PRE-EMPLOYMENT INQUIRY AUTHORIZATION AND RELEASE

Applicant Instructions:
Please complete ***Section 1*** and return this Release to Maxim with your Application for Employment.

Section 1:Please clearly print or type all information		
Last Name:	**First Name:**	
Previous Employer:		
Previous Employer's Street Address:	**City, State:**	**Zip Code**
Supervisor's Name:	**Title:**	
Telephone No.	**Fax No.**	

In connection with my application for employment, I understand and agree that Maxim will seek information as to my character, work habits, job performance, skills and abilities. I authorize my previous employer, referenced above, to release any and all information relating to my employment. This authorization remains valid for a period of 12 months from the date below. I acknowledge that a facsimile or copy of this release shall be as valid as the original.

Applicant Signature: _____ ***Date:*** _____

Section 2: To be completed by the applicant's previous employer

Dear Employer:
The above named applicant is seeking employment with Maxim and has listed your organization as a former place of employment. In accordance with the Release signed by the applicant, please provide the information requested below. We appreciate your cooperation with providing the information below and answering the following questions. Your responses will be held in the strictest of confidence and will not be released to the applicant. Thank you in advance for your assistance.

- Position(s) Held by Applicant _____
- Dates of employment, From: _____ To: _____
- Is Applicant eligible for rehire? ☐ YES ☐ NO
- Reason for Separation: ☐ Voluntary Resignation ☐ Termination ☐ Temporary/Seasonal ☐ Other:_____

	Above Average	Average	Fair	Poor
Quality of Work Performed				
Quantity of Work Performed				
Communication Skills				
Adherence to policies & procedures				
Establishes Priorities				
Ability to Relate to Patients				
Ability to Relate to Staff				
Ability to Handle Stress				
Adaptability to Change				
Quality of Clinical Documentation				
Attendance/Punctuality				
Personal Appearance				

Name of person providing the above information: _____
Date:

Reference Conducted By: (print) _____ Date: _____

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	Above Average	Average	Fair	Poor
Quality of Work Performed				
Quantity of Work Performed				
Communication Skills				
Adherence to policies & procedures				
Establishes Priorities				
Ability to Relate to Patients				
Ability to Relate to Staff				
Ability to Handle Stress				
Adaptability to Change				
Quality of Clinical Documentation				
Attendance/Punctuality				
Personal Appearance				

Name of person providing the above information: _____
Date:

Reference Conducted By: (print) _____ Date: _____

EMPLOYMENT APPLICATION

Maxim is an Equal Opportunity Employer

PLEASE PRINT: Date: _____ For what position are you applying? _____

Name: _____ Social Security #: _____

Address: _____
Street No. City State Zip

Day Telephone #: _____ Evening/Cellular #: _____ E-Mail: _____

Are you 18 years or older: ☐ Yes ☐ No

If less than 18 yrs of age, will you be able to provide a work permit if employed? ☐ Yes ☐ No

How did you learn of this opening? ☐ Newspaper ☐ Internet ☐ Employee Referral ☐ Job Fair

☐ Other: _____

Type of work: ☐ Full Time ☐ Part Time ☐ On-Call ☐ Temporary/Seasonal

Date available to start work: _____

Please indicate your shift availability: ☐ Day ☐ Evening ☐ Night ☐ Weekend ☐ Holidays

Desired Rate of Pay: _____ Per _____

Will you accept employment that will include travel? ☐ Yes ☐ No

Have you ever applied to/previously worked for Maxim or any other division of Maxim Healthcare Services: ☐ Yes ☐ No

If yes, when? _____

Do you have any relatives/ friends currently working for Maxim or any other division of Maxim Healthcare Services? ☐ Yes ☐ No

If yes, state the individual's name & relationship to you: _____

Have you ever been discharged from any employment/position or asked to resign? ☐ Yes ☐ No

If yes, please explain: _____

Can you provide documentation of your identity & eligibility to work in the United States? ☐ Yes ☐ No

Can you perform, with or without accommodation, the essential functions of the position for which you are applying? ☐ Yes ☐ No

Do you have a valid driver's license? (For driving related positions only) ☐ Yes ☐ No

Have you ever been convicted of a felony*? ☐ Yes ☐ No

If yes, please explain: _____

(*Note: An applicant will not be denied employment based solely on the grounds of a conviction for a criminal offense. The type of offense, the date and the relevance of the criminal conviction to the position applied for may be considered in the employment decision)

EDUCATION

	Name & Location of School	Major Course of Study	Did you Graduate?	Type of Degree Earned
High School			☐ Yes ☐ No	
Undergraduate College or University			☐ Yes ☐ No	
Graduate or Professional School			☐ Yes ☐ No	
Trade, Vocational or Other Training			☐ Yes ☐ No	

PROFESSIONAL LICENSE & CERTIFICATION INFORMATION

CURRENT PROFESSIONAL DISCIPLINE:		SPECIALTY:
ORIGINAL STATE OF LICENSURE:	LICENSE #:	EXP. DATE:

Has the license listed above been subject to any disciplinary action, suspension or revocation? ☐ Yes* ☐ No

*If yes, please explain, in detail, the reason for the disciplinary action, suspension or revocation:

_____

_____

PLEASE LIST ANY ADDITIONAL PROFESSIONAL LICENSES OR CERTIFICATIONS HELD:

LICENSE TYPE OR NAME OF PROFESSIONAL CERTIFICATION	LICENSE OR CERTIFICATION #	STATE	ACTIVE	EXP. DATE	Has this license OR certification ever been subject to disciplinary action, suspension or revocation?
			☐ Yes ☐ No		☐ Yes* ☐ No
			☐ Yes ☐ No		☐ Yes* ☐ No
			☐ Yes ☐ No		☐ Yes* ☐ No
			☐ Yes ☐ No		☐ Yes* ☐ No

* If "Yes", please explain in detail the reason for the disciplinary action, suspension or revocation below:

_____

_____

Please list your membership in any professional organizations which are directly related to your field of specialty:

_____

EMPLOYMENT HISTORY

PLEASE FULLY COMPLETE ALL SECTIONS

I understand consideration for employment with **Maxim** will be contingent upon the results of reference and criminal background checks. I authorize **Maxim** to investigate all information I provide on this application for employment, including previous employment, experience and educational credentials. I also give **Maxim** permission to contact my former employer(s), all listed references or any other person who can verify the information I provide on this application. I hereby authorize and direct my current and former employers and other contacted persons to respond to any questions pertaining to the information included on this application.

