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UMS currently has agreements to provide contract nurses to over fifty medical facilities in Lafayette and the surrounding areas. These facilities require basic information about the nurses who perform services at their facilities. In an effort to provide better services to both the contract nurses and the facilities, UMS has assembled the information required by the various facilities in the enclosed packet.

If you wish to contract your services to any of our facilities, please fill out the enclosed package and return it to our office. We will in turn forward this information to any facility you choose to work with. Please advise our staff of your available shift times and areas or departments of preference.
Thank you for choosing to contract your services through UMS. If you have any questions, please contact our office.

## Information Checklist

**The following items are contained in the information package.**

1. **Contract Nurse Information**
2. **Payment Instruction Form**
3. **W-9 Tax Information Form**
4. **Agreement Form for Contract Nursing**
   **** (Please sign and date all forms provided)**
5. **Skills Checklist**
6. **Criminal Background Check Form**
7. **Hepatitis B Form**
8. **Skills Assessment Checklist**
9. **OSHA Video**
10. **Age Specific Check List**

**If you wish to contract your services through United Medical Staffing, Inc., please submit the following:**

1. **Driver's License**
2. **Social Security Card**
3. **Current CNA Certificate**
4. **Current CPR Card**
5. **Any other credentials that you may have**
   ****Ex. ACLS, PALS, NALS, IV certification for LPN's**
6. **Current TB/PPD verification**
   **** (Must be valid for one year)**
7. **Proof of Malpractice Insurance**
8. **Proof of Worker's Comp**
   ****If Applicable**
9. **Proof of Hep. B shots if applicable**

**All medical facilities require a yearly TB skin test, a current Nursing License and a current CPR card. Fax # (337) 769-9069. Anytime you receive a new TB or CPR, please fax accordingly. Please fax your new Nursing License to our office each January.**

# Contract Nurse Information

**Instructions**: This form is a professional document and must be complete, true, and accurate. This information may, upon request, be furnished to those facilities which receive services from a contract nurse. Please fill in all blanks.

**Name:________________________ ____________________ __________________**
**Last First Middle**
**Address:_____________________________________________________________**
**City/State:________________________,_____________ Zip Code_____________**
**Home phone: ____________________________**
**Cellular phone: _________________________**
**Pager: _________________________________**
**Alternate phone 1:_______________________**
**Email Address:___________________________**
**Social Security No.______-________-_________**
**Date of Birth**:_____________________________

**Please Check One:**
**Registered Nurse_______**
**Licensed Practical Nurse_______**
**Certified Nursing Assistant________**
**Tele Tech ___________**
**Preferred Shifts ___________________________________________________**

**Work History -- (Beginning with most recent)**
**Name of Company_________________________________________________**
**Address_________________________________________________________**
**City/State/Zip____________________________________________________**
**Phone No.____________________________________**
**From__________________ To____________________**
**Position_______________________________________**
**Duties__________________________________________________________**
**____________________________________________________________________**

**Name of Company_________________________________________________**
**Address_________________________________________________________**
**City/State/Zip____________________________________________________**
**Phone No.____________________________________**
**From__________________ To____________________**
**Position_______________________________________**

**Name of Company____________________________________________________**
**Address_____________________________________________________________**
**City/State/Zip________________________________________________________**
**Phone No.____________________________________________**
**From_____________________ To_________________________**
**Position_______________________________________________**
**Duties________________________________________________________________**
**_____________________________________________________________________**

**Name of Company_____________________________________________________**
**Address_____________________________________________________________**
**City/State/Zip________________________________________________________**
**Phone No.____________________________________________**
**From____________________ To__________________________**
**Position______________________________________________**
**Duties________________________________________________________________**
**______________________________________________________________________**

**<u>Education:</u>**
**School name #1: ______________________________________ Yr. grad: ___________**
**City/State: ________________________, _________________ Degree:______________**

**School name #2: ______________________________________ Yr. grad: ___________**
**City/State: ________________________, ________________ Degree:______________**

