

All Health Staffing

To: All Valued Clinicians

Welcome to All Health Staffing! As a new associate of All Health Staffing, you are eligible for healthcare coverage for you and your family. All Health Staffing pays up to \$200 towards the cost of this coverage. Enclosed for your review is an insurance packet from our healthcare provider, HealthMarket. Please review the information, and if you are interested in taking advantage of this plan, please fill out the enclosed paperwork and return it ASAP. We will then complete our portion and return it to the insurance broker. Should you desire more information regarding HealthMarket, you can access them on the internet at HealthMarket.com. Our group number is 37720. You have (31) thirty-one days from your hire date to enroll in the insurance plan. If you do not enroll during this time, you can enroll during the next open enrollment, which is annually every May. Please return your paperwork to us no later than two weeks after your start date in order to meet the deadline for enrollment.

In the event you are not interested in taking advantage of this insurance plan, please complete the enclosed waiver and return it in lieu of the application. Your completed waiver allows you the opportunity to enter our health insurance plan at any time, not only during open enrollment. However, this is true only if you presently have coverage through a different employer, such as, your spouse's employer. In the event you have an individual plan, you will have to show that you have had eighteen months of continuous coverage in order to get on this insurance plan at a time other than our open enrollment. If you have questions regarding this matter, please feel free to contact me toll free at 877-577-8233 extension 300. I am the Payroll and Benefits Coordinator for All Health Staffing, so if at any time you have questions regarding your insurance, payroll or any other matter, please do not hesitate to call. Again, welcome to All Health Staffing!

Sincerely,

Audrey Helms
Payroll and Benefits Coordinator

ALL HEALTH STAFFING

Drug Testing Consent Form

I have applied for employment with All Health Staffing in a position that requires me to administer different medicine. As a condition for my application being considered, I understand and agree to undergo substance screening. I understand that if my test results are positive, I shall not be considered further by All Health Staffing for a clinical position.

I hereby authorize any physician, laboratory, hospital or medical professional retained by All Health Staffing for screening purposes to conduct such screening, and to provide the results to All Health Staffing, and I release All Health Staffing and any person affiliated with All Health Staffing and any such institution or person conducting the screening, from liability thereof.

Applicant's signature: _____

Applicant's name: _____

Date: _____

All Health Staffing

"Where do you want to work today?"

301 S. 9th Street
Suite 207
Richmond, TX 77469
Toll free 877-577-8233
Fax 877-436-1693

License or Certification Verification

Name _____	Discipline _____
License or Certification Number _____	State _____
Expiration Date _____	SS# _____

The above employee hereby authorizes the state board or organization of certification as appropriate to release all pertinent information regarding the above state license of certification to All Health Staffing.

_____	_____
Employee Signature	Date

DO NOT WRITE BELOW - FOR OFFICE USE ONLY

Is the above information correct?

Yes _____

No _____ If no, please
comment _____

Is the above license certification in good standing?

Yes _____

No _____ If no, please comment below

All Health Staffing

Statement of Permanent Residence

Name: _____	Social Security #: _____
Permanent Address: _____	_____
_____	_____
_____	_____
_____	_____

Please provide answers to the following questions:

1. Do you plan on returning to your permanent residence for an extended period of time (at least 30 days) during the following year? Yes____ No____
2. Do you have a driver's license in the state of your permanent residence? Yes____ No____
3. Do you incur monthly expenses (i.e. rent, mortgage, etc.) to maintain your permanent residence? Yes____ No____
4. Are you registered to vote in the district of your permanent residence? Yes____ No____
5. Did you file a state and/or local tax return at your permanent residence during the previous year? Yes____ No____

I hereby certify that the answers to the above questions are true to the best of my knowledge and that the above address is my permanent residence which I will continue to maintain and plan to reside in when I am not on assignment with All Health Staffing. I agree to notify All Health Staffing should any of the above information changes.

Signature: _____	Date: _____
Signature: _____	Date: _____

ACCIDENT PREVENTION

It is important that the facility is a safe environment for patients, employees and visitors. The following are reminders:

- If there is any question as to how to use any piece of equipment, ASK.
- Any patient that appears in your judgment to require more assistance than what your assignment requires, please ask for assistance.
- Report any unusual occurrences to the charge nurse or supervisor as appropriate.
- For any lifting, use proper body mechanics, (i.e. leg muscles vs. back); the object you are lifting is close to your body.
- Clean up spills as they occur.

