

LICENSURE

RN	License #:	State:	Exp. Date:
LPN	License #:	State:	Exp. Date:
CNA	License #:	State:	Exp. Date:
PT/OT	License #:	State:	Exp. Date:
OTHER:	License #:	State:	Exp. Date:

Have you ever had a claim for malpractice insurance filed against you? NO YES
 If yes, explain: _____

EDUCATION

	NAME / ADDRESS OF SCHOOL	HIGHEST LEVEL COMPLETED	COURSE / MAJOR / DEGREE
HIGH SCHOOL		9 10 11 12	
VOCATIONAL/TRADE		9 10 11 12	
ASSOCIATES DEGREE			
COLLEGE		1 2 3 4 4+	
MASTERS			
OTHER			

EMPLOYMENT HISTORY (PLEASE LIST MOST RECENT FIRST)

1. Company Name: _____
 Address: _____
 Supervisor: _____ Phone #: _____
 Clinical Area/Title: _____ Date: (From) _____ (To) _____
 Salary - Annual/Hourly: _____
 Briefly describe your work duties: _____

Reason for leaving: _____

2. Company Name: _____
 Address: _____
 Supervisor: _____ Phone #: _____
 Clinical Area/Title: _____ Date: (From) _____ (To) _____
 Salary - Annual/Hourly: _____
 Briefly describe your work duties: _____

Reason for leaving: _____

3. Company Name: _____
 Address: _____
 Supervisor: _____ Phone #: _____
 Clinical Area/Title: _____ Date: (From) _____ (To) _____
 Salary - Annual/Hourly: _____
 Briefly describe your work duties: _____

Reason for leaving: _____

INDEPENDENT AFFILIATIONS

Agency Name(s): _____

1. Hospital: _____ From: _____ To: _____
Clinical Area: _____ # of yrs: _____ Salary / Rate: _____

2. Hospital: _____ From: _____ To: _____
Clinical Area: _____ # of yrs: _____ Salary / Rate: _____

3. Hospital: _____ From: _____ To: _____
Clinical Area: _____ # of yrs: _____ Salary / Rate: _____

CRIMINAL BACKGROUND CHECK

Have you ever been convicted of a crime? NO YES

If yes, please state offense: _____ Date: _____

Explain: _____

AGREEMENT

I hereby authorize CURE STAFFING, INC. and all former employers, and others given by me as reference, to answer all questions and to give all information in connections with this application or in any way concerning me. I agree, if employed by CURE STAFFING, INC., that if I ever make claims against CURE STAFFING, INC. for personal injuries, Upon your request I shall submit to examinations by physicians of your selection. Your employment of me may be terminated by CURE STAFFING, INC. at any time without any liability to me except for wages and salary as have been earned to me at the date such termination. In consideration of your employing me, I agree that I shall neither seek nor accept employment without your permission, directly or indirectly, in this state from any customer of CURE STAFFING, INC. to whom I have been assigned to work, for (1) year after the date my employment is terminated.

Signature: _____ Date: _____

BENEFITS AGREEMENT

As an employee of CURE STAFFING, INC., you will be eligible in the Temporary Employee Benefits Program offered by CURE STAFFING, INC. You will receive information about this program from our representative during your interview.

Please read and sign the following statement that indicates that you understand that you will be a CURE STAFFING, INC. employee and not an employee of any client company to which you may be assigned. Thank You.

I, the undersigned, voluntarily acknowledge and agree to the following:

1. I am an employee of CURE STAFFING, INC. and I will not, at any time while performing services for CURE STAFFING, INC., be considered an employee of any CURE STAFFING, INC.

client to whom I am assigned to perform services.

2. I am not entitled to exercise any rights, or seek any employee benefits, including but not limited to, any retirement, pension, profit sharing, insurance, stock purchase, hospitalization, health or any other plan which may now be in effect or which may hereafter be adopted by the Client, accruing to the employees of the Client by virtue of the services rendered by me to the Client or otherwise.
3. I understand this agreement applies only while I am an employee/consultant of CURE STAFFING, INC.

