



P.O. Box 1734, Upper Marlboro, MD 20773-1734

Phone: 301-574-8100 Fax: 301-627-1955

www.militarycaregiversofamerica.org

Thank you for requesting information regarding our company. We are a woman-owned nursing referral service agency that is proud to offer excellent hourly rates and expert nursing resources. Please review the information and if you have any questions, feel free to call our office at 301-574-8100. The application packet must be returned to our mailing address listed above.

CAN I FAX MY APPLICATION?

Sure! If you choose to fax your application packet, call prior to faxing to let us know. Afterwards, we will call to verify that we have received all of the pages sent on our end. Fax # 301-627-1955.

WHAT HAPPENS AFTER MY APPLICATION IS RECEIVED?

A recruiter will call you as soon as we receive your application. Please list all valid phone numbers where you can be reached. Normally we can process your application the day it is received so you may begin accepting shifts soon thereafter.

WE LOOK FORWARD TO HAVING YOU ON OUR TEAM!



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Please submit the following to complete your application package:

- _____ INDEPENDENT CONTRACTOR APPLICATION (FORM PROVIDED)
- _____ COPY OF SOCIAL SECURITY CARD
- _____ COPY OF DRIVER'S LICENSE
- _____ COPY OF NURSING LICENSE
- _____ COPY OF CPR CARD
- _____ 3 REFERENCES (FORMS PROVIDED)
- _____ PHYSICIAN'S STATEMENT/HEALTH CERTIFICATE (FORM PROVIDED)
- _____ CURRENT TUBERCULIN SKIN TEST REPORTING FORM OR CXR
- _____ HEPATITIS B WAIVER OR RECORD (FORM PROVIDED)
- _____ MMR/VARICELLA FORM (FORM PROVIDED)
- _____ PROFESSIONAL CREDENTIAL AND CERTIFICATIONS (FORM PROVIDED)
- _____ PROOF OF GENERAL AND PROFESSIONAL LIABILITY INSURANCE COVERAGE (REQUIRED)
- _____ BACKGROUND CHECK FINGERPRINT VERIFICATION
- _____ ADDITIONAL RIGHTS REGARDING DISCLOSURE OF BACKGROUND INVESTIGATIONS
- _____ FORM I-9 (EMPLOYMENT ELIGIBILITY VERIFICATION)
- _____ SUBSTANCE ABUSE TESTING PROGRAM FOR INDEPENDENT CONTRACTