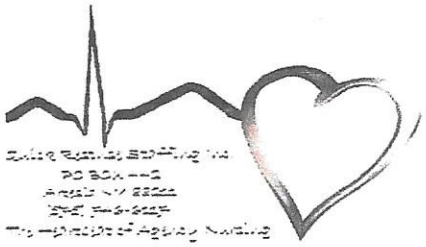


Checklist

***All items on this check list must be received before placement can be made.

___Application
___Resume
___Current License
___Current BLS, ACLS, PALS and other certifications
___2 Reference Letters
___Copy of Driver's License
___HIPAA Confidentiality Agreement
___W-4
___Employment Eligibility Verification Form I-9
___Health Coverage Acknowledgment of Receipt
___Hepatitis Verification/Declination
___Varicella Verification/Declination
___Influenza Vaccine Verification/Declination
___TB Test
___Rubella Titer
___ Immunization Record
___Background Check Consent
___Drug Screen
___Skills Checklist
___Physical Exam
___Education Verification (Diploma or Transcript)
___Color Blind Test (www.enchroma.com)
___Respiratory Fit Test
___Direct Deposit Information Form
___Responsibility Acknowledgment

I understand that no shifts will not be offered until all items on the checklist have been completed and returned to Quick Response Staffing Inc.

Signature: _____ Date: _____

Quick Response Staffing Inc.

Employment Application

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Date Available: _____ Social Security No.: _____ Desired Salary:$ _____

Position Applied for: _____

Are you a citizen of the United States? YES ☐ NO ☐ If no, are you authorized to work in the U.S.? YES ☐ NO ☐

Have you ever worked for this company? YES ☐ NO ☐ If yes, when? _____

Have you ever been convicted of a felony? YES ☐ NO ☐

If yes, explain: _____

Education

High School: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Diploma:: _____

College: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

Other: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

Licenses/Certifications

RN/LPN/CNA License#: _____ *Expiration Date:* _____

BLS: _____ ACLS: _____ TNCC: _____ PALS: _____ NRP: _____ Other: _____

CCRN: _____ CEN: _____ Chemotherapy: _____ CNOR: _____

References

Full Name: ______________________ Relationship: ______________

Company: ______________________ Phone: ______________

Full Name: ______________________ Relationship: ______________

Company: ______________________ Phone: ______________

Previous Employment

Company: ______________________ Phone: ______________

Address: ______________________ Supervisor: ______________

Job Title: ______________ Starting Salary:$ ________ Ending Salary:$ ________

Responsibilities: ____

From: __________ To: __________ Reason for Leaving: ______________

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company: ______________________ Phone: ______________

Address: ______________________ Supervisor: ______________

Job Title: ______________ Starting Salary:$ ________ Ending Salary:$ ________

Responsibilities: ____

From: __________ To: __________ Reason for Leaving: ______________

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Company: ______________________ Phone: ______________

Address: ______________________ Supervisor: ______________

Job Title: ______________ Starting Salary:$ ________ Ending Salary:$ ________

Responsibilities: ____

From: __________ To: __________ Reason for Leaving: ______________

May we contact your previous supervisor for a reference? YES ☐ NO ☐

Experience

Unit:	Experience Years/Months:	Used in Last Year? Yes/No
Acute Hospital Experience/Nursing		
Charge Nurse Experience		
Critical Care Experience/ CC Course		
Medical/Surgical		
Pediatrics		
Labor and Delivery/ Post Partum		
Proficiency in phlebotomy and IV Therapy		
Telemetry/EKG Course/Cardiac Rhythm Recognition		

Disclaimer and Signature

Have you ever had a license of certification investigated, revoked, or suspended? If yes, please attach a detailed explanation. □Yes □No Do you have at least one year of current experience on a hospital floor? □Yes □No Are you willing to submit to a criminal background check? □Yes □No Are you willing to submit to a drug screen? □Yes □No Can you perform the essential functions of the job for which you are applying? □Yes □No

