GLOBAL
HEALTHCARE AGENCY , LLC
11 Quantum Way
Fredericksburg, VA 22406
Tel: 571-401-1933 Fax: 571-401-1934

Employment Application Packet 1

Please complete this Application Packet and send back by either Fax at (571) 401-1933 or e-mail at staffing@globalhealthcareagencyllc.com

To ensure our compliance with the standards of both our clients and the Joint Commission, Global Healthcare Agency, LLC requires the following documentation in our system.

REQUIREMENTS:

☐ **RESUME**

- Explain **GAPS IN EMPLOYMENT**, if any to avoid delays in your Pre-Qualification process
- Please indicate the **CITY AND STATE** plus **MONTH AND YEAR** per work history
- Also if you speak any Language other than English.

☐ **APPLICATION FOR EMPLOYMENT**

- Platinum Application Form
- Employment History
- Emergency Contact
- Legal Questionnaire

☐ **EMPLOYMENT REFERENCE #1**

☐ **EMPLOYMENT REFERENCE #2**

☐ **CLINICAL SKILLS CHECKLIST – COMPLETED & SIGNED**

☐ **PROFESSIONAL CREDENTIALS – Please attach the following when submitting this Application:**

1. CA Professional License – Front and Back copies with signature
2. Driver's License
3. BLS/CPR – Front and Back copies with signature. American Heart Associstion for healthcare provider
4. ACLS,PALS,MAB,EKG/ARRYTHMIA Certification as Applicable/Back should be signed, AHA provider
5. Diploma (Hospital requirement for education verification)
6. Physician Statement, taken within the last 12 months, *Physician Statement with Signature of M.D
7. Chest X-Ray or PPD Test
8. Drug Screen
9. Immunization Records (MMR and Varicella)
    - TB/PPD Test
    - Rubella Titre, Rubeola Titre, Mumps Titre
    - Vaccine Zoster Titre, Immunity by History of Disease as Verified by MD and Vaccination
10. Hepatitis B Declination, Proof of Series, or Titre Showing Immunity.

Clear Form

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Application for Employment

(Please complete event if attaching a resume)

Name (Last, First and Middle Initial) _____ Maiden/Other _____

Street Address _____ City _____ Select State _____ Zip _____

E-mail Address _____ Social Security Number _____

Date of Birth _____ Driver's License _____ Select State _____ Expiration Date _____

Home Phone # _____ Alternate Phone # _____ Cell Phone # _____ Preferred call time _____

Primary Emergency Contact Name and Phone # _____ Secondary Emergency Contact Name and Phone # _____

Date Available: _____ Shift Preferred: ☐ Day ☐ Night

Type of position applying for (check all that applies): ☐ Per Diem ☐ 8 Weeks ☐ 13 Weeks+ ☐ Permanent

Do you speak any languages other than English? ◯ Yes ◯ No If yes, Please list _____

How were you referred to us? ◯ Advertising ◯ Internet site ◯ Friend / Associate _____

◯ Other _____

Were you recruited by a Platinum Staff? ◯ Yes ◯ No If yes, Recruiter's name _____

Have you done a Travel assignment before? ◯ Yes ◯ No If yes, with which company(s)? _____

Are you able to perform the basic functions of the position for which you are applying without any restrictions? ◯Yes ◯No

If no, Please explain _____

Please use the space below to let us know your preferences in terms of Facility, Commute, Restrictions, Pay, etc.

_____

_____

Emergency Contact Information

We would like to have the names of two (2) contacts that we could call in the case of emergency. Please provide that information below for our files and reference.

Primary Contact: _____

Relationship: _____

Address: _____

_____

_____

Contact No.: _____

Secondary Contact: _____

Relationship: _____

Address: _____

_____

_____

Contact No.:_____

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Professional Credentials

Education: _____ From: _____ To: _____
College or University / Location
Degree Earned: _____

Education: _____ From: _____ To: _____
College or University / Location
Degree Earned: _____

Education: _____ From: _____ To: _____
College or University / Location
Degree Earned: _____

Specialty (Please list most current experience first)

1. _____ Years of Experience _____ as of (Indicate Date)_____
2. _____ Years of Experience _____ as of (Indicate Date)_____

Professional Licenses (Please attach a copy of each including front and back copies)

1. CA Medical License # _____ Expiry Date: _____
2. _____ Expiry Date: _____
3. _____ Expiry Date: _____

Certifications (Please attach a copy of each including front and back copies)

☐ BLS / CPR	Expiry Date: _____	☐ ACLS	Expiry Date: _____
☐ PALS	Expiry Date: _____	☐ NRP / NALS	Expiry Date: _____
☐ MAB	Expiry Date: _____	☐ CCRN	Expiry Date: _____
☐ CNOR	Expiry Date: _____	☐ TNCC	Expiry Date: _____
☐ EKG Cert	Expiry Date: _____	☐ CHEMO	Expiry Date: _____
☐ Other:	_____	Expiry Date: _____	

Employment History (Please list in order, most recent first and explain gaps in employment if any)

Date Employed: From: _____ To: _____
Facility: _____
Position Held: _____
◯ FT ◯ PT ◯ Traveler-Agency _____
Address: _____
_____
Immediate Supervisor: _____

Business Phone: _____
May We Contact? ◯ Yes ◯ No
Specialty Unit: _____
City and State: _____
Pay / HR: _____
Reason for leaving: _____

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Employment History cont. (Please list in order, most recent first and explain gaps in employment if any)

Date Employed: From: ________________ To: ________________
Facility: ____
Position Held: _______________________________________
○FT ○PT ○Traveler-Agency ____________________
Address: ____
____
Immediate Supervisor: ______________________________

Business Phone: ________________________
May We Contact? ○Yes ○No
Specialty Unit: ________________________
City and State: ________________________
Pay / HR: ________________________
Reason for leaving: ____________________

Date Employed: From: ________________ To: ________________
Facility: ____
Position Held: _______________________________________
○FT ○PT ○Traveler-Agency ____________________
Address: ____
____
Immediate Supervisor: ______________________________

Business Phone: ________________________
May We Contact? ○Yes ○No
Specialty Unit: ________________________
City and State: ________________________
Pay / HR: ________________________
Reason for leaving: ____________________

Date Employed: From: ________________ To: ________________
Facility: ____
Position Held: _______________________________________
○FT ○PT ○Traveler-Agency ____________________
Address: ____
____
Immediate Supervisor: ______________________________

Business Phone: ________________________
May We Contact? ○Yes ○No
Specialty Unit: ________________________
City and State: ________________________
Pay / HR: ________________________
Reason for leaving: ____________________

Date Employed: From: ________________ To: ________________
Facility: ____
Position Held: _______________________________________
○FT ○PT ○Traveler-Agency ____________________
Address: ____
____
Immediate Supervisor: ______________________________

Business Phone: ________________________
May We Contact? ○Yes ○No
Specialty Unit: ________________________
City and State: ________________________
Pay / HR: ________________________
Reason for leaving: ____________________

Date Employed: From: ________________ To: ________________
Facility: ____
Position Held: _______________________________________
○FT ○PT ○Traveler-Agency ____________________
Address: ____
____
Immediate Supervisor: ______________________________

Business Phone: ________________________
May We Contact? ○Yes ○No
Specialty Unit: ________________________
City and State: ________________________
Pay / HR: ________________________
Reason for leaving: ____________________

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Name: _____ Date: _____

Position applied for: _____

LEGAL QUESTIONNAIRE

Have you ever:

1. been named as a defendant in a malpractice action? _____ If yes, when? _____
   Who was your employer at that time? _____
2. had a license or certification in any jurisdiction limited, suspended, revoked or voluntarily relinquished? _____
   If yes, when? _____ In what state? _____
3. been licensed or practiced professionally under a different name? _____
   If yes, under what name? _____ and what state? _____
4. Are you eligible to work in the U.S.? ◯ Yes ◯ No Alien ID number _____ (if applicable)
5. been denied a license? _____ If yes, what state? _____ when? _____
   What reason? _____
6. been convicted by misdemeanor, felony including traffic violations? _____
   If yes, when? _____ in what state? _____
   What county? _____

(this includes any offense where you were found guilty, plead guilty or plead nolo contendere (no contest). You may omit: a conviction of misdemeanor while under the age of 18, if the records were sealed under the Penal code 1203.45b. Any conviction specified in Health and Safety code section 11361.5 which pertains to various marijuana offenses (a conviction will not necessarily disqualify you from consideration for employment).

7. been arrested and are you out on bail on your own recognizance and still awaiting trial? _____
8. been released or discharged from employment or resigned to avoid such release or discharged? _____
   If yes, please provide dates and circumstances? _____

   _____

   _____
9. had your driver's licensee suspended or revoked? _____ If yes, when? _____
   Please explain why? _____

   _____

My signature certifies that all information contained within my application is correct and maybe verified by Global Healthcare Agency, LLC in compliance with the Virginia Law. It also acknowledges that I am aware that it is my responsibility to review and policy and procedure documents of each hospital/facility in which I work, prior to beginning my initial shift.

Applicant's Signature _____ Date _____ Position _____

I have reviewed the applicant's qualifications and skills that qualify for the position.

Evaluator's Signature _____ Date _____

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Employment Reference Check #1

• Clinical references must provide dates of employment, give a rating of work history, state the position or specialty that the candidate worked. State the title of the person giving the references such as Charge RN, RN Supervisor, DON, Nurse Manager. The referece MUST be someone who the candidate reported to directly on the floor unit. •

_____ _____

Applicant's Name **Position Held**

_____ _____

Dates of Employment **Current / Former Employer**
(From month & year – To month & year)

_____ _____ _____

City **State** **Supervisor's Name**

☐ I hereby give permission to the above named employer to release information to Platinum Healthcare regarding my performance while employed at the facility.

_____ _____

Applicant's Signature **Date**

Employment History

The person above is applying for an employment with Global Healthcare Agency, LLC and has listed you as previous employer. We would appreciate your assistance in verifying employment and evaluating job performance. All information will be treated with utmost confidentiality.

Is this employee eligible for rehire? ○ **YES** ○ **NO**

Personal Evaluation	Above Average	Satisfactory	Did not meet expectations	Poor
Clinical Competency	☐	☐	☐	☐
Quality of Work	☐	☐	☐	☐
Quantity of Work	☐	☐	☐	☐
Attitude and Cooperation	☐	☐	☐	☐
Ability to get along with others	☐	☐	☐	☐
Adaptability to Work Situations	☐	☐	☐	☐
Dependability	☐	☐	☐	☐
Attendance and Punctuality	☐	☐	☐	☐
Personal Appearance	☐	☐	☐	☐

Comments:

_____

_____

_____

_____ _____ _____

Employer's Signature **Title** **Date**

Note to Staffer – Please indicate this is verbal Verification: _____

Clear Form

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Employment Reference Check #2

• Clinical references must provide dates of employment, give a rating of work history, state the position or specialty that the candidate worked. State the title of the person giving the references such as Charge RN, RN Supervisor, DON, Nurse Manager. The referece MUST be someone who the candidate reported to directly on the floor unit. •

_____ _____
Applicant's Name **Position Held**

_____ _____
Dates of Employment **Current / Former Employer**
(From month & year – To month & year)

_____ _____ _____
City **State** **Supervisor's Name**

☐ I hereby give permission to the above named employer to release information to Platinum Healthcare regarding my performance while employed at the facility.