**School name #3: ______________________________________ Yr. grad: ___________**
**City/State: ________________________, ________________ Degree:______________**

**<u>Other Licensure:</u>**
**State: __________________ Lic.#: ______________ Expires: _____________**

**Certification Number________________________ State____________________**
**Has your nursing license ever been suspended?_______ If so, explain why._____**
**______________________________________________________________________**

**Malpractice Ins. Co. ____________________________________________________**
**Policy#: ______________________________**
**Exp. date: ___________________________**
**Worker's Compensation Insurance Co. and Policy No. _____________________**
**Exp. Date_____________________________**

**Signature and Title: ____________________________ Date:_______________**

## Consent for Criminal Background Check

I hereby authorize **AccuScreen Systems** through Larry Bruce Childers and/or Darin N. Morgan, authorized agent under Title 40 R.S. 1300.51 to perform a criminal background check and/or a State Police records check I Authorize the release of the results of the background check to **United Medical Staffing, Inc**. and any facility to whom I have contracted my services through **United Medical Staffing, Inc**. I hereby hold harmless **AccuScreen Systems**, Larry Bruce Childers, Darin N. Morgan and **United Medical Staffing,** from any cause of action that may arise from inaccurate information contained in State Police records. I also understand any adverse information contained within the files of State police and release to the authorized agency will be provided to me upon written request within ten (10) business days of receiving notice that a record exists. **FAX this form to:(225) 383-6445 or (225) 343-9237**

**Signature: ____________________________ Date: ________________**

To ensure an accurate and timely search, PLEASE **PRINT clearly** and complete this form **entirely**.

**PRINT Complete Name: ________________________________**

**Date of Birth: __________ Race: _________ Sex: _______**

**SSN: ___________________ Driver's Lic.#: _______________ State Issued:_____**

Street Address: ______________________________________________________

City, State, Zip: _____________________________________________________

If you have lived in any state other than Louisiana in the **LAST 7 YEARS ONLY**, complete the following:

City, State,Zip___________________________________________

Country/Parish_____________ Mo./Yr.________________________

All last names YOU used while living here_____________________

City, State, Zip__________________________________________

Country/Parish_____________________ Mo./Yr.______________

All last names YOU used while living here______________________

City, State,Zip _________________________________________

Country/Parish______________ Mo./Yr.____________________

All last names YOU used while living here_____________________

**Professional License or Education Verification**

Prof. Lic./ Degree Earned______________________ License Number_________________

State/ institution Issuing License/ Degree________________ Date Issued___________

Additional Comments:________________________________________

# CNA Skills Assessment Checklist

**Name:________________________________________ Date:____________________**

**CNA #:______________________________ Expiration Date:____________________**

**Certifications (List):______________________________________________________**

**Past Experience (List places and areas you worked in/time spent there)**

**________________________________________________________________________**

**________________________________________________________________________**

**List experience in the last six months:_______________________________________**

**School and date when training was completed:________________________________**

**Skills List: (Check if you are experienced in the following areas)**

| | | |
|---|---|---|
| **Occupied Bed Making___** | **Complete Bed Bath___** | **Shower___** |
| **Unoccupied Bed Making__** | **Partial Bed Bath___** | **Setting up food tray___** |
| **Feeding patients___** | **Axillary Temp.___** | **Oral Temp.___** |
| **Rectal Temp.___** | **Apical Pulse___** | **Radial Pulse___** |
| **Respirations___** | **Blood Pressure___** | **Using a Stethoscope___** |
| **Turning Pt.___** | **Dangling Pt.___** | **Pt. up in chair___** |
| **Range of Motion___** | **Recording I&O___** | **Enemas___** |
| **Collection of Urine___** | **Clean Catch Urine___** | **Sputum Collection___** |
| **Stool Collection___** | **24-hr. Urine Collection___** | **Inserting Foley___** |
| **Catheter Care___** | **Application of stockings___** | **Using cold compresses___** |
| **Using Hot Compresses___** | **Post-Op Care___** | **Using bed scale___** |
| **Using upright scale___** | **Recognizing Codes___** | **Calling a code___** |
| **One on one contact with psychiatric patients___** | | **Answering Phones___** |
| **Recognizing infiltrated IV sites___** | | **Charting/Abbreviations___** |