Date: _____

Applicant's Signature of Agreement: _____

Applicant's Name: _____

Social Security#: _____



EMPLOYEE MEDICAL INFORMATION
CONFIDENTIAL

Name: _____ Social Security #: _____ DOB: _____

Address: _____

I hereby authorize the requested information below to be released to CURE STAFFING, INC.

(Signature)

(Print Name)

DATE OF EXAM: _____ Height _____ Weight _____ Blood Pressure _____ Pulse _____

Annual PPD: Date of implant: _____ Date of PPD results: _____

If PPD positive, date of chest x-ray: _____ Results: _____

TITERS: (Please attach lab results)

Varicella: Titre: _____ mm Immune / Not Immune or Vaccination Date: _____

Rubella: Titre: _____ mm Immune / Not Immune or Vaccination Date: _____

Rubeola: Titre: _____ mm Immune / Not Immune or Vaccination Date: _____

Mumps: Titre: _____ mm Immune / Not Immune or Vaccination Date: _____

Hepatitis B:

Immune Titre: Reactive: _____ Date: _____ OR Vaccination Series: 1 - _____
Non-Reactive: _____ Date: _____ 2 - _____

OR 3 - _____

Hepatitis B Signed Declination: _____

Drug Screening Results (9/10/11 panel): _____

DPT immunizations within last 10 years? _____ Yes _____ No Date: _____

Based on health history, physical examination, assessment, and on laboratory tests performed, this person is free from any health impairment that s a potential risk to the patient, or may Interfere with the performance of his/her duties including the habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs or substance which may after the Individuals behaviour.

I have examined the above named Individual and determined that he/she Is health to be adequate for work In the healthcare field.

Physician Signature: _____ Date: _____

Physician Name: _____
(Print Name)

Physician Stamp:

Address: _____

City/State/ZIP: _____



HEPATITIS B DECLINATION

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

However, I decline **Hepatitis B** vaccination at this time. I understand that by declining this vaccination, I continue to be at risk of acquiring Hepatitis B, a serious disease.

If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the series at no charge to me.

Applicant's Name
(please print)

Social Security #

Applicant's Signature

Date



REFERENCE VERIFICATION
CONFIDENTIAL

Attention: _____ Facility: _____ Date: _____

Address: _____ City: _____ State: _____ ZIP: _____

Your name has been given as a reference by the applicant named below. We place great emphasis on the thorough screening of all our applicants. Your reply will be of major importance. All information will be held in strict confidence. Thank you for your prompt reply.

Applicant's Name: _____	Applicant's SS#: _____
Position Held _____	Dates employed from _____ to _____
Applicant's Signature _____	Date _____

PLEASE EVALUATE APPLICANT	POOR	GOOD	VERY GOOD	EXCELLENT	COMMENTS
Quality Performance					
Attendance & Dependability					
Cooperation					
Job Knowledge					
Ability to work with others					
Personal Appearance					
Initiative/Judgment					

1. Please specify specialty areas in which applicant has had experience:

2. Please indicate, in your opinion, information that can guide us in placing this applicant

3. Would you rehire? YES NO

If no, why not? _____

4. How do you know this individual?

Please circle one: **Supervisor** **Co-Worker** **Friend** **Instructor**

5. Additional Comments:

Signature of individual giving this verification: _____ Title: _____ Date: _____



REFERENCE VERIFICATION
CONFIDENTIAL

Attention: _____ Facility: _____ Date: _____

Address: _____ City: _____ State: _____ ZIP: _____

Your name has been given as a reference by the applicant named below. We place great emphasis on the thorough screening of all our applicants. Your reply will be of major importance. All information will be held in strict confidence. Thank you for your prompt reply.

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PLEASE EVALUATE APPLICANT	POOR	GOOD	VERY GOOD	EXCELLENT	COMMENTS
Quality Performance					
Attendance & Dependability					
Cooperation					
Job Knowledge					
Ability to work with others					
Personal Appearance					
Initiative/Judgment					

2. Please specify specialty areas in which applicant has had experience:

2. Please indicate, in your opinion, information that can guide us in placing this applicant

3. Would you rehire? YES NO

If no, why not? _____

4. How do you know this individual?

Please circle one: **Supervisor** **Co-Worker** **Friend** **Instructor**

5. Additional Comments:

Signature of individual giving this verification: _____ Title: _____ Date: _____



STAFFING MEDICAL

SKILLS CHECKLIST

Please check all areas that pertain to your experience.