_____ _____
Applicant's Signature **Date**

Employment History

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Is this employee eligible for rehire? ○ **YES** ○ **NO**

Personal Evaluation	Above Average	Satisfactory	Did not meet expectations	Poor
Clinical Competency	☐	☐	☐	☐
Quality of Work	☐	☐	☐	☐
Quantity of Work	☐	☐	☐	☐
Attitude and Cooperation	☐	☐	☐	☐
Ability to get along with others	☐	☐	☐	☐
Adaptability to Work Situations	☐	☐	☐	☐
Dependability	☐	☐	☐	☐
Attendance and Punctuality	☐	☐	☐	☐
Personal Appearance	☐	☐	☐	☐

Comments:

_____
_____
_____

_____ _____ _____
Employer's Signature **Title** **Date**

Note to Staffer – Please indicate this is verbal Verification: _____

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Name: _____ **Date:** _____

Do Not Send Prevention: Quiz

_____ 1. Its 4:45 a.m. and La Tasha Davis has just been confirmed for the day shift at a Medical Center across town from her. La Tasha lives across town from and has never been to the Medical Center. Which of the sequences will below provide La Tasha with greatest chances of making a great first impression and having a successful shift?

a) Wake up at 6:15a.m., take a shower, get dressed, hit the road at and head in general direction of the facility and call directions from the car.

b) Get out of bed at 0500 obtain detailed directions and the nursing office phone number.

c) Eat a small healthy breakfast, shower, dress neatly, gather nursing tools (ID Badge, Medication book, stethoscope etc.) and be on the road by 0545.

d) Get out of bed 0500 to the gym, come home, shower, get dressed, walk the dog, be on the road at 0705, call the staffing firm and say she got lost.

e) Refuse to go to the Medical Center located across town, call the staffing firm at 0730 and ask if the hospital she usually works at has any late call needs.

_____ 2. Lynn Carson RN is alone at the Nursing station in a facility in which she has been working twice a week, for over a year, she is faxing a new order to the Pharmacy, Before Lynn leaves the Nursing station the phone rings, and several lines are blinking. Which of the following answers is the best example of excellent customer service?

a) Lynn looks around and sees the unit secretary speaking to the charge nurse, the nurse manager, and two executives with hospital badges and wearing suits and yells out to the secretary that the "Phones are ringing!" and walks away from Nursing Station.

b) Lynn answers the phone lines and politely explains to every caller that she is not the unit secretary and cannot help them before hanging up, and walking away from the Nursing Station.

c) Lynn finished faxing her new medication order to the Pharmacy, doesn't acknowledge any of the phones ringing and walks away from the Nursing Station.

d) Lynn sits down at the Nursing Station answers all the lines and directs the calls courteously and professionally. Lynn then remains at the Nursing Station, Handling the phones for a few minutes until unit secretary returns. Lynn then passes along all relevant information upon being relieved.

_____ 3. Kenny Slater, RN has an extremely heavy assignment working day shift in a very busy Telemetry unit for the first time. Kenny's patients tell him he has done a great job. However, the night shift Charge Nurse makes Kenny a Do Not Send, stating incomplete documentation as the reason. Which of the options below is the most reliable way to prevent this from happening in the future?

a) Kenny could have communicated the condition of his patients, explained how busy he was, asked for help requested the dayshift Charge Nurse to audit his charts several hours before his shift ended.

b) Kenny could have avoided fulfilling his pts requests, not followed up on MD orders, and missing medications and made completing his documentation his first priority.

c) Kenny could have stated that his assignment was unfair and unsafe then complained to his patients and their families.

d) Kenny could have done nothing more, it wasn't his fault. It was the hospital's fault for giving him such a hard assignment and not showing him all the details of the documentation process in the first place.

4. An MD on a pediatric floor orders .1mg of M.S prn q 1° and a Dig level QD. Please write in the correct versions of the abbreviations used above, which comply with Joint Commission National Patient Safety Goals.

a) _____

_____ 5. Its 0930 and Ude Amin, RN. Who also works as a Real Estate agent, is working in the ICU. At the end of her morning break, Ude checks her voice mail. Ude checks her voice mail. Ude finds out an offer for a 2 million dollar property, from one of her clients, has been accepted! Which of the following actions would be appropriate?

a) Ude tells the Charge RN she has severe family emergency and leaves the facility immediately.

b) Ude excitedly calls the seller's broker back from the Nursing Station, and asks him to fax the counter offer to the ICU, so she can fax it to her client right away.

c) Ude waits until her lunch break to call the seller's broker back. She uses her mobile phone outside of the hospital.

d) Ude uses the Nursing Station computer, logs on to the internet, and prints out pictures of the 2 million dollar house she just sold. she then borrows another RN's calculator to estimate the commission she expects to earn from the sale.

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NAME: _____ **DATE:**_____

TERMINATION SCALE ACKNOWLEDGEMENT

Do Not Sends

The Following point system is used to determine termination as a result of ***Do Not Sends***.

1Point

- **Attitude / lack of professionalism / customer service**

2 Points

- **Clinical Incompetence – poor clinical performance**
- **Poor time management**
- **Medication Error**
- **Documentation Deficiencies Lack of Compassion**

3 Points

- **Danger to patient.**
- **No call, No Show.**
- **Departing facility before end of shift secondary to dissatisfaction with assignment.**
- **Do Not Send from any Travel Assignment regardless of origin.**

5 Points

- **Illegal Behavior (Includes false identity; falsified documentation, use of or distribution of controlled substances etc.)**
- **PT. abandonment. When nurse is under investigation for above behavior they will be considered terminated until exonerated from all accusations.**
- **Error resulting in Pt. Death or Permanent physical or mental damage.**
- **Self-terminating travel assignment without proper notice to facility or Staffing Agency.**

A nurse who receives *5* points will be considered for termination.
Any nurse involved in illegal activity will be terminated immediately.

I have read and understand the Termination Scale Policy of Global Healthcare Agency, LLC in particular the Sectio n entitled "Do Not Send policy and Process."