Statement of Certification, Authorization, and Agreement

I certify that the information that I have provided in this application form, in my resume, and interview(s) is complete and accurate. I authorize all my former employers and personal references to answer inquiries made by the employer and I hereby release all such parties, including the employer, it's subsidiaries, employees, subscribers, and agents from liability as a result of doing so. I agree that if, in the exclusive opinion of the employer, I have made any misrepresentation, or the results of the investigation are not satisfactory, any offer of employment may be withdrawn or, if already hired and working, I may be terminated without liability, except for payment at the rate agreed upon for my services actually rendered. I understand this authorization to investigate my background is extended to, and covers, the entire period of my employment. A copy of this agreement and certification can serve as an original. I understand and agree that the employer is an "at will" employer and that this means my compensation can be changed by the company at any time or my employment can be terminated by me or the company at any time and for any reason, or for no reason at all, and that no one, except the employer's president, is authorized to enter into a contract or agreement of employment with me for any specific period of time or offer me any benefits different than those generally available to other similarly situated employees. Any such agreement must be in writing and signed by me and the employer's president. Any other such agreements, oral or written, by anyone else are considered null and void. I also understand that once I have entered into agreement upon signature, I will be unable to accept formal employment at any facility worked in as agency for a twelve month period, regardless of employment termination from either party, unless otherwise agreed upon by president with written permission signed by me and the employer's president. If I am hired, I understand I will be required to complete all forms and documentation the company requires for new hire processing. My failure to do so may result in withdrawal of any employment offer or termination if I have already started work. After employment, I understand that I will be required to complete all documentation the company requires upon demand including, but not limited to, tax withholding, personal information changes, benefit enrollment forms, performance appraisals, and warning notices and other corrective actions. My failure to do so may result in disciplinary action up to and including termination, as deemed appropriate by the company. I understand I must adhere to the policies and procedures of the company while I am an employee of the company.

Signature: _____ Date: _____

The employer is an EQUAL OPPORTUNITY EMPLOYER. Qualified applicants receive consideration for employment without regard to race, religion, color, ancestry, age, sex, or disability. To be considered for employment, this application must be completed fully, including its addenda. Your responses to the questions in this application form must be accurate and complete and they will be judged in relation to the requirements of the job you are seeking. Applications may remain active for six months. Applicants selected for employment will be required to prove U.S. citizenship or a legal right to work in the U.S. as determined by the U.S. Citizenship and Immigration Services.

HIPAA Confidentiality Agreement

Nurses working as temporary staff at contracted facilities will have access to confidential information, both written and oral, in the course of their job responsibilities. It is imperative that this information is not disclosed to any unauthorized individuals to maintain the integrity of the patient or resident information. An unauthorized individual would be any person that is not currently directly related to the care of patients or residents of facilities. Any other disclosures may only occur at the direction of the privacy Office or by patient authorization.

I have read and understand the practice's policies with regards to privacy and security of personal health information. I agree to maintain confidentiality of all information obtained in the course of my contract including, personal and sensitive information regarding patients, employees, and vendors. I understand that inappropriate disclosure or release of patient information is grounds for termination.

_____ _____

Printed Name Date

_____

Signature

Form W-4 (2018)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2018 if **both** of the following apply.

- For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2018 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

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 might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. *Head of household please note:* Generally, you can claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse, during the year.

Line F. Credit for other dependents. When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

---

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you're 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

2018

1 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 filing separately, check "Married, but withhold at higher Single rate."	
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 800-772-1213 for a replacement card. ▶ ☐	

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2018, 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
(This form is not valid unless you sign it.) ▶ **Date** ▶

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	**9** First date of employment	**10** Employer identification number (EIN)

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself	A	
B	Enter "1" if you will file as married filing jointly	B	
C	Enter "1" if you will file as head of household	C	
D	Enter "1" if: • You're single, or married filing separately, and have only one job; or • You're married filing jointly, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	D	
E	**Child tax credit.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "4" for each eligible child. • If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "2" for each eligible child. • If your total income will be from $175,551 to $200,000 ($339,001 to $400,000 if married filing jointly), enter "1" for each eligible child. • If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter "-0-"	E	
F	**Credit for other dependents.** • If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "1" for each eligible dependent. • If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents). • If your total income will be higher than $175,550 ($339,000 if married filing jointly), enter "-0-"	F	
G	**Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here	G	
H	Add lines A through G and enter the total here ▶	H	

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work**, and the combined earnings from all jobs exceed $52,000 ($24,000 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 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 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income.

