High Quality Care Nursing, Inc.
Bringing Quality Care To You

FOR OFFICE USE ONLY

CNA/MT

217 Main Street
LANHAM, MD 20706

TEL: (301) 577-8742
FAX: (301) 577-8530

HUMAN RESOURCES DEPARTMENT
INDEPENDENT CONTRACTOR FILE CONTENT CHECKLIST

_____ NURSING LICENSE/CERTIFICATE MD/VA/DC **EXP. DATE _____**

_____ CURRENT CPR CARD **EXP. DATE_____**

_____ CURRENT FIRST AID CARD **EXP. DATE _____**

_____ TB SKIN TEST/CHEST X-RAY

_____ HEPATITIS FORM (OPTIONAL)

_____ SOCIAL SECURITY CARD

_____ FORM W-9

_____ DRIVER'S LICENSE/ STATE ID

_____ APPLICATION

_____ PHYSICAL (OPTIONAL)

_____ LIABILITY INSURANCE

_____ FINGER PRINT/BACKGROUND CHECK

_____ INTERVIEWER'S FORM

_____ REFERENCE SHEETS

_____ FILE CONTENT CHECKLIST
PLEASE CHECK "X" FOR MISSING ITEM

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217 Main St. Laurel. Md 20707 Tel: 301-617-9315 Fax: 240-786-5382 Fax: 301-364-9119

EMPLOYMENT APPLICATION

(Please Print)

Full Name _____

Address _____

City: _____ **State :** _____ **Zip code**:_____

Phone _____ **Soc-Sec#** _____-_____-_____

Position Applied for: _____

Are you a citizen of the United States of America? Yes _____ NO _____

If not, do you have a valid work Authorization? Yes _____ NO _____

Are you a Verteran? _____**Yes** _____**NO Branch of Service**_____

Education

High School _____
Did you Graduate? Yes _____ NO _____

Vocation/Trade_____
Did you Graduate? Yes _____ NO _____

College/ University _____
Did you Graduate? Yes _____ NO _____

Graduate School/Post Graduate _____
Did you Graduate? Yes _____ NO _____

PREVIOUS EMPLOYMENT (Begin with most recent position) :

Firm ____

Address ____

Supervisor ____

Nature of Business ____

Dates of Employment *Begin*: __________ *TO* __________ *Ending Wages/ Salary*_______

Position (s) Held: ____

Reason for Leaving: ____

Firm ____

Address ____

Supervisor ____

Nature of Business ____

Dates of Employment *Begin*: __________ *TO* __________ *Ending Wages/ Salary*_______

Position (s) Held: ____

Reason for Leaving: ____

Firm ____

Address ____

Supervisor ____

Nature of Business ____

Dates of Employment *Begin*: __________ *TO* __________ *Ending Wages/ Salary*_______

Position (s) Held: ____

Reason for Leaving: ____

REFERENCES:

Please furnish the names and addresses of two people to whom you are not related and by whom you have not been employed.

Name: _____

Address: _____

Name : _____

Address: _____

Name: _____

Address: _____

Who referred You to us? (Person(s) or Agency) _____

_____

Summarize your special skills or qualifications: _____

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CONSENT TO REQUEST AND AUTHORIZATION TO REVEAL INFORMATION ABOUT EMPLOYMENT HISTORY

As part of my application for contractual employment with High Quality Care Nursing Agency Inc., I consent that High Quality Care Nursing Agency, Inc may request from any of my former employers all information that High Quality Care Nursing Agency, Inc. may need concerning me, my character, my skills, or my work performance. I correspondingly authorize all my former employers to reveal all such information to High Quality Care Nursing Agency, Inc. upon request.

Name: _____ Signature :_____ Date: _____

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AUTHORIZATION FOR RELEASE OF CENTRAL REGISTRY INFORMATION

I understand that the State of Maryland Regulations COMAR 10.22.03.02B (d) (e) and COMAR 01.04.04.07E requires that High Quality Care Nursing Agency, Inc. access the Central Registry of Abuse Reports to obtain any discloseable information concerning me that may be contained therein.

This is my authorization for High Quality Care Nursing Agency, Inc. to seek any discloseable information regarding me from the Central Registry of Child Abuse maintained by the local Department of Social Services.

Name _____ Soc. Sec. # _____

Address _____

Date of Birth _____

Maiden Name_____

Date : _____ Signature : _____

Date : _____ Signature : _____

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CONFIDENTIALITY AGREEMENT

The nature of services provided by High Quality Care Nursing Agency, Inc. requires information to be handled in a private, confidential manner.