SIGNATURE: _____

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Employee Handbook Acknowledgement Form

I acknowledge that I have received a copy of Global Healthcare Agency, LLC, Inc. Employee Handbook. I acknowledge that I have been informed that the complete Global Healthcare Agency, LLC. employee handbook is available at www.globalhealthcareagencyllc.com

I understand that in processing my application with Global Healthcare Agency, LLC. an investigation may be made in which information is obtained through personal interviews, and a review of information held by law enforcement or other government agencies. I authorize you to verify my past employment and education, criminal records, motor vehicle records, personal references, and other job related data provided on this application, or via the interview process. I authorize appropriate individuals, companies, institutions or agencies to release information, and I release them from any liability as a result of such inquires or disclosures. A consumer report may be generated summarizing this information. I further understand and waive my right of privacy in this investigation and release and hold harmless Global Healthcare Agency, LLC. from any liability. I agree that any decision to hire me is contingent upon the results of my report and certify that all statements and answers on my application, resume, or Interview are true and complete to the best of my knowledge. I understand that if any statements are false or that if information has been omitted, this will be cause for disqualification and immediate termination of my employment if employed. I further authorize Global Healthcare Agency, LLC. to check my credit and conviction records, as needed, on a continuous basis as it relates to my employment. I am granting Global Healthcare Agency, LLC. authorization to release confidential medical Information upon the request from Global Healthcare Agency, LLC. clients while I am actively working at the client's facility and /or during the profiling and placement processes.

I understand that Global Healthcare Agency, LLC's goal is to always provide me with a consistent level of service. If for any reason I am dissatisfied with Global Healthcare Agency, LLC.' service or the service provided by one of Global Healthcare Agency, LLC. Clients, I am encouraged to contact the local manager to discuss the issue. Global Healthcare Agency, LLC. has processes in place to resolve customer complaints in an effective and efficient manner. If the resolution does not meet my expectation, I am encouraged to call the Global Healthcare Agency, LLC. corporate office at (571) 401-1933. A corporate representative will work with me to resolve my concern. I understand that any individual or organization that has a concerns about the quality and safety of patient care delivered by Global Healthcare Agency, LLC. healthcare professionals, which has not been addressed by Global Healthcare Agency, LLC. management, is encouraged to contact the Joint Commission at
www.jointcommission.org or by calling the Office of Quality Monitoring at 630 792 5636. Global Healthcare Agency, LLC. demonstrates this commitment by taking no retaliatory or disciplinary action against employees when they do report safety or quality of care concerns to the Joint Commission.

I have read and understand the entire Global Healthcare Agency, LLC. policies and my requirements as a Global Healthcare Agency, LLC. employee In particular the Section entitled "Do Not Send policy and Process". I understand that if I have any questions and/or need clarification for items addressed in the handbook, it is my responsibility to contact the Global Healthcare Agency, LLC. office to discuss.

_____	_____	_____
EMPLOYEE NAME	**EMPLOYEE SIGNATURE**	**DATE**

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Acknowledgement of Annual Education and Confidentiality of Patient Healthcare Information

Administrative
Code Of Conduct
Standards of Conduct
- Dress Code / Fingernail Policy
- Substance Abuse : Drugs in the Workplace
- Sexual and Other Unlawful Harassment
- Customer service
- Physical Assault / Workplace Violence
- Child & Elder Abuse

Safety Management
- Life Safety (FIRE) Management
- Environmental Safety
- Emergency Preparedness / Disaster Safety
- Electrical Safety
- Chemical Safety / Hazardous Communications

Joint Commission Education
- National Patient Safety Goals
- Do-Not-Use Abbreviations
- Infection Control
- CDC Hand Hygiene Guidelines
- Isolation and Standard Precautions
- Bloodborne Pathogens
- Tuberculosis

Medication Safety and Documentation System (MSDS)
Suspected Abuse : Identification, Treatment and Reporting
Domestic Violence
Nursing Essentials
- Restraints
- End Of Life Care
- Emergency Codes
- Age specific Education
- EMTALA
- The HIPPA Privacy Rule
- Body Mechanics
- Advance Directives Understanding
- Cultural Diversity Discharge
- Planning
- Patient Rights and
- Responsibilities Utility
- Management
- Patient Education
- Medical Equipment Management
- Pain Management
- Radiation Safety
- Fall Prevention

Preventing Medication Errors

Compliant Resolution (Staff and Customer)
Human Resources
Performance Improvement and Education Program
Reporting Any Issues
Clinical Incidents and Sentinel Events

I understand that the above mentioned materials provide guidelines and summary information about the company's policies and procedures. I also understand that it is my responsibility to read, understand, become familiar with, and comply with the standards that have been established.

Name : _____

Signature : _____

Date : _____

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Authorization to Disclose information on Employment file, Background check, Medical Records and Drug Screening

By affixing my signature hereunder, I authorize Global Healthcare Agency, LLC. to release any and all confidential employment background check and medical information contained in my employment file to any medical facility or entity with which Global Healthcare Agency, LLC. has staffing agreement, and to any other governmental or regulatory agency such agency's request. For all other purposes, Global Healthcare Agency, LLC, shall keep my employment confidential and shall advise any medical facility or other entity to which records have been provided to also keep such record confidential. I hereby hold Global Healthcare Agency, LLC. harmless for any result (s) that arises with regards to the release of this confidential information by Global Healthcare Agency, LLC. Medical records information is confidential and Global Healthcare Agency, LLC. will instruct client facilities and / or other entities to treat the provided information confidential as well.

I consent to a urine, blood or breath sample for the purpose of an alcohol drug, intoxicant or substance abuse screening test. Furthermore, I consent to the release of the results for purposes for determining the fitness of employment or continued employment.

I authorize Global Healthcare Agency, LLC. to contact past employers and references regarding my employment history. I hereby release all previous employers and references from any liability for furnishing this information in this application, reference information and medical information to Global Healthcare Agency, LLC. and any facilities I might be sent on assignment.

