

## **Information Checklist**

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

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

1. Driver's License
2. Social Security Card
3. Current Nursing License
4. Current CPR Card
5. Any other credentials that you may have  
\*\*Ex. ACLS, PALS, NALS, IV certification for LPNs
6. Current TB/PPD verification
7. Proof of Hepatitis B shots, if applicable
8. Name Tag with Name and Title and voucher will be provided upon receiving completed packet.

All medical facilities require a yearly TB skin test, a current Nursing License, and a current CPR card. Anytime you receive a new TB or CPR, please fax all new information to your local office. Please fax your new Nursing License to our office each January.





A PROFESSIONAL MEDICAL STAFFING COMPANY

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Phone No.: \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_

Position: \_\_\_\_\_

Duties: \_\_\_\_\_

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: \_\_\_\_\_

Name of Company \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone No.: \_\_\_\_\_



**From:** \_\_\_\_\_ **To:** \_\_\_\_\_

**Position:** \_\_\_\_\_

**Duties:** \_\_\_\_\_

\_\_\_\_\_

**Education:**

**School Name #1:** \_\_\_\_\_ **Yr. Grad:** \_\_\_\_\_

**City/State:** \_\_\_\_\_ **Degree:** \_\_\_\_\_

**School Name #2:** \_\_\_\_\_ **Yr. Grad:** \_\_\_\_\_

**City/State:** \_\_\_\_\_ **Degree:** \_\_\_\_\_

**School Name #3:** \_\_\_\_\_ **Yr. Grad:** \_\_\_\_\_

**City/State:** \_\_\_\_\_ **Degree:** \_\_\_\_\_

**Other Licensure:**

**State:** \_\_\_\_\_ **Lic.#:** \_\_\_\_\_ **Expires:** \_\_\_\_\_

**Nursing License 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**

## 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 FCMS if I will continue to contract my services through FCMS 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 FCMS.**

\_\_\_\_\_  
Signature and Title

\_\_\_\_\_  
Date

First Choice Medical Staffing, Inc., has in place an annual education program to train healthcare workers to be knowledgeable and understand the OSHA standards CFR 1910:1030 and JCAHO requirements of safety.

I have demonstrated competency and understanding in the following areas:

- A. Fire Safety
- B. Body Mechanics
- C. Chemical Hazards/MSDS
- D. CDC Guidelines & Infection Control
- E. Bloodborne Pathogens, Universal Precautions, Aids, & TB
- F. Venipuncture Assessment
- G. Pharmacology Exam
- H. HIPPA COMPLIANCE

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**AGE SPECIFIC CRITERIA CHECKLIST**

**Independent Contractor's Name:** \_\_\_\_\_

**Please check all applicable areas:**

	Neo-Natal			Peds			Adolescents			Adult			Geriatrics			
	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 (i.e., meds, equipment, etc.)																
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:**

## HIPAA

I have been instructed on the policies and procedures of First Choice Medical Staffing, Inc. and HIPAA regulations. I have completed a post-test on HIPPA regulations which is located in my personnel record. I have fulfilled First Choice Medical Staffing, Inc.'s formal orientation and have read and signed the job description pertaining to my responsibilities and classification.

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Employee Signature

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Date

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Print Name

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Agency Representative

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Date

**URINE DRUG SCREEN  
DRUG CHECK  
Nx STEP ONSITE**

**DONOR INFORMATION**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

EMPLOYEE ID: \_\_\_\_\_

TYPE OF IDENTIFICATION PROVIDED:

DRIVER'S LICENSE \_\_\_\_\_ EMPLOYEE PHOTO ID: \_\_\_\_\_ OTHER: \_\_\_\_\_

**SCREEN RESULTS**

TEST REF# 60605 TIME COLLECTED \_\_\_\_\_ (A.M./P.M.) TIME INTERPRETED \_\_\_\_\_  
TEMPERATURE: \_\_\_\_\_ NORMAL(90-100 F) OTHER \_\_\_\_\_

DRUG NAME	SYMBOL	NEGATIVE	POSITIVE
COCAINE	(COC)	_____	_____
MARIJUANA	(THC)	_____	_____
OPIATES	(OPI)	_____	_____
AMPHETAMINES	(AMP)	_____	_____
PHENCYCLIDINE	(PCP)	_____	_____
BENZODIAZEPINE	(BZD)	_____	_____
BARBITURATE	(BAR)	_____	_____
METHADONE	(MTD)	_____	_____
METHAMPHETAMINE	(MET)	_____	_____
ECSTASY	(MD MA)	_____	_____
PROPOXYPHENE	(PPX)	_____	_____

**CERTIFICATION**

I hereby agree to submit to a urinalysis for the purpose of testing for drug metabolites.  
The specimen provided is my own and has not been substituted or adulterated.