INFECTION CONTROL MEASURES

Hand washing is the key to prevent transmission of disease and should be done at least:

- Before and after each patient contact
- Before and after using the bathroom
- After handling any contaminated article

FIRE PREVENTION

In case of fire: Pull nearest fire alarm and notify house supervisor. Contain the fire by closing doors and windows. Extinguish the fires using the proper fire extinguisher if possible.

R	-	Rescue
A	-	Alarm
C	-	Contain
E	-	Extinguish

GIFTS, GRATUITIES AND PAYMENT

All Health Staffing employees may not accept any cash, jewelry, etc. from residents for services provided. You may accept small acts of kindness such as candy, cakes, cookies, etc.

UNIFORMS

The dress code for All Health Staffing employees in the facility is the same as the staff employees working on your unit.

Signature of Employee: _____ Date: _____

All Health Staffing

“Where do you want to work today”

Exposure Control Plan

Purpose:

This plan sets forth All Health Staffing policy that identifies tasks and procedures as well as job classifications where occupational exposures to blood or other potentially infectious material may occur. It also sets forth the schedule for implementing the provisions of the OSHA blood borne pathogen standard.

Policy:

This plan must be accessible to All Health Staffing employees and it must be reviewed and if needed, updated at least annually or whenever necessary. The plan must be available to representatives of federal and state regulatory and accrediting bodies as needed for examination or copying.

1. Exposure Determination:

A. Job classifications in which all employees have occupational exposure include RN, HHA, CNA, LOP (V) V/RNA, RT, PCA, CMA, who provide direct care to clients.

B. Job classifications in which some employees may have occupational exposure include, but are not limited to:

- Caretakers/Companions
- DME/Pharmacy Delivery personnel
- Pharmacists
- PT's
- OT's
- ST's
- Registered Dieticians
- Janitors

C. Tasks in which occupational exposure may occur as performed by employees in Group B includes:

- Cleaning surfaces or laundering of materials contaminated with blood or other potentially infectious materials.
- Disposition of contaminated equipment or infectious hazardous waste.
- Coming into contact with soiled supplies (i.e.). TPN (tubing) or client blood or other potentially infectious material in the course of providing services to the client.
- Contact with saliva with the possibility of blood present.

II

A. Compliance

All employees shall be notified of availability of vaccine.
Post exposure evaluation and follow-up will be implemented.

B. Record Keeping

Required information regarding Hepatitis B vaccination status will be available on file in our office.

I ACKNOWLEDGE that I have received and understand this Exposure Control Plan.

--	--

Employee Signature

Date

HEPATITIS B IMMUNIZATION PROGRAM

and

HEPATITIS B INFORMATION SHEET

HEPATITIS B - THE DISEASE

Hepatitis B, formerly called, “serum hepatitis” is a viral infection that affects the liver. The incubation period ranges from 40 to 180 days. Acute hepatitis can be mild and completely without outward symptoms or it can be severe, prolonged, and possibly fatal. Other body fluids such as urine, bile, tears, saliva, wound drainage, vaginal secretions, semen, and breast milk may also be infectious. The greatest threat to health care workers is the nearly one million Hepatitis B carriers in the country. 90-95% of whom are not identified.

THE HEPATITIS B VACCINE

There is a vaccine available for protection against Hepatitis B. This vaccine is recommended for those with frequent exposure to the above sources. Three doses of vaccine are required; the initial dose, a second dose a month later and a third dose five months later. A booster dose may be needed after five years for continued protection. Documentation of needle puncture and exposures to the disease must continue even after the vaccine series is completed.

Hepatitis B vaccine will not prevent hepatitis caused by other agents, such as Hepatitis A virus, Non a - Non B Hepatitis viruses, or by other viruses known to infect the liver. Although information available to date indicates that the vaccine is highly effective in protecting against Hepatitis B, it has not proven totally effective in preventing Hepatitis B among all persons vaccinated.

More than 20,000 people have received the Hepatitis B vaccine to date. The follow-up studies indicate that the most common side effect is injection site soreness. Low-grade fever occurs occasionally. Other less common complaints include malaise, fatigue, headache, nausea, and joint pain. These symptoms are infrequent and limited to the first few days following the vaccine. Rash has been reported rarely. The possibility exists that more serious side effects may be identified with extensive use of the vaccine.

PRECAUTIONS

Any serious active infection prior to receipt of the vaccine is reason to delay receipt of the vaccine.

Employees with a history of cardiopulmonary disease or who are at risk from a possible febrile or systemic reaction must consult their private physician prior to receipt of the vaccine and have an authorization from their private physician for administration of the Hepatitis B vaccine.