_____ _____

SIGNATURE ***DATE***

PLEASE LIST ALL PRIOR EMPLOYMENT DURING THE PAST 10 YEARS.
BEGIN WITH THE CURRENT OR MOST RECENT EMPLOYER AND INCLUDE ANY MILITARY SERVICE

Please complete all sections even if attaching a resume

May we contact your present employer: ☐ **Yes** ☐ **No**

Present/Most Recent Employer:		Position Held:	From: Month/Year	To: Month/Year
Street Address		Reason for Leaving:	Starting Wage:	Ending Wage:
City/State/Zip Code		Was this a travel assignment? ☐ Yes ☐ No	A research/teaching facility? ☐ Yes ☐ No	
		Job Duties & Specialty:		
Telephone No:	Fax No.:	Supervisor's Name:	Supervisor's Title:	

Employer 2:		Position Held:	From: Month/Year	To: Month/Year
Street Address		Reason for Leaving:	Starting Wage:	Ending Wage:
City/State/Zip Code		Was this a travel assignment? ☐ Yes ☐ No	A research/teaching facility? ☐ Yes ☐ No	
		Job Duties & Specialty:		
Telephone No:	Fax No.:	Supervisor's Name:	Supervisor's Title:	

Employer 3:		Position Held:	From: Month/Year	To: Month/Yr
Street Address		Reason for Leaving:	Starting Wage:	Ending Wage:
		Was this a travel assignment? ☐ Yes ☐ No	A research/teaching facility? ☐ Yes ☐ No	
City/State/Zip Code		Job Duties & Specialty:		
Telephone No.:	Fax No.:	Supervisor's Name:	Supervisor's Title:	

Employer 4:		Position Held:	From: Month/Year	To: Month/Yr
Street Address		Reason for Leaving:	Starting Wage:	Ending Wage:
		Was this a travel assignment? ☐ Yes ☐ No	A research/teaching facility? ☐ Yes ☐ No	
City/State/Zip Code		Job Duties & Specialty:		
Telephone No.:	Fax No.:	Supervisor's Name:	Supervisor's Title:	

Employer 5:		Position Held:	From: Month/Year	To: Month/Yr
Street Address		Reason for Leaving:	Starting Wage:	Ending Wage:
		Was this a travel assignment? ☐ Yes ☐ No	A research/teaching facility? ☐ Yes ☐ No	
City/State/Zip Code		Job Duties & Specialty:		
Telephone No.:	Fax No.:	Supervisor's Name:	Supervisor's Title:	

Form W-4 (2006)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2006 expires February 16, 2007. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds $850 and includes more than $300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/two-job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See line **E** below.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax.

Two earners/two jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2006. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Recent name change? If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 to initiate a name change and obtain a social security card showing your correct name.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . **A** _____

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,000 or less.

. . **B** _____

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . **C** _____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . **D** _____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . **E** _____

F Enter "1" if you have at least $1,500 of **child or dependent care expenses** for which you plan to claim a credit . . **F** _____
(**Note.** Do **not** include child support payments. See **Pub. 503,** Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit):
- If your total income will be less than $55,000 ($82,000 if married), enter "2" for each eligible child.
- If your total income will be between $55,000 and $84,000 ($82,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have four or more eligible children. **G** _____

H Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶ **H** _____

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $35,000 ($25,000 if married) see the **Two-Earner/Two-Job Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2006

1 Type or print your first name and middle initial.	Last name	**2** Your social security number
Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	**4** **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a new card.** ▶ ☐	

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) **5**

6 Additional amount, if any, you want withheld from each paycheck . . . . . **6** $

7 I claim exemption from withholding for 2006, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . . ▶ **7**

Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(Form is not valid unless you sign it.) ▶ **Date** ▶

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

FORM

MW 507

Employee's Maryland Withholding Exemption Certificate

Print your full name	Your social security number
Address (including ZIP code)	County of residence (or Baltimore City)

1. Total number of exemptions you are claiming from worksheet below 1. _____

2. Additional withholding per pay period under agreement with employer 2. _____

3. I claim exemption from withholding because I do not expect to owe Maryland tax. See instructions below and check boxes that apply.

   ☐ a. Last year I did not owe any Maryland income tax and had a right to a full refund of all income tax withheld,

   AND

   ☐ b. This year I do not expect to owe any Maryland income tax and expect to have the right to a full refund of all income tax withheld. (This includes seasonal and student employees whose annual income will be below the minimum filing requirement.)

   If both **a** and **b** apply, enter year applicable _____ (year effective) Enter "EXEMPT" here 3. _____

4. I claim exemption from withholding because I am domiciled in one of the following states. Check state that applies.

   ☐ District of Columbia ☐ Pennsylvania ☐ Virginia ☐ West Virginia

   I further certify that I do not maintain a place of abode in Maryland as described in the instructions on page 2.

   Enter "EXEMPT" here 4. _____

Under the penalty of perjury, I further certify that I am entitled to the number of withholding allowances claimed on line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on line 3 or line 4, whichever applies.

Employee's signature _____ Date _____

Employer's name and address (including zip code) (For employer use only)	Federal employer identification number

Worksheet and instructions

Line 1

a. Number of personal exemptions (total exemptions on lines A, C and D of the federal W-4 or W-4A worksheet). **a.** _____

b. Number of additional exemptions for dependents over 65 years of age. **b.** _____

c. Number of additional exemptions for certain items, including estimated itemized deductions, alimony payments, allowable child care expenses, qualified retirement contributions, business losses and employee business expenses for the year. **c.** _____

d. Number of additional exemptions for taxpayer and/or spouse at least 65 years of age and/or blind. **d.** _____

e. Total - add lines a through d and enter here and on line 1 (Form MW 507). **e.** _____

EXEMPTIONS FOR DEPENDENTS To qualify as your dependent, you must be entitled to an exemption for the dependent on your federal income tax return for the corresponding tax year.

ADDITIONAL EXEMPTIONS FOR DEPENDENTS OVER 65 YEARS OF AGE An additional exemption is allowed for dependents who are 65 years of age or older.

ADDITIONAL EXEMPTIONS You may claim additional exemptions for certain items, including estimated itemized deductions, alimony payments, allowable child care expenses, qualified retirement contributions, business losses and employee business expenses for the year. One additional withholding exemption is permitted for each $2,400 of estimated itemized deductions or adjustments to income that exceed the standard deduction allowance.

NOTE: Standard deduction allowance is 15% of Maryland adjusted gross income with a minimum of $1,500 and a maximum of $2,000 for each taxpayer.

MAXIM
HEALTHCARE SERVICES, INC.

Employee Status Form

New Hire: _____ OR Change: _____

Office #: _____ State Working In: _____ Employee #: _____

Name: _____

Social Security #: _____ Birth Date: _____

Telephone #: _____ Hire Date: _____

African-American: _____ Caucasian: _____ Hispanic: _____

Asian / Pacific Islander: _____ American Indian / Alaskan Native: _____

Male _____ Female _____ Single _____ Married _____

Address: _____

City: _____ County: _____

State: _____ Zip Code: _____

RN: _____ LPN: _____ CNA: _____

Other (please specify): _____

Number of Exemptions: Fed: _____ (from W-4) State: _____

Additional $: FIT _____ SIT: _____

Comments: _____

_____

_____

Person Completing this form: _____

* Please fill out entire form **completely** & **legibly**!

