# 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.

First Choice medical staffing, inc.    A PROFESSIONAL MEDICAL STAFFING COMPANY

# Contract Nurse Information

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

**Name:** ____________________ ________________________ ______________________
**Last** **First** **Middle (full)**

**Address:** ____________________________________________________________________

**City/State:** ______________________________________ **Zip Code:** __________________

**Home Phone:** ________________________________

**Cellular Phone:** ______________________________

**Pager:** ______________________________________

**Alternate Phone 1:** ____________________________

**Alternate Phone 2:**_____________________________

**Email Address:** _______________________________

**Social Security No.:** ___________________________

**Date of Birth:** ________________________________

**Referred By:** _________________________________

**Please Check One:**

**Registered Nurse:** _______

**Licensed Practical Nurse** ________

**Certified Nursing Assistant** _______

**Preferred Shifts:** _________________________________________________________________

**Work History – (Beginning with most recent)**

**Name of Company** ______________________________________________________________

**Address:** _______________________________________________________________________

**City/State/Zip:** __________________________________________________________________

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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.:** ______________________________________________________________

A PROFESSIONAL MEDICAL STAFFING COMPANY

**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: _____________

First Choice medical staffing, inc.

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# 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** | **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.

________________________________ ________________________

Employee Signature Date

________________________________

Print Name

________________________________ ________________________

Agency Representative Date

# URINE DRUG SCREEN
# DRUG CHECK
# Nx STEP ONSITE

**DONOR INFORMATION**

LAST NAME: ___________________________ FIRST NAME:__________________________

EMPLOYEE ID:_______________________________

TYPE OF IDENTITFICATION 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) | _______ | ________ |
| PHENCYLIDINE | (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**

First Choice medical staffing, inc.

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# 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**

# MED/SURG RN JOB DESCRIPTION

The basic function of this position is to plan, direct, and control all nursing activities for a specific area on a nursing unit in conjunction with the Head Nurse or charge nurse of the unit.

**RESPONSIBILITIES**

Accepts responsibilities delegated by the Head Nurse or team leader and evaluates the nursing care provided in the area assigned.

Provides leadership in the interpretation and application of the philosophy and objective of nursing service in assigned area.

As a team leader, directs and develops the abilities and skills of staff assigned to her jurisdiction, and makes oriented nurses notes according to audit committee standards.

Assists the physician with procedures and treatments. Administers treatments including sterile procedures.

Participates in team conferences with team leader and makes up team assignments.

Guides personnel in evaluating patient needs.

Performs patient care within the principles of Team Nursing, reporting pertinent observations or complaints to the team leader and/or Head Nurse.

Assists Head Nurse or charge nurse in personnel work evaluation.

Administers medications according to hospital policy.

Practices economical use of equipment and supplies, informs proper authority of discrepancies.

Attends and supports Inservice Education Programs.

Participates in or initiates CPR and Codes when necessary.

Serves on Nursing Committee when requested.

May make out patient assignment sheets if delegated by the Head Nurse.

__________________________ ______________________

Agency Nurse Date

Nurse Signature Date

# Medical/Surgical Skills Checklist

**Name________________________**

**A - Never Performed. You have never performed the stated task and have no experience with this type of skill.**

**B - Familiar with. You are familiar with the stated task; but you would need more experience and practice to feel comfortable and proficient in this type of skill.**

**C - Experience in. You have performed this task several times; you feel moderately comfortable functioning independently, but you would require a resource person to be nearby.**

**D - Expert. You have performed this task frequently; you feel comfortable and proficient in this skill; you would not require supervision or practice.**