**List any other skills that you may have:______________________________________**

**________________________________________________________________________**

Signature:____________________
Date:______________________

# AGE SPECIFIC CRITERIA CHECKLIST

**Independent Contractor's Name:** ________________________

**Please check all applicable areas:**

| | Neo- Natal | | | Peds | | | Adolescence | | | Adult | | | Geriatrics | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | N | Y | N/A | N | Y | N/A | N | Y | N/A | N | Y | N/A | N | Y | N/A |
| Knowledge of human growth and development | | | | | | | | | | | | | | | |
| Ability to assess age specific data: Possesses skills/ knowledge to perform treatments ( IE: meds, equipment, etc.) | | | | | | | | | | | | | | | |
| Ability to interpret age specific data: Ability to interpret age specific response to treatment | | | | | | | | | | | | | | | |
| Ability to involve family or significant other in decision-making related to plan of care: | | | | | | | | | | | | | | | |

**Independent Contractor's Signature:** **Date:**

# Hepatitis B Vaccine Verification

I understand that due to my occupational exposure to blood and other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine from a physician or other facility of my choice and at my own expense. If I have already received the Hepatitis B vaccine or receive the vaccine in the future, I agree to provide the written documentation to verify the same to UMS if I will continue to contract my services through UMS as an independent contractor.

I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series from a physician or other facility of my choice and at my own expense.

With my **signature** in the appropriate space below, I hereby agree that I decline the Hepatitis B vaccine or have or will provide the written documentation to verify that I have received the Hepatitis B vaccination series.

**I decline the Hepatitis B vaccine.** ___________________________________

**I have received the Hepatitis B vaccine.** ______________________________

**I will provide verification of the Hepatitis B vaccine.** ____________________

**I will take the Hepatitis B vaccine and provide that info to UMS.** __________

_________________________________________________________________

**Date**_______________________

## AGREEMENT TO SOLICIT AND PROVIDE NURSING SERVICES

**This Agreement outlines the arrangement between ___________________________, hereinafter referred to as IC and UNITED MEDICAL STAFFING, INC., hereinafter referred to as UMS. IC and UMS are the only parties to this agreement.**

**UMS's principal place of business is located at 109 South College Road, Lafayette, Louisiana 70503. IC's principal place of business is located at:**

**Street Address:_______________________________________________________________**
**City/State/Zip:_______________________________________________________________**

**In consideration of the terms hereinafter expressed, IC, the undersigned Independent Contractor, hereby contracts with UMS, to solicit professional nursing services on behalf of IC to be rendered by IC. IC hereby agrees to provide professional nursing services as a CERTIFIED NURSING ASSISTANT to various medical facilities with whom UMS has agreed to provide supplemental staffing services (hereinafter referred to as FACILITY) . IC understands that IC is not guaranteed a position with any FACILITY or with UMS for any period of time and that IC will be asked to provide professional nursing services to FACILITY for periodic staffing projects as the needs of the FACILITY dictate and that this is beyond the control of UMS.**

**IC understands that in providing the services described in this contract that IC is not employed by UMS within the meaning of Louisiana Revised Statutes 23:1472(12)E or Internal Revenue Service Ruling 61-196, page 715 et seq. IC understands that the monies paid to IC are not wages and that this contract is not a contract of hire. IC agrees to provide professional nursing services to the FACILITY at a negotiated rate to be determined by UMS and IC on a case by case basis and that IC will be paid for those services by UMS on a case by case basis. IC understands that IC is not a member of the regular staff of UMS and that IC is not guaranteed a position with any FACILITY or with UMS. The express intention of the parties is that IC is an Independent Contractor and not an employee, agent, joint venture or partner of UMS. Nothing in this Agreement shall be interpreted or construed as creating or establishing the relationship of employee and employer between IC and UMS or any employee or agent of IC or UMS. Both parties acknowledge that IC is not an employee for state or federal tax purposes. IC understands that IC will perform professional nursing services at his or her sole discretion and control as requested by FACILITY.**