1	Enter an estimate of your 2018 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income. See Pub. 505 for details	1	$
2	Enter: $24,000 if you're married filing jointly or qualifying widow(er); $18,000 if you're head of household; $12,000 if you're single or married filing separately	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2018 adjustments to income and any additional standard deduction for age or blindness (see Pub. 505 for information about these items)	4	$
5	**Add** lines 3 and 4 and enter the total	5	$
6	Enter an estimate of your 2018 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses	7	$
8	**Divide** the amount on line 7 by $4,150 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H above	9	
10	**Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/ Multiple Jobs Worksheet,** also enter this total on line 1, page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet

Note: Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

1 Enter the number from the **Personal Allowances Worksheet,** line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) . . . . . 1 _____

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don't enter more than "3" . . . . . 2 _____

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . . 3 _____

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet . . . . . 4 _____

5 Enter the number from line 1 of this worksheet . . . . . 5 _____

6 **Subtract** line 5 from line 4 . . . . . 6 _____

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . . 7 $ _____

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . 8 $ _____

9 **Divide** line 8 by the number of pay periods remaining in 2018. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2018. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $7,000	0
5,001 - 9,500	1	7,001 - 12,500	1
9,501 - 19,000	2	12,501 - 24,500	2
19,001 - 26,500	3	24,501 - 31,500	3
26,501 - 37,000	4	31,501 - 39,000	4
37,001 - 43,500	5	39,001 - 55,000	5
43,501 - 55,000	6	55,001 - 70,000	6
55,001 - 60,000	7	70,001 - 85,000	7
60,001 - 70,000	8	85,001 - 90,000	8
70,001 - 75,000	9	90,001 - 100,000	9
75,001 - 85,000	10	100,001 - 105,000	10
85,001 - 95,000	11	105,001 - 115,000	11
95,001 - 130,000	12	115,001 - 120,000	12
130,001 - 150,000	13	120,001 - 130,000	13
150,001 - 160,000	14	130,001 - 145,000	14
160,001 - 170,000	15	145,001 - 155,000	15
170,001 - 180,000	16	155,001 - 185,000	16
180,001 - 190,000	17	185,001 and over	17
190,001 - 200,000	18		
200,001 and over	19		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $24,375	$420	$0 - $7,000	$420
24,376 - 82,725	500	7,001 - 36,175	500
82,726 - 170,325	910	36,176 - 79,975	910
170,326 - 320,325	1,000	79,976 - 154,975	1,000
320,326 - 405,325	1,330	154,976 - 197,475	1,330
405,326 - 605,325	1,450	197,476 - 497,475	1,450
605,326 and over	1,540	497,476 and over	1,540

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You aren't required to provide the information requested on a form that's 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 Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶ **START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

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 boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP! *Employer Completes Next Page* STOP!

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
Employer's Business or Organization Address (Street Number and Name)	City or Town	State / ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any)* *(mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized 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	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		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		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		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		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. Native American tribal document
		6. Military dependent's ID card		6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		8. Native American tribal document		8. Employment authorization document issued by the Department of Homeland Security
		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		

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

Refer to the instructions for more information about acceptable receipts.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
QUICK RESPONSE STAFFING INC	20-4688836
5. Employer address	**6. Employer phone number**
2606 FAIRWAY DRIVE	575-746-6117

7. City	8. State	9. ZIP code
ARTESIA	NM	88210

10. Who can we contact at this job?

11. Phone number (if different from above)	12. Email address

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

Acknowledgment of Receipt

I hereby acknowledge the receipt of the following documents from my employer:

1) New Health Insurance Marketplace Coverage Options and Your Health Coverage (form OMB No. 1210-0149).

_____

Employee Name (please print)

_____ _____

Employee Signature Date

HEPATITIS B VACCINE DECLINATION / ACCEPTANCE FORM

I understand that due to my occupational exposure to blood and other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine at no charge to me.

I understand that if I decline the vaccine I continue to be at risk of acquiring the Hepatitis B Virus (HBV) infection. If in the future I continue to have occupational exposure to blood or any other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I will consult with my physician and obtain written approval before receiving the Hepatitis B vaccine. I also understand I can then receive the Hepatitis B vaccine at no charge to me.

