

NORMAN'S NURSING HOME CARE SERVICES, LLC
CHECKLIST FOR
INDEPENDENT CONTRACTOR'S REGISTRATION FILES

Independent Contractor's Name: _____

Registration Date: _____ Title: _____

SIDE 1

DOCUMENTS	√	Exp. Date
1. Application to register		
2. Availability Record		
3. Independent Contractor's Information Sheet		
4. Telephone Reference Check		
5. Professional Liability Insurance		
6. Proof of Authorization to Work in the USA		
7. W-9		
8. I-9		
9. Copy of Driver's License		
10. Copy of Automobile Insurance		
11. Copy of Social Security Card		
12. Independent Contractor's Agreement		
13. Physician Statement and Physical Examination		
14. Attestation of Compliance with Background Screening Requirements		
15. F.B.I Level II Background Screening Results		
16. Job Referral Confirmation		

APPLICATION TO REGISTER

NORMAN'S NURSING HOME CARE SERVICES, LLC..

First:	M/I:	Last:	Social Security #: _____ - _____ - _____ Date of Birth
Address:			
City:	State:	Zip:	Telephone:

DESIRED POSITION

Position:	Date You Can Start:	Desired Salary:
Are You Currently Employed:	If Employed, May We Inquire of Your Current Employer:	
Have You Applied to This Job Before:	If so, where & when:	

EDUCATION

High School	Name and Location of School:
	Years Attended Date Graduated: Completed (Diploma/Degree)
University/College Undergraduate	Name & Location of School:
	Years Attended Date Graduated Completed (Diploma/Degree)
University/College Graduate	Name & Location of School:
	Years Attended Date Graduated Completed (Diploma/Degree)
Trade, Business or Correspondence School	Name & Location of School:
	Years Attended Date Graduated Completed (Diploma/Degree)

EMPLOYMENT HISTORY

Employer:	Job Title:	
Address:	Duties:	
Phone:	Salary:	
Date From:	Date To:	Reason for Leaving:
Employer:	Job Title:	
Address:	Duties:	
Phone:	Salary:	
Date From:	Date To:	Reason for Leaving:
Employer:	Job Title:	
Address:	Duties:	
Phone:	Salary:	
Date From:	Date To:	Reason for Leaving:

REFERENCES

Name:	Occupation:
Address:	Relationship:
Phone Number:	Years Known:

Name:	Occupation:
Address:	Relationship:
Phone Number:	Years Known:

Name:	Occupation:
Address:	Relationship:
Phone Number:	Years Known:

PHYSICAL RECORD

Do you have any disabilities that prevent you from performing the work for which you are applying? If so, describe:	
Have you ever been injured?	Provide Details:
In case of emergency notify:	
Name:	
Address:	Phone:

ADDITIONAL AREAS OF EXPERTISE

Areas of specialized study; research or additional experience:	
List the foreign language you speak fluently:	Read: Write:
U.S. Military Service:	Present membership in National Guard or Reserves:
Rank:	
Have you ever been in the U.S. Armed Force:	
What is your present selective services classification:	
Are you currently a member of Reserves or National Guard?	
If so, when is your enlistment up?	

**REFERENCE AND PRIOR EMPLOYMENT CHECK**

INDIVIDUAL CONTACTED	NAME OF FIRM	RESULTS OF CHECK

AVAILABILITY RECORD

Primary position desired _____

Will you accept another position? ☐ Yes ☐ No

If so, what? _____

Are you available to work: Weekends? ☐ Yes ☐ No
Holidays ☐ Yes ☐ No
Rotating Shifts ☐ Yes ☐ No

Please Indicated Days and Hours You Are Available For Work (Be Specific)

DAY	FROM	TO
Sunday	A.M.	A.M.
	P.M.	P.M.
Monday	A.M.	A.M.
	P.M.	P.M.
Tuesday	A.M.	A.M.
	P.M.	P.M.
Wednesday	A.M.	A.M.
	P.M.	P.M.
Thursday	A.M.	A.M.
	P.M.	P.M.
Friday	A.M.	A.M.
	P.M.	P.M.
Saturday	A.M.	A.M.
	P.M.	P.M.

Do you have responsibilities that would limit your availability?