Applicant's Name: _____ Date: _____

ADMINISTRATIVE ASSISTANT

Number of Years Paid Work Experience: _____ Executive Personal Assistant

COMPUTER SYSTEMS

- MAC Excel Lotus Notes
- Microsoft Word Power Point Access
- Word Perfect Ver. ____ Lotus MS Outlook/Internet Source

BILLER

- Number of Years Paid Work Experience: _____ School: _____
- ICD-9/CPT-4 Codes Accounts Payable Denials Inpatient
 - HMO 3rd Party Medicaid Outpatient
 - Workers Compensation Posting of Payments Medicare Medical Records
 - Collections Charge Entries Coding Color Coding
 - Accounts Receivable Referrals Strict Term Digit

SOFTWARE SYSTEMS

System

- ADS
- IDX
- Medical Manager
- Medisoft
- Omnipro
- SMS
- Medex
- Other

Billing

Scheduling Appointments

PHLEBOTOMIST

- Number of Years Paid Work Experience: _____ School: _____
- Nationally Certified Home Care
 - State Certified Lab Specimen Testing:
 - OSHA Trained # of Sticks per Draw: _____ # of Sticks per Hour: _____

MEDICAL ASSISTANT

- Number of Years Paid Work Experience: _____ School: _____
- Certified Urinalysis
 - OSHA Trained Holter Monitor
 - Phlebotomy Blood Pressure
 - EKG Vitals
 - X-Ray Stress Test
 - Surgical Assistant Drug Screening
 - Endoscopy Own Equipment
- Specialty**
- OB/GYN Lab Coat
 - Pediatrics Scrubs
 - HIV Counseling Whites
 - Other: _____
 - Heel Sticks
 - Finger Sticks

RECEPTIONIST

- Number of Years Paid Work Experience: _____ School: _____
- Front Desk Check out/Co-Payments Filing Out Referrals
 - Switchboard # of lines: _____ Insurance Verification/Denial Accepting Referrals
 - Scheduling Appointments: Manual Data Entry Speed: _____
 - Scheduling Appointments: Computerized Alpha: _____ Numeric: _____
 - Taking Messages: Manual Typing Speed: _____
 - Taking Messages: Computerized Billing
 - Registration Patient Demographics

SECRETARY

Number of Years Paid Work Experience: _____ School: _____
 Medical Secretary Surgical Scheduling Transcription
 Dictation Typing Speed: _____
 Shorthand Medical Terminology

TRANSCRIPTIONIST

Number of Years Paid Work Experience: _____ School: _____
 Dictaphone Neurology Surgery
 Medical Terminology Orthopedic
 Cardiology Pathology Other _____
 Dental Radiology
 Data Entry

TECHNICAL

Number of Years Paid Work Experience: _____ School: _____
 Ultrasound Tech Trans Vag/Rectal Small Parts
 Abdomen Pelvic OB/GYN
 Carotid Doppler Echo
 Vascular Neuro Neo Natal
Equipment: 1. _____ 2. _____
 Cardiovascular Tech Radiology Tech Equipment: 1. _____ 2. _____
 CT Tech Equipment: 1. _____ 2. _____
 Mammo Tech Equipment: 1. _____ 2. _____
 MRI Tech Equipment: 1. _____ 2. _____
 Nuclear Med Tech Nuclear Cardiology Equipment: 1. _____ 2. _____
 Radiation Therapy Tech EKG Tech
 EEG Tech EMG Tech Lab Tech
Specialties: 1. _____ 2. _____
 Blood Bank Medical Tech IV Tech
 Pacemaker Tech Holter/Event Monitor Stress Test

THERAPY

Number of Years Paid Work Experience: _____ School: _____
 Physical Therapy Physical Therapy Asst. Physical Therapy Aide
 Occupational Therapy Occ. Therapy Asst. Speech Therapy
 Respiratory Therapy Counseling HIV Drug