I have decided to: (place a check mark next to the appropriate line)

____ receive the Hepatitis B vaccine

____ decline the Hepatitis B vaccine

_____
Employee Name

_____
Employee Signature

_____
Social Security Number

_____
Date

_____
Witness

_____
Date

VARICELLA VACCINATION FORM Varicella (Chicken Pox)

- One Varicella vaccination if received at the age of 12 or younger or
- Two Varicella vaccinations if received at the age of 13 or older
- A positive Varicella titer or
- A declination due to your history of having had the virus Certification of Varicella Vaccination

I certify that I, _____ was inoculated against Varicella on the following dates:

First: Date _____ Lot No. _____

Administered by: _____

Second: Date _____ Lot No. _____

Administered by: _____

Positive Titer Completed: Date _____ Lot No. _____

Administered by: _____

Declination of Varicella Vaccinations

I, _____, understand that due to my occupational exposure I may be at risk of acquiring the varicella virus. I have been given the information by Quick Response Staffing Inc. regarding these risks. However, I decline the varicella vaccinations due to my history of having the varicella virus.

_____ _____

Employee's Signature Date

_____ _____

QRS Inc. Signature Date

Quick Response Staffing Inc.
PO Box 442
Artesia NM 88211

MEASLES, MUMPS, AND RUBELLA VACCINATION FORM (MMR)

I certify that I, _____ was inoculated against MMR on the following dates:

First: Date _____ Lot No. _____

Administered by: _____

Second: Date _____ Lot No. _____

Administered by: _____

Positive Titer Completed: Date _____ Lot No. _____

Administered by: _____

Declination of MMR Vaccinations

I, _____, understand that due to my occupational exposure I may be at risk of acquiring the measles, mumps, or rubella. I have been given the information by Quick Response Staffing Inc. regarding these risks. However, I decline the MMR vaccinations.

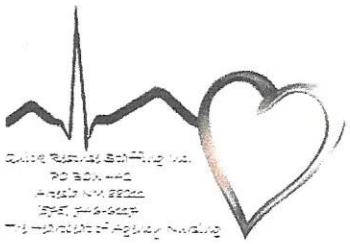
_____ _____

Employee's Signature Date

_____ _____

QRS Inc. Signature Date

Quick Response Staffing Inc.
PO Box 442
Artesia NM 88211



Declination of Influenza Vaccination

Quick Response Staffing Inc has recommended that I receive Influenza vaccination to protect the patients that I serve.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect patients from influence, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients.
- If I become infected with influenza, even if my symptoms are mild or non-existent, I can spread it to others and they can become seriously ill.
- I understand that the strains of virus that cause influenza infection change almost every year, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended each ear.
- I understand that I cannot get influenza for the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including
    - All patients
    - My coworkers
    - My family
    - My community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons:

_____

_____

_____

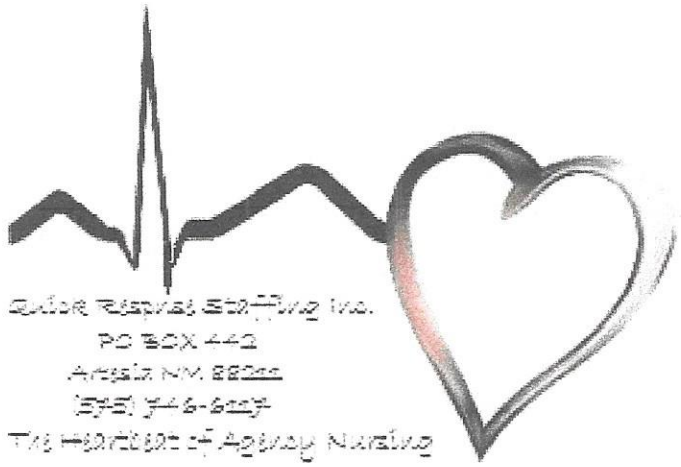
I understand that I can change my mind at any time and accept influenza vaccinations, if vaccine is still available.

I have read and fully understand the information on this declination form.

Signature: _____ Date: _____

Name (print): _____

Reference: CDC, Prevention and Control of Influenza with Vaccines—Recommendations of ACIP at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html



Physician's Statement

Patient's Authorization to Release Information:

This form, signed by me, authorizes the release of any and all medical information/records to Quick Response Staffing Inc. and affiliates and/or any of its client hospitals or institutions which are relevant to my employment. Under company policy and federal law, personnel who obtain access to health information and medical records as part of employment records may use the information for purposes only permitted by law.