**Please select the column that most accurately describes your proficiency level.**

| Skill | A | B | C | D | Skill | A | B | C | D |
|---|---|---|---|---|---|---|---|---|---|
| **NEUROLOGY:** | | | | | **CARDIOVASCULAR: (Cont.)** | | | | |
| Neurological Assessment: | | | | | Maintenance | | | | |
| Neuro Vital Signs | | | | | Obtaining 12 - Lead EKG | | | | |
| Glascow Coma Scale | | | | | Cardiopulmonary Rescusitation | | | | |
| Levels of Consciousness | | | | | Defibrillation/Cardioversion | | | | |
| Seizure Precautions | | | | | Care of Patient with: | | | | |
| Care of the Patient with: | | | | | Acute MI | | | | |
| Seizures | | | | | Pre-Post Cardiac Cath | | | | |
| CVA | | | | | Post Cardiac Surgery | | | | |
| Spinal Cord Injury | | | | | Post Thoracic Surgery | | | | |
| Spinal Surgery | | | | | CHF | | | | |
| Craniotomy | | | | | **RESPIRATORY:** | | | | |
| Neuromuscular Disease | | | | | Respiratory Assessment | | | | |
| Pre & Post Mylogram | | | | | Auscultation | | | | |
| Pre & Post Cerebral Angiogram | | | | | Airway Care & Maintenance: | | | | |
| Crutchfield Tongs | | | | | Oral Airway | | | | |
| Halo Traction | | | | | Nasal Airway | | | | |
| Roto Rest Bed | | | | | Endotracheal Tube | | | | |
| Stryker Frame | | | | | Tracheostomy | | | | |
| Skin & Skeletal Traction | | | | | Suctioning: | | | | |
| Assist w/ Lumbar Puncture | | | | | Oral Pharyngeal | | | | |
| Maintenance of Skin | | | | | Nasal Tracheal | | | | |
| **CARDIOVASCULAR:** | | | | | Tracheal Via ET Tube | | | | |
| Cardiovascular Assessment | | | | | Tracheal Via Trach | | | | |
| Auscultation | | | | | Incentive Spirometry | | | | |
| Arrhythmia Interpretation | | | | | Chest Physio Therapy | | | | |
| Telemetry | | | | | Care of Patient With: | | | | |
| Initiation | | | | | AIDS | | | | |

## Medical Surgical Skills Checklist Cont..............

| Skill | A | B | C | D | Skill | A | B | C | D |
|---|---|---|---|---|---|---|---|---|---|
| **RESPIRATORY: (Cont.)** | | | | | **GASTROINTESTINAL: Cont.)** | | | | |
| Pneumonia | | | | | Feeding Tubes | | | | |
| COPD | | | | | Duo Tube | | | | |
| Lung CA | | | | | Keo Feed | | | | |
| Chest Tubes | | | | | Maintenance of Enteral Nutrition: | | | | |
| Emersion Suction | | | | | Continuous | | | | |
| Pleur - Evac Suction | | | | | Intermittent | | | | |
| Maintenance of Oxygen Therapy: | | | | | **GENITOURINARY/RENAL:** | | | | |
| Nasal Cannula | | | | | GU Assessment: | | | | |
| Aerosol Mask | | | | | Palpation | | | | |
| Venti Mask | | | | | Interpretation of Lab Values | | | | |
| Trach Collar | | | | | Insertion of Foley Catheter | | | | |
| T-Piece | | | | | Male | | | | |
| Ventilators | | | | | Female | | | | |
| Types: | | | | | Care of Patient With: | | | | |
| Ambu Bag | | | | | Supra pubic Catheters | | | | |
| Assist With: | | | | | 3-Way Foley | | | | |
| Arterial Puncture for ABG | | | | | GU Irrigations | | | | |
| Insertion/removal chest tubes | | | | | Continuous | | | | |
| Thorocentesis | | | | | Intermittent | | | | |
| Changing Tracheostomy Tubes | | | | | AV Fistulas | | | | |
| **GASTROINTESTINAL:** | | | | | Shunts | | | | |
| Gastrointestinal Assessment: | | | | | Quinton Catheters | | | | |
| Auscultation | | | | | **INTERVENOUS THERAPY:** | | | | |
| Palpation | | | | | Insertion and Care of: | | | | |
| Care of the Patient With: | | | | | Heparin Locks | | | | |
| Abdominal Distention | | | | | Periphral IV | | | | |
| GI Bleed | | | | | Assist With and Care of: | | | | |
| Multiple Abdom. Wounds & Drains | | | | | Central Lines | | | | |
| Colostomy | | | | | Triple Lumen | | | | |
| Gastrostomy | | | | | Care of the Patient With: | | | | |
| Jejunostomy | | | | | Implantable Venous Access Devices | | | | |
| T- tube | | | | | Broviac | | | | |
| Hemovac | | | | | Groshong | | | | |
| Dehiscence | | | | | Porta Cath | | | | |
| Nasogastric Tubes | | | | | Other | | | | |
| Salem Sump | | | | | | | | | |
| Levine Tube | | | | | | | | | |