☐ Yes ☐ No If yes, explain _____

If your availability changes. It is your responsibility to fill in an "Availability Card" indication the changes. Such changes will be effective then for my future employment.

Applicant Signature

Date

AUTHORIZATION TO RELEASE INFORMATION

I voluntarily give NORMAN'S NURSING HOME CARE SERVICES, LLC. the right to make a thorough investigation of my past employment and activities, and agree to cooperate in such investigation and release from all liability or responsibility all persons, companies or corporations supplying such information. I consent to take the pre-assignment physical examination, and such future physical examinations as may be required by NORMAN'S NURSING HOME CARE SERVICES, LLC. at such times and places they designate.

I understand that I will be required to follow the policies and rules of NORMAN'S NURSING HOME CARE SERVICES, LLC. and that infractions of said rules may lead to termination of my contract. I also understand that my contract as an independent Contractor may be terminated for any misstatement or omission of fact appearing in this application form.

Date

Applicant's Signature

NORMAN'S NURSING HOME CARE SERVICES, LLC.
INDEPENDENT CONTRACTOR'S INFORMATION SHEET

Name: _____

Home Telephone Number: () _____

Pager Number: () _____

Cellular Phone Number: () _____

Address: _____

Number

Street

City

State

Zip

Person(s) to Contact in Case of Emergency:

1. Name: _____

Relationship: _____

Telephone number: () _____

Address: _____

2. Name: _____

Relationship: _____

Telephone number: () _____

Address: _____

Other important Contact Telephone Numbers: _____

TELEPHONE REFERENCE CHECK

Applicant's Name: _____
(Last) (First) (MI)

Position Applied For: _____

Person Contacted: _____ Position & Dept.: _____

Date Called: _____ 2nd Try: _____ 3rd Try: _____

Employment Date: From: _____ To: _____

Position Held: _____

Reason(s) for Leaving: _____

Eligible for Rehire: Yes () No () If No, State Reason(s): _____

Works Well With Others: Yes () No () If No, State Reason(s): _____

Strong Points: _____

Weak Points: _____

Attendance: Good: () Average () Poor () Explain: _____

Overall Evaluation of Applicant: _____

Employment: Approved () Position Hired For: _____

Denied () Reason: _____

Comments: _____

Reference check completed by: _____ Date: _____

**PROFESSIONAL LIABILITY
INSURANCE**

NORMAN'S NURSING HOME CARE SERVICES LLC.

**PROOF OF AUTHORIZATION TO WORK IN THE
USA (WORK PERMIT,
US PASSPORT,
GREENCARD/CITIZENSHIP)**

SOCIAL SECURITY CARD COPY

INDEPENDENT CONTRACTOR'S AGREEMENT

This contract is entered into this day of _____, by and between _____ whose address is _____ and NORMAN'S NURSING, LLC., 840 SW 81ST Avenue, Suite #300k, North Lauderdale, Florida 33068.

Independent Contractor seeks to register with the company for purpose of receiving referrals to provide services as a Home Health Aide, Certified Nursing Assistant, Licensed Practical Nurse, or Registered Nurse.

The Company seeks to register Independent Contractor forgiving referrals for appropriate services, based on the skills, training, and experience of the Independent Contractor, for the clients of the company.

Therefore, in the consideration of the mutual promises and covenants of the parties contained in this agreement, the parties agree and contract as follows:

