Elite Healthcare Nursing Services, Inc.

"We provide excellency for your loved ones"

APPLICATION FOR NURSING/ ADMINISTRATIVE INDEPENDENT CONTRACTOR

Personal Information:

Date: _____

Last Name: _____ First name: _____ Middle name: _____

Street address:_____

City: _____ State: _____ Zip code: _____ S.S.#: _____

DOB: _____/_____/_____

Drivers License #: _____ Exp. Date: _____ Issuing State: _____

Home Tel: (_____)_____ Cell #: (_____)_____ Work #: (_____)_____

Position desired: _____ Availability: _____

What is your primary interest: _____ Live in. _____ Pediatric Private Duty. _____ Staff Nursing

_____ Administrative.

Are you legally eligible for employment? Yes _____ No _____ If Yes your permit #: _____

Are you a legal resident of U.S.A? Yes _____ No _____ If Yes your Naturalization #: _____

Are you a U.S Citizen? Yes _____ No _____

ANY ADDITIONAL SKILLS:

Can you type? Yes _____ No _____ Can you take diction? Yes _____ No _____ Experience with Microsoft office software? Yes _____ No _____

MILITARY SERVICE:

Date of veteran's service: From: _____ To _____

Are you currently on active duty? Yes _____ No _____

Have you had any convictions other than minor traffic violations? Yes _____ No _____ If Yes give completed details on the other side:_____

_____

_____

Please answer questions by an "X" in the appropriate box.

A. Are you?

B. Are you handicapped?

1. ( ) Male
2. ( ) Female

1. ( ) Yes
2. ( ) No

C. Race / Ethic identification – Please check only one.

1. ( ) White (not of Hispanic origin) Include persons having origin in any of the original peoples of Europe, North America of Middle East.
2. ( ) Black (not of Hispanic origin) Include persons having origins in the Black racial group of Africa.
3. ( ) Asian or Pacific Islanders: Include persons having origins in any of the original peoples of the far East, South East Asia, the Indian Subcontinent or the Pacific Islands. This area includes, e.g China, Japan, Korea, the Philippine Islands and Samoa.
4. ( ) American Indian or Alaskan Native: Includes persons having origins in any of the original peoples of North Antarctica, and who maintain cultural identification through tribal affiliation.
5. ( ) Hispanic: Include persons of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.
6. ( ) Other.

INDEPENDENT CONTRACTOR EDUCATIONAL PROFILE

School	Name and Location of School	Course of study	No. of years completed	Did you Graduate?	Degree or Diploma
Graduate				Yes ( ) No ( )	
Business / Trade / Technical				Yes ( ) No ( )	
High School				Yes ( ) No ( )	
Elementary				Yes ( ) No ( )	

Additional comments: _____

_____

_____

_____

I here authorize EHCNS, Inc. to release the above information or former and current educational, employment and medical organizations for the purpose of potential credential verification.

_____ _____

Independent contractor's signature Date

CLASSIFICATION OF INDEPENDENT CONTRACTOR:

_____ RN _____ LPN _____ CNA / GNA _____ Office Manager _____ RN Supervisor

_____ Companionship _____ Administrative Assistant

INDEPENDENT CONTRACTOR EMPLOYMENT PROFILE (Start with present company first)

Company name: _____

Address: _____

Name of Supervisor: _____

Phone #: _____ Employed From: _____ to _____

Weekly pay: Start: _____ Last: _____

State job title and describe your work: _____

Reason for leaving: _____

Company name: _____

Address: _____

Name of Supervisor: _____

Phone #: _____ Employed From: _____ to _____

Weekly pay: Start: _____ Last: _____

State job title and describe your work: _____

Reason for leaving: _____

Company name: _____

Address: _____

Name of Supervisor: _____

Phone #: _____ Employed From: _____ to _____

Weekly pay: Start: _____ Last: _____

State job title and describe your work: _____

Reason for leaving: _____

PERSONAL REFERENCES (3 Personal references, excluding relatives)

Name: _____

Address: _____

Telephone #: _____

Name: _____

Address: _____

Telephone #: _____

Name: _____

Address: _____

Telephone #: _____

INCASE OF AN EMERGENCY WE CONACT (2 Person contacts)

Name: _____

Relationship: _____

Telephone #: _____

Name: _____

Relationship: _____

Telephone #: _____

I agree that the information in this application is true, correct, and complete.

I understand that as an independent contractor with EHCNS, Inc. does not make me an employee of EHNS, Inc.

_____ _____

Applicant's signature Date.

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INDEPENDENT CONTRACTOR AGREEMENT

The undersigned independent contractor acknowledges attainment for one or several of the following contractual services for Elite Healthcare Nursing Services, Inc.

Healthcare Provider: _____
(RN, LPN, CNA/GNA, Home Health Aide, Companionship)

Office Manager: _____

Administrative Assistant: _____

RN Supervisor: _____

It is further acknowledged that:

1. The undersigned shall be deemed an independent contractor and is not bided for any length of time with EHCNS, Inc for employment, partnership, joint venture or other agency association.