## Medical/Surgical Skills Checklist Cont...............

| Skill | A | B | C | D | Skill | A | B | C | D |
|---|---|---|---|---|---|---|---|---|---|
| **MED ADMINISTRATION:** | | | | | **NURSING ADMIN.:** | | | | |
| Oral | | | | | Charge Nurse | | | | |
| IM | | | | | Patient/Family Teaching | | | | |
| IVP | | | | | | | | | |
| IV Piggy Back | | | | | | | | | |
| IV Admixture | | | | | | | | | |
| Unit Dose | | | | | | | | | |
| Administration for 1-10 Patients | | | | | | | | | |
| Administration for 10-20 Patients | | | | | | | | | |
| Pediatric Conversions | | | | | | | | | |
| Knowledge of Chemotherapy: | | | | | | | | | |
| Preparation | | | | | | | | | |
| Administration | | | | | | | | | |
| Disposal | | | | | | | | | |
| Admin. of blood and blood products | | | | | | | | | |
| Experience with the following: | | | | | | | | | |
| Aminophylline | | | | | | | | | |
| Dopamine | | | | | | | | | |
| Hyperalimentation | | | | | | | | | |
| Intralipid Administration | | | | | | | | | |
| Lidocaine | | | | | | | | | |
| Lasix | | | | | | | | | |
| Lanoxin | | | | | | | | | |
| Heparin | | | | | | | | | |
| Insulin | | | | | | | | | |

Signature : ________________________________

Date:___________________________

# Critical Care Skills Checklist

If Applicable

**Name**______________________

**A - Never Performed.** You have never performed the stated task and have no experience with this type of skill.

**B - Familiar with.** You are familiar with the stated task; but you would need more experience and practice to feel comfortable and proficient in this type of skill.

**C - Experience in.** You have performed this task several times; you feel moderately comfortable functioning independently, but you would require a resource person to be nearby.

**D – Expert. You have performed this task frequently; you feel comfortable and proficient in this skill; you would not require supervision or practice.**

**Please select the column that most accurately describes your proficiency level.**

| Skill | A | B | C | D | Skill | A | B | C | D |
|---|---|---|---|---|---|---|---|---|---|
| **NEUROLOGY:** | | | | | **MED ADMINISTRATION:** | | | | |
| Neurological Assessment: | | | | | Drug Calculations in: | | | | |
| Glascow Coma Scale | | | | | MCG/KG/MIN | | | | |
| Levels of Consciousness | | | | | MG/MIN | | | | |
| Detection of Elevation ICP | | | | | MCG/MIN | | | | |
| Care of the Patient with: | | | | | Administration of: | | | | |
| Craniotomy | | | | | Decadron | | | | |
| CVA | | | | | DDAVP | | | | |
| Acute Head Injury | | | | | Dilantin | | | | |
| Intercranial Hemorrhage | | | | | Mannitol | | | | |
| Seizures (Precautions) | | | | | Phenobarbitol | | | | |
| Spinal Cord Injury | | | | | Vasopressin | | | | |
| Cadaver Care for Organ Donation | | | | | **CARDIOVASCULAR:** | | | | |
| CSF Drains | | | | | Cardiovascular Assessment: | | | | |
| Lumbar SA | | | | | Auscultation of Heart Sounds | | | | |
| Ventriculostomy | | | | | Peripheral Perfusion | | | | |
| ICP Monitoring | | | | | Palpation | | | | |
| Ventricular Catheter | | | | | Doppler | | | | |
| Epidural Screw | | | | | Initiation of Intravenous Therapy: | | | | |
| **EQUIPMENT:** | | | | | Heparin Locks | | | | |
| Roto Rest Bed | | | | | Peripheral IV | | | | |
| Initiation of Rotorest Therapy | | | | | External Jugular | | | | |
| Maintenance of Rotorest Therapy | | | | | Infusion Pumps: | | | | |
| Stryker Frame | | | | | IVAC | | | | |
| Halo Traction | | | | | IMED | | | | |
| Crutchfield Tongs | | | | | Other | | | | |
| Hypothermia Mattress | | | | | Admin of Blood and Blood Products | | | | |
| | | | | | EKG | | | | |