03/13/2006 1:03 PM

DIRECT DEPOSIT AUTHORIZATION

Print all information completely and accurately. Please verify your ABA Routing Number

PLEASE ATTACH THE FOLLOWING DOCUMENTS:

Voided check(s) for Checking Account(s) ***Deposit Slip(s) for Other Accounts***

☐ Enrollment ☐ Cancellation ☐ Change Request (Check appropriate box(es) below:)

☐ Financial Institution ☐ Account Type

☐ Account # ☐ Add New Account

PLEASE ALLOW UP TO THREE (3) WEEKS TO ACTIVATE ALL NEW DIRECT DEPOSITS AND/OR ACCOUNT CHANGES

I hereby authorize **Maxim Healthcare Services ("Maxim")** to initiate electronic credit entries and, if necessary, debit entries and/or adjustments for any credit entries made in error into the account(s) at the financial institution(s) named below. I authorize these financial institution(s) to credit these deposits to my account(s) and to debit my account(s) for any credit errors. This authorization will remain in effect until I notify **Maxim** in writing, using a Direct Deposit Authorization form, of the cancellation or change. I understand it is my responsibility to verify that the funds are in my account correctly prior to drawing on these funds and to notify **Maxim** of any discrepancies within 48 hours after the scheduled pay date. I hereby agree to hold the company harmless from any errors or omissions the company may make in depositing or failing to deposit the funds to the designated account(s) resulting from incomplete or incorrect information on this Authorization Form. I understand that it is my responsibility to immediately notify **Maxim** should I close any of the account(s) listed below. I hereby hold harmless **Maxim Healthcare Services** for any and all fees and/or charges I may incur resulting from the crediting or debiting of funds to a closed account or should I draw on these funds before verifying the deposit.

Signature: _____ **Date:** _____

DIRECT DEPOSIT ACCOUNTS

Print Name: _____ First /Middle Initial /Last	**Social Security #:** _____
Branch Number/Name: _____	**Employee Type:** ☐ **External** ☐ **Internal**

FINANCIAL INSTITUTION (BANK) INFORMATION

Please verify the ABA Routing Number and Checking/Savings Account Number(s) with your financial institution. The employee is responsible for the accuracy of the ABA Routing number. Please attach a voided copy of a check for each checking account.

ACCOUNT #1 (Please attached a voided check for Checking Accounts/Deposit Slips for savings accounts)

ABA Routing Number:		Account Number:
Type of Account: (Check Only One Box) ☐ Checking ☐ Savings	**Amount of Deposit**: ☐ Full Amount of Check ☐ Partial Deposit of : $ _____	**Financial Institution**: _____ (Name of Bank) _____ (Telephone Number)

ACCOUNT #2 (Please attached a voided check for Checking Accounts/Deposit Slips for savings accounts)

ABA Routing Number:		Account Number:
Type of Account: (Check Only One Box) ☐ Checking ☐ Savings	**Amount of Deposit**: ☐ Full Amount of Check ☐ Partial Deposit of : $ _____	**Financial Institution**: _____ (Name of Bank) _____ (Telephone Number)

ACCOUNT #3 (Please attached a voided check for Checking Accounts/Deposit Slips for savings accounts)

ABA Routing Number:		Account Number:
Type of Account: (Check Only One Box) ☐ Checking ☐ Savings	**Amount of Deposit:** ☐ Full Amount of Check ☐ Partial Deposit of : $ _____	**Financial Institution**: _____ (Name of Bank) _____ (Telephone Number)

MAXIM STAFFING SOLUTIONS	OSHA SKILLS TEST	*Office Use Only* **Total Score:** _____

Applicant Name: _____ **Date:** _____

APPLICANT INSTRUCTIONS:
Circle the ONE correct answer to each question. Please return this Skills Test to Maxim with your employment application. If you are selected for employment, this test will be given become part of your official personnel record.

---

1. OSHA recommends that all workers who come into contact with blood be vaccinated to prevent HBV infections.
   a. TRUE b. FALSE

2. HIV can cause a flue-like illness with fever, aches and swollen glands.
   a. TRUE b. FALSE

3. OSHA has introduced a standard based on guidelines developed by the CDC that are designated to protect you from blood borne disease.
   a. TRUE b. FALSE

4. An HBV or HIV carrier may have no symptoms but can spread the disease to others.
   a. TRUE b. FALSE

5. Which group faces the greatest risk of getting AIDS?
   a. Healthcare workers b. Married couples
   c. Drug users who share needles d. Blood donors

6. Blood tests are used to determine if you have been infected with HIV or HBV.
   a. TRUE b. FALSE

7. Blood is the most common source of HIV and HBV in the workplace.
   a. TRUE b. FALSE

8. Universal Precautions should be observed when working with which group?
   a. Homosexuals b. Only patients with AIDS
   c. Drug users d. All patients

9. Blood on instruments or equipment cannot infect you.
   a. TRUE b. FALSE

10. If recapping used needles it is necessary, you should always use the one-handed scoop method or a recapping device to prevent needle stick injury.
    a. TRUE b. FALSE

11. Which task requires wearing protective gloves?
    a. Cleaning up blood b. Assisting in minor surgery
    c. Changing a dressing d. All of the above

12. Masks and protective eyewear are designed to protect you from _____.
    a. Needle stick injury b. Clothing contamination
    c. Mucous membrane contact d. All of the above

13. Clearly marked, puncture-resistant containers should be available to dispose of used needles or other disposable sharps.
    a. TRUE b. FALSE

14. Which activity can spread HIV or HBV from one person to another outside of work?
    a. Using a toilet b. Giving blood
    c. Shaking hands d. Having sex

15. You can get HIV or HBV from puncture wounds, broken skin contact, and mucous membrane contact.
    a. TRUE b. FALSE

MAXIM STAFFING SOLUTIONS	**HIPAA EDUCATION PROGRAM** **HIPAA Post-test**	**Test Score:** _____

Name (Please Print)_____ **Date** _____

1. What is HIPAA?
- a Health Insurance Portability and Accountability Act
- b Health Information Publicity Amendment
- c Healthcare Information Act

2. What is the purpose of the HIPAA Privacy Standard?
- a Provide patients with more control over the use and disclosure of their medical information
- b Provide health care providers and doctors with a way to organize documents
- c Provide patients with a unique health care number

3. What is PHI?
- a Patient Health Information
- b Protected Health Information
- c Patient Health Insurance

4. Where is PHI in the organization?
- a In the medical record
- b Everywhere: on paper, computers and in conversations
- c In the nursing unit

5. What should you do if you find PHI on a desk or on the floor?
- a Call Housekeeping
- b Step over it
- c Secure it immediately: pick it up – either file or discard it

6. Name 2 rights a patient has that affect the privacy of patient information.

_____

_____

7. Who controls the use and release of patient information?
- a The physician
- b The patient
- c The insurance company

8. If a patient has requested that information should not be released, what do you tell the caller?
- a Provide caller with information requested
- b We do not have any information on a patient by that name
- c Ask your supervisor before you release any information

9. All complaints about privacy violations must be in writing.

a True b False

10. Writing a patient name on a whiteboard does not violate HIPAA regulations.

a. True b. False

Facility Staffing Guideline Screening Test

Name: _____ Date: _____

1. All patients have the right to have pain assessed at the time of admission.
   a. True b. False

2. After giving pain medication you do not need to do anything else.
   a. True b. False

3. It is not your responsibility to be aware of the facilities policy and procedures.
   a. True b. False

4. EMTALA is a statute that allows emergency rooms to refuse treatment to patients.
   a. True b. False

5. You are transferring a patient- you do not need to give report the RN that is accepting the patient.
   a. True b. False