Signature: _____ Date: _____

Print Name: _____

Social Security Number: _____

Statement of Health

To be completed by a Medical Professional

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

Medical Provider's Signature: _____ Date: _____

Phone Number: _____ Fax Number: _____

Consent for Drug/Alcohol Screen Testing

If you are offered and accepted employment with Quick Response Staffing Inc., in the interest of safety for all concerned, you will be required to take a urine test for drug and/or alcohol use. This test is mandatory and will be required yearly. I, _____, have been fully informed of the reason for this urine test for drug and/or alcohol, I understand what I am being tested for, the procedure involved, and do hereby freely give by consent. In addition, I understand that the results of this test will be forwarded to my potential contractor and become a part of my record. If this test is positive, and for this reason I am not hired, I understand that I will be given the opportunity to explain the results of this test.

I hereby authorize these test results to be released to Quick Response Staffing Inc.

_____

(Print Full Name)

_____ Date:_____

(Signature)

Background Check Consent Form

I hereby authorize Quick Response Staffing Inc. to receive any criminal history on file pertinent to me from any federal, state, or local criminal justice agency.

_____

(Print Full Name)

_____

(Signature

_____

Street Address

_____

City State Zip

_____

*Sex *Ethnicity *DOB *Social Security Number

*The above information is necessary to retrieve criminal history information.

AUTHORIZATION TO RELEASE EMPLOYMENT INFORMATION

Date: _____

To: _____

The Undersigned authorizes the release of the below checked employment information to:

_____ Quick Response Staffing Inc.

_____ Any Third Party

Those terms for which information may be released include:

_____ Salary

_____ Position and Department

_____ Dates of Employment

_____ Part Time/Full Time or hours worked

_____ Reason for Separation

_____ Medical/Accidental/Illness Reports

_____ Other:

Thank You for Your Cooperation

_____ _____

Employee Signature | Social Security Number

_____ _____

Address | Position or Title

_____ _____

Date of Employment | Department

Nursing (RN/LPN) Skills Competency Checklist

Name: _____ Date: _____

Total years of nursing clinical experience: _____

Please rate your SKILL level:

1 – No Experience. Theory Only/Not Applicable
2 – Some Experience (Some Assistance Required)
3 – Experienced/ Proficient.
4 – Performs Well. Performed frequently and independently (No Assistance Required)

Skill	1	2	3	4
Neurological System:				
assess level of consciousness				
assess sensory motor function				
assess cranial nerves				
assist with lumbar puncture				
halo traction				
pre/post op neuro surgical care				
seizure precautions				
documentation of seizure				
shunts (i/e/ ventriculoperitoneal)				
use of Glasgow Scale				
use of anticonvulsants:				
Oral				
IM				
IV				
care of patients with:				
acute head injury				
aphasia				
autonomic dysreflexia				
cancer of the brain				
craniotomy				
CVA				
head trauma				
impending DT's				
multiple sclerosis				
Parkinson's				
quadriplegia				
seizure disorders				
spinal cord injury				
CV/ Circulatory:				
ability to perform 1 person rescue:				
(CPR) infant/child				
adult				
assess heart sounds (norm vs abnorm)				
basic EKG interpretation				
initiation of arrest procedure				
admin of meds during procedure				
set up/run 12 lead EKG				

Skill	1	2	3	4
CV/Circulatory Continued...				
use of cardiac monitor				
use of doppler				
care of patients with:				
aneurysm				
acute CHF				
acute MI				
blood lymph disease				
cardiac surgeries				
CVA				
bypass/vascular procedures				
pacemakers				
transplant/cardiac				
Respiratory:				
Ambu techniques				
apnea monitor usage				
assess lung sounds				
chest tube care and maintenance				
incentive spirometer				
IPPB machine				
nebulizers				
oxygen therapy:				
nasal cannula				
face mask				
precautions				
use of portable oxygen tank				
pulmonary hygiene:				
oral suctioning				
tracheotomy suctioning				
chest physiotherapy (CPT)				
determining proper catheter size				
nasotracheal suctioning				
thoracentesis				
tracheostomy:				
cleaning of inner cannula				
changing trach/tubing				
emergency management				
skin care/ dressing changes				