MEDICAL

Number of Years Paid Work Experience: _____ School: _____
 Physicians Assistant Nurse Practitioner RN LPN
Specialties: 1. _____ 2. _____ 3. _____
 Medical Assistant Cert. Nursing Assistant IV Cert.
 Phlebotomy/Venepunct. CPR Certification

LANGUAGES

1. _____ 2. _____ 3. _____

AREA WORKED

Bronx Queens Manhattan
 Brooklyn Staten Island Westchester

AVAILABILITY

Part Time Full Time
 Temp Perm.
Monday _____ Tuesday _____ Wednesday _____
Thursday _____ Friday _____ Saturday _____
Sunday _____ Holiday _____

(Provide Times Available In Spaces Above)

Medical Benefits:

Required Preferred



ANNUAL MANDATES
OSHA / HIPAA
ACKNOWLEDGMENT FORM

I hereby attest that I have received, read and understood the following Mandated Topics of Cure Staffing, Inc.:

- HIPAA
- Patient Bill of Rights
- Safety Orientation
- Bloodborne Pathogens
- Infection Control
- Fire Safety
- Elder Abuse & Neglect
- Age Specific Care
- Cultural Diversity
- Advance Directives
- Customer Service

- Pain Management
(for NP's, RN's & LPN's only)

I also acknowledge that Cure Staffing, Inc. has explained to my satisfaction the above topics.

Applicant's Name

Applicant's Signature

Date



CONFIDENTIALITY OF PATIENT INFORMATION
(HIPPA)

I understand that as a Healthcare Professional working for Cure Staffing, Inc. at any client/hospital/facility that I may be exposed to and/or acquire Confidential Information.

Confidential Information may include data, reports, records, summaries, tables and studies whether written, oral, fixed in hard copy or contained in a computer. It is my responsibility to protect the confidentiality of all patient information. I will not disclose to any third party, except where permitted or required by law, any confidential information, and will comply with all Federal and State laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and the Federal Security Standard for HIPAA, effective as of April 20, 2005, as well as the policies of Cure Staffing, Inc.

Failure to maintain patient confidentiality may lead to discharge or other disciplinary action.

I have read and understand the above policy.

Applicant's Name

Applicant's Signature

Position / Skill

Social Security #

Date



**CRIMINAL BACKGROUND CHECK &
DRUG SCREENING / TOXICOLOGY
AUTHORIZATION**

I, _____, authorize Cure Staffing to conduct a
(Applicant's Name)

Criminal Background Check & Drug Screening / Toxicology necessary to complete my application process.

Have you ever used a different name or names other than the one above? NO YES
If yes, please list them:

- 1) _____
- 2) _____
- 3) _____

Date of Birth (mm/dd/yyyy): _____

Social Security #: _____

Address #1 (Current): _____

Last 2 address' in the past 7 years:

Address #2: _____

Address #3: _____

Note: A conviction will not necessarily disqualify an applicant.
This information will be used to the full extent permitted by law.

(Applicant's Signature)

Date



NON-HABITUATION FORM

I, _____ certify that I am not
(Applicant's Name)
using or habituated or addicted to depressants, stimulants, narcotics,
alcohol or other drugs that may alter my behavior and that I am fully able
to perform the duties as a/an _____
(Skill / Position)
requested by Cure Staffing, Inc.

Applicant's Signature

Date



DEGREE VERIFICATION

Applicant must complete this upper portion, so we may verify your degree / certificate
(Please Print)

I. APPLICANT'S INFORMATION:

Applicant's Full Name: _____

(* Maiden name if applicable): _____

Social Security # : _____ - _____ - _____

Date of Graduation (Month/Year): _____

Degree(s) / Certificate(s) Completed: _____

Name of Educational Institution: _____

Address of Educational Institution: _____

I hereby give my permission to release the information requested on this form.