\_\_\_\_\_  
Donor Signature

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date/Time

## Consent for Criminal Background Check

This authorization will allow you to release to First Choice Medical Staffing, Inc., or its representatives, all information you may have regarding any criminal **convictions** of any nature whatsoever regarding the individual named below.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Parish: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Authorized Agent

Driver's License Verified: \_\_\_\_\_  
Date Initial

Social Security Card Verified: \_\_\_\_\_  
Date Initial

**CNA JOB DESCRIPTION/SKILL CHECKLIST**

**QUALIFICATIONS:**

1. Certified by the State of Louisiana
2. Current CPR
3. 1 year experience

**RESPONSIBILITIES:**

1. Observed and chart finding on the proper form
2. Bathe Patients
3. Feed patients by mouth
4. Take vital signs
5. Help monitor intake and output
6. Help ambulate patients
7. Make beds
8. Prepare food
9. Make beds
10. Prepare food
11. Wash clothes
12. Turn patients
13. May not give medication
14. May not run errands outside home or hospital while on duty
15. May not transport patients outside the home or hospital while on duty
16. May not drive personal vehicle or drive patient/clients vehicle while on duty

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Certified Nursing Assistant

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Date

<b>CNA SKILLS CHECKLIST:</b>	1	2	3	4	5
Observed & Chart Findings					
Bathe patients					
Feed patients by mouth					
Take vital signs					
Help monitor intake and output					
Make beds					
Prepare food					
Wash clothes					
Turn patients q two hours or as ordered					
Ambulate patients					
Cold applications					
Dry-Hot applications					
Bed positioning					
Daily catheter changes					
Urine collections					
Enemas					
Ostomy care					
O2 safety					
ROM exercises					
Restraints as needed and ordered					
Reporting findings to RN as needed					

Please check number for each skill as it applies to you:

- 1 \_\_ need instruction
- 2 \_\_ need to observe procedure
- 3 \_\_ need further practice under supervision
- 4 \_\_ have basic understanding (may need to be spot checked)
- 5 \_\_ can perform procedure safely and without supervision

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**INDEMNITY/HOLD HARMLESS AGREEMENT**

This is an agreement between First Choice Medical Staffing of Louisiana, Inc. (hereafter "First Choice") and the personnel (hereafter referred to as the "undersigned" or "personnel") it places as contract workers in healthcare/provider facilities. First Choice's mission is to place needed personnel into various healthcare facilities. At all times, when personnel is traveling to, performing work at, and/or traveling away from the healthcare facility, the undersigned person is an independent contractor as defined under LA R.S. 23: 1021(7).

First Choice does not exercise any control or supervision whatsoever over said personnel when they are performing their employment duties at the healthcare facility. Personnel are under the supervision and control of the healthcare facility where he or she is working at all times.

First Choice suggests that independent contractors should maintain their own medical and disability insurance at all times.

As such, First Choice and \_\_\_\_\_, the undersigned, agree that in the event of an accident of any kind or cause, First Choice will not be held responsible or liable for damages by the undersigned in tort, workers' compensation, or under any other avenue of compensation. The undersigned agrees to indemnify First Choice against liability and assume all risks associated his or her duties while working as an independent contractor in any healthcare facility where he or she is placed.

This agreement will remain in effect unless the undersigned notifies First Choice in writing that he or she wishes to terminate the agreement, at which time the undersigned will be ineligible for placement services from First Choice.