## Critical Care Skills Checklist Cont...............

| Skill | A | B | C | D | Skill | A | B | C | D |
|---|---|---|---|---|---|---|---|---|---|
| **CARDIOVASCULAR: (Cont.)** | | | | | **CARDIOVASCULAR: Cont.)** | | | | |
| Bedside Monitoring | | | | | Chest Tubes | | | | |
| Hewlet Packard | | | | | Emerson Suction | | | | |
| Siemens | | | | | Pleur-Evac | | | | |
| Other | | | | | Medical Stenial Sumps | | | | |
| Portable Monitoring | | | | | Pacemakers: | | | | |
| Defibrillation/Cardioversion | | | | | Temporary | | | | |
| Obtaining 12-lead EKG | | | | | Atrial | | | | |
| Interpretation of: | | | | | Ventricular | | | | |
| Rhythm Strip | | | | | A-V Sequential | | | | |
| 12-lead EKG | | | | | Transvenous | | | | |
| Arrythmia Treatment | | | | | Transthoracic | | | | |
| Atrial | | | | | Permanent | | | | |
| Heart Blocks | | | | | Principles of Hemodynamic Monitoring | | | | |
| Ventricular | | | | | Analysis of Wave forms | | | | |
| V-TACH | | | | | Obtaining Cardiac Outputs | | | | |
| V-FIB | | | | | Calculating HemodynamicProfiles | | | | |
| Cardio/Pulmanary Arrest | | | | | **MED. ADMINISTRATION:** | | | | |
| Intial Resuscitation | | | | | Atropine | | | | |
| ACLS Protocol | | | | | Bretillium | | | | |
| Care of Patient With: | | | | | Calcium Chloride | | | | |
| Acute MI | | | | | Digoxin | | | | |
| Aneurysm | | | | | Dobutrex | | | | |
| Angina | | | | | Dopamine | | | | |
| Post Angioplasty | | | | | Epinephrine | | | | |
| Cardiac Tamponade | | | | | Heparin | | | | |
| Cardiogenic Shock | | | | | Innovar | | | | |
| CHF | | | | | Isuprel | | | | |
| Heart Transplant | | | | | Insulin | | | | |
| Vascular Surgery | | | | | KCL | | | | |
| Assist with Insertion & Care of : | | | | | Lidocaine | | | | |
| Arterial Line | | | | | Levophed | | | | |
| Central Venous Lines | | | | | Magnesium Sulfate | | | | |
| PA - Lines | | | | | Morphine Sulfate | | | | |
| Swan- Ganz Line | | | | | Neosynephrine | | | | |
| Oximetric | | | | | Pavulon | | | | |
| $SVO_2$ Monitoring | | | | | Pronestyl | | | | |
| Intra Aortic Balloon Pump | | | | | Streptokinase | | | | |

