High Quality Care Nursing, Inc.
Bringing Quality Care To You
217 Main St. Laurel. Md 20707. Tel: 301-617-9315 Fax: 240-786-5382 Fax: 301-364-9119

FOR OFFICE USE ONLY **RN/LPN**

HUMAN RESOURCE 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 ITEMS

HIGH QUALITY CARE NURSING AGENCY, INC

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: ______________________________________

____

____

____

*This is not a test. This is rather a checklist to assist us in placing you in appropriate assignments for In-Home care.

	YES	NO
Have you worked in pediatric or neonate intensive care?	____	_____
Have you worked with ventilators?	____	_____
Have you had experience with tracheostomies?	____	_____
Have you had experience with tracheal suctioning	____	_____
Have you had experience with nasopharyngeal suctioning	____	_____
Have you worked with NG tubes-continuous feedings?	____	_____
Have you ever passed a gavage tube?	____	_____
Have you worked with gastrostomy tubes ?	____	_____
Are you comfortable providing gastrostomy tube feedings?	____	_____
Have you ever worked with colostomies or ileostomies?	____	_____
Are you comfortable with adult/pediatric medication administration?	____	_____
Are you comfortable with calculating pediatric dosages?	____	_____
Are you comfortable with adult/pediatric IV therapy?	____	_____
Are you comfortable in starting adult/pediatric IV’s	____	_____
Are you comfortable with angio, butterfly?	____	_____
Do you have experience with Broviacs or Hickman?	____	_____
Do you have experience with IV pumps?	____	_____

	YES	NO
Have you experience with or comfortable with CPR		
. In adults	____	_____
.In Children	____	_____
Have you experience with or comfortable with CPR		
. In infants	____	_____

I certify that my answers are true and complete to the best of my knowledge

I authorize you to make such investigation and inquiries of my personal, employment educational, financial, or medical history and other related matters as may be necessary for an employment decision. I hereby release employers, schools, or persons from all liability in responding to inquiries in connection with my application.

In the event I am employed, I understand that false or misleading information given in my application or interview(s) may result in discharge.

_____________________________ _____________________________

Signature of Applicant Date

For Department Use only

Action: ____

____

person reviewing Application: ____

Equal Employment Opportunity: It is the policy of Agency to:

- Follow personnel procedures that will promote equal employment opportunity for all people without regard to race, color, religion, creed, national origin, sex, age, ancestry, marital status, disability, veteran or draft status, or physical or mental handicap or disability.
- Achieve understanding and acceptance of Agency policy on equal employment opportunity by all personnel.
- Thoroughly investigate instances of alleged discrimination and take corrective action as warranted.
- Be continually alert to identify and correct any practices by individuals that are at variance with the intent of the equal employment opportunity policy.

Specific Care	Self Assessment Competent		DEMONSTRATION HIGH QUALITY CARE NURSING AGENCY INC. MEDICAL STAFF			
	YES	NO	Competent	Incompetent	Supervisor Initial	Date Observed
ASSESSMENT						
Neurological						
Respiratory						
Identify Breath Sounds						
-Rates						
-Rhonchi						
-Crackles						
Identify Respiratory Distress						
Cardiovascular						
Skeletal						
Integumentary						
Gastro Intestinal						
TUBE FEEDING						
Bolus feed						
Use of feeding pump						
Medication via GT						
Medication via NGT						
Providing GT Care						
Checking for GT/NGT placement and patercy						
G Tube Insertion						
NGT Insertion						

____________________________ ________________

Signature and Name of Nurse Date

__________________________________ ________________

Signature and Name of RN/ Supervisory Date

Specific Care	Self Assessment Competent		DEMONSTRATION HIGH QUALITY CARE NURSING AGENCY INC. MEDICAL STAFF			
	YES	NO	Competent	Incompetent	Supervisor Initial	Date Observed
ADMINSTERING 02 THERAPY						
With humidity						
Via mask						
Nasal Canula						
Trach Collar						
Determine 02 amt						
Checking 02 for fullness						
EQUIPMENT						
Pulse Oximetry						
Apnea Monitor						
Feeding Pump						
Nebulizer Machine						
Chest Vest						
Performing Chest Physiotherapy						
Compressor						
URINARY CARE						
Foley Catheter care						
Insertion of Foley Catheter						
Straight Catherization						
Giving vaginal medication						
Performing a douche						
Giving an Enema						

____________________________ Signature and Name of Nurse

______________ Date

Specific Care	Self Assessment Competent		DEMONSTRATION HIGH QUALITY CARE NURSING AGENCY INC. MEDICAL STAFF			
	YES	**NO**	**Competent**	**Incompetent**	**Supervisor Initial**	**Date Observed**
SUCTIONING						
Oral						
Nasopharyngeal						
Tracheal						
Chest Physiotherapy						
Deep suctioning						
TRACHEOSTOMY CARE						
Performing Tracheal Care						
Cleaning the inner Cannula						
Inserting the Trach						
Changing the Trach ties						
Replacing the Trach Collar						
CARE OF THE CLIENT ON VENTILATOR						
LTV – 950-1000						
Tbird Legacy						
LP-10						
VITAL SIGNS						
Oral Temp						
Rectal Temp						
Axillary Temp						
Ear						
Pulse-brachial						
Pulse-Radial						
Pulse- Femoral						

_______________________________   _______________

Signature and Name of Nurse   Date

PEDIATRIC
SKILLS CHECK LIST

SKILL	**Date Described**	**Date Demonstrated**	**Signature and Title Observer/ Supervisor**		
			Initial/Title and sign below	Supervisor Initial &sign below	
Assessment					
Breath Sounds - Auscultation					
Before Suction					
After Suction Need for Nebulizer treatments					
Assessment related to Physician Notification orders specify					
Signs and Symptoms a. Respiratory distress b. Hypoxia c. Side effects of medication d. Fluid retention					
Procedures					
Chest Physical Therapy					
Nebulizer use: a. Solution b. Equipment					
Suctioning a. Positioning b. Bulb Syringe c. Nasopharyngeal					
Oxygen a. Basic Safety b. Placement of nasal Cannula, mask					
Bagging via Mouth					
Pulse Ox					
CR monitor					
Delivery Service					
Vital Signs					
Skin Care					
Oral Hygiene					
Other					

____
Signature and Name of RN/ Supervisor

____
Signature and Name of Nurse

____
Date

____
Date

PEDIATRIC
SKILLS CHECK LIST

SKILL	Date Described	Date Demonstrated	Signature and Title Observer/ Supervisor		
			Initial/Title and sign below	Supervisor Initial &sign below	
Assessment					
Breath Sounds - Auscultation					
Before Suction					
After Suction Need for Nebulizer treatments					
Assessment related to Physician Notification orders specify					
Signs and Symptoms a. Respiratory distress b. Hypoxia c. Side effects of medication d. Fluid retention					
Procedures					
Chest Physical Therapy					
Nebulizer use: a.Solution b.Equipment					
Suctioning Positioning .Bulb Syringe Nasopharyngeal					
Ventilator					
Bi pap/ C pap					
Pulse Ox					
Trach Care Clean Trach Site Change Trach Ties Change Trach Tube Cleaning of inner Cannula Place on Trach Collar					
Bagging Via Trach Via mouth					
Emergency Protocol/ Procedure					
Knowledge of “Mock” demonstration					

Signature and Name of RN/ Supervisor

Signature and Name of Nurse

PEDIATRIC
SKILLS CHECK LIST

SKILL	Date Described	Date Demonstrated	**Signature and Title Observer/ Supervisor**		
			Initial/Title and sign below		Supervisor Initial &sign below
Intravenous Access					
1. Type of Access Device					
2. Site Care					
a. Hand washing b. Dressing Changes c. Site Injection					
3. Maintaining Patency					
a. Flushing with saline b. Flushing with heparin					
4. Accessing the Device a. Central line b. Port c. Peripheral IV d. Use of the needle or needle-less system					
Drugs/Solution					
1. Administration of medications a. Drug b. Dose/label accuracy c. Slide effects/adverse effect d. Container integrity e. Appropriate storage					
2. Solution a. Additives to solution b. Glucose monitoring(blood or urine) c. Cycle / taper					
Ventilator					
Other					

_______________________________ Signature and Name of RN/ Supervisor

_______________________________ Signature and Name of Nurse

_______________ Date

_______________ Date

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 ________________

Date : ___________________ Signature : _________________________

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

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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.

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.

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INDEPENDENT CONTRACTOR AGREEMENT

This agreement made this ______________ day of ____________ 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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Professional Liability Insurance

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

High Quality Care Nursing, Inc.

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REFERENCE FORM

TO ____
____
____

TELEPHONE (   ) ____

The person listed below has applied to High Quality Care Nursing Agency for employment and has submitted your name as a former employer for reference purposes. The serious nature of our responsibility to our patients and our institutions is such that any consideration of the individual by High Quality Care Nursing Agency is dependent upon receipt of a satisfactory reference. We would therefore, appreciate your cooperation in responding to the question listed below. Please be assured that your response will be kept in the strictest confidence. Thank you in advance for this courtesy.

____
HIGH QUALITY CARE NURSING AGENCY

____
SIGNATURE OF APPLICANT

APPLICANT'S NAME ____

POSITION HELD IN YOUR EMPLOYMENT ____

EMPLOYMENT DATES: FROM _________________________ **TO** _____________________

CHECK ONE: APPLICANT: ☐ RESIGNED ☐ WAS TEMPORARY EMPLOYEE ☐ WAS TERMINATED

WOULD YOU REHIRE? ____

PERSONAL EVALUATION	ABOVE AVERAGE	SATISFACTORY	NEEDS IMPROVEMENT	POOR
QUALITY OF WORK	______	______	______	______
INTEREST AND ENTHUSIASM	______	______	______	______
ABILITY TO RELATE TO PATIENTS	______	______	______	______
ABILITY TO RELATE TO STAFF	______	______	______	______
ADAPTABILITY TO CHANGE	______	______	______	______
ABILITY TO HANDLE STRESS	______	______	______	______
ATTENDANCE	______	______	______	______
PERSONAL APPEARANCE	______	______	______	______
PUNCTUALITY	______	______	______	______

COMMENTS

____

DATE--
SIGNATURE OF PERSON VEREFING -------------------
NAME/TITLE--

FOR OFFICE USE ONLY
REFERENCE DONE BY PH ----------/ MAIL FAX--------
HQCN STAFF NAME/ DATE --------------

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REFERENCE FORM

TO ____

____

TELEPHONE (   ) ____

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HIGH QUALITY CARE NURSING AGENCY

____
SIGNATURE OF APPLICANT

APPLICANT'S NAME ____

POSITION HELD IN YOUR EMPLOYMENT ____

EMPLOYMENT DATES: FROM __________________________ **TO** ______________________

CHECK ONE: APPLICANT: ☐ **RESIGNED** ☐ **WAS TEMPORARY EMPLOYEE** ☐ **WAS TERMINATED**

WOULD YOU REHIRE? ____

PERSONAL EVALUATION	ABOVE AVERAGE	SATISFACTORY	NEEDS IMPROVEMENT	POOR
QUALITY OF WORK	________________	______________	_____________	_________
INTEREST AND ENTHUSIASM	________________	______________	_____________	_________
ABILITY TO RELATE TO PATIENTS	________________	______________	_____________	_________
ABILITY TO RELATE TO STAFF	________________	______________	_____________	_________
ADAPTABILITY TO CHANGE	________________	______________	_____________	_________
ABILITY TO HANDLE STRESS	________________	______________	_____________	_________
ATTENDANCE	________________	______________	_____________	_________
PERSONAL APPEARANCE	________________	______________	_____________	_________
PUNCTUALITY	________________	______________	_____________	_________

COMMENTS

____

DATE---

SIGNATURE OF PERSON VEREFING -------------------

NAME/TITLE---

FOR OFFICE USE ONLY

REFERENCE DONE BY PH ----------/ MAIL FAX---------

HQCN STAFF NAME/ DATE --------------

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INTERVIEWING CHECKLIST

CANDIDATE: ______________________

DATE: _________________________

POSITION APPLIED FOR: ______________________

Date of Birth	
Maiden Name	
Marital Status	
Name of Spouse	
Spouse's Occupation	
Previous Married Name(s)	
How long have you been a LPN /CNA ?	
Do you have Children?	
Number of Children?	
Have you arranged for Proper Child Care?	
Do you have Pediatric Experience?	
How many years Experience?	
Do you have Adult / Geriatric Care?	
Have you ever been arrested?	
Were you ever convicted?	
What is your Nationality?	
What is your Race?	
Age	
Sex	
Religion	

Salary requested: ________________________________

Candidates for Promotion with: ______________________________

Interviewer: _________________________________