1. I understand that I am an Independent Contractor and not an employee of NORMAN'S NURSING, LLC. I also understand that I register with the company for the purpose of receiving referrals involving the performance set forth above, and the company registers Independent Contractors to perform these services for the clients.
2. This agreement begins on _____, _____ and shall automatically be renewed annually unless either party advises the other in writing at least 30 days before any renewal, or there is a breach in any of the terms and conditions or provisions of the agreement. The company reserves the right to modify the agreement and notify the Independent Contractor of such.
3. Independent Contractor has the absolute right to accept or refuse any referral offered by the company. Company has the absolute right to determine which Independent Contractor will use for a particular client.
4. I understand and agree that as an Independent Contractor, I am solely responsible for all taxes on my earnings, including but not limited to Social Security and Self-Employment taxes. I also understand that, as Independent Contractor, none of the benefits, if any, that the company may provide for its employees shall not be available to me.
5. The company will provide the Independent Contractor a copy of their form 1099, submitted to the IRS, under applicable Internal Revenue Code Terms or terms/provisions.
6. I understand and agree that as an Independent Contractor, it is my responsibility to provide my own Workers Compensation coverage at my own expense. I understand and agree that as an Independent Contractor I am solely responsible for all injuries and related expenses and lost wages that may incur while working with my patients/clients. I understand and agree that as an Independent Contractor, NORMAN'S NURSING, LLC. does not provide me with Worker's Compensation coverage and I will not attempt to hold NORMAN'S NURSING, LLC. or any of its officer liable if I fail to provide my own Worker's Compensation coverage.
7. I understand and agree that the patient and the patient only is the individual or entity that determine my schedule, the time I am to begin and end work, my days off, how my work is to be performed, and the method in which my work is done, not NORMAN'S NURSING, LLC.
8. I understand and agree that the control and methods of my work is evaluated by the patient/client and not NORMAN'S NURSING, LLC.
9. I understand and agree that I am not obligated to obtain work strictly from NORMAN'S NURSING, LLC., but may also obtain work from more than one registry.
10. I understand and agree that NORMAN'S NURSING, LLC. does not provide me with tools to accomplish any of my duties for any of my patients/clients.

11. I understand and agree that although the patients determine my schedule, I must adhere to my job description as specified and acknowledge by me in my Registration folder. I also understand that I must inform NORMAN'S NURSING, LLC. and obtain the client's approval before I can engage others to assist in the performance of service under this agreement.
12. I understand and agree that I am expected to work only within the scope of my license or certification.
13. I understand and agree that I must comply with NORMAN'S NURSING, LLC. rules and regulations in all instances as an Independent Contractor.
14. I understand and agree that I must communicate problems, concerns and changes I observe with my patients and/or expressed by my patients to the appropriate personnel, in writing, at NORMAN'S NURSING, LLC.
15. I understand and agree that I must respect and protect the rights of all patients I come in contact with.
16. I understand and agree that, in order to terminate this agreement, I must notify NORMAN'S NURSING, LLC. in writing, no less than thirty (30) days prior to my last date of service.
17. I further understand and agree that, according to Florida Statutes, the following are statements characteristics of how I conduct my business as an Independent Contractor.
 - A. The Independent Contractor maintains a separate business with his or her own work facility, truck, equipment, materials, or similar accommodations.
 - B. The Independent Contractor holds or has applied for a federal employer identification number, unless the Independent Contractor is a sole proprietor who is not required to obtain a federal employer identification number under state and federal requirements.
 - C. The Independent Contractor performs or agrees to perform specific service or work for specific amounts of money and controls the means of performing the service or work.
 - D. The Independent Contractor incurs the principal expenses related to the service or work that he or she performs or agrees to perform.
 - E. The Independent Contractor is responsible for the satisfactory completion of work or service that he or she performs or agrees to perform and is or could be held liable for a failure to complete the work or the service.
 - F. The Independent Contractor receives compensation for work or services performed for a commission or on a per job or competitive-bid basis and not on any other basis.
 - G. The Independent Contractor receives compensation for work or services performing work or services.
 - H. The Independent Contractor has continuing or recurring business liabilities or obligations.
 - I. The success or failure of the Independent Contractor's business depends on the relationship of business receipts to expenditures.

18. Health Insurance Portability Accountability Act (HIPAA)

As an Independent Contractor, I am required to protect the confidentiality of patients' medical or health information. I understand that all medical, financial and personal information is confidential and I will protect such patient information from unauthorized viewing, discussion and disclosure.

19. No Independent Contractor will be referred unless that Independent Contractor has complied with all Federal, State and Local Laws, Company Policies and Procedures, and has completed an orientation with the company. The Independent Contractor must continue to comply with all Laws and policies and procedures of the company.

