDIOGRAPHER

CARDIAC CATH/SPECIALS TECHNOLOGISTS

SPEECH LANGUAGE PATHOLOGISTS

PHYSICAL THERAPISTS

PHYSICAL THERAPY ASSISTANTS

**OCCUPATIONAL THERAPISTS
CERTIFIED OCCUPATIONAL THERAPIST ASSISTANTS
NURSE PRACTITIONER**

- 3. Methods of Compliance – Universal precautions should be executed at the facility to which the employee is working and to be observed to prevent contact with blood or other potentially infectious materials. Differentiation between body fluid types is difficult or impossible; all body fluids shall be considered potentially infectious materials, regardless of the perceived status of the source individual.**

Engineering and work practice controls shall be utilized to eliminate or minimize employee exposure. Should occupational exposure remain after implementation of these controls, personal protective equipment shall also be put to use.

Engineering controls should be examined and monitored or replaced on a regular schedule per the facility of which the employee is working.

Employees who are exposed to blood or other potentially infectious materials hand-washing facilities should be made available. OSHA requires if hand-washing facilities are not feasible, it is the facilities responsibility to provide appropriate antiseptic hand cleanser in conjunction with clean cloth/paper towels or antiseptic towelettes. The facility shall ensure that the employee wash their hands and any other skin with soap and water after removal of gloves or other personal protective equipment as soon as possible. It is the on site supervisor of the employee's responsibility to ensure that if the employee involves exposure to their skin or mucous membranes then those areas shall be washed or flushed with water immediately or as soon as feasible.

NEEDLES - Shearing or breaking of contaminated needles is prohibited. Contaminated needles and other contaminated sharps shall not be bent, recapped or removed unless the employer can demonstrate that no alternative is feasible or that such action is required by a specific medical procedure. Recapping or needle removal must be accomplished through the use of a mechanical device or a one-handed technique. After use, contaminated reusable sharps shall be placed in appropriate containers that are puncture resistant, labeled and leakproof.

RESTRICTIONS – Work areas that are at risk of occupational exposure to blood or other potentially infectious materials; employees are not to eat, drink, smoke, apply cosmetics or lip balm. Handling contact lenses is also prohibited.

Mouth/Pipetting/suctioning of blood or other possible infectious materials is also prohibited. Procedures must be done in a manner that is to minimize splashing, spraying, spattering, and generation of droplets of these substances. Laboratory coats, gowns, smocks, uniforms, or other appropriate protective clothing shall be used in all work areas deemed necessary by facility of which the employee is working.

SPECIMENS – Specimens of blood or other potentially infectious materials shall be placed in a container that prevents leakage during collection, handling, processing, storage, transport, or shipping. The container for storage transport or shipping shall be labeled or color-coded accordance to OSHA standard. The standard provides an exemption for specimens from the labeling/color coding requirement of the standard provided facility must utilize universal precautions while handling all specimens and the containers that are recognized as containing specimens. This exemption applies only while on site at the facility, If the specimen could puncture the primary container, the primary container shall be placed within a second container that prevents leakage during handling, processing, storage, transport, or shipping and is labeled or color-coded according to the OSHA requirements.

PERSONAL PROTECTIVE EQUIPMENT – If employee may incur occupational exposure to blood or other potentially infectious materials the facility shall provide employee at no cost protective equipment for the employee. Equipment is chosen based on the anticipated exposure to blood or other potentially infectious materials. Personal protective equipment is considered appropriate only if it does not permit blood or other potentially infectious materials to pass through to or reach the employees work clothing, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time while the personal protective equipment is used. Protective equipment should be provided directly by facility that the employee is working at, if the facility does not or refuses to provide necessary protective equipment, the employee is to contact Ardor Health Solutions immediately to resolve the situation.

HOUSEKEEPING – The facility that the employee is working at is responsible to ensure cleanliness and decontamination of all areas on a regular basis. Worksite must be maintained in a clean and sanitary condition. The facility shall determine and implement an appropriate written schedule for cleaning and method of decontamination based on the location within the facility. Surfaces, equipment and all working areas must be cleaned. Broken glassware that may be contaminated shall not be picked up directly with hands. It must be cleaned up by mechanical means. Reusable sharps that are contaminated with blood or other potentially infectious materials should not be stored or processed in a manner that requires employees to reach by hand into the containers where these sharps have been placed.

LAUNDRY – Contaminated laundry shall be handled infrequently as possible with a minimum of agitation. Laundry that is potentially contaminated shall be bagged or containerized at the location where it is used and shall not be sorted or rinsed in the location of use. If facility ships contaminated laundry off site to a second facility which does not utilize universal precautions in the handling of all laundry facility generating the contaminated laundry facility must place laundry in containers which are labeled or color-coded in accordance to OSHA regulations. Laundry should be placed and transported in bags or containers labeled or color-coded in

accordance with OSHA regulations. Facility should utilize precautions in handling of all soiled laundry, alternative labeling or color-coding is sufficient if it permits all employees to recognize the containers as requiring compliance with universal precautions. The facility at which the employee is working shall ensure that employees who have contact with contaminated laundry wear protective gloves and other personal protective equipment that deems appropriate. Facility shall use universal precautions while shipping or storing laundry that may have incurred exposure to blood or other potentially infectious materials.

HEPATITIS B VACCINE AND POST - Exposure Evaluation and Follow Up. Ardor Health Solutions shall make available the Hepatitis B vaccine and vaccination series to all employees who have occupational exposure, and shall provide post exposure evaluation and follow-up to employees who have had an exposure incident (in which case should contact Ardor Health Solutions immediately following incident) at no cost.