Applicant's Signature

Date

II. VERIFICATION BY EDUCATIONAL INSTITUTION

To: Educational Institution Registrar's Office

Registrar must complete this lower portion, so we may very applicant's degree/certificate

It is our hiring policy to verify educational background prior to an employment commitment. Please complete the information below and fax to the number shown so that we may consider the applicant for the position with our company. We would appreciate a response at your earliest convenience. If you have any questions concerning this matter, please feel free to contact me. Thank you for your cooperation.

Cure Staffing, Inc. Representative

Date

Phone #

Fax #

Information Verified by:

Name (Please print): _____

Title: _____

Signature: _____

Date: _____

Department: _____

Phone#: _____



PAYROLL POLICIES & PROCEDURES
ACKNOWLEDGEMENT FORM

Welcome to Cure Staffing!

In order to maintain good relations with our clients and ensure proper payment for shifts worked, it is important to follow all Cure Staffing, Inc. Payroll Policies and Procedures.

I hereby attest that I understand the proper procedures available to me to address any payroll related issues.

I also acknowledge that my coordinator at Cure Staffing, Inc. has explained to my satisfaction the Payroll Policies and Procedures.

As a Cure Staffing, Inc. employee, I also acknowledge that my coordinator has given and explained to me the policy regarding ID Badges.

Applicant's Name (Please print)

Coordinator's Name

Applicant's Signature

Coordinator's Signature

Date

Date



EMPLOYEE DIRECT DEPOSIT

No More Extra Trips to the Bank!

To request Direct Deposit Service for your weekly paycheck, read and complete the following authorization agreement, and give it to your payroll department. If you are eligible to participate, they'll set you up for the Direct Deposit Service with your bank.

Please deposit my entire net pay into the account specified below.

Circle One: **Checking** **Savings**

Account #: _____

Routing / Transit #: _____

**Attach a VOID check, bank letter, or specification sheet.
Deposit tickets are NOT accepted.**

EMPLOYEE INFORMATION

Name: _____

Social Security #: _____

Home Address: _____

City _____

State: _____ Zip: _____

AUTHORIZATION:

I authorize my employer, "CURE STAFFING, INC." (hereinafter Company) to deposit my net pay each payday directly into my account. In the event that the Company deposits funds erroneously into my account, I hereby authorize the Company to debit by account for an amount not to exceed the original amount of erroneous credit.

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

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

Applicant's Signature: _____ **Date:** _____



APPLICATION & ONGOING REQUIREMENTS

REQUIREMENTS	FREQUENCY
Current NEW YORK / NEW JERSEY STATE REGISTRATION & LICENSE to practice in NY / NJ	You must bring in new Registration every three (3) years and License prior to expiration date
Professional Liability (Malpractice) Insurance Policy Certificate at \$1M – \$6M coverage	Annually
Recent Physical/Health Examination – General Wellness (must include PPD results and all TITERS with LAB results)	Annually
PPD (result must include measurement in mm) If positive (+) PPD, need Chest X-Ray	PPD – Annually CXR - Every two (2) years
Proof of Rubella Immunity or Vaccination	ONCE – Every ten (10) years
Proof of Rubeola Immunity or Vaccination	ONCE – Every ten (10) years
Proof of Varicella Immunity or Vaccination	ONCE – Every ten (10) years
Proof of Mumps Immunity or Vaccination	ONCE – Every ten (10) years
Proof of Hepatitis Vaccinations OR Signed Hepatitis B Declination Form	ONCE
ID's Proof of Citizenship and Identity for I-9 form – Employment Eligibility e.g., US Passport, Certificate of Naturalization, Alien Registration card OR A combination of any Identification Card (e.g., driver's license, school/work ID, state ID) and/or Birth Certificate AND SOCIAL SECURITY CARD.	ONCE Nurse Testing.com
REFERENCES (2) from previous supervisors	Nurse Testing.com
Certification in CPR/BCLS ACLS, PALS, NALS as required	Recertification required before expiration date
Annual Mandatories as required by licensure (OSHA / HIPAA)	Annually (or expiration date on certificate)
Pharmacology + Specialty Exam(s) for RN's & LPN's	Nurse Testing.com
Nurses Aide (C.N.A) TRAINING CERTIFICATE and STATE CERTIFICATION - NY / NJ	You must bring in new certification prior to expiration date
Nurses Aide (C.N.A) EXAM	Nurse Testing.com



Payroll Protocol

Welcome to Cure Staffing, Inc.!