6. Good customer service includes wearing your name badge and a clean uniform.
   a. True b. False

7. As a healthcare provider, it is your job to change the patient's cultural beliefs if we don't agree with them.
   a. True b. False

8. Domestic violence is not a reportable crime.
   a. True b. False

9. Some signs of elder abuse are depression, signs of trauma, poor hygiene, malnutrition and fear of the caregiver.
   a. True b. False

10. An example of a desired outcome of restraints is the patient has not caused harm to himself or others.
    a. True b. False

11. Patients have the right to inspect and copy their own medical information.
    a. True b. False

12. X-ray exposure has no potential health risk.
    a. True b. False

13. If a patient is to heavy to lift, get help before attempting to lift patient.
    a. True b. False

14. Maxim provides back brace education to all healthcare staff.
    a. True b. False

15. Ergonomics is the study of a person's ego as it pertains to self.

a. True b. False

16. The first line of defense in infection control is “good hand washing”.
a. True b. False

17. Healthcare workers are at high risk of exposure to Blood Borne Pathogen disease.
a. True b. False

18. Many people with Hepatitis B have a lot of signs of infection.
a. True b. False

19. When performing a procedure and there is a risk of blood exposure no protective equipment is needed.
a. True b. False

20. Recapping needles is a safe practice.
a. True b. False

21. An LVN and RN can verify blood products before it is given to the patient.
a. True b. False

22. Checking the medication and dosage is the responsibility of the pharmacy in a hospital.
a. True b. False

23. All healthcare professional need to be aware of the disaster plan of the hospital.
a. True b. False

24. Explaining procedures and treatments is something the physician does alone.
a. True b. False

25. All patients are the same no matter what age.
a. True b. False

Signature: _____

HIPAA
CERTIFICATE OF COMPLETION

The below signed attendee has successfully completed the

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY TRAINING SELF-STUDY MODULE

Employee Name - Print

Signature of Employee Date

Signature of Maxim Representative Date

HANDBOOK ACKNOWLEDGEMENT

Employment-at-will

Employment with Maxim Staffing Solutions, Maxim Healthcare Services, Inc. and its affiliated companies is "at will" and for an indefinite period. Employees may be separated from the Company at any time, for any reason or no reason at all, with or without cause or notice. At the same time, employees may resign from the Company, for any reason, with or without cause or notice.

Additionally, Maxim employees are not guaranteed work assignments, shifts or any specific number of hours on a weekly basis. Although many employees may work full time hours for an extended period of time during their tenure with Maxim, assignment availability will be solely determined by the needs of Maxim's clients, which are subject to change with or without advance notice.

Company Policies & Procedures Acknowledgement

The purpose of this handbook is to describe the Company's current personnel policies and is to provide general guidance only. The Company reserves the right to change these policies at any time and without notice. **THIS HANDBOOK IS NOT AN EMPLOYMENT CONTRACT, NOR DOES THIS HANDBOOK GUARANTEE ANY FIXED TERMS OR CONDITIONS OF YOUR EMPLOYMENT.**

This is to acknowledge that I have received and reviewed a copy of the Maxim Employee Handbook, and I hereby agree to follow all of the policies and procedures outlined in the Handbook, including all changes to such policies and procedures as may occur after the date hereof. If at any time I have any questions about Maxim's policies and procedures, I will promptly ask my Maxim Recruiter or Account Manager, or contact Maxim's Corporate Office at 1-800-79MAXIM.

_____ _____

Date Employee Signature

_____

Please Print Name

1.0 PURPOSE

Persons who are impaired by substance abuse endanger clients, co-workers, and themselves. By prohibiting substance abuse and establishing a program to determine whether employees are engaged in substance abuse, this policy seeks to prevent its risks and ill effects. This policy replaces all existing policies concerning substance abuse and drug testing of employees.

2.0 POLICY

2.1 In the later part of 1988, the federal government passed into law a requirement that all government contractors establish guidelines, which specifically identify a company's posture regarding the use, possession, and sale of drugs and alcohol by its employees. Maxim Healthcare Services, Inc. is fully committed to the idea of keeping drugs/alcohol out of the workplace and has established the Substance Abuse Policy.

2.2 It is the policy of Maxim Healthcare Services to prohibit in the workplace the unlawful possession, use, dispensation, distribution or manufacture of controlled substances, illegal drugs and alcohol. Violation of this policy will result in disciplinary action, up to and including termination of employment. Depending upon the circumstances, other action, including the notification of appropriate law enforcement and professional licensing agencies/boards, may be taken against any violator of this policy.

2.3 In accordance with the Drug-Free Workplace Act of 1989, and as a condition of employment, employees must comply with this policy and notify management within five (5) days of conviction for any criminal drug violation occurring in the workplace. Failure to do so will result in the immediate termination of employment. Any staff member arrested in connection with a criminal drug violation occurring in the workplace will be placed on an unpaid leave of absence and subject to termination of employment pending the outcome of any legal investigation and conviction.

2.4 Maxim reserves the right to require drug and alcohol test in the following situations: Pre-employment, Reasonable cause or suspicion, Post on-the-job incident which results in serious personal injury or property damage, or Random/Client-requested. All drug and alcohol testing will be performed by a state licensed laboratory, in accordance with the guidelines for Federal Workplace Testing and state drug testing regulations.

3.0 DEFINITIONS

3.1 **Drugs:** Drugs are defined as alcoholic beverages, any illegal substance, and/or any legal substance, such as a prescription drug, that is obtained illegally, is not being used for prescribed purposes, and/or is not being taken according to prescribed dosages.

3.2 **Substance Abuse:** The use or possession of any drug in a manner prohibited by law or the use of alcohol or any legal drug or other substance in such a way that the user's performance is impaired or endangers clients, co-workers, or themselves.

3.2 **Impaired:** Impaired shall mean that a persons mental or physical capabilities are reduced below their normal levels (with or without reasonable accommodation for a disability).

3.3 **Positive Drug Test:** A positive drug test shall mean any drug test whose results indicate that the employee has committed substance abuse, according to the current National Institute on Drug Abuse (NIDA) standards and the definitions in this policy.

3.4 **Negative Drug Test:** A negative drug test shall mean any drug test whose results do not indicate a positive drug test.

3.5 **Reasonable Cause:** Reasonable cause shall mean that evidence which forms a reasonable basis for concluding that it is more likely than not that a person has engaged in substance abuse, such as the odor of alcohol or drugs, impaired behavior (slurred speech, decreased motor coordination, etc.), marked changes in personality or job performance, and unexplained accidents or injury.

3.6 **Covered Employees:** All employees at Maxim Healthcare Services are covered under this policy.

4.0 DRUG TESTING

4.1 **Pre-employment Drug Testing:** Pre-employment drug testing may be required for some positions at Maxim Healthcare Services. An applicant who is tested as part of the hiring process is not subject to Maxim's company policies. As such, a pre-employment consent form should be completed and signed. The consent form should include permission to test the employee and for Maxim to receive the pre-employment drug test results from the Medical Review Officer. Any questions regarding the pre-employment test should be asked by the applicant and answered by Maxim prior to conducting the test. In some cases, a pre-employment drug test may be a condition of employment with Maxim.