**IC understands and warrants that IC has a professional status and that IC holds himself out to the public and to UMS as capable of exercising an independent calling requiring specialized skills and that IC ordinarily has full discretion in administering IC's professional services and that IC is not under the direction or control of UMS so as to create an employment relationship with UMS. IC further declares that IC has complied with all federal, state and local business permit and licensing requirements necessary to conduct business.**

**IC understands that the fees for his or her services will be billed directly to the FACILITY by UMS at a rate different from what IC has negotiated with UMS and that IC may not directly bill the FACILITY to receive monies from the FACILITY. IC understands that IC will be paid at IC's discretion, upon submission of a written invoice to UMS.**

**IC agrees that if IC provides services directly to the FACILITY during the term of this agreement other than as an independent contractor through UMS, IC will be required to pay UMS $1,000.00 in damages. This will apply only to FACILITIES for whom IC's services have been solicited through UMS.**

**IC represents to UMS and the FACILITY that he/she is duly licensed as a CERTIFIED NURSING ASSISTANT in the State of Louisiana and that in providing the referenced professional services, IC will be free from any control or direction by UMS in the performance of professional services under this contract. IC further understands warrants and represents that the referenced professional services will be provided outside of all of the places of business of UMS for which that service is performed and that IC is customarily engaged in the independently established profession as a CERTIFIED NURSING ASSISTANT. IC declares that IC has obtained professional liability**

**insurance for any and all employees or agents of IC and that IC shall make all applicable premium payments, deductibles, and renewal payments for such policies of IC. IC also declares that IC has obtained workers' compensation for IC and any and all employees or agents of IC. IC agrees to hold harmless and indemnify UMS for any and all claims arising out of any injury, disability, or death of IC or any employees or agents of IC. IC understands that the insurance contract and other information IC provides to UMS may be disclosed to any FACILITY desiring to utilize IC's professional nursing services. IC understands that UMS shall not obtain or pay for any insurance on behalf of IC.**

**IC reserves the sole right to control or direct the manner in which services are to be performed. IC shall retain the right to perform similar services for other entities during the term of this Agreement.**

**IC shall perform the services required by this Agreement at any place or location and at any time as IC deems necessary and appropriate. IC shall be responsible for all costs and expense incidental to the performance of services contracted through UMS, including without limitation, all costs of fees, fines, licenses or taxes required of or imposed against IC and all other IC's costs of doing business. UMS shall not be responsible for any expenses incurred by IC in performing services contracted through UMS.**

**IC, may at its own expense, hire assistants or substitutes to perform services with or on behalf of IC subject to acceptance of assistants or substitutes by FACILITY. All such assistants and/or substitutes shall be employees of IC and not of UMS. IC assumes full responsibility for assistants and/or substitutes, including but not limited to all applicable state and federal taxes, unemployment insurance, social security, workers' compensation and other applicable taxes or withholdings.**

**IC further understands and agrees that as an independent contractor, IC will be responsible for all city, parish, state, federal, FICA, unemployment, professional and other taxes or fees which may accrue or become due as a result of any professional fees earned by IC for professional services rendered by IC pursuant to this contract. IC agrees to hold UMS completely harmless for the payment of the aforesaid taxes or fees and to fully indemnify UMS for any sums including all taxes, fees, costs, attorney fees (expended by UMS) and penalties (incurred by UMS) should IC not pay the aforesaid taxes or fees for any reason or should any agency seek to collect from UMS any taxes or fees due by IC. IC understands that IC will be responsible for filing quarterly federal and state tax returns and for paying all federal and state taxes due as a result of the fees earned for services rendered by IC. IC further acknowledges that federal and state taxes are due monthly and federal and state tax returns are due on April 30, July 31, October 31, and January 31 of each year.**

**The term of this agreement shall be for a period of 1 year from the date specified below.**

**This agreement signed in Lafayette, Lafayette Parish, Louisiana this _____ day of __________, 2009.**

**Accepted By:**

**UNITED MEDICAL STAFFING, INC.**

___________________________________ ___________________________________

**Authorized Agent** **Independent Contractor**

# United Medical Staffing, Inc.
# Payment Instruction Form

I, the undersigned, do hereby instruct and direct United Medical Staffing (UMS) to pay all sums due to me for services rendered as an independent contractor upon my submission of invoice.