Payroll is processed on a weekly basis according to the following schedule:

1. Faxed copies of completed timesheets must be received in the office no later than 12noon on Mondays. Original timesheets must be received in the office in order for paychecks to be released. They may be dropped off in person or in our drop box (mailbox) located by the office entrance or mailed to our office.
2. Paychecks are ready for employee pick-up or mailing out after 12noon on Fridays, providing the preceding conditions have been met.
3. Late or incomplete submittals or failure to provide originals will prevent paycheck process and release.

Please fax copies of completed timesheets to the following numbers:

New York, NY Fax#: (718) 747-2279
Livingston, NJ Fax#: (973) 422-1421

Please mail timesheets to the following address:

17-08 Francis Lewis Blvd., Whitestone, NY 11357
2 West Northfield Road, Suite 212, Livingston, NJ 07039

Each week, please use one (1) timesheet, per site / per assignment / per location / per job / per unit. If you need more blank timesheets, please ask your coordinator to fax or mail you more copies. This way the client facility can track billing issues.

Please make sure that each timesheet is filled out correctly.
Incorrect/incomplete timesheets will not be processed.

How to fill out a timesheet:

1. Firm Name – name of facility or company (Ex. Hospital name, Dr.'s Office, Nursing home, Company name, etc.)
2. Department – Unit / Floor / Section (May be used as a job description line if no department is assigned.)
3. Week Ending Sunday (date of the Sunday ending the week you worked)
4. Name and Social Security Number
5. Indicate if assignment is "Continuing" or "Completed"
6. Indicate if still "Available" (for the coming week(s))
7. Indicate what you want us to do with your paycheck - "PU – Pick up / Mail / Direct Deposit" Paychecks marked "Hold" can be picked up between 12 noon and 5pm on Friday. If neither box is checked, the paychecks will automatically be mailed on Friday by 4:30pm.
8. Please fill in the appropriate column for first, second, or third shift. Please indicate the DATES worked, TIME STARTED, TIME FINISHED, LUNCH PERIOD, TOTAL HOURS FOR THE DAY and TOTAL HOURS FOR THE WEEK.
9. Employee signature must be on all timesheets.
10. Supervisor's signature must be on all timesheets – No signature, not a valid timesheet. (In cases supervisor is not present at the end of the week /assignment, please call your coordinator for assistance)



WELCOME!

Welcome to Cure Staffing, Inc.!
Congratulations!

You have been chosen to represent our agency on your temporary work assignment.
Please follow our policies and protocols listed below:

THE 1ST DAY OF YOUR WORK ASSIGNMENT

- ❖ **Make sure to arrive promptly (ON TIME) on the first day of your assignment.**
(We recommend you arrive 15 minutes before your shift starts, in order to get acquainted with your work area and protocols)
- ❖ **When you arrive and are settled in the facility, call your staffing coordinator with the telephone number where you can be reached.**

IMAGE & PROFESSIONALISM

Cure Staffing, Inc. services New York and New Jersey's finest Medical Facilities and Fortune 1,000 companies, therefore, we ask that on all work assignments, corporate attire is worn (unless otherwise instructed).

1. **MEN/MALE:** Suit / Shirt & Tie with Jacket & Slacks (tailored trousers) + ID Badge
 2. **WOMEN/FEMALE:** Suit / Skirt/Slacks & Blouse + ID Badge
 3. **CLINICAL EMPLOYEES:** Scrubs / Nursing Uniform (when applicable) + ID Badge
- (Note: Cure Staffing, Inc. ID Badges are to be worn to all work assignments at all times. Please make sure to call your staffing coordinator for the annual renewal of your ID badge)

We also ask that as a temporary employee of Cure Staffing, Inc., you maintain a positive and professional attitude at work. If any **ISSUES / INCIDENTS** arise at your work assignment, please call your staffing coordinator immediately! Don't try to handle the problem on your own.