4.2 **Reasonable Cause or Suspicion Drug Testing:** All covered employees shall undergo a drug screening test when reasonable cause exists to believe that they have committed substance abuse. If any employee has reason to believe that another employee is engaged in substance abuse in violation of this policy, they should report the suspected employee to a supervisor immediately. If reasonable cause exists, the supervisor should seek the appropriate authorization to request the suspected employee submit to a drug test.

4.3 **Post-On-the-job Incident Drug Testing:** Employees may be required to submit to a drug test in the event of an on-the-job incident that results in serious injury or property damage.

4.4 **Random or Client-requested Drug Testing:** Maxim reserves the right to conduct random, job-related drug testing on all covered employees. Also, some clients require employees to submit to a drug test prior to being assigned to a case. Active employees who are required to submit to a drug test at the request of a client may be subject to both Maxim's Substance Abuse policy and the client's Substance Abuse policies.

5.0 DRUG TESTING PROCEDURES

5.1 Once a request for an employee to submit to a drug test has been made, the employee will have forty eight (48) hours in which to report to the designated state licensed facility where the test will be performed. Employees who fail to report to the appropriate facility to submit to a requested drug test within forty-eight hours, and employees who refuse to submit to a requested drug test, will be considered to have voluntarily resigned from their position at Maxim.

5.2 An applicant or employee who provides a "cold" or diluted, unusable sample will be required to remain at the drug testing facility until a usable sample can be obtained. Failure to provide a usable sample at the first scheduled drug testing appointment will end the applicant's consideration for employment or be considered an employee's voluntary resignation from Maxim.

5.3 An employee who has been asked to submit to a drug test may be placed on unpaid leave pending the results of the drug test.

5.4 The Medical Review Officer (MRO) will return the drug test results to Maxim's Corporate Human Resources department for review. The MRO will contact the Corporate Human Resources department or the employee's direct supervisor for all positive drug tests. The MRO may request documentation of legally prescribed controlled substances or proof of the use of over-the-counter substances. The employee should provide the documentation, as requested, to the MRO. Failure to provide the appropriate documentation within seventy-two (72) hours after requested may result in the termination of employment.

5.5 As safety is a priority for Maxim, the MRO may make recommendations regarding the employee's continued employment in his/her current capacity based on the drug testing results even after the employee has provided appropriate and adequate documentation substantiating a positive drug testing result.

5.6 An employee may request that any positive drug testing result be verified with a second clinical test on the same sample. This request should be made to the MRO within seventy-two (72) hours of the employee's notification of a positive result. The employee is responsible for all fees or charges associated with this second test.

5.7 A positive drug testing result will result in disciplinary action, up to and including the termination of employment. Maxim may also report a positive drug testing result to the appropriate law enforcement or professional licensing agencies/boards.

6.0 ACKNOWLEDGEMENT OF SUBSTANCE ABUSE POLICY

6.1 The Drug-Free Workplace Act requires that companies be able to document the notification and receipt of its policy by each employee. Employees should sign an acknowledgement of receipt and understanding of the Substance Abuse Policy. You should retain a copy for yourself and a copy will be placed in your Personnel File so that Maxim can maintain its compliance with the federal regulations.

TO: MAXIM HEALTHCARE SERVICES, INC.

I have received and reviewed a copy of the Maxim policy on Substance Abuse, have read and understood the provisions of the policy, and will comply with all aspects of the policy.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

MAXIM REPRESENTATIVE: _____

PLEASE READ EACH PARAGRAPH BELOW. IF YOU DO NOT UNDERSTAND ANY PART OF THE INFORMATION INCLUDED IN EACH PARAGRAPH, PLEASE ASK THE INTERVIEWER BEFORE SIGNING.

*All employees, contractors and lessees are required to adhere to the **Maxim** Drug & Alcohol Policy. The information provided below is intended to be a brief summary of this policy and is not inclusive. All persons selected for employment with **Maxim** will receive a complete copy of the Drug & Alcohol policy. Our complete policy is also available for review upon request in our Human Resources Department.*

I understand that **Maxim** maintains a Drug & Alcohol-free workplace and may require a drug & alcohol screening test as a condition of employment for specific job classifications. If I do not complete the pre-employment drug & alcohol testing within 24 hours of being offered a position for which pre-employment drug & alcohol testing is required or if I test positive, refuse to test or submit an adulterated specimen, I understand I will not be considered for employment.

I further understand that if I am employed by **Maxim,** I will be required to submit to random drug testing only if I am employed in a safety sensitive position. If I sustain a work related injury, I may be required to submit to post-accident drug testing if the circumstances surrounding the cause of such accident indicate that I was at fault or if it is unclear if I was at fault. **Maxim** may also conduct reasonable suspicion drug & alcohol testing during the course of my employment. Testing positive, refusing to test within the designated time period or submitting an adulterated specimen for any random, reasonable suspicion or post-accident drug & alcohol screening during my employment will be considered a voluntary resignation of such employment.

I understand that **Maxim** abides by an employment-at-will policy, which means either the company or the employee may terminate the employment relationship at anytime, for any reason or for no reason, with or without notice. Nothing contained in this employment application, any employee handbook or conveyed to me during an interview is intended to create an employment contract, implicit or implied. I also understand and agree that any future changes in my title, duties, compensation, working conditions, or company benefits, policies and/or procedures will not alter this at-will agreement. This at will agreement can only be changed or modified in writing by the President of Maxim Healthcare Services.

If I am applying for a position for which driving a vehicle is a mandatory job duty, I am required to possess a current and valid driver's license and I agree to provide **Maxim** with a certified copy of my driving record. I also understand that any offer of employment is contingent upon my overall driving record, and my ability to be covered by the company's vehicle insurance policy.

I certify that I completed this application for employment by myself and that all of the information provided herein is true. I understand that any omission, misstatement or inclusion of false information on this application or any documents used to secure employment with **Maxim** shall be grounds for rejection of this application or for immediate discharge if I am employed, regardless of the time elapsed before discovery.

I understand that this application is considered current for three months. If I wish to be considered for employment after this 3-month period, I must complete and submit a new employment application.

My signature below certifies that I have read and fully understand the information included on this application and agree to the terms and conditions outlined in this document.

Applicant's Signature _____ Date _____

UNDER THE EMPLOYEE POLYGRAPH ACT OF 1988, AN EMPLOYER MAY NOT REQUIRE OR DEMAND, AS A CONDITION OF EMPLOYMENT, PROSPECTIVE EMPLOYMENT, OR CONTINUED EMPLOYMENT THAT AN INDIVIDUAL, UNLESS SPECIFICALLY EXEMPTED FROM THIS ACT, SUBMIT TO TAKE A LIE DETECTOR OR SIMILAR TEST. ANY EMPLOYER WHO VIOLATES THIS LAW IS GUILTY OF A MISDEMEANOR AND SUBJECT TO A FINE.