Respiratory Continued...	1	2	3	4
ventilators:				
pressure pre-set				
volume pre-set				
CPAP				
PEEP				
portables				
care of patients with:				
AIDS				
asthma/wheezing				
cancer of lung				
COPD				
emphysema				
pneumonia				
TB				
transplant/pulmonary				
GI/Nutrition:				
abdominal drain care/ maintenance				
assess GI status				
bowel training				
enemas				
Gastrostomy tube care:				
G-Tube feedings				
G-Tube change				
Nasogastric tube insertion/reinsertion				
NG Tube feedings				
nasal intestinal tubes (ie. Miller-Abbot)				
ostomy/stoma care				
ostomy irrigations				
ostomy education				
paracentesis				
parenteral feedings:				
complications of				
indications for				
routes of administration				
verification of fluid/caloric				
removal of fecal impaction				
use of pumps for enteral feedings				
care of patients with:				
anorexia				
bowel disease				
cancer of colon				
cancer of esophagus				
cancer of rectum				
GI bleeds				
hepatic encephalopathy				
hepatitis				
inflammatory bowel disease				
liver failure				
liver transplant				

GI/Endocrine:	1	2	3	4
bladder irrigations				
bladder training				
care/maintenance/removal of:				
3 way indwelling catheter				
supra pubic indwelling catheter				
catheter insertion male/female				
diabetic care:				
ADA diet				
blood glucose testing				
foot care				
infection prevention				
insulin prep and administration				
insulin site rotation and education				
skin care				
S & S hypo/hyper glycemia				
urine glucose testing				
use of blood test meters				
dialysis:				
hemo				
peritoneal				
GYN exam/ PAP procedures				
ileostomy care				
intermittent catheterization				
S & S of UTI				
urinary diversions (ileo-conduit)				
care of patients with:				
AV shunt/fistula				
bladder disease				
cancer of kidney				
cancer of prostate				
female reproductive organ cancer				
hysterectomy				
hypo/hyperthyroidism				
mastectomy				
nephrectomy				
renal failure				
transurethral resection				
Integumentary/Orthopedic				
amputations/stump care				
assist in use of prosthetic devices				
cast care				
cast/splint application and removal				
circo-electric bed				
range of motion				
Spika cast				
Stryker frame				
TENS				
traction: skin				
skeletal				

Integumentary/Orthopedic Cont...	1	2	3	4
transfers:				
documentation of wounds				
preventative skin care				
sterile dressing changes				
use of Braden scale				
wound enzyme debriders				
wound irrigations				
care of patients with:				
amputation				
arthritic disease				
burns				
decubitus ulcers				
gun shot				
hip replacement				
incisions				
knee replacement				
laminectomy				
skin cancer				
stab wounds				
Oncology:				
bone marrow transplant				
counseling for:				
altered image				
grieving process				
imagery				
relaxation techniques				
assessing analgesic effectiveness				
morphine pumps				
narcotics via continuous infusion				
side effects of chemotherapy				
radiation therapy				
radium plants				
IV Therapy:				
administration of chemotherapy				
administration/mixing IV meds				
blood/blood product administration				
calculate dosages				
care of central lines:				
infusion procedures				
care of insertion site				

IV Therapy Continued...	1	2	3	4
dressing changes				
S & S complications				
record keeping				
pump operations				
hanging IV piggybacks				
S & S infection				
S & S infiltration				
Insertion of peripheral lines				
TPN (Total Parenteral Nutrition)				
IV Therapy Continued...				
intralipids				
heparin lock				
Hickman catheter				
porta-Cath				
triple lumen catheter				
Additional Nursing Responsibilities:				
admission procedure				
initial assessment				
discharge planning				
injections				
universal precautions				
knowledge of unit doses				
lab value interpretation				
pre/post op teaching				
problem oriented medical records				
SOAP charting				
specimen collection:				
arterial blood gas draw				
capillary draw				
heel stick				
venipuncture				
sputum				
stool				
clean catch urine				
24 hour urine				
urine via indwelling catheter				
wound culture				
use of restraints				
charge nurse responsibilities				
primary nurse responsibilities				
team leading				

Certified Nursing Assistant (CNA) Skills Competency Checklist

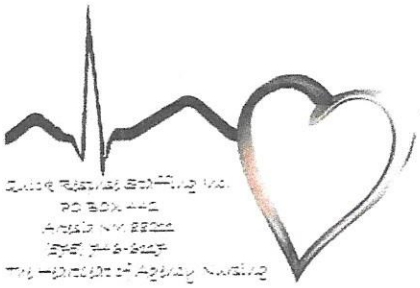
Name: _____ Date: _____

Total years of CNA clinical experience: _____

Please rate your SKILL level:

0 – No Experience. Theory Only
1 – Limited Competency/ Proficiency. Supervision Required.
2 – Acceptable Competency/ Proficiency.
3 – Competency/ Proficient. Performed frequently and independently during the past two years.