KEEPING YOUR COORDINATOR INFORMED

- A) AVAILABILITY** Keep your staffing coordinator informed of your day-to-day availability.
- B) RUNNING LATE** If you are running late, please call a Cure Staffing, Inc. representative immediately. Do not try to contact the client.
- C) CANCELLATION** If you must cancel out of an assignment, please call and speak to a live Cure Staffing, Inc. representative at least two (2) hours prior to the start of your work shift!
Our 24-hour phone line can be reached by dialing **973.422.1422**.
- D) UPDATES** If you are ending an assignment earlier than the scheduled end date please let your staffing coordinator know so that we can start working on getting another assignment for you.
- E) INCIDENT REPORT** All incidents or events that have outcomes, which are unexpected and may cause harm or have caused harm or injuries to a patient and/or an employee must be reported to Cure Staffing, Inc. immediately!
An incident report form must be filled out by the employee and employer involved in the incident and faxed over to Cure Staffing, Inc. within 24 hours of incident. (Please call your coordinator to request for an Incident Report Form)
- F) ADDRESS CHANGES AND PAYCHECK INSTRUCTIONS** In order for us to properly process your weekly paycheck, you are responsible for reporting any address changes and all paycheck instructions to your payroll representative and/or staffing coordinator (at Cure Staffing, Inc.) Please remember to fill out a new W-4 form every time you change your address and submit it to Cure Staffing, Inc. immediately.

Form I-9, Employment Eligibility Verification

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

Instructions

Please read all instructions carefully before completing this form.

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

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and non-citizen) hired after November 6, 1986 is authorized to work in the United States.

When Should the Form I-9 Be Used?

All employees, citizens and noncitizens, hired after November 6, 1986 and working in the United States must complete a Form I-9.

Filling Out the Form I-9

Section 1, Employee: This part of the form must be completed at the time of hire, which is the actual beginning of employment. Providing the Social Security number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

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

Section 2, Employer: For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors. Employers must complete Section 2 by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required

document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, Section 2 must be completed at the time employment begins. **Employers must record:**

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the Form I-9. **However, employers are still responsible for completing and retaining the Form I-9.**

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

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

What Is the Filing Fee?

There is no associated filing fee for completing the Form I-9. This form is not filed with USCIS or any government agency. The Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

USCIS Forms and Information

To order USCIS forms, call our toll-free number at **1-800-870-3676**. Individuals can also get USCIS forms and information on immigration laws, regulations and procedures by telephoning our National Customer Service Center at **1-800-375-5283** or visiting our internet website at www.uscis.gov.

Photocopying and Retaining the Form I-9

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

The Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR § 274a.2.

Privacy Act Notice

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

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

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

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

Paperwork Reduction Act

We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: 1) learning about this form, and completing the form, 9 minutes; 2) assembling and filing (recordkeeping) the form, 3 minutes, for an average of 12 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529. OMB No. 1615-0047.

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

Form I-9, Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

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

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

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

I attest, under penalty of perjury, that I am (check one of the following):

- A citizen or national of the United States
- A lawful permanent resident (Alien #) A _____
- An alien authorized to work until _____
(Alien # or Admission #) _____

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

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

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

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

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

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

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

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)	
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.		
Document Title: _____	Document #: _____	Expiration Date (if any): _____

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

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

LISTS OF ACCEPTABLE DOCUMENTS

LIST A Documents that Establish Both Identity and Employment Eligibility	LIST B Documents that Establish Identity	LIST C Documents that Establish Employment Eligibility
OR		AND
1. U.S. Passport (unexpired or expired)	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. U.S. Social Security card issued by the Social Security Administration <i>(other than a card stating it is not valid for employment)</i>
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 <i>(Form FS-545 or Form DS-1350)</i>
3. An unexpired foreign passport with a temporary I-551 stamp	3. School ID card with a photograph	3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal
4. An unexpired Employment Authorization Document that contains a photograph (Form I-766, I-688, I-688A, I-688B)	4. Voter's registration card	4. Native American tribal document
	5. U.S. Military card or draft record	5. U.S. Citizen ID Card <i>(Form I-197)</i>
5. An unexpired foreign passport with an unexpired Arrival-Departure Record, Form I-94, bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, if that status authorizes the alien to work for the employer	6. Military dependent's ID card	6. ID Card for use of Resident Citizen in the United States <i>(Form I-179)</i>
	7. U.S. Coast Guard Merchant Mariner Card	
	8. Native American tribal document	7. Unexpired employment authorization document issued by DHS <i>(other than those listed under List A)</i>
	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	