Applicant's Signature _____ Date _____

Maxim is an Equal Opportunity Employer. All qualified applicants will receive consideration without regard to race, color, religion, gender, gender identity, national origin, age, disability, veteran status or any other status protected under local, state or federal law.

RELEASE AND AUTHORIZATION TO OBTAIN CONSUMER AND/OR INVESTIGATIVE CONSUMER REPORT FOR EMPLOYMENT PURPOSES ONLY

I, the undersigned consumer, hereby authorize **MAXIM HEALTHCARE SERVICES, INC.** and its affiliated companies (collectively, "**MAXIM"),** by and through its independent contractors, **E-VERIFILE, INC. ("EVI")**, **INTELLICORP RECORDS INC. ("IntelliCorp")**, **or any other Consumer Reporting Agency** to procure a consumer report and/or investigative consumer report on me for employment purposes only. These reports may include, but are not necessarily limited to, information regarding my personal characteristics, means and manner of living, character and general reputation, and may be obtained through one or more of the following sources: employment and education verifications; my personal credit history based on reports from any credit bureau; personal references; personal interviews; driving history, including any traffic citations; a social security number verification; present and former addresses; criminal and civil history/records; and any other public records.

I understand that I am entitled to a complete and accurate disclosure of the nature and scope of any investigative consumer report of which I am the subject upon my written request to **EVI, IntelliCorp or any other Consumer Reporting Agency**, if such request is made within a reasonable time after the date hereof. I also understand that I may receive a written summary of my rights under 15 U.S.C. § 1681 et. seq. and Cal. Civ. Code §1786.

I also authorize any person, business or governmental agency that may have information relevant to the above, including but not limited to, all courts, public agencies, law enforcement agencies and credit bureaus, to disclose the same to **MAXIM, EVI, Intellicorp** and/or to **any other Consumer Reporting Agency**, regardless of the manner in which such person, business entity or governmental agency obtained the information itself.

I hereby release **MAXIM**, **EVI, IntelliCorp** and any and all persons, business entities and governmental agencies providing information, whether public or private, from any and all liability, claims and/or demands, by me, my heirs or others making such claim or demand on my behalf, for providing the consumer report(s) and/or investigative consumer report(s) authorized by me herein. I understand that this Release and Authorization shall remain in effect for the duration of my employment with **MAXIM**, and that **MAXIM** may obtain additional consumer and /or investigative consumer report(s) on me.

Additionally, I hereby authorize **MAXIM** to investigate any incidents of workplace misconduct made against or involving me both during and after the term of my employment with **MAXIM**

I HEREBY CERTIFY THAT THE INFORMATION CONTAINED ON THIS RELEASE AND AUTHORIZATION FORM IS TRUE AND CORRECT AS OF THE DATE HEREOF, AND THAT MY APPLICATION OR EMPLOYMENT WILL BE TERMINATED BASED ON ANY FALSE, OMITTED OR FRAUDULENT INFORMATION.

Signature: _____

PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION BELOW:

Printed Name:_____ **Date:** _____
First Middle Last

Other Names Used (alias, maiden, nickname)_____ YEARS USED_____

Current Address:_____
Street City State Zip Code County Dates

Former Address: _____
Street City State Zip Code County Dates

Social Security Number: _____ Daytime Telephone Number: _____

Driver's License Number: _____ State of Issuance: _____

Date of Birth*: _____ Gender*_____ Race (Optional)* _____

- Have you ever been sanctioned or had your licenses suspended or revoked? Yes____ No____
- Are you currently under any investigation or pending charge? Yes____ No____
- **Please provide me with a copy of my background investigation report. Yes ☐ No ☐**

***This information will enable us to properly identify you in the event that we find adverse information during the course of our background search.**

HEALTHCARE SERVICES

ACKNOWLEDGEMENT OF TEMPORARY POSITION

Date _____

Employer _____

I, _____, understand that I am accepting a temporary position with the above referenced employer. I further understand that it is my responsibility to contact the above referenced employer at the completion of any assignment. I understand that if I do not contact the employer at that time I will be considered to have voluntarily terminated my employment and that this may have an effect on benefits for which I might otherwise be eligible.

Employee Signature_____

Witness _____

MAXIM STAFFING SOLUTIONS	**PEER REFERENCES**

Include the names of at least two (2) people you have worked with in the last year that work in the same skill level as you. These people should be current or former coworkers. This will allow Maxim the opportunity to receive additional input on your clinical experience.

Please print all information:

1) Name: _____ Telephone: _____

Skill/Position: _____ Employer: _____

Nature of Relationship: ☐ Current Co-worker ☐ Former Co-worker ☐ Other: _____

2) Name: _____ Telephone: _____

Skill/Position: _____ Employer: _____

Nature of Relationship: ☐ Current Co-worker ☐ Former Co-worker ☐ Other: _____

3) Name: _____ Telephone: _____

Skill/Position: _____ Employer: _____

Nature of Relationship: ☐ Current Co-worker ☐ Former Co-worker ☐ Other: _____

4) Name: _____ Telephone: _____

Skill/Position: _____ Employer: _____

Nature of Relationship: ☐ Current Co-worker ☐ Former Co-worker ☐ Other: _____

In connection with my application for employment, I understand and agree that Maxim may seek information as to my character, work habits, job performance, skills and abilities. I authorize my current and/or previous co-workers, referenced above, to release any and all information relating to my employment. This authorization remains valid for a period of 12 months from the date below. I acknowledge that a facsimile or copy of this release shall be as valid as the original.

Applicant Signature: _____

Date: _____

ACKNOWLEDGMENT OF HEPATITIS B VACCINE POLICY

MAXIM has provided information regarding the efficacy, safety and administration procedure for the Hepatitis B vaccination series and has offered to pay for the series. I certify that I have read and understand the policy and release **MAXIM** from all liability for any adverse reactions that may result from this Hepatitis B vaccine series.

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 cost to myself.

Please check one of the following:

HEPATITIS B VACCINATION DECLINATION

☐ **I decline the Hepatitis B vaccination series offered by Maxim 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 want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me. I release MAXIM from all liability regarding the contraction of Hepatitis B in the performance of my job duties.

_____

Employee Name - PRINT

_____

Employee Signature Date

☐ **I decline the Hepatitis B vaccination series because I have already been vaccinated for Hepatitis B within the last ten (10) years.**

_____

Employee Name - PRINT

_____

Employee Signature Date

HEPATITIS B VACCINATION ACCEPTANCE

☐ **I accept the Hepatitis B vaccination series offered by Maxim.**

_____

Employee Name - PRINT

_____

Employee Signature Date

MAXIM STAFFING SOLUTIONS	TB QUESTIONNAIRE

PRINT NAME: _____ **DATE:** _____

INSTRUCTIONS:

- If you receive PPD's on an annual basis, complete ***STEP I only and attach a copy of your most recent PPD results.***
- If you have had a verified **positive PPD** in the past, ***go to Step II and attach a copy of your most recent chest x-ray results***

STEP I – Complete the following:

DATE OF LAST PPD: _____ RESULTS OF LAST PPD IN MM: _____

STEP II

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

  DATE OF LAST CHEST XRAY: _____

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

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

*If you checked **YES** to any of the above question, are you currently treating with a physician? ☐ YES ☐ NO

Please explain: _____

_____

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

APPLICANT SIGNATURE **DATE**

BACK BRACE ACCEPTANCE/DECLINATION

Name (print): _____

I have been informed that:

1) Back care educational material is available for viewing at anytime during office hours.
2) A back brace is available to me for the cost of $8.50 ($4.25 payroll deduction X 2)

Please choose one of the following:

ACCEPTANCE STATEMENT

☐ I have received the above stated Back Brace information, and choose to purchase the back brace at this time. I authorize Maxim to deduct two payments of $4.25 ($8.50 total) from my pay check to cover the cost of my voluntary purchase of a back brace.