20. The Independent Contractor agrees not to provide service with clients of the company for 1 year after they discontinue providing services to the client as an Independent Contractor of NORMAN'S NURSING, LLC. either refers to the Independent Contractor again to the client or gives the Independent Contractor permission to perform the services. In the event the Independent Contractor breaches this provision, the Independent Contractor agrees to pay the amount of \$10, 000 due immediately, in addition to being subject to all other terms and provisions in this agreement.
21. If the Independent Contractor breaches any of the terms or terms/provisions of this agreement, the company has the right to terminate this agreement immediately and to pull the Independent Contractor from any client engagement for which the Independent Contractor is providing service. The company also has the right to proceed against the Independent Contractor in law or in equality for any damages caused to the company by breach and if the breach constitutes a criminal act against the company, to file a criminal action against the Independent Contractor.
22. This agreement is the entire agreement between the parties and shall replace any other agreements in effect between the parties.
23. If any terms/provisions of this agreement are found, held, or deemed to be void, unlawful, or unenforceable under any status or other law, the rest of the agreement shall continue in full force and effect.
24. The company reserves the right to not pursue any action against the Independent Contractor for breach of any terms/provision of this agreement. Waiver of any breach of any term/provision of this agreement shall not be considered to be a waiver of any other breach nor any other terms/provision.
25. This agreement shall be governed and enforced in accordance with the law of the state of Florida.
26. Any notice required or permitted under this agreement may be done orally or in writing. If in writing, the company will send to the Independent Contractor address listed at the beginning of this agreement or the last address provided by the Independent Contractor. The Independent Contractor will send to NORMAN'S NURSING, LLC., address listed at the beginning of this agreement.

I have read, understand and accept the above terms/provisions of this agreement.

INDEPENDENT CONTRACTOR'S SIGNATURE, TITLE, and DATE

INDEPENDENT CONTRACTOR'S PRINTED NAME

INDEPENDENT CONTRACTOR'S SOCIAL SECURITY # AND DRIVER'S LICENSE #

NURSE REGISTRY ADMINISTRATOR'S SIGNATURE AND DATE

NURSE REGISTRY ADMINISTRATOR'S PRINTED NAME

NORMAN'S NURSING, LLC. is committed to compliance with the Civil Rights requirement, pursuant to Chapter 760. F.S.



ATTESTATION OF COMPLIANCE with Background Screening Requirements

Authority: This form may be used by **all employees** to comply with:

- the attestation requirements of **section 435.05(2), Florida Statutes**, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; **AND**
- the proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes** which requires proof of compliance with level 2 screening standards that have been screened through the Care Provider Background Screening Clearinghouse created under Section 435.12, F.S., or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S., and in accordance with the standards in Section 408.809(2), F.S., if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an **application for a health care provider license**, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:

Health Care Provider/ Employer Name:

Address of Health Care Provider:

I hereby attest to meeting the requirements for employment and that I have not been arrested for or and been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense, or have an arrest awaiting a final disposition prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

Criminal offenses found in section 435.04, F.S.

- (a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.
- (b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.
- (c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.
- (d) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
- (e) Section 782.04, relating to murder.

(f) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

(g) Section 782.071, relating to vehicular homicide

(h) Section 782.09, relating to killing of an unborn quick child by injury to the mother.

(i) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

(j) Section 784.011, relating to assault, if the victim of the offense was a minor.

(k) Section 784.03, relating to battery, if the victim of the offense was a minor.

(l) Section 787.01, relating to kidnapping.

(m) Section 787.02, relating to false imprisonment.

(n) Section 787.025, relating to luring or enticing a child.

(o) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(p) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(q) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(r) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(s) Section 794.011, relating to sexual battery.

(t) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(u) Section 794.05, relating to unlawful sexual activity with certain minors.

(v) Chapter 796, relating to prostitution.

(w) Section 798.02, relating to lewd and lascivious behavior.

(x) Chapter 800, relating to lewdness and indecent exposure.

(y) Section 806.01, relating to arson.

(z) Section 810.02, relating to burglary.

(aa) Section 810.14, relating to voyeurism, if the offense is a felony.

(bb) Section 810.145, relating to video voyeurism, if the offense is a felony.

(cc) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(dd) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(ee) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ff) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(gg) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(hh) Section 826.04, relating to incest.

(ii) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child

(jj) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(kk) Former s. 827.05, relating to negligent treatment of children.

(ll) Section 827.071, relating to sexual performance by a child.