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

Form W-4 (2009)

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. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2009 expires February 16, 2010. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/multiple job situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

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

Nonwage income. If you have a large amount of nonwage income, such as interest or

dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2009. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

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

B Enter "1" if:
 { • You are single and have only one job; or
 • You are married, have only one job, and your spouse does not work; or
 • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. } . . . **B** _____

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

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

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

F Enter "1" if you have at least \$1,800 of child or dependent care expenses for which you plan to claim a credit . . . **F** _____
 (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
 • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children.
 • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children. **G** _____

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

For accuracy, complete all worksheets that apply.
 { • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.
 • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$25,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.
 • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

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

Form W-4 Department of the Treasury Internal Revenue Service		Employee's Withholding Allowance Certificate		OMB No. 1545-0074 2009
1 Type or print your first name and middle initial. Last name		2 Your social security number		
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.		
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ► <input type="checkbox"/>		
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 _____		
6 Additional amount, if any, you want withheld from each paycheck		6 \$ _____		
7 I claim exemption from withholding for 2009, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here		7 _____		
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.				
Employee's signature (Form is not valid unless you sign it.) ►		Date ►		
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)	10 Employer identification number (EIN)	

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions, claim certain credits, adjustments to income, or an additional standard deduction.

- 1 Enter an estimate of your 2009 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2009, you may have to reduce your itemized deductions if your income is over \$166,800 (\$83,400 if married filing separately). See *Worksheet 2* in Pub. 919 for details.) . . . 1 \$ _____
- 2 Enter:

{	\$11,400 if married filing jointly or qualifying widow(er)	}	2	\$	
\$ 8,350 if head of household						
\$ 5,700 if single or married filing separately						
- 3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" 3 \$ _____
- 4 Enter an estimate of your 2009 adjustments to income and any additional standard deduction. (Pub. 919) 4 \$ _____
- 5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 8* in Pub. 919.) 5 \$ _____
- 6 Enter an estimate of your 2009 nonwage income (such as dividends or interest) 6 \$ _____
- 7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" 7 \$ _____
- 8 **Divide** the amount on line 7 by \$3,500 and enter the result here. Drop any fraction 8 _____
- 9 Enter the number from the **Personal Allowances Worksheet**, line H, page 1 9 _____
- 10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10 _____

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

- 1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1 _____
 - 2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you are married filing jointly and wages from the highest paying job are \$50,000 or less, do not 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 4-9 below to calculate 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 2009. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2008. 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

Table 2

Married Filing Jointly		All Others		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	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 - \$4,500	0	\$0 - \$6,000	0	\$0 - \$65,000	\$550	\$0 - \$35,000	\$550
4,501 - 9,000	1	6,001 - 12,000	1	65,001 - 120,000	910	35,001 - 90,000	910
9,001 - 18,000	2	12,001 - 19,000	2	120,001 - 185,000	1,020	90,001 - 165,000	1,020
18,001 - 22,000	3	19,001 - 26,000	3	185,001 - 330,000	1,200	165,001 - 370,000	1,200
22,001 - 26,000	4	26,001 - 35,000	4	330,001 and over	1,280	370,001 and over	1,280
26,001 - 32,000	5	35,001 - 50,000	5				
32,001 - 38,000	6	50,001 - 65,000	6				
38,001 - 46,000	7	65,001 - 80,000	7				
46,001 - 55,000	8	80,001 - 90,000	8				
55,001 - 60,000	9	90,001 - 120,000	9				
60,001 - 65,000	10	120,001 and over	10				
65,001 - 75,000	11						
75,001 - 95,000	12						
95,001 - 105,000	13						
105,001 - 120,000	14						
120,001 and over	15						

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. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. 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 also 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 using it 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 are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by 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.