2. The relationship between the undersigned contractor and EHCNS, Inc is based on the independent contractor's decision to work at his/her discretion with regards to self-scheduling on shifts available to any case/cases or required position.

3. Consistent with the foregoing EHCNS, Inc will not be responsible or held liable for the following: Federal Medical State, FICA and any other Tax deductions. The undersigned independent contractor acknowledges his/her responsibility to pay all of the above mentioned tax liabilities.

4. The understand independent contractor further acknowledges that he/she is not entitled to any employee benefits of EHCNS, Inc pension, profit sharing, IRS's, Works' Compensation Insurance, Unemployment Insurance, Professional Liability, overtime pay, bonuses, sick leave, vacation leave, family leave, tuition reimbursement and travel reimbursement.

5. The undersigned independent contractor accepts the mentioned terms for referral of services by EHCNS, Inc. and payment strictly for hours worked at the rate of $ _____ per hour.

Signed on this (date) _____day of (month) _____ of year _____

_____ _____

Independent contractor signature EHCNS, Inc Representative signature

_____ _____

Independent contractor printed name EHCNS, Inc Representative printed name.

Elite Healthcare Nursing Services, Inc.
5411 Old Frederick Road, Suite 2
Baltimore, Maryland 21229
(Phone) 410-455-6418 (Fax) 410-455-6419

AUTHORIZATION TO PROVIDE PROFESSIONAL REFERENCE INFORMATION

Dear Applicant:
Please clearly and completely fill out the information in this section.

Date: _____ My classification was (please check appropriate Box)

ATTN: _____ ------ RN -----LPN ----- N/A ----- Other

Company: _____

Address: _____

Employment from: _____ to _____

Phone #: _____

Fax#: _____

_____ _____
Applicant's Name Signature

Dear Employer:
The applicant listed above has applied to EHCNS, INC. for employment and furnished your name as a reference. Please note the applicant's signature as notice to authorize release of the information below. Please check the appropriate boxes.

	Outstanding	Excellent	Good	Fair
Knowledge				
Appearance				
Initiative				
Punctually				
Performance				
Cooperation				
Dependability				
Personality				

Type of Work Performed: _____
Reason for Leaving: _____
Would you Consider Applicant for Rehire? _____

_____ _____ _____
Signature Position Date

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I, _____, hereby release any and all prior employers or current employers from liability or claims arising out of the provision of information about my employment with such employer. I hereby waive any case of action I might otherwise have against such employer arising out of the provision of information concerning my employment.

_____
Print Name

_____ _____
Signature Date

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CNA/GNA SKILL CHECKLIST

Skills	Yes	No	Satisfactory	Unsatisfactory	Supervisor Initial	Date Observed
ADLs						
Bathing the infant						
Bathing the child						
Positioning the child						
Positioning the adult						
Brushing the teeth						
Flossing the teeth						
Teaching mouth care						
Performing mouth care						
Dressing the infant						
Dressing the adult						
Changing the diaper						
Washing the hair						
Obtaining Vital Signs						
Oral Temperature						
Rectal Temperature						
Auxiliary Temperature						
Ear Thermometer						
Obtaining respirations						
Obtaining blood pressures						
Obtaining a pulse						
Brachial						
Radial						
Carotid						
Femoral						
Apical						
Infection Control						
Hand washing						
Utilizing good infection control technique						
Maintaining a clean working environment						
Making a 1/10 bleach solution						
Cleaning up blood spills						
Turning and positioning						
Caring for client with sensitive skin						

Skills	Yes	No	Satisfactory	Unsatisfactory	Supervisor Initial	Date Observed
Infection control (Cont.)						
Non-sterile dressing changes						
Applying ace wraps						
Gastrointenstinal						
Assessing nutritional status						
Assessing bowel and elimination						
Feeding the baby by mouth						
Feeding the child by mouth						
Giving an enema (SS)						
Checking for constipation						
Care for incontinence clients						
Obtaining heights and weights						
Caring for the client with a foley catheter						
Measuring intake and output						
Performing a douche						
Writing Nursing Progress Notes						
Utilizing the progress notes						
Prioritizing responsibilities						
Teaching the family and client						
Documenting patient changes						
Care of Febrile Client						
Cool water baths						
Offering fluids if indicated						
Administrating ice packs						
Activities						
Applying leg braces						
Applying splints						
Applying Passive ROM						
Performing active ROM						
Using a stroller						
Using the crib						
Using a Hoyer Lift						
Caring for a Client with Bowel Problems						
Caring for a colostomy						
Caring for a ileostomy						
Irrigating the colostomy						
Care of the stoma						
Applying an ostomy bag						

Skills	Yes	No	Satisfactory	Unsatisfactory	Supervisory Initial	Date Observed
Caring for a Client with Vision problems						
Applying an eye patch						
Checking Pupils						
Evaluation of…						
Intake and output						
Dehydration						
Respiratory distress						
Cardiac Distress						

_____

CAN/GNA Name

_____ _____

CAN/GNA Signature **Date**

_____ _____

Supervisor Signature **Date**