\_\_\_\_\_  
Independent Contractor/Undersigned

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

## Request for Taxpayer Identification Number and Certification

**Give form to the  
 requester. Do not  
 send to the IRS.**

Print or type See Specific Instructions on page 2	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/ Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶ .....	<input type="checkbox"/> Exempt from backup withholding
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
List account number(s) here (optional)		

### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number								
OR								
Employer identification number								

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

### Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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### Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

**U.S. person.** Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

**Foreign person.** If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

**Nonresident alien who becomes a resident alien.**

Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

**Example.** Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

**Payments you receive will be subject to backup withholding if:**

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 4 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules regarding partnerships* on page 1.

## Penalties

**Failure to furnish TIN.** If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

**Civil penalty for false information with respect to withholding.** If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

**Criminal penalty for falsifying information.** Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

**Misuse of TINs.** If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

## Specific Instructions

### Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

**Sole proprietor.** Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

**Limited liability company (LLC).** If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

**Other entities.** Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

**Note.** You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

### Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

**Note.** If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

**Exempt payees.** Backup withholding is not required on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
  2. The United States or any of its agencies or instrumentalities,
  3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
  4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
  5. An international organization or any of its agencies or instrumentalities.
- Other payees that may be exempt from backup withholding include:
6. A corporation,
  7. A foreign central bank of issue,
  8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
  9. A futures commission merchant registered with the Commodity Futures Trading Commission,
  10. A real estate investment trust,
  11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
  12. A common trust fund operated by a bank under section 584(a),
  13. A financial institution,
  14. A middleman known in the investment community as a nominee or custodian, or
  15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 <sup>1</sup>	Generally, exempt recipients 1 through 7 <sup>2</sup>

<sup>1</sup> See Form 1099-MISC, Miscellaneous Income, and its instructions.

<sup>2</sup> However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a federal executive agency.

## Part I. Taxpayer Identification Number (TIN)

**Enter your TIN in the appropriate box.** If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

**Note.** See the chart on page 4 for further clarification of name and TIN combinations.

**How to get a TIN.** If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at [www.socialsecurity.gov](http://www.socialsecurity.gov). You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at [www.irs.gov/businesses](http://www.irs.gov/businesses) and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting [www.irs.gov](http://www.irs.gov) or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

**Note.** Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

**Caution:** A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

## Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt From Backup Withholding* on page 2.

**Signature requirements.** Complete the certification as indicated in 1 through 5 below.

**1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.

**2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

**3. Real estate transactions.** You must sign the certification. You may cross out item 2 of the certification.

**4. Other payments.** You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

**5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions.** You must give your correct TIN, but you do not have to sign the certification.

## What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account <sup>1</sup>
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor <sup>2</sup>
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee <sup>1</sup>
b. So-called trust account that is not a legal or valid trust under state law	The actual owner <sup>1</sup>
5. Sole proprietorship or single-owner LLC	The owner <sup>3</sup>
For this type of account:	Give name and EIN of:
6. Sole proprietorship or single-owner LLC	The owner <sup>3</sup>
7. A valid trust, estate, or pension trust	Legal entity <sup>4</sup>
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

<sup>1</sup> List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

<sup>2</sup> Circle the minor's name and furnish the minor's SSN.

<sup>3</sup> You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one). If you are a sole proprietor, IRS encourages you to use your SSN.

<sup>4</sup> List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules regarding partnerships* on page 1.

**Note.** If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

## Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.



## ***PAYMENT INSTRUCTION FORM***

I, the undersigned, do hereby instruct and direct FCMS to pay all sums due to me for services rendered as an independent contractor on the following basis:

Daily \_\_\_\_\_  
Weekly \_\_\_\_\_  
Bi-Weekly \_\_\_\_\_  
Monthly \_\_\_\_\_

Facility: \_\_\_\_\_

Rate Of Pay: \_\_\_\_\_

I understand that I am an Independent Contractor and not an employee of FCMS and that it is my desire that FCMS regard the information signed by me on the daily invoice as accurate. I understand that I have the complete authority and power to elect to be paid on a basis purely of my own control and direction. I further understand that FCMS will issue payment to me for sums due within two working days after the end of the period elected above.

I understand that I am self-employed and am responsible for filing and paying my own federal, state, Social Security, and F.I.C.A. taxes. I also understand that I am not qualified to receive unemployment benefits under First Choice Medical Staffing. I further understand that FCMS is not responsible for my tax liability for fees received while sub-contracting my services through FCMS.