My signature hereunder further indicated that I have read and understood the Employee authorization to release confidential information on employment file, background check, medical records and drug screening.

I certify that the facts contained in this application are true and accurate. I authorize the employer to investigate any and all questions relating to this application. I release all parties from all liability, including but not limited to, the employer and any person, firm or corporation who provides information concerning my prior education, employment or character.

Global Healthcare Agency, LLC. does not discriminate in respect to hiring, termination, compensations and all other terms and conditions of privileges of employment on the basis of race, color, national origin, ancestry, sex, age, pregnancy or related medical conditions, marital status, religious creed or disability.

_____	_____	_____
Name (Print Name)	**Signature**	**Date**

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PHYSICIAN'S STATEMENT

I hereby authorize Platinum Healthcare Staffing to use or disclose this information to its client facilities, which may be relevant in evaluating my qualifications for employment opportunities and related activities.

_____ _____
Applicant Signature Date

I certify that _____ is in good physical and mental health, free of any communicable diseases, and is able to physically perform the job functions without restrictions.

_____ _____
Patient's Date of Birth Patient's Social Security Number

_____ _____
Physician's Signature Date of Medical Examination

_____ _____
Physician's License Number Physician's Name

CLINIC STAMP:
(Please make sure to have this stamped by the clinic)

Clear Form

Voluntary Self-Identification of Disability

Form CC-305
OMB Control Number 1250-0005
Expires 1/31/2017

Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities.[i] To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Deafness
- Cancer
- Diabetes
- Epilepsy
- Autism
- Cerebral palsy
- HIV/AIDS
- Schizophrenia
- Muscular dystrophy
- Bipolar disorder
- Major depression
- Multiple sclerosis (MS)
- Missing limbs or partially missing limbs
- Post-traumatic stress disorder (PTSD)
- Obsessive compulsive disorder
- Impairments requiring the use of a wheelchair
- Intellectual disability (previously called mental retardation)

Please check one of the boxes below:

☐ YES, I HAVE A DISABILITY (or previously had a disability)
☐ NO, I DON'T HAVE A DISABILITY
☐ I DON'T WISH TO ANSWER

_____ _____
Your Name Today's Date

Reasonable Accommodation Notice

Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

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[i] Section 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

GLOBAL
HEALTHCARE AGENCY, LLC
11 Quantum Way
Fredericksburg, VA 22406
Tel: 571-401-1933 Fax: 571-401-1194

TB QUESTIONNAIRE

Employment Name: _____ **Date:** _____

STEP I:
If you have had a positive PPD in the past, **go to STEP II.** If you received PPD's on an annual basis, complete **STEP I ONLY**.

DATE OF LAST PPD: ____/____/_____ **RESULTS OF LAST PPD IN MM:** _____

STEP II:
Since you have had a positive / sensitive PPD and are no longer required to have an annual chest x-ray, the following is to be completed annually and maintained in the personnel file. However, you must have the results of at least one XRAY on file.

DATE OF LAST XRAY: ____/____/_____

Please read and put a checkmark in the correct YES / NO space if you are experiencing any of the following symptoms or if any of the following apply to you:

	YES	NO
1. Unplanned loss of weight (>10% of body weight).....	☐	☐
2. Night sweats.....	☐	☐
3. Fever lasting several weeks.....	☐	☐
4. Frequent coughing in the absence of a cold or flu	☐	☐
5. Coughing blood-streaked sputum.....	☐	☐
6. Unusual tiredness or weakness lasting weeks.....	☐	☐
7. Pain in chest when taking a breath	☐	☐
8. Have you been recently diagnosed with diabetes, silicosis, HIV disease, renal disease or liver disease?.....	☐	☐
9. Have you been recently been exposed to a family member or other with active TB?.....	☐	☐

If you checked YES to any of the above questions, are you currently treating with a physician?

☐ **YES** ☐ **NO**

Please explain:

_____

_____

_____

IF YOU DEVELOP ANY OF THE SYMPTOMS LISTED ABOVE, PLEASE CONTACT YOUR PHYSICIAN AND AGENCY **IMMEDIATELY**. A CHEST X-RAY **MUST** BE PERFORMED PRIOR TO WORKING AGAIN.

SIGNATURE: _____

Clear Form

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Hepatitis B Vaccine informed consent / waiver

HEPATITIS B

Is a viral infection caused by Hepatitis B virus (HBV) which causes death in 1-2% of patients. Most people with hepatitis B recover completely but approximately 5-10% becomes chronic carriers of the virus. Most of these people have no symptoms but can continue to transmit the disease to others. Some may develop chronic active hepatitis and cirrhosis. **HBV also appears to be a causative factor in the development of live cancer.** Thus, immunization against hepatitis can prevent acute hepatitis and also reduce sickness and death from chronic active hepatitis, cirrhosis and liver cancer.

VACCINE

The Hepatitis B vaccine is produced from the plasma of chronic HBV carriers. The vaccine consists of highly purified formalin-inactivated hepatitis B antigen (viral coating material). It has been extensively tested for safety in chimpanzees and three doses of vaccine achieve high levels of surface antibody.
(anti-HBS) and protection against Hepatitis B. Persons with immune system abnormalities such as dialysis patients have less response to the vaccines but, over half of those receiving it do develop antibodies. Full immunization requires 3 doses of vaccine over 6 month's period although; some persons may not develop immunity after 3 doses. There is no evidence that the vaccine has ever caused hepatitis B or AIDS. However, persons who have been infected with HBV prior to receiving the vaccine may go on to develop clinical hepatitis in spite of immunization. The duration of immunity is unknown at this time, but is probably long term.

POSSIBLE SIDE EFFECTS

The incidence of side effects is very low. No serious side effects have been reported with the vaccine. A few persons experienced tenderness and redness at the site injection. Low grade fever may occur. Rash, nausea, joint pain and mild fatigue have also been reported. The possibilities exist that more serious side effects may be identified in the future.