## Critical Care Skills Checklist Cont..............

| Skill | A | B | C | D | Skill | A | B | C | D |
|---|---|---|---|---|---|---|---|---|---|
| **MED. ADMIN. (Cont.)** | | | | | **RESPIRATORY (Cont.):** | | | | |
| Tridil | | | | | Chest Trauma | | | | |
| Verapamil | | | | | Pulmonary Edema | | | | |
| Valium | | | | | Pneumonia | | | | |
| Versed | | | | | Pneumothorax | | | | |
| **RESPIRATORY:** | | | | | Chest Trauma | | | | |
| Respiratory Assessment: | | | | | Pulmonary Edema | | | | |
| Auscultation | | | | | **GASTROINTESTINAL:** | | | | |
| Percussion | | | | | Gastrointestinal Assessment: | | | | |
| ABG Interpretation | | | | | Auscultation | | | | |
| Direct Arterial Puncture | | | | | Palpation | | | | |
| Interpretation of CXR | | | | | Care & Maintenance of: | | | | |
| Oxygen Therapy: | | | | | Nasogastric Tubes | | | | |
| Nasal Cannula | | | | | Salem Sumps | | | | |
| Aerosol Mask | | | | | Levine | | | | |
| Venti Mask | | | | | Nasointestinal Tubes: | | | | |
| Non rebreather | | | | | Miller - Abbott | | | | |
| Maked CPAP | | | | | Cantor | | | | |
| Ambu Bag/Ambu Techniques | | | | | Sengstaken-Blakemore Tube | | | | |
| Assist w/ Intubation /Extubation | | | | | GOMCO Suction | | | | |
| Ventilators: | | | | | Feeding Tubes | | | | |
| Emerson | | | | | Duo Tube | | | | |
| Bird | | | | | Keofeed Tube | | | | |
| Bear | | | | | Jejunostomy | | | | |
| MAI & II | | | | | Maintenance of Enteral Feedings: | | | | |
| Other | | | | | Care of Patient with: | | | | |
| Airway Care & Maintenance: | | | | | Abdominal Distention | | | | |
| Oral Airway | | | | | Paralytic Illius | | | | |
| Nasal Airway | | | | | GI Bleed | | | | |
| Endotracheal Tube | | | | | Shock: | | | | |
| Tracheostomy | | | | | Hypovolemic | | | | |
| Suctioning: | | | | | Septic | | | | |
| Oral Pharyngeal | | | | | Abdominal Surgery | | | | |
| Nasal Tracheal | | | | | Colostomy | | | | |
| Via ET | | | | | Multiple Abdominal Wounds & Drains | | | | |
| Via Trach | | | | | Hemovac | | | | |
| Care of the Patient With: | | | | | Jackson Pratt | | | | |
| Acute Resp. Distress Syndrome | | | | | Saratoga Sump | | | | |
| AIDS | | | | | T - Tubes | | | | |

## Critical Care Skills Checklist Cont...............

| Skill | A | B | C | D | Skill | A | B | C | D |
|---|---|---|---|---|---|---|---|---|---|
| **GASTROINTESTINAL: (Cont.)** | | | | | **GENITOURINARY/RENAL:(Cont.)** | | | | |
| Other | | | | | Continuous | | | | |
| Liver Transplants | | | | | A-V Fistula | | | | |
| Dehiscence | | | | | SHUNTS | | | | |
| **GENITOURINARY/RENAL:** | | | | | Quinton Catheters | | | | |
| GU Assessment | | | | | Acute/Chronic Renal Failure | | | | |
| Interpretation of Lab Values | | | | | Nephretomy | | | | |
| Insertion of: | | | | | Renal Transplant | | | | |
| Female Catheter | | | | | Perform Peritoneal Dialysis | | | | |
| Male Catheter | | | | | Perform Hemodialysis | | | | |
| 3 - Way Foley | | | | | **PRECAUTIONS:** | | | | |
| Care of Patient With: | | | | | Universal Precautions | | | | |
| Suprapubic Catheter | | | | | Respiratory Isolation | | | | |
| GU Irrigations: | | | | | Wound and Skin Isolation | | | | |
| Intermittant | | | | | Reverse Isolation | | | | |
| | | | | | Sterile Dressing Changes | | | | |
| | | | | | Burn Care | | | | |

# Emergency Room Skills Checklist

If Applicable

**Name**______________________

1 - NO EXPERIENCE.
2 - SOME EXPERIENCE. (Require assistance/supervision)
3 - EXPERIENCED. (Need initial review, then can perform independently)
4 - VERY EXPERIENCED. (Can perform well independently.)