TYPES OF HEPATITIS

6. Hepatitis A - Transmitted by the local fecal oral route, occurs only as an acute infection of variable duration. Recovery is associated with lifelong immunity.
7. Hepatitis B - is transmitted percutaneously primarily through intravenous (IV) drug abuse, sexually, and prenatal. Screening of donated blood for Hepatitis B serologic markers have reduced the previously high incidence of transfusion related disease. In about twenty per cent of patients, chronic Hepatitis B develops which may result in chronic active hepatitis, or sequelae such as cirrhosis and hepatocellular carcinoma. Serologic markers are available for the acute and chronic infection and for the carrier state.

8. Hepatitis C - Is thought to be responsible for the majority of cases of what was formerly designated non-A, non-B hepatitis. The recently approved assay is expected to reduce its incidence by identifying contaminated blood and infected patients. The disease has a 5% incidence of progression to a chronic state, which carries a high risk of cirrhosis and perhaps hepatocellular carcinoma.
9. Hepatitis D - Or delta hepatitis occurs only as superinfection in-patients already infected with Hepatitis B. It is further mainly confined to risk groups with hemophilia and IV drug users. An assay is available for the infection, which should be suspected in patients with markers for chronic Hepatitis B or clinical signs of acute hepatitis. Other possible causes are in exacerbation of underlying disease or superimposition of acute Hepatitis A or C of a non-viral hepatitis.
10. Hepatitis E - Refers to an epidemic form of hepatitis that has characteristics of Hepatitis A, such as enteric transmission and lack of a chronic phase. The disease is uncommon in developed countries but relatively common elsewhere. The virus has only recently been defined.

The Hepatitis B vaccine is not recommended for use by pregnant women or nursing mothers. It is also recommended that the employee not become pregnant during the six-month period while the vaccine is being administered.

HIGH RISK EMPLOYEES

Employees with frequent exposure to body fluids which may contain the virus responsible for Hepatitis B are considered to be in a high risk category (defined by OSHA as anyone exposed to blood and body fluids one or more times monthly.) Anyone in this category should give serious consideration to receiving the hepatitis vaccine.

The Hepatitis B vaccine is available to all high risk All Health Staffing employees. HBV antibody testing will be done prior to receipt of the vaccine. A small amount of the employee's blood will need to be drawn in order to conduct the test. There is no cost to the employee provided they comply with the schedule of injections. The vaccine will be administered in accordance with the following procedures.

11. Each employee desiring to receive the Hepatitis B vaccine will completely read the Hepatitis B Information Sheet Policy, and sign in the appropriate space on the Hepatitis B Authorization Sheet. Those employees who already have antibody to Hepatitis B virus are not at risk of contracting the disease and do not need to receive the vaccine.
12. Three injections of the vaccine are required. The injection will be administered as follows:

- First injection - scheduled date
- Second injection - one month after first injection
- Third injection - six months after first injection

Any adverse reaction to the vaccine by any employee who received the vaccination must be reported and the employee should seek follow-up medical assistance.

A post-vaccine Hepatitis B antibody testing will be done six months after the final injection was received. If the testing is done, the Health Care Worker will be informed of the test results. If the test does not reveal an acceptable level of immunity, the HCW will require a "booster" of the vaccine. One month after the "booster" is given; the HCW should be tested again. If the HCW still does not have an acceptable level of immunity, he/she may be considered a "non converter". Advice from the HCW's private physician should be requested at this point before any further vaccines are given.

REQUEST FOR VACCINATION

I have read the Hepatitis B information sheet provided to me and have had an opportunity to ask questions about it. I understand the risks and benefits of receiving the Hepatitis B vaccine. I also understand that three doses of the vaccine are required to confer immunity. Further, I understand that as with all medical treatment, there is no guarantee that I will become immune or that I will not experience an adverse side effect from the vaccine.

With this clear understanding, I request that the Hepatitis B vaccine be given to me.

Printed Name of Employee: _____

Signature of Employee: _____

Date: _____

Date Vaccinated	Initials
1. _____	_____
2. _____	_____
3. _____	_____

Employee shall initial by each date to reaffirm consent.

REFUSAL OF VACCINATION

I understand that due to my occupational exposure to blood or 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 at no charge to myself. However, decline the Hepatitis B vaccination at this time. 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 wish to be vaccinated with Hepatitis B vaccine, I can, upon request, receive the vaccination series at no charge to me.