Hepatitis B Vaccination will be made available within ten (10) working days of first assignment to all employees who have an occupational exposure to blood or other infectious materials, unless the employee in question has had previously received the complete Hepatitis B vaccination series. Unless the employee has engaged in antibody testing and has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons.

The facility shall not make participation in a prescreening program a prerequisite for receiving Hepatitis B Vaccination. The employee has the right to decline the vaccination, but at a later date while still covered under the standard decides to accept the vaccination, the vaccination shall be made available. All employees that decline the vaccination offered shall sign the OSHA required waiver indicating their refusal. Should the U.S. Public Health Service recommend a routine booster dose(s) of Hepatitis B vaccine at future date, such booster doses shall be made available.

POST EXPOSURE EVALUATION AND FOLLOW-UP – Exposure incidents shall be reported, investigated, and documented. Following a report of an exposure incident the facility shall make immediately available to the exposed employee a confidential medical evaluation and follow-up, including at least the following:

1. Documentation of the route(s) of exposure and the situation under which the exposure incident occurred.
2. Identification and documentation of the source individual, unless the facility can establish the identity is infeasible or prohibited by the state or local law.
3. Source individuals blood shall be tested as soon as possible after the consent is obtained in order to determine HBV or HIV infectivity. If consent is not obtained, the facility shall establish that the legally required consent cannot be obtained. If law does not require the source individuals consent, the

source individuals blood, only if available, shall be tested and the results documented.

4. Source individual is already identified to be infected with HBV or HIV, testing for the source individuals known HBV or HIV status need not be repeated.
5. Results of the source individuals testing shall be made available to the exposed employee, and employee shall be informed of applicable laws and regulations concerning the disclosure of the identity and infectious status of the source individual.

Collection and testing of blood by the exposed employee's personal physician for HBV and HIV serological status should comply with the following according to the OSHA regulations:

1. The exposed employee's blood shall be collected as soon as possible and tested after consent is received.
2. If the exposed employee consents to baseline blood collection, but does not give consent at that time for HIV serologic testing, the sample shall be preserved for at least 90 days. If within 90 days of the exposure incident, the employee decides to have the baseline sample tested, such testing shall be done as soon as feasible.

All employees that have incurred an exposure incident will be offered post-exposure evaluation and follow up in accordance with the OSHA regulations. Employee's physician must perform all post exposure follow-ups. Medical record required shall be maintained in accordance with OSHA regulation.

LABELS – The facility that the employee is working at shall follow OSHA regulation for all labels and signs. Biohazard Labels shall be fluorescent orange-red or predominantly so lettering or symbols in a contrasting color. Labels required should be affixed as close as possible to the container by string, wire or adhesive or other method that prevents the loss or unintentional removal. Individual containers of blood or other potentially infectious materials that are placed in a labeled container during storage, transport shipment or disposal are exempted from the labeling requirement. The facility shall use universal precautions for all biohazard materials.

INFORMATION and TRAINING – The facility to which the employee is assigned at the time of initial assignment to tasks where occupational exposure may occur and should be reviewed annually thereafter.

1. A copy of the standard Bloodborne pathogens will be made available to the employee by the facility of which the employee is working. If the facility does not have one available the employee must contact Ardor Health Solutions and a copy will be forwarded immediately.
2. An explanation of epidemiology and symptoms of Bloodborne pathogens.

3. An explanation of the modes of transmission of Bloodborne pathogens.
4. An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials.
5. An explanation of exposure control plan.
6. An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices and personal protective equipment.
7. Information on the types proper use, location, removal handling decontamination and disposal of personal protective equipment.
8. Information on how exposure occurs and Hepatitis B vaccine including information on its efficacy safety method of administration and the benefits of being vaccinated and that the vaccination will be offered free of charge.
9. Information on proper actions to take and person to contact in an emergency involving blood or other potentially infectious materials.
10. An explanation of signs and labels.
11. Facility specific information on the evaluation and follow-up required after an employee exposure incident.
12. An explanation of the procedure to follow if an exposure incident occurs, including the medical report and follow-up.

The person conducting the training shall be knowledgeable in the subject matter covered by the elements contained in the training program as it relates to the workplace that the training will address. In the event the facility of which the employee is working does not or will not offer training in accordance with OSHA Standard 29 CFR 1910.1030; the employee is to contact Ardor Health Solutions .

RECORD KEEPING – In the case of an incident medical recorders shall be established and maintained and for each employee with occupational exposure in accordance with the OSHA Standard 29 CFR 1910.1030. These records will be kept confidential and must be maintained for at least the duration of employment. Records shall include the following:

1. Name and Social Security number of employee
2. A copy of employee's Hepatitis B vaccination status including the dates of all the Hepatitis B vaccination and any medical records relative to the employee's ability to receive vaccination.
3. A copy of all results of examinations, medical testing, and follow-up procedures.
4. A copy of the information provided to the healthcare professional including a description of the employee's duties as they relate to the exposure incident, and documentation of the routes of exposure and circumstances of the exposure.

TRAINING RECORDS – Ardor Health Solutions requires that all employees that are at risk of exposure to blood and other potentially infectious materials receive a copy of

this policy. An acknowledgement of receipt will be kept as a permanent part of the employee's personnel file.

***AVAILABILITY* – All employee's records shall be made available to the Assistant Secretary of Labor for the Occupational Safety and Health Administration and the Director of the National Institute for Occupational Safety and Health upon request in accordance with the OSHA 29 CFR 1910.1030.**