Information about our business or our contractual medical personnel or clients will only be released to people or agencies outside High Quality Care Nursing Agency, Inc. with our written consent. Follow legal or regulatory guidelines provide the only exceptions to this policy. All report, memoranda, notes or other documents will remain part of High Quality Care Nursing Agency, Inc. confidential records.

The names, addresses, phone numbers or salaries of our contractual medical personnel will only be released to people authorized by the nature of their duties to receive such information and only with the consent of management or the contractual employee.

The undersigned contractual employee agrees to abide by this confidentiality agreement.

_____
Contractual Employee

_____
Witness

_____
Date

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EMPLOYEE NON-COMPETE AGREEMENT

For good consideration and as an inducement for High Quality Care Nursing Agency, Inc to employ/contract with:

_____
Independent Contractor Name (please print)

The undersigned hereby agrees not to directly or indirectly compete with the business of High Quality Care Nursing Agency, Inc. and its successors and assigns during the period of Contractual medical personnel while in the employment of High Quality Care Nursing Agency, Inc. and its clients and following termination of contractual medical personnel and not withstanding the cause or reason for termination

The term "not compete" as used herein shall mean that the Contractual Medical Personnel shall not own, manage, operate, consult to or be contractual employed in a business substantially similar to our competitive with the present business of High Quality Care Nursing Agency, Inc. or such other business activity in which High Quality Care Nursing Agency, Inc. may substantially engage during the term of contractual employment.

The Contractual Medical Personnel acknowledges that High Quality Care Nursing Agency, Inc. shall or may in reliance of this agreement provide Contractual Medical Personnel access to trade secrets, customers and other confidential data and that the provisions of this agreement are reasonably necessary to protect High Quality Nursing Agency, Inc. and its good will.

Contractual Medical Personnel agrees to retain said information as confidential and not to use said information on his or her own behalf or disclose same to any third party.

This agreement shall be binding upon for the benefit of the parties, their successors, assigns and personal representatives.

Signed this _____ day of _____

_____
High Quality Care Nursing Agency, Inc.

_____
Contractual Medical Personnel

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ACKNOWLEDGEMENT OF INDEPENDENT CONTRACTOR
(CONSULTING SERVICES)

The Undersigned acknowledges attainment by High Quality Care Nursing Agency, Inc. for the purpose of:

Consulting Services

It is further acknowledged that High Quality Care Nursing Agency, Inc

1. The undersigned shall be deemed an Independent Contractor and is not an employee, partner, agent engaged in joint venture with High Quality Care Nursing Agency, Inc.

2. Consistent with the foregoing, High Quality Care Nursing Agency, Inc. Shall not deduct withholding taxes, FICA, or any other taxes required to be deducted by an employer as I acknowledge my responsibility to pay same as an Independent Contractor.

3. I further acknowledge that I shall not be entitled to any fringe benefits, pension retirement, profit sharing, workman's compensation, or any other benefits accruing to employees.

4. Hourly pay rate or annual pay rate @ $ _____

Signed under this (date) _____ Day of (month) _____

Consultant
Signature: _____ Approved By : _____

Print Name :_____ Print Name : _____

Title : _____ Title : _____

WORKERS' COMPENSATION COMMISSION

SOLE PROPRIETOR'S STATUS AS A COVERED EMPLYEE FORM

I hereby represent to the Maryland Workers' Compensation Commission, that I am a sole proprietor doing business in and about the State of Maryland, and the date set forth below my signature, and under the penalty of perjury, the following checked box represents my status as a covered employee.

☐ I have elected to become a covered employed under section 9-227 of the Labor and Employment Article, and have submitted the Requisite Inclusion Form (C15R) with the Workers' Compensation Commission.

☐ I have not elected to become a covered employee under section 9-227 of the Labor and Employee Article.

Name of Sole Proprietor: _____

Address: _____

Social Security Number or FEIN Number :_____

I AFFIRM UNDER THE PENALTY OF PERJURY THAT THE FOREGOING INFORMATION IS TURE TO THE BEST OF MY KNOWLEDGE, INFORMATIN AND BELIEF.

_____ _____

SIGNATURE **DATE**

Note: No Investigation or hearing was conducted by the workers' compensation commission to verify this representation, but as it was made under the penalty of perjusry. It is accepted as being true and correct on the date set forth above. This representation is not binding on the Workers' Compensation Commission under any circumstance.