I understand that I am an independent contractor and not an employee of UMS and that it is my desire that UMS regard the information signed by me on the daily time slip as accurate. However, I do understand that UMS has total authority to verify any time slips before submitting payments.

I understand that I am self-employed and am responsible for filing and paying my own federal, Social Security and F.I.C.A. taxes. I further understand that UMS is not responsible for my tax liability for fees received while sub-contracting my services through UMS.

I authorize UMS to release my check to the following named persons:

1.___________________________________
2.___________________________________
3.___________________________________
4.___________________________________

I understand and agree that this release will remain valid until I notify UMS in writing, either by mail or personally hand deliver to UMS a written statement canceling this release. I further agree that I will hold UMS harmless for the monies due me if misappropriated by the above named individuals.

I would like my check mailed to me. (initial if applicable) x_________

Signature: ______________________________

Date: __________________________________

**I have viewed the video entitled "OSHA Standards and Safety Procedures" with reference to each of the following.**

**____ A. Fire Prevention and Evacuation**

**____ B. Body Mechanics**

**____ C. Chemical Hazards**

**____ D. Infection Control, Universal Precautions, and Aids**

**____ E. Exposure to Blood borne Pathogens Standards**

**Date:___________________________________**

Signature:______________________________

# HIPPA PRIVACY PROTECTION

In accordance with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act, 45 (forty-five) CFR parts 160 and 164 (the "Privacy Regulations"), **United Medical Staffing, Inc.,** and ___________________________ **Independent Contractor** understand and agree to abide by the Facility privacy policies and to not use or further disclose and patient's personal health information except as expressly permitted by this Agreement or as otherwise authorized in writing by the patient through a consent or authorization meeting the requirements of the Privacy Regulations.

**United Medical Staffing, Inc.** and **Independent Contractor** may only use a patient's personal health information for the sole purpose of treatment, and/or health care operations and may not release any information to unauthorized parties. **United Medical Staffing, Inc**. and **Independent Contractor** agree to implement appropriate safeguards to prevent the unauthorized use and disclosure of any patient's personal health information received by Facility under this Agreement. In addition, **United Medical Staffing, Inc.** and **Independent Contractor** shall make available to the Facility the protected health information for amendment pruposes, should changes to the information be necessary or to provide an accounting of disclosures of the protected health information.

If an unauthorized disclosure of personal health information occurs, **United Medical Staffing, Inc.** and/or **Independent Contractor** shall immediately contact Facility to inform them of the disclosure and any remedial action taken to prevent further disclosures. **United Medical Staffing, Inc**. and **Independent Contractor** understand that any unauthorized disclosure of a patient's personal health information is grounds for immediate termination of this Agreement and/or a staffing assignment.

____________________________________________________

INDEPENDENT CONTRACTOR'S Signature

____________________________________________________

UNITED MEDICAL STAFFING, INC.

_________________________

DATE

# Confidentiality Statement

You have the right to confidentiality –that means that the information given by you will not be released without your written consent, except to facilities in which you have or will work. We do not discriminate in the delivery of services. This means you will not be treated differently from others because of your race, color, sex, age disability, religious beliefs, nation origin or political beliefs.

This form gives UMS permission to release to any contracted facility, the Independent Contractors credentials, including, but not limited to; background checks, health screenings, certifications and/or licenses, etc.

This agreement signed this ____ day of ______________, 2008.

Accepted By:
UNITED MEDICAL STAFFING, INC.

______________________ ______________________

**Authorized Agent** **Independent Contractor**