Employee's Signature: _____ Date: _____

DECLINATION STATEMENT

☐ I have received the above stated Back Brace information, but choose not to purchase the back brace at this time.

Employee's Signature: _____ Date: _____

PHYSICIAN'S STATEMENT

Notice to Applicant:

This physician's statement must be completed before you can begin any assignment with Maxim. **DO NOT** delay sending your completed application and other forms. This statement may be sent as a later date, but must be sent prior to the start of your employment.

APPLICANT INFORMATION: (Please Print)

Name_____ Date_____

Address_____

City_____State_____Zip_____

PHYSICIAN'S STATEMENT

The patient named above has been examined by me and found to be in good physical and mental health. The patient is free from communicable diseases and is able to perform at full capacity.

Date of exam: _____

Test Performed

*TB Skin Test Date Performed_____ Results_____

*Chest X-Ray (if skin test, N/A) Date Performed_____ Results_____

All test results must be current (within a year)

Immunization Records

Mumps Titer or Vaccine Date Performed_____ Results_____

Rubella Titer / or Vaccine Date Performed_____ Results_____

Rubeola Titer / or Vaccine Date Performed_____ Results_____

Varicella Date Performed_____ Results_____

Hepatitis Vaccine 1 Date Performed_____ Results_____

Hepatitis Vaccine 2 Date Performed_____ Results_____

Hepatitis Vaccine 3 Date Performed_____ Results_____

Hepatitis Titer (if vac., N/A) Date Performed_____ Results_____

All Maxim professionals must have the above (*) test(s) performed to complete their employment files. Individual facilities may have additional requirements.

Additional Comments: _____

_____

Name of Physician (please print) _____

Physician Address _____

City _____**State** _____**Zip** _____

Physician Signature: _____ **License number**_____

Aug-05

Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address *(Street Name and Number)*		Apt. #	Date of Birth *(month/day/year)*
City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):
- ☐ A citizen or national of the United States
- ☐ A Lawful Permanent Resident (Alien # A_____
- ☐ An alien authorized to work until ___/___/___
  (Alien # or Admission #) _____

Employee's Signature	Date *(month/day/year)*

Preparer and/or Translator Certification. *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name
Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s)

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date *(if any)*: ___/___/___		___/___/___		___/___/___
Document #: _____				
Expiration Date *(if any)*: ___/___/___				

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* **___/___/___ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name Maxim Staffing	Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name *(if applicable)*	B. Date of rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title:_____ Document #: _____ Expiration Date (if any): ___/___/___

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date *(month/day/year)*

LISTS OF ACCEPTABLE DOCUMENTS

LIST A

Documents that Establish Both Identity and Employment Eligibility

1. U.S. Passport (unexpired or expired)
2. Certificate of U.S. Citizenship *(INS Form N-560 or N-561)*
3. Certificate of Naturalization *(INS Form N-550 or N-570)*
4. Unexpired foreign passport, with *I-551 stamp or* attached *INS Form I-94* indicating unexpired employment authorization
5. Permanent Resident Card or Alien Registration Receipt Card with photograph *(INS Form I-151 or I-551)*
6. Unexpired Temporary Resident Card *(INS Form I-688)*
7. Unexpired Employment Authorization Card *(INS Form I-688A)*
8. Unexpired Reentry Permit *(INS Form I-327)*
9. Unexpired Refugee Travel Document *(INS Form I-571)*
10. Unexpired Employment Authorization Document issued by the INS which contains a photograph *(INS Form I-688B)*

OR

LIST B

Documents that Establish Identity

1. Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address
2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority

For persons under age 18 who are unable to present a document listed above:

10. School record or report card
11. Clinic, doctor or hospital record
12. Day-care or nursery school record

AND

LIST C

Documents that Establish Employment Eligibility

1. U.S. social security card issued by the Social Security Administration *(other than a card stating it is not valid for employment)*
2. Certification of Birth Abroad issued by the Department of State *(Form FS-545 or Form DS-1350)*
3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal
4. Native American tribal document
5. U.S. Citizen ID Card *(INS Form I-197)*
6. ID Card for use of Resident Citizen in the United States *(INS Form I-179)*
7. Unexpired employment authorization document issued by the INS *(other than those listed under List A)*

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

Employment Eligibility Verification

INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1- Employee. All employees, citizens and noncitizens, hired after November 6, 1986, must complete Section 1 of this form at the time of hire, which is the actual beginning of employment. **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Preparer/Translator Certification. The Preparer/Translator Certification must be completed if Section 1 is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete Section 1 on his/her own. However, the employee must still sign Section 1 personally.

Section 2 - Employer. For the purpose of completing this form, the term "employer" includes those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors.

Employers must complete Section 2 by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, Section 2 must be completed at the time employment begins. **Employers must record: 1)** document title; **2)** issuing authority; **3)** document number, **4)** expiration date, if any; and **5)** the date employment begins. Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the I-9. **However, employers are still responsible for completing the I-9.**

Section 3 - Updating and Reverification. Employers must complete Section 3 when updating and/or reverifying the I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in Section 1. Employers **CANNOT** specify which document(s) they will accept from an employee.

- If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B and:
  - examine any document that reflects that the employee is authorized to work in the U.S. (see List A **or** C),
  - record the document title, document number and expiration date (if any) in Block C, and
  - complete the signature block.

Photocopying and Retaining Form I-9. A blank I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed I-9s for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

For more detailed information, you may refer to the Department of Homeland Security (DHS) Handbook for Employers, (Form M-274). You may obtain the handbook at your local U.S. Citizenship and Immigration Services (USCIS) office.

Privacy Act Notice. The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of the U.S. Immigration and Customs Enforcement, Department of Labor and Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Reporting Burden. We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: **1)** learning about this form, 5 minutes; **2)** completing the form, 5 minutes; and **3)** assembling and filing (recordkeeping) the form, 5 minutes, for an average of 15 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachuetts Avenue, N.W., Washington, DC 20529. OMB No. 1615-0047.

NOTE: This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

EMPLOYERS MUST RETAIN COMPLETED FORM I-9
PLEASE DO NOT MAIL COMPLETED FORM I-9 TO ICE OR USCIS

Form **8850**
(Rev. October 2002)
Department of the Treasury
Internal Revenue Service

Pre-Screening Notice and Certification Request for the Work Opportunity and Welfare-to-Work Credits

► **See separate instructions.**

OMB No. 1545-1500

Job applicant: Fill in the lines below and check any boxes that apply. Complete only this side.