10 East Baltimore Street* Baltimore, Maryland 21202-1641
410-864-5100 * E-Mail: info@wcc.state.md.us * Web: http:// www.wcc.state.md.us

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INDEPENDENT CONTRACTOR AGREEMENT

This agreement made this _____ day of _____ by and between HIGH QUALITY CARE NURSING AGENCY, INC., hereafter known as HQN and (your name) _____, hereafter known as the Independent Contractor or Vendor.

HQN will place the Independent Contractor as and when needed with a facility / client who is in need of the Independent Contractor's services for a fee to be agreed upon prior to the Independent Contractor's commencement of services. HQN only serves as a **TEMPORARY PLACEMENT AGENCY.**

HQN will pay to the Independent Contractor the sum of _____ per hour (subject to change depending on where you work) for these services. **These payments will be made to the Independent Contractor, if the signed time slip(s) is (are) received by HQN by the end of business day on the Tuesday before payday.** All paychecks will be ready for pick-up every other Friday after 2pm.

The Independent Contractor understands and acknowledges that HQN will not be held responsible for the negligence or intentional wrongs of the Independent Contractor towards the facility / client.

The Independent Contractor is responsible for his or her own Liability Insurance and Worker's Compensation Insurance coverage.

If for any reason the Independent will not be able to carry out the assignment that he or she has already accepted, HQN must be informed 4 hours ahead of time in order for HQN to be able to get a replacement for the assignment; if this is not done, HQN will deduct 4 hrs from the Independent Contractor's pay.

Independent Contractors are not to call another nurse or individual to relieve him or her temporarily or permanently or to take another shift on any nursing case without notifying HQN.

When an Independent Contractor discontinues working on any nursing assignment before the case is ended, he or she must turn the case over to HQN and shall not under any circumstances, turn the case over to another nurse, private individual or agency (private duty cases).

At no time before ninety (90) days after being sent to a facility or case by HQN, can an independent contractor accept a job placement from the facility /patient or another direct competitor. Doing so, will cost the said independent contractor the sum of three thousand dollars ($3000.00), payable directly to HQN for breach of contract.

_____

Signature of Independent Contractor

HQN under this term of agreement does not pay Independent Contractor overtime, holiday or sick pay. HQN does pay A FLAT RATE FOR ALL JOBS PERFORMED BY THE INDEPENDENT CONTRACTOR.

The Independent Contractor is NOT EMPLOYED by HQN and has not authority to bid, negotiate or contract for his Agency.

This agreement will remain in force for one year from the date of signing or until the independent contractor enters into another contract with HQN.

THIS AGENCY IS NOT OBLIGATED TO ISSUE ANY EMPLOYMENT, TERMINATION OR ENDORSEMENT LETTERS OR ANYTHING THAT IS IN ANY WAY RELATED TO SUCH LETTERS. AGAIN THIS IS ONLY A TEMPORARY AGENCY.

_____WITNESS the signatures above on this day, _____ year,_____

_____

INDEPENDENT CONTRACTOR

I HAVE READ AND UNDERSTAND THE ABOVE CONTRACT AND HAVE RECEIVED A COPYU OF THE CONTRACT

THE INDEPENDENT CONTRACTOR ACKNOWLEDGES AND UNDERSTANDS THAT HQN IS A TEMPORARY AGENCY, AND WILL THEREFORE PROVIDE ASSIGNMENT ONLY WHEN AVAILABLE.

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To Whom It May Concern:

It has come to the attention of High Quality Care Nursing, Inc. that the State of Maryland, Department of Health and Mental Hygiene, Mandates that all Nurse's Aides working at an in-home setting must be insured by a professional liability insurance company.

Please find enclosed, a copy of a liability insurance application for nurses/nurses aides. Please fill out accordingly and return to the office immediately. The office will forward the application and payment to the insurance company. The amount of the yearly annual premium, $89.00 (please check the box beside " home health aides"), will then be deducted from your paychecks in two installments of $30.00 and a last one of $29.00.

Your insurance card will be mailed to your address. Please be sure to fill out the form with your correct address and social security number. Please remember that this is mandatory and needs to be completed, and returned to the office immediately.

If for any reason, you cannot comply with this mandate, we will have no other choice but to withdraw you from the case.
Sincerely,

Joy Davis
Vice President

Email: info@highqualitycareinc.com **web: www.highqualitycareinc.com**