Declination

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 informed and have the opportunity to ask questions and understand the benefits and risks of Hepatitis B vaccine. I understand that I must have three (3) doses of vaccine to confer immunity. However, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience an adverse side effects from the vaccine. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B which is a serious disease.

Name:_____ Position: _____ Date: _____

Attestation

I have already been vaccinated for Hepatitis B. I will be able to provide the proper documentation or record of my vaccination.

Name: _____ *Position:* _____ *Date:*_____

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Respiratory Fit Test

Participant's Name (Please print): _____

Classification: _____Sensitivity # (Number of squeezes needed to detect taste): _____

Breathing normally	____**Pass**	____**Fail**
Breathing deeply	____**Pass**	____**Fail**
Turning head from side to side	____**Pass**	____**Fail**
Nodding head up and down	____**Pass**	____**Fail**
Resuming normal breathing	____**Pass**	____**Fail**
Bending Over	____**Pass**	____**Fail**
Grimace (15 seconds)	____**Pass**	____**Fail**
Speaking	____**Pass**	____**Fail**

Based on standard criteria used in respiratory fit-testing procedures, the above participant has the following designation after being tested:

____**Alpha Protech N95** ____**3M N95**

The above participant has been determined to be fitted for the following size respirator:

____**SMALL** ____**MEDIUM** ____**LARGE**

Tested By (Print Name):_____

Tester's Signature: _____ Date: _____

Safe use of respiratory equipment is the responsibility of the user. Re-testing shall be performed in the event of a weight change of 20 pounds or more, significant facial scarring, major dental changes, cosmetic surgery or any other change which may affect respirator sealing. It is the responsibility of the wearer to inform their supervisor of the OSHA-regulated facility of any changes necessary for re-testing.

Participant's Signature: _____ Date: _____

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TEL: 571-401-1933 FAX: 571-401-1194

Vaccination Attestation Form

ANNUAL FLU VACCINE

☐ I have been vaccinated for influenza this flu season. Date: _____ (On file agency)

☐ I have a contraindication to receiving the influenza vaccine.

☐ I decline the influenza vaccine, and I understand that due to my occupational exposure, I may be at risk of acquiring influenza infection. In addition, I may spread influenza to my patients and other healthcare workers, and my family, even if I have no symptoms. This can result in serious infection, particularly in persons at high risk for influenza complications. Accordingly, I understand that for infection control purposes I will be required to wear a surgical mask (except in the main lobby or cafeteria) throughout the flu season.

H1N1 VACCINE

☐ I have been vaccinated for H1N1 flu season. Date: _____ (On file agency)

☐ I have a contraindication to receiving the H1N1 flu vaccine.

☐ I decline the H1N1 vaccine, and I understand that because I work in a healthcare environment I may place patients or co-workers at risk of illness or death if I work while infected with H1N1 (flu) virus. I am required to wear a mask at all times while in any clinical area during the influenza season. My agency and manager, including division and department leadership will be notified that I declined.

_____
Signature

_____
Print Name

_____
Date of Attestation

_____
Agency Representative Signature

Clear Form

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Fredericksburg, VA 22406
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LATEX ALLERGY QUESTIONNAIRE

EMPLOYEE NAME: _____
POSITION: _____

1. Please check the appropriate answer:
   - Are you allergic to latex? YES_____ NO_____
     - Do you wear latex gloves? YES_____ NO_____
   - Do you suffer from skin rashes on your hands? YES_____ NO_____
2. If you have ever worn latex gloves: YES_____ NO_____
   - Have you had a rash, itching, or cracking of your hands? YES_____ NO_____
   - Have these symptoms recently changed? YES_____ NO_____
   - Have you been using different types of rubber gloves? YES_____ NO_____
   - If you have tried non-latex gloves, did your problem persist? YES_____ NO _____
3. When you are wearing or around others that wearing latex gloves, have you noted any:
   - Itchy red eyes, sneezing, runny or stuffy nose? YES_____ NO_____
   - Shortness of breath, wheezing, or chest tightness? YES_____ NO_____
4. If you have answered YES to any of the above questions, please explain:

_____
_____
_____

EMPLOYEE SIGNATURE: _____ **DATE:** _____

Clear Form

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11 Quantum Way, Fredericksburg, VA 22406
Tel: 571 401 1933 Fax: 571 401 1934
www.globalhealthcareagencyllc.com

TDAP Immunization Declination Form

I understand that my occupational exposure to patients, blood or other potentially infectious materials at healthcare facilities with the following vaccine preventable diseases puts me at risk of acquiring the disease. I have had the opportunity to be vaccinated, however, I choose to decline the vaccination(s) checked below at this time. I understand that by declining vaccine protection I continue to be at risk of acquiring the disease.

_____ I have received the TDAP vaccine on _____ (date)

_____ I have received TD vaccine on _____ (date)

_____ I refuse vaccination at this time

I understand that in the event of exposure, I may be requested to not visit healthcare facilities for at least the incubation period of the disease to which I have been exposed.

I acknowledge that each healthcare facility determines vaccination requirements, and that a vaccination declination may not satisfy these requirements.

Printed Name: _____

Signature: _____

Date: _____

GLOBAL
HEALTHCARE AGENCY, LLC
11 Quantum Way
Fredericksburg, VA 22406
Tel: 571-401-1933 Fax: 571-401-1194

Welcome to Global Healthcare Agency, LLC. Your employment at Platinum Global Healthcare Agency, LLC is at will and either party may terminate employment with or without cause. This agreement is not designed to be a contract or to alter the at-will nature of the employment relationship. If you accept employment with Platinum Healthcare, you agree to abide by the Company's rules and policies set forth in this agreement and in the employee manual.