(mm) Section 843.01, relating to resisting arrest with violence.

(nn) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(oo) Section 843.12, relating to aiding in an escape.

(pp) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(qq) Chapter 847, relating to obscene literature.

(rr) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(ss) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(tt) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(uu) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(vv) Section 944.40, relating to escape.

(ww) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(xx) Section 944.47, relating to introduction of contraband into a correctional facility.

(yy) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(zz) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

Criminal offenses found in section 408.809(4), F.S.

- (a) Any authorizing statutes, if the offense was a felony.
- (b) This chapter, if the offense was a felony.
- (c) Section 409.920, relating to Medicaid provider fraud.
- (d) Section 409.9201, relating to Medicaid fraud.
- (e) Section 741.28, relating to domestic violence.
- (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection.
- (g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
- (h) Section 817.234, relating to false and fraudulent insurance claims.
- (i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony.
- (j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider.
- (k) Section 817.505, relating to patient brokering.
- (l) Section 817.568, relating to criminal use of personal identification information.
- (m) Section 817.60, relating to obtaining a credit card through fraudulent means.
- (n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.
- (o) Section 831.01, relating to forgery.
- (p) Section 831.02, relating to uttering forged instruments.
- (q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.
- (r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.
- (s) Section 831.30, relating to fraud in obtaining medicinal drugs.
- (t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.
- (u) Section 895.03, relating to racketeering and collection of unlawful debts.
- (v) Section 896.101, relating to the Florida Money Laundering Act.

- ☐ **I have been granted an Exemption from Disqualification through the Agency for Healthcare Administration (AHCA).**

Date of Decision: _____

- ☐ **I have been granted an Exemption from Disqualification through the Florida Department of Health.**

Date of Decision: _____

****A copy of the Exemption from Disqualification decision letter must be attached****

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening: _____

Screening conducted by: _____ Date of Prior Screening: _____

- ☐ Agency for Healthcare Administration
- ☐ Department of Health
- ☐ Agency for Persons with Disabilities

- ☐ Department of Elder Affairs
- ☐ Department of Financial Services
- ☐ Department of Children and Family Services

Attestation

Under penalty of perjury, I, _____, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.

Employee/Contractor Signature

Title

Date

**INSERT F.B.I. LEVEL II
BACKGROUND SCREENING
RESULTS**

NORMAN'S NURSING HOME CARE SERVICES LLC.



PRIVACY POLICY ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, which describe the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

I understand and agree that I will read and comply with the guidelines contained in the privacy policies.

Employee/Contractor Name (Printed)

Employee/Contractor Signature

Date

US Department of Justice
Federal Bureau of Investigation
Criminal Justice Information Services Division



FBI PRIVACY ACT STATEMENT

Authority:

The FBI's acquisition, preservation, and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L. 92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L. 94-29; Pub.L. 101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion or approval of your application.

Social Security Account Number (SSAN).

Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

Principal Purpose:

Certain determinations, such as employment, security, licensing, and adoption, may be predicated on fingerprint-based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as may be relevant to the activity for which this application is being submitted, the FBI may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses:

The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as may be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice/FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement, counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law, treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing this application, they may have additional routine uses.

Additional Information:

The requesting agency and/or the agency conducting the application-investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice in the Federal Register describing any system(s) of records in which that agency may also maintain your records, including the authorities, purposes, and routine uses for the system(s).

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

NORMAN'S NURSING, LLC..

INDEPENDENT CONTRACTOR'S JOB PLACEMENT CONFIRMATION

I. INDEPENDENT CONTRACTOR'S INFORMATION

Name: _____ Placement Date: _____

Title: RN; LPN; C N A; Homemaker, Companion/Sitter (Circle One)

Address: _____ Phone #: _____

_____ Pager #: _____

Professional: License / Certification #: _____ Fla. Driver's License #: _____

Job Summary: _____

II. PATIENT INFORMATION / FACILITY INFORMATION (CIRCLE ONE)

Name: _____ Phone#: _____

Address: _____

RESPONSIBLE PARTY / CONTACT PERSON (CIRCLE ONE)

Name: _____ Phone # : _____

Alternate #: _____

Address: _____