**Please select the column that most accurately describes your experience level.**

| Experience Level | 1 | 2 | 3 | 4 | Experience Level | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|---|---|---|
| Crisis Intervention | | | | | Third Degree | | | | |
| Upholding Patient's Rights | | | | | Electrocution | | | | |
| Suicidal Patient's Rights | | | | | Dressing Procedure | | | | |
| Patient with Overdose | | | | | Hazardous Materials Exposure | | | | |
| Patient in Restraints | | | | | Radiation Exposure | | | | |
| Neuro Assessment | | | | | Pulmonary Edema | | | | |
| Monitoring Neuro Signs | | | | | C.O.P.D. | | | | |
| Use of Glascow Coma Scale | | | | | Pneumothorax | | | | |
| Acute Head Injury | | | | | Assisting with Intubation | | | | |
| Acute T.I.A. /C.V.A. | | | | | Assisting with Extubation | | | | |
| Acute Spinal Cord Injury | | | | | Tracheotomy | | | | |
| Seizure Precautions | | | | | Trach Tube | | | | |
| Observing Increased Intracranial Pressure | | | | | T-Piece | | | | |
| Application of Orthopedic Appliances | | | | | Obtaining Arterial Blood Gases from Radial Artery | | | | |
| Transport of Patient with Spinal Cord Injury | | | | | Obtaining Arterial Blood Gases from Femoral Artery | | | | |
| Assist with Lumbar Puncture | | | | | Obtaining Arterial Blood Gases from Arterial Line | | | | |
| Calculating Emergency Medication Dosages | | | | | Setting up of Arterial Line | | | | |
| Knowledge of Normal Serum Lab Values | | | | | Ventilator | | | | |
| Pediatric Arrest/Resuscitation | | | | | O2 Mask | | | | |
| Epiglottitis | | | | | O2 Cannula | | | | |
| Overdose/Poison Ingestion | | | | | Venturi Mask | | | | |
| Near Drowning | | | | | Ambu Bags | | | | |
| Child Abuse | | | | | O2 Cylinders | | | | |
| Spontaneous Abortion | | | | | Nebulizer Set Up | | | | |
| Hemorrhage | | | | | Oropharyingeal Suction | | | | |
| Placenta Previa | | | | | Nasotracheal Suction | | | | |
| Abruptio Placenta | | | | | Endotracheal Suction | | | | |
| Preeclampsia/Eclampsia | | | | | Assisting with Chest Tube Insertion | | | | |
| Emergency Delivery | | | | | Use of Pleuravac Drainage System | | | | |
| Communicable Diseases | | | | | Use of Emerson Drainage System | | | | |
| Air Transport of Trauma Patient | | | | | G.I. Bleed | | | | |
| Major Trauma | | | | | Abdominal Wounds | | | | |
| Minor Trauma | | | | | G.I. Tubes | | | | |
| M.A.S.T. Suit | | | | | Acute Abdominal Disorders | | | | |
| First Degree | | | | | Insertion of Nasogastric Tube | | | | |
| Second Degree | | | | | Gastric Lavage | | | | |