Print Name of Employee Refusing Vaccine

Signature of Employee Refusing Vaccine

Date

I have been given the opportunity to be vaccinated for Hepatitis B; however, I cannot accept the vaccination because:

_____ I have been previously vaccinated against Hepatitis B. I received my last dose on:

_____ I am currently immune to Hepatitis B in accordance with antibody testing performed on:

_____ I cannot take Hepatitis B vaccine because of allergy to the compounds of the vaccine or for other medical reasons.

Name of employee exempt from vaccine

Signature of employee exempt from vaccine

Date

All Health Staffing Employment Agreement

This Employment Agreement is entered into by The Helms Group dba All Health Staffing, Texas Corporation located at 301 S. 9th Street, Suite 207, Richmond, TX 77469 (herein referred to as “Company”) and _____, a healthcare professional interested in a temporary staffing assignment (herein referred to as “Clinician”).

COMPANY agrees to:

- 1) Pay Clinician for each hour (or portion thereof) worked while on assignment with Company. Clinician will be paid only for hours actually worked and will not be paid for sick days, vacation days, holidays not worked or time off between assignments.
- 2) Pay you weekly for any time worked with Company as long as a signed time sheet is received no later than 12:00 noon Central Time on the following Monday after shifts worked.
- 3) Cover your malpractice insurance with coverage of a minimum of \$1M per occurrence and \$3M aggregate.
- 4) Withhold all federal, state, FICA and all other employment-related taxes applicable in the state(s) in which you work for Company.
- 5) Company will arrange and provide a fully furnished, one-bedroom apartment (utilities may be excluded) to Clinician while on assignment with Company or offer a housing stipend, if Clinician provides housing for assignment period. Company may reduce this amount should Clinician fail to work the guaranteed number of hours as set forth in the Assignment Confirmation letter.
- 6) Reimburse Clinician’s relocation expenses based on .34/mile (up to \$500 round trip) to and from assignment community. Reimbursement will be paid within two (2) weeks after receipt of completed Expense Report with corresponding receipts.
- 7) Reimburse clinician for applicable state licensure fees for state in which you work with Company after Company receives completed Expense Report. Company will reimburse Clinician for renewals only for states in which Clinician is already licensed.
- 8) Schedule and arrange all telephone interviews for Clinician prior to acceptance of assignment. Clinician shall have final decision in whether to accept and assignment with Company and Company’s client (i.e. hospital, outpatient clinic, school etc.).
- 9) Resolve Clinician’s concerns as quickly, fairly and honestly as possible.
- 10) Provide health insurance coverage for Clinician (up to \$200 per month) while Clinician is on assignment with Company.
- 11) Provide dental insurance (Free) for clinician. Clinician is responsible for dependent coverage.
- 12) Offer a SIMPLE IRA retirement plan for each clinician and match 100% of the clinician’s contribution, up to 3% of the annualized salary.
- 13) Guarantee a minimum of thirty-six (36) hours per week.

CLINICIAN agrees to:

- 1) Accurately represent education, credentials, work history, skills, and any criminal history.
- 2) Accurately report actual hours worked and fax time sheet weekly with appropriate facility representative and Clinician signature to Company no later than 12:00 noon Central Time on the Monday after shifts worked. Failure to comply may result in a delay in Clinician’s pay for that week.
- 3) Accurately report all expenses on Company Expense Report along with supporting receipts and signature.

- 4) Utilize phone interview to determine if assignment opportunity is commensurate with Clinician’s skill

level and ability to perform assigned tasks.

- 5) Upon acceptance of assignment with Company, Clinician agrees to work for the mutually agreed upon term of contract.
- 6) Immediately notify Company of any failure on the part of facility to offer the agreed upon number of guaranteed hours in order to allow Company to correct the situation.
- 7) Conform and adapt to Company client's schedules, documentation standards, policies and procedures.
- 8) Immediately notify Company representative of any medical treatment or billing practices which a Company client asks Clinician to perform which may be considered illegal or unethical.
- 9) Not to accept a position with a Company client in which you are introduced by Company either as a temporary employee, independent contractor or permanent employee for a period of one (1) year after initial introduction. This provision is waived by Company while clinician works in Albuquerque and surrounding area.
- 10) Allow Company to deduct or withhold all or a portion of final paycheck to pay the uncovered costs related to housing and relocation should Clinician's assignment be terminated for poor performance, unprofessional behavior or unprofessional conduct. Should assignment be cancelled for any other reason, other than those outlined above, Clinician will bear no financial responsibility whatsoever and this provision will be waived in its entirety.