Skill	0	1	2	3	Skill	0	1	2	3
Assist with Admission of Patient					Observing Patients				
Assist with Ambulation					Oral Hygiene				
Assist with Bedpan/Urinal/Commode					Patient Safety Standards/ Precautions				
Backrub/ Back Care					Perineal Care				
Basic Medical Asepsis					Positioning Patients				
Bathing: Complete/Partial/ Sitz					Prosthetic Devices (Denture Care)				
Bed Cradles					Range of Motion Exercises				
Bed Making: Occupied/Unoccupied					Reporting Changes of Pt Condition				
Bed Rails: When/ How to use					Reporting/ Recording Pt Pain Level				
Cast Care					Restraints				
Charting/ Checklists/ Graphic Charts					Skin Care				
Compresses: Warm/Cold					Specimen Collection				
Coughing/ Deep Breathing					Routine Urine				
CPR					Clean Catch				
Crutch Walking: Assisting Patient					12 & 24 Hour Specimen				
Dangling Patient					Stool				
Dietary Restrictions					Culture				
Discharge of Patient					Sputum				
Documentation: Vital Signs, I&O					Collection from Foley Catheter				
Douches					Vital Signs				
Elastic Stockings (AE Hose)					Blood Pressure				
Elimination Check and Record					Pulse				
Enemas, Rectal Tubes, Harris Flush					Respirations				
Feed Patient					O2 Saturation				
Foley Catheter Care and Emptying					Temperature				
Footboard					Oral				
Hand Hygiene					Axillary				
Height: Measure and Record					Tympanic				
Intake & Output Measure and Record					Rectal				
Infection Control Precautions:					Age Appropriate Care				
Standard Universal Precautions					Newborn/Infant/Toddler				
Reverse Isolation					Preschooler/School Age				
TB/Airborne Precautions					Adolescent/Young Adult				
MRSA/VRE Precautions					Middle Adult				
Nourishment for Patients					Older Adult				



Direct Deposit Information

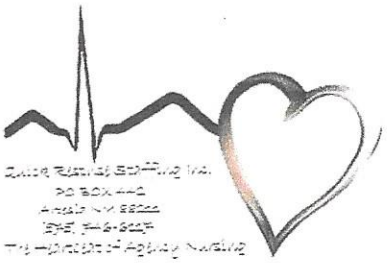
Name as it appears on account: _____

Name of Bank: _____

Type of Account: (Checking / Savings)

Routing Number: _____ Account Number: _____

Email Address: _____



Responsibilities

As you consider working with Quick Response Staffing Inc., here are a few things you should know...

QRS Inc. is NURSE owned and operated. Our goal is to work for and with you so that you are in control of your own career. We make every effort to keep you as busy as you want to be and are here for you when you need us, 24 hours a day, 7 days a week.

We at QRS are proud of the relationships that we have built with each facility we contract. We know that this is only possible because of the professionalism of the nurses we have working in those facilities.

This is how you can help us to help you: *(please initial)*

_____ As an independent contractor, you are strongly encouraged to carry your own liability insurance. This is for your protection.

_____ The work week begins on Sunday and ends on Saturday. Always use the QRS time sheets that we have provided, unless otherwise instructed. Remember to make copies!! Make sure that your documented time matches the time clock. Your timesheet must be signed by a charge or approved staff member. Fax, email, or bring in time sheets BEFORE 10:00am on each Monday.

_____ Pay is remitted weekly, each Friday, via direct deposit. Paystubs are sent electronically, via email. Paystubs are password protected. Your password is the first four letters of your LAST name and the last four numbers of your social security number. (example: smit1234).

_____ Shifts are booked in 8 or 12 hour increments, in accordance with the facility shift times. Please be at assigned facility 15 minutes before your shift starts.

_____ If you clock in more than 15 minutes prior to your shift beginning or later than 15 minutes after your shift ends, make sure that the approved staff member is aware before signing your timesheet.