## Emergency Room Skills Checklist Cont………

| Experience Level | 1 | 2 | 3 | 4 | Experience Level | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|---|---|---|
| Acute Renal Failure | | | | | Rape Kit | | | | |
| Chronic Renal Failure | | | | | Reporting Procedures for Acts of Violence | | | | |
| Peritoneal Dialysis | | | | | Hypothermia | | | | |
| Set up for Cast Application | | | | | Heat Stroke | | | | |
| Checking C.M.S. | | | | | Heat Exhaustion | | | | |
| Set up for OCL Splinting | | | | | Snake Bite | | | | |
| Set up for Insertion of Steinman Pin/K-wires | | | | | Administration of Antivenin | | | | |
| Assist with Close Fracture/Dislocation Reduction | | | | | Animal Bite | | | | |
| Sedation Monitoring | | | | | Poison Index | | | | |
| Application of Orthopedic Appliances | | | | | Isolation Procedures | | | | |
| Set up for Flourescein/Woods Lamp Exam | | | | | Triage Procedures | | | | |
| Use of Morgan Lens Irrigation | | | | | Care of Patient with AIDS | | | | |
| Ear Irrigations | | | | | Lab Values | | | | |
| Eye Irrigations | | | | | Procedure for Patient Signing AMA | | | | |
| Eye Patch Application | | | | | Consent for Treatment of a Minor | | | | |
| Nasal Packing | | | | | Disaster Protocol | | | | |
| Remove Contact Lens | | | | | Heparin/Saline Lock | | | | |
| Visual Acuity | | | | | Starting IV's (Adult) | | | | |
| Setting up Suture Tray | | | | | Starting IV's (Peds) | | | | |
| Assist with Sutures | | | | | Universal Precautions | | | | |
| Assist with Staples | | | | | Assist with Peritoneal Lavage | | | | |
| Suture Removal | | | | | Pelvic Tray | | | | |
| Staples Removal | | | | | Cut Down Tray | | | | |
| Steri Strips | | | | | Procto Tray | | | | |
| Acute MI, CHF, Angina | | | | | CVP Tray | | | | |
| Abdominal Aortic Aneurysm | | | | | Trach Tray | | | | |
| Cardiac Monitoring | | | | | Culdocentesis Tray | | | | |
| Recognizing Arrhythmias | | | | | Thoracentesis | | | | |
| Obtaining 12 Lead EKG's | | | | | Dilantin | | | | |
| Cardiopulmonary Arrest | | | | | Phenobarbital | | | | |
| Cardioversion | | | | | Decadron | | | | |
| Defibrillation | | | | | Mannitol | | | | |
| Open Chest Heart Massage | | | | | Solu-Medrol | | | | |
| Assist with Insertion of Permanent Pacemaker | | | | | Administration of Blood and Blood Products | | | | |
| Assist with Insertion of Temporary Pacemaker | | | | | Lidocaine | | | | |
| Trans-Thoracic Pacemaker | | | | | Bretylium | | | | |
| Pervenous Pacemaker | | | | | Nipride | | | | |
| Set Up and Use of CVP | | | | | Dopamine | | | | |
| Interpretation of CVP Readings | | | | | Digitalis | | | | |
| Interpretations of Swan Ganz Readings | | | | | Sodium Bicrabonate | | | | |
| Thrombolytic Therapy | | | | | Atrpine | | | | |
| Anaphalactic Shock | | | | | Epinephrine | | | | |
| Cardiogenic Shock | | | | | Dobutrex | | | | |
| Septic Shock | | | | | Tridil/Nitroglcerine | | | | |
| Hypovolemic Shock | | | | | | | | | |

## 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

Form **W-9**
(Rev. November 2005)
Department of the Treasury
Internal Revenue Service

# 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: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ------------------ ☐ 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.

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

**Social security number**
| | | – | | – | | | |

**or**

**Employer identification number**
| | – | | | | | | |

## 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.)

**Sign Here** | **Signature of U.S. person ▶** | **Date ▶**

## 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 [1] | Generally, exempt recipients 1 through 7 [2] |

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] 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*. 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* 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* 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 [1] |
| 3. Custodian account of a minor (Uniform Gift to Minors Act) | The minor [2] |
| 4. a. The usual revocable savings trust (grantor is also trustee) | The grantor-trustee [1] |
| b. So-called trust account that is not a legal or valid trust under state law | The actual owner [1] |
| 5. Sole proprietorship or single-owner LLC | The owner [3] |
| **For this type of account:** | **Give name and EIN of:** |
| 6. Sole proprietorship or single-owner LLC | The owner [3] |
| 7. A valid trust, estate, or pension trust | Legal entity [4] |
| 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 |

[1] 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.

[2] Circle the minor’s name and furnish the minor’s SSN.

[3] 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.

[4] 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.

First Choice medical staffing, inc. A PROFESSIONAL MEDICAL STAFFING COMPANY

# First Choice Medical Staffing, Inc.
# 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 _________

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 time slip 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 a check 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, Social Security, and F.I.C.A. taxes. 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 check to the following named persons:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

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 check mailed to me. (Initial if applicable.)

1. ___________

Signature: _________________________________

Date: _____________________________________