I authorize FCMS to release my payment for services to the following named persons:

1. \_\_\_\_\_
2. \_\_\_\_\_

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

I would like my payment for services mailed to me. (Initial if applicable.) \_\_\_\_\_

Independent Contractor: \_\_\_\_\_

Date: \_\_\_\_\_

## AGREEMENT TO SOLICIT AND PROVIDE NURSING SERVICES

This agreement outline the arrangement between an Independent Contractor, hereinafter referred to as IC and First Choice Medical Staffing, Inc., hereinafter referred to as FCMS. IC and FCMS are the only parties to this agreement.

FCMS's principal place of business is located at 2512 Prairie Rhonde Rd., Ville Platte, LA 70586  
IC principal place of business is located at:

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

In consideration of the terms hereinafter expressed, I, the undersigned Independent Contractor, hereby contract with FCMS, to solicit professional nursing services on my behalf to be rendered by me. I hereby agree to provide professional nursing services as a NURSE to \_\_\_\_\_ (hereinafter referred to as FACILITY) in need of those services. I understand that I am not guaranteed a position with any FACILITY for any period of time and that I will be asked to provide professional nursing services to FACILITY as the needs of the FACILITY dictate and that this is beyond the control of FCMS.

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

I understand and warrant that I have a professional status and that I hold myself out to the public and FCMS as capable of exercising an independent calling requiring specialized skills and that I ordinarily have full discretion in administering my professional services and that I am not under the direction or control of FCMS so as to create an employment relationship with FCMS. I further declare that I have complied with all federal, state, and local business permit and licensing requirements necessary to conduct business.

I understand that the fees for my services will be billed directly to the FACILITY by FCMS at a rate different from what I have negotiated with FCMS and that I may not directly bill the FACILITY to receive monies from the FACILITY. I understand that I may elect to be paid at a time of my choosing and that FCMS will pay me within two working days. If I elect to be paid in conjunction with FCMS's other accounts payable, I will be paid on the Thursday following each one-week billing period. (Each billing period commences Monday at 7:00 a.m. and terminates on the following Monday at 6:59 a.m.)

I agree that if I provide services directly to the FACILITY during the term of this agreement other than as an independent contractor through FCMS, I will be required to pay FCMS \$1,000.00 in damages. This will apply only to FACILITIES for whom my services have been solicited through FCMS.

I represent to FCMS and FACILITY that I am duly licensed as a NURSE in the State of Louisiana and that in providing the referenced professional services, I will be free from any control or direction by FCMS in the performance of professional services under this contract. I further understand, warrant, and represent that the referenced professional services will be provided outside all of the places of business of FCMS for which that service is performed and that I am customarily engaged in the independently established profession as an RN. I understand that I will be under the direction and control of only the FACILITY in need of the services I will render.

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 FCMS, 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. FCMS shall not be responsible for any expenses incurred by IC in performing services contracted through FCMS.

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 the FACILITY. All such assistants or substitutes shall be employees and/or subcontractors of IC and not of FCMS. IC assumes full responsibility for any assistants 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.

I further understand and agree that as an independent contractor I am and 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 me through professional services rendered by me pursuant to this contract. I agree to hold FCMS completely harmless for the payment of aforesaid taxes or fees and to fully indemnify FCMS for any sums including all taxes, fees, costs, attorney fees (expended by FCMS) and penalties (incurred by FCMS) should I not pay the aforesaid taxes or fees for any reason and/or any agency seeks to collect from FCMS any taxes or fees due by me. I understand that I will be responsible for filing a quarterly tax return and to pay on a quarterly basis the federal, state, and FICA taxes due as a result of the fees which I receive and that those taxes and the forms are due on April 15, October 15, and January 15 of each year.

The term of this agreement shall be for a period of 120 days from the date specified below or until such time as FACILITY terminates the staffing project.

This agreement signed in Ville Platte, Evangeline Parish, Louisiana this \_\_\_\_\_ day of \_\_\_\_\_, 2006.

Accepted by:

FIRST CHOICE MEDICAL STAFFING, INC.

\_\_\_\_\_  
Authorized Agent

\_\_\_\_\_  
Independent Contractor