General Terms and Conditions:

- 1) Either party may terminate this relationship at the end of the mutually agreed upon assignment contract period. Company reserves the right to immediately terminate this agreement if Clinician is asked by Company client to vacate an assignment due to poor performance, unprofessional behavior or unprofessional conduct.
- 2) This agreement may be transferred or assigned by Company.
- 3) The laws of the State of Texas, county of Fort Bend shall govern this agreement.
- 4) Any or a part of the terms and conditions of this agreement may be modified for an individual assignment upon the mutual written consent of both Parties.

Employee Signature

Date

All Health Staffing Employee Direct Deposit Form

Employee Name _____

Social Security No. _____

I would like my wages/salary deposited to the following bank account(s):

- | | |
|---|--|
| <input type="checkbox"/> Checking | <input type="checkbox"/> Savings |
| <input type="checkbox"/> Bank Name _____ | <input type="checkbox"/> Bank Name _____ |
| (Attach a voided check, bank letter, or specification sheet. Deposit tickets are not accepted.) | |
| <input type="checkbox"/> Entire Net Pay | <input type="checkbox"/> Entire Net Pay |
| <input type="checkbox"/> _____% of Net | <input type="checkbox"/> _____% of Net |
| <input type="checkbox"/> Specific Dollar Amount \$ _____ .00 | <input type="checkbox"/> Specific Dollar Amount \$ _____ .00 |

Place voided check here.

I hereby authorize my employer, All Health Staffing (hereinafter COMPANY), to deposit any amounts owed me by initiating credit entries to the account at the financial institution (hereinafter BANK) indicated above. Further, I authorize BANK to accept and to credit any credit entries indicated by COMPANY to my account. In the event the COMPANY deposits funds erroneously into my account, I authorize COMPANY to debit my account for an amount not to exceed the original amount of the erroneous credit.

Any dispute arising out of or in connection with this agreement, if not otherwise resolved, shall be determined by arbitration in Richmond, Texas, in accordance with the Rules of the American Arbitration Association, and it is the expressed desire of both parties that the prevailing party be awarded costs and attorney's fees and that the award be entered as a judgment in any jurisdiction in which the non-prevailing party does business.

This authorization is to remain in full force and effect until COMPANY and BANK have received written notice from me of its termination in such time and in such manner as to afford COMPANY and BANK a reasonable opportunity to act on it.

Employee Signature _____ Date _ / _ / _

Account Holder Signature _____ Date _ / _ / _

ALL HEALTH STAFFING

Orientation Employment Checklist

Travel

The information provided in this employment package should be completed by the applicant. Please sign and return everything A.S.A.P. as they are necessary to be in your file before you begin your new assignment.

- | | | | |
|--------------------------|---|--------------------------|--------------------------------|
| <input type="checkbox"/> | Medical Release Authorization | <input type="checkbox"/> | Physician Statement |
| <input type="checkbox"/> | Immunization / Vaccination Records for MMR/Varicella/Hepatitis B | | |
| <input type="checkbox"/> | I-9 (Employment Eligibility Verification Form) | <input type="checkbox"/> | W-4 Form |
| <input type="checkbox"/> | Direct Deposit Agreement (attach a voided check and/or savings deposit slip) | | |
| <input type="checkbox"/> | Employee Agreement | <input type="checkbox"/> | Health Insurance Waiver |
| <input type="checkbox"/> | Documentation of Perm Residence | <input type="checkbox"/> | Housing/Furniture Information) |
| <input type="checkbox"/> | Age Specifics Review/Checklist | <input type="checkbox"/> | Insurance/Benefits Form |
| <input type="checkbox"/> | HIPAA Policy | <input type="checkbox"/> | Background Check/Disclosure |
| <input type="checkbox"/> | Drug Screen Consent | | |
| <input type="checkbox"/> | Clinical Proficiency Profile (Skills Checklist) | <input type="checkbox"/> | Resume |
| <input type="checkbox"/> | Proof of Current Licensure (attach a copy of current licenses) | | |
| <input type="checkbox"/> | CPR Certification (attach a copy of all current certifications, front and back) | | |
| <input type="checkbox"/> | TB Test or Chest X-ray | <input type="checkbox"/> | Copy of Valid Driver's License |
| <input type="checkbox"/> | Copy of Social Security Card | <input type="checkbox"/> | Letters of Reference (2) |

I have enclosed all of the items listed above.

Applicant Signature

Date