Your name _____ Social security number ► _____

Street address where you live _____

City or town, state, and ZIP code _____

Telephone number ( ) -

If you are under age 25, enter your date of birth (month, day, year) / /

Work Opportunity Credit

1 ☐ Check here if you received a conditional certification from the state employment security agency (SESA) or a participating local agency for the work opportunity credit.

2 ☐ Check here if **any** of the following statements apply to you.

- I am a member of a family that has received assistance from Temporary Assistance for Needy Families (TANF) for any 9 months during the last 18 months.
- I am a veteran and a member of a family that received food stamps for at least a 3-month period within the last 15 months.
- I was referred here by a rehabilitation agency approved by the state or the Department of Veterans Affairs.
- I am at least age 18 but **not** age 25 or older and I am a member of a family that:

  a Received food stamps for the last 6 months **or**

  b Received food stamps for at least 3 of the last 5 months, **but** is no longer eligible to receive them.
- Within the past year, I was convicted of a felony or released from prison for a felony **and** during the last 6 months I was a member of a low-income family.
- I received supplemental security income (SSI) benefits for any month ending within the last 60 days.

Welfare-to-Work Credit

3 ☐ Check here if you received a conditional certification from the SESA or a participating local agency for the welfare-to-work credit.

4 ☐ Check here if you are a member of a family that:

- Received TANF payments for at least the last 18 months, **or**
- Received TANF payments for any 18 months beginning after August 5, 1997, **and** the earliest 18-month period beginning after August 5, 1997, ended within the last 2 years, **or**
- Stopped being eligible for TANF payments within the last 2 years because Federal or state law limited the maximum time those payments could be made.

All Applicants

Under penalties of perjury, I declare that I gave the above information to the employer on or before the day I was offered a job, and it is, to the best of my knowledge, true, correct, and complete.

Job applicant's signature ► **Date** / /

For Employer's Use Only

Employer's name Maxim Healthcare Telephone no. ( ) - EIN ▶

Street address

City or town, state, and ZIP code

Person to contact, if different from above **ADP Tax Credit Services** Telephone no. **(843) 667-1836**

Street address **2205 Enterprise Drive, Suite C / PO Box 108850**

City or town, state, and ZIP code **Florence, SC 29501**

If, based on the individual's age and home address, he or she is a member of group 4 or 6 (as described under **Members of Targeted Groups** in the separate instructions), enter that group number (4 or 6) . . . . . ▶

Date applicant:	Gave information / /	Was offered job / /	Was hired / /	Started job / /

Under penalties of perjury, I declare that I completed this form on or before the day a job was offered to the applicant and that the information I have furnished is, to the best of my knowledge, true, correct, and complete. Based on the information the job applicant furnished on page 1, I believe the individual is a member of a targeted group or a long-term family assistance recipient. I hereby request a certification that the individual is a member of a targeted group or a long-term family assistance recipient.

Employer's signature ▶ **Title** **Date** / /

Privacy Act and Paperwork Reduction Act Notice

Section references are to the Internal Revenue Code.

Section 51(d)(12) permits a prospective employer to request the applicant to complete this form and give it to the prospective employer. The information will be used by the employer to complete the employer's Federal tax return. Completion of this form is voluntary and may assist members of targeted groups and long-term family assistance recipients in securing employment. Routine uses of this form include giving it to the state employment security agency (SESA), which will contact appropriate sources to confirm that the applicant is a member of a targeted group or a long-term family assistance recipient. This form may also be given to the Internal Revenue Service for administration of the Internal Revenue laws, to the Department of Justice for civil and criminal litigation, to the Department of Labor for oversight of the certifications performed by the SESA, and to cities, states, and the District of Columbia for use in administering their tax laws. In addition, we may disclose this information to Federal, state, or local agencies that investigate or respond to acts or threats of terrorism or participate in intelligence or counterintelligence activities concerning terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is:

Recordkeeping . . . . 2 hr., 46 min.
Learning about the law or the form . . . . . 36 min.
Preparing and sending this form to the SESA . . . . . 36 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can write to the Tax Forms Committee, Western Area Distribution Center, Rancho Cordova, CA 95743-0001.

Do not send this form to this address. Instead, see **When and Where To File** in the separate instructions.

MFD-RFV-1-0100

REQUEST FOR VERIFICATION

Your employer participates in the Work Opportunity (WOTC) and Welfare-to-Work (WTW) Tax Credit programs.
The following information will assist your company in obtaining these valuable credits.

***Section I**: Please complete all information, sign and date.*

Name: _____ Social Security Number: ___ - __ - ____

New Employee Job Title _____ Starting Hourly Wages $ _____

Date of birth (MMDDYYYY): __ / __ / ____ Job Start Date (MMDDYYYY): __ / __ / ____

I hereby authorize agencies, organizations, or individuals to release the information below to ADP Tax Credit Services. I understand this information will be used solely to qualify my employer for the Work Opportunity and/or Welfare-to-Work Tax Credit programs.

Employee Signature: _____ *Date:*____/____/____

***Section II:** Please complete all information that applies to you.*

FOOD STAMPS

Have you, your spouse, parents or a family member (while living in your household) received Food Stamps anytime within the last fifteen (15) months?

YES ☐ NO ☐

Primary Recipient: _____

Relation to You: _____

Benefits received in:

City/State: _____

County: _____

Are you a veteran of the US Armed Forces?

YES ☐ NO ☐

Branch of Service:_____

Dates of Service: _____

If you served in the military and answered yes to the food stamps question above, if available, please attach a copy of your DD-214 (discharge papers).

AFDC/TANF/WELFARE-TO-WORK

Have you or any family member with whom you lived received AFDC/TANF benefits within the last two (2) years?

YES ☐ NO ☐

Are you a member of a family that stopped being eligible for AFDC/TANF benefits within the last two (2) years because of federal or state limitations?

YES ☐ NO ☐

Have you received any child care, housing or transportation assistance from the government anytime since 18 months ago?

YES ☐ NO ☐

AFDC (Aid to Families with Dependent Children)
TANF (Temporary Assistance for Needy Families)
(also known as welfare benefits)

Primary Recipient:_____

Relation to you:_____

Benefits received in:

City/State: _____ County:_____

SSI—SUPPLEMENTAL SECURITY INCOME

Have you received SSI benefits within the last ninety (90) days?

YES ☐ NO ☐

VOCATIONAL REHABILITATION

Have you participated in a vocational rehabilitation program?

State Agency YES ☐ NO ☐

Veteran Administration YES ☐ NO ☐

Counselor's Name: _____

City/State: _____

FELONY

Are you currently participating in a Work Release Program, Halfway House or Transition Center?

YES ☐ NO ☐

----OR----

Within the last twelve (12) months have you been convicted of, deferred adjudication for or released from prison for a felony?

YES ☐ NO ☐

Conviction Date:____/____/____ Release Date:____/____/____

Probation/Parole Officer's Name:_____

City/State:_____

Phone Number:_____