1. I understand that I will be required to provide, in a timely manner, all necessary documentation, including but not limited to, my resume, licenses, certificates, physical report, drug screens, background checks etc. in order for me to be approved for any travel/per-diem assignment with a Platinum Healthcare client. Failure to do so may result in termination of my employment with Platinum Healthcare.

2. I understand that as part of the above approval process, an investigation may be made in which information is obtained through personal interviews, and a review of information held by law enforcement or other government agencies. I hereby authorize you to verify my past employment and education, criminal records, motor vehicle records, personal references, and other job related data provided on this application, or via the interview process. I authorize appropriate individuals, companies, institutions or agencies to release information, and I release them from any liability as a result of such inquiries or disclosure.

3. I understand that I am not in any obligation to accept an assignment offered by Platinum Healthcare. But once I accept a travel/per-diem assignment, I pledge the following:

    a. To cooperate with the Client's reasonable instructions and accept the direction, supervision, and control of any and all responsible person(s) in the Client facility
    b. To observe any relevant rules and regulations of the Client facility to which my attention has either been drawn or which I might reasonably be expected to ascertain
    c. To not engage in any conduct detrimental to the interests of the Client
    d. To honor my commitment to complete any assignment/shift that I have accepted. If I fail to complete any assignment/shift, I understand that I have voluntarily terminated my employment with Platinum Healthcare.

4. I understand that I am to contact my Platinum Healthcare representative immediately if I am experiencing any difficulty on my assignment/shift or if there are any changes in job description, location, or working hours by the Client.

5. I am to contact Platinum Healthcare immediately if it is impossible for me to report to work. Platinum Healthcare staffers are available 24/7, so you may call us any time of the day or night; however our normal office hours are 8:00 am to 5:00 pm, Monday to Friday. Please call us in enough time that we might schedule a replacement for your position. **I understand that if I do not report to my assignment and/or do not call Platinum Healthcare, I have voluntarily terminated my employment with Platinum Healthcare.** I understand that I must notify Platinum Healthcare beforehand if I am late for work or take time off, **failing which I understand that I have voluntarily terminated my employment with Platinum Healthcare.**

6. If I am confirmed for a shift and I cancel my availability for that shift later than 2 hours before the start of that shift, then I may be required to pay a late cancellation fee equivalent to 4 hours times the Client bill rate. The late cancellation penalty will be applied to my payroll by deducting the full amount from the next payroll cycle.

7. While on a temporary assignment, if the Client offers me a permanent position or if one is discussed, I will contact my Platinum Healthcare representative immediately. All fees and conditions are to be handled by Platinum Healthcare. It is unlikely that one of Platinum Healthcares' Clients would ask me to work for them on my own rather than through Platinum Healthcare. I understand that if I go work directly for a Client within one year of my temporary assignment, I will be responsible for paying all employment fees or charges incurred.

8. I understand that Platinum Healthcare is committed to maintaining a safe working environment for all employees. If I am ever asked to do anything unsafe, observe unsafe working conditions, or am injured at work, I will contact Platinum Healthcare immediately. Furthermore, I agree to perform all work in as safe a manner as possible. If I experience an accident or injury while working for Platinum Healthcare, I will notify Platinum Healthcare within 48 hours of the incident.

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9. I understand that all client and patient information supplied to me shall be held in strictest confidence, and all product and materials, including, but not limited to, patent records, client records, documentation, reports, charts, manuals, letters, programs and any and all other sources of information given to me or obtained by me from the client or at the work location will be returned to the Client at the completion of my shift/assignment. I also agree not to disclose any company trade secrets or confidential information of Platinum Healthcare or its Client to any other entities or individuals.

10. Platinum Healthcare issues paychecks every Friday for the hours worked in the preceding week. I understand I am required to present to Platinum Healthcare, EVERY MONDAY, an actual timesheet signed by the Client in order to have my paycheck issued on Friday. If I fail to provide such time card in a prompt manner, I understand that it will result in my pay being carried over to the next pay period.

11. I understand that ALL overtime hours must be pre-authorized by Platinum Healthcare. If I work overtime that is not pre- authorized, I accept and understand that I will not be paid for those hours. I further understand that all matters relating to the Platinum Healthcare wages and rates are confidential and I will not discuss them with Clients, other employees of client or Platinum Healthcare, or any co-worker at the work location, and in doing so, could result in my immediate dismissal from the assignment and possible termination from Platinum Healthcare.

12. I understand that any monies due Platinum Healthcare resulting from loans, advances, damaged property, lost property including badges, or unauthorized use of property, including, but not limited to late shift cancellation penalties, the unauthorized or improper use of telephone, postage meters, computer equipment, software etc. at Platinum Healthcare or the Client, may be deducted from my paycheck(s).

13. **When assigned to a contract or per-diem assignment, I understand that within 24 hours from the last day of my assignment, I am required to confirm my availability for a new assignment. I understand that it must be in WRITING ONLY, by either email to staffing@globalhealthcareagencyllc.com OR fax to 571 401 1934. I accept and understand that when I do not email or fax my availability within the specified time period, I am refusing further work with Platinum Healthcare and thereby voluntarily resigning from my employment with Platinum Healthcare. I understand that my unemployment benefits may be denied when I voluntarily resign my employment with any company.**

14. I understand that the assignment is based on the agreement between Platinum Healthcare Staffing and the Client Facility. Client Facility has the right and privilege to cancel or modify the terms of the assignment with or without notice. I understand and accept that Platinum Healthcare will not be liable for any consequential damages, losses, expenses, inconveniences, or loss of alternative employment as a result of Client Facility's changes to the assignment. I understand Platinum Healthcare Staffing will be obligated to pay only for the approved hours worked as indicated on a client-approved timesheet.

15. I understand and agree that in case of dispute or controversy arising from or relating to this Employment Agreement, the matter shall be referred for resolution to Platinum Healthcare, whose decision shall be final and binding on both parties.