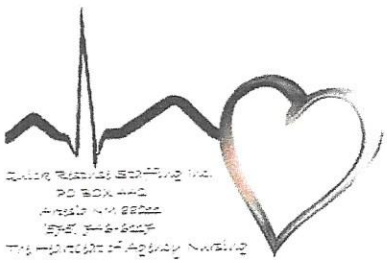
_____ Make sure that, if required by the facility, you clock in and out using their time system. This helps us to make your case if there is any questions in regards to the hours you worked. Some facilities require you to provide a copy of their timeclock hours in addition to our timesheet. We will make sure you are aware of this facility policy if applicable.

_____ If you agree to work, and we confirm your shift with a facility, you cannot cancel.

_____ If you do cancel for a shift, QRS Inc. may automatically be fined your rate times 12 hours. This charge will be passed on to you for collection. Remember, facilities use agency because they DO NOT have the staff to cover the need. If you pick up the shift, you need to be there.

_____ If the facility cancels you with less than 2 hours' notice, the facility is fined their rate times 2 hours. This credit will be passed on to you.

_____ Once you have worked at a facility, you will be unable to obtain formal employment at that facility for a twelve-month period, unless arrangement of formal employment is otherwise mutually agreed upon between QRS



Inc. president and facility administration. Signed consent of release must be obtained prior to accepting any staff position. If approached by a facility for employment, it is your responsibility to report this to QRS Inc.

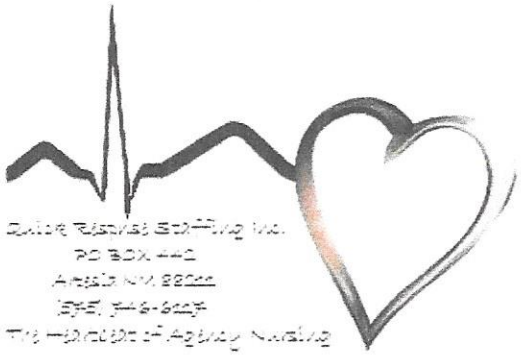
QRS Inc. works for you, and we are here to help you in any way we can. If you have any questions please feel free to call, text, and email or message us at any time. All contact numbers can be found on the contact sheet provided.

Thank You-

Quick Response Staffing Inc.

By signing below you are stating that you have read and agree to the list of **Responsibilities.**

Applicant Signature Date



Stephanie Jones
575-361-0509
Email: Stephanie@qrsnurse.com
(Staffing Manager)

Renee Pinson
575-308-8002
Email: renee@qrsnurse.com
(Payroll/Accounting Manager)

Shablee DeMerritt
575-420-9916
Email: shablee@qrsnurse.com
(Office Manager/Human Resources)

QRS Phone answered 24 hours
575-746-6117
Fax: 575-746-6997

Timesheets may be faxed or emailed to qrs@qrsnurse.com

Quick Response Staffing, Inc.
P.O. Box 442
Artesia NM 88211
Office (575) 746-6117 Fax (575) 746-6997

Name	Address
Facility Assignment	_____PRN _____Contract

PLEASE USE MILITARY TIME

PAY PERIOD SUNDAY-SATURDAY	DATE	DEPARTMENT	CLOCKED IN	CLOCKED OUT	TOTAL HOURS	MILEAGE	Supervisor signature stating hours entered are correct and accurate.
SUNDAY							
MONDAY							
TUESDAY							
WEDNESDAY							
THURSDAY							
FRIDAY							
SATURDAY							

I certify that the hours shown above were worked by me during the week designated and were certified by an authorized signature belonging to a house supervisor, charge nurse or department director._____

Signature of house supervisor, charge nurse or department director certifies that the hours above are correct and further agrees to the terms and conditions previously set per contract.

***ALL TIMESHEETS MUST BE SIGNED BY AUTHORIZED PERSONAL AND FAXED BEFORE 10AM ON EACH MONDAY.**

Quick Response Staffing, Inc.
P.O. Box 442
Artesia NM 88211
Office (575) 746-6117 Fax (575) 746-6997

Name	Address
Facility Assignment	_____PRN _____Contract

PLEASE USE MILITARY TIME

PAY PERIOD SUNDAY-SATURDAY	DATE	DEPARTMENT	CLOCKED IN	CLOCKED OUT	TOTAL HOURS	MILEAGE	Supervisor signature stating hours entered are correct and accurate.
SUNDAY							
MONDAY							
TUESDAY							
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