As a condition of my employment with Platinum Healthcare, I hereby acknowledge and agree to the above on this _____day of _____, 20____. I acknowledge that before I signed the document, I was provided a copy for my review and was advised to seek legal counsel before signing this document.

_____ _____

PRINT NAME **SIGNATURE**

_____ _____

WITNESSED BY **DATE**

Clear Form

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. 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-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name (*Family Name*)	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

Address (*Street Number and Name*)	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	___-___-____		

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 of the United States
- ☐ A noncitizen national of the United States *(See instructions)*
- ☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- ☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

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.

Signature of Preparer or Translator:	Date *(mm/dd/yyyy):*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

CLEAR FORM

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A OR List B AND List C		
Identity and Employment Authorization	**Identity**	**Employment Authorization**
Document Title:	Document Title:	Document Title:
Issuing Authority:	Issuing Authority:	Issuing Authority:
Document Number:	Document Number:	Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:	Expiration Date *(if any)(mm/dd/yyyy)*:	Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:		
Issuing Authority:		
Document Number:		
Expiration Date *(if any)(mm/dd/yyyy)*:		
Document Title:		
Issuing Authority:		
Document Number:		
Expiration Date *(if any)(mm/dd/yyyy)*:		

3-D Barcode
Do Not Write in This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ **(*See instructions for exemptions.*)**

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name
		GLOBAL HEALTHCARE AGENCY, LLC.

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code
11 QUANTUM WAY	FREDERICKSBURG	VA	22406

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)* Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	**B.** Date of Rehire *(if applicable) (mm/dd/yyyy):*

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date *(if any)(mm/dd/yyyy)*:

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized 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 *(mm/dd/yyyy):*	Print Name of Employer or Authorized Representative:

CLEAR FORM

Form W-4 (2016)

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 2016 expires February 15, 2017. 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 $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

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 can 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. 505 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. 505 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. 505 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. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • 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** _____
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** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . .	**E** _____
F	Enter "1" if you have at least $2,000 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** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child . .	**G** _____
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** _____

For accuracy, complete all worksheets that apply.

- 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 are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 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.

---------- **Separate 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

Employee's Withholding Allowance Certificate

► **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.**

OMB No. 1545-0074

2016

1	Your first name and middle initial	Last name	**2** **Your social security number**
	Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ 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.** ► ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2016, and I certify that I meet **both** of the following conditions for exemption. • 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**	

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)

Global Healthcare Agency, LLC.

11 Quantum Way
Fredericksburg, VA 22406
Tel: (571) 401 1933 Fax (571) 401 1934

Direct Deposit Agreement Form

Authorization Agreement

I hereby authorize **Global Healthcare Agency, LLC.** to initiate automatic deposits to my account at the financial institution named below. I also authorize **Global Healthcare Agency, LLC.** to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold **Global Healthcare Agency, LLC.** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until **Global Healthcare Agency, LLC.** receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

Account Information

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____ Checking ☐ Savings ☐

Signature

Authorized Signature (Primary): _____ **Date:** _____

Authorized Signature (Joint): _____ **Date:** _____

Please attach a voided check or deposit slip and return this form to the Payroll Department.

PAYCHEX

Direct Deposit Signup/Change Form

WORKER – REQUIRED INFORMATION

PLEASE PRINT

Worker Name _____

Last four digits of Social Security Number ___ ___ ___ ___

WORKERS: Retain a copy of this form for your records. Return the original to your employer.

EMPLOYERS: Return this form to your local Paychex office.

COMPLETE TO ENROLL OR CHANGE ENROLLMENT IN DIRECT DEPOSIT

Bank Account Number*	Type of Account	Bank Name	Deposit Type (check one):	Change My Deposit Amount to:
	☐ Checking ☐ Savings		☐ Remainder of Net Pay ☐ _____% of Net ☐ Specific Dollar Amount $ _____ .00	☐ Remainder of Net Pay ☐ _____ % of Net ☐ Specific Dollar Amount $_____ .00 ☐ **Remove from Direct Deposit**
	☐ Chase Pay Card *Plus*	If Chase Pay Card *Plus*, fill out attached application.		
	☐ Checking ☐ Savings		☐ Remainder of Net Pay ☐ _____% of Net ☐ Specific Dollar Amount $ _____ .00	☐ Remainder of Net Pay ☐ _____ % of Net ☐ Specific Dollar Amount $_____ .00 ☐ **Remove from Direct Deposit**
	☐ Chase Pay Card *Plus*	If Chase Pay Card *Plus*, fill out attached application.		

Please attach one of the following for Checking or Savings accounts (check one):

- ☐ **Voided check with name imprinted (no starter checks)**
- ☐ **Deposit slip (only accepted if the verbiage "ACH R/T" appears before the routing number)**
- ☐ **Bank letter or specification sheet (the signature of your local bank representative MUST be included)**

***Certain accounts may have restrictions on deposits and withdrawals. Check with your bank for more information specific to your account.**

WORKER CONFIRMATION STATEMENT

I authorize my employer to deposit my wages/salary into the bank accounts specified above. My signature below indicates that I am agreeing that I am either the accountholder or have the authority of the accountholder to authorize my employer to make direct deposits into the named account.

Worker Signature _____ **Date** _____

Accountholder Signature _____

(if worker's name does not appear on bank documentation)

EMPLOYER SECTION ONLY

PLEASE PRINT

Company Name _____

Service Location/Client Number _____

Federal ID Number (last 4 digits) ___ ___ ___ ___

If bank documentation provided is different from what is listed above, the following must be completed by the employer:

I confirm that the above named employee has added or changed a bank account for direct deposit transactions processed by Paychex, Inc.

Employer Signature _____ **Date** _____

Paychex Use Only

Worker # _____ Time & Date _____

PRS _____ Contact _____

Verified By _____ CSS _____

Scanning instructions are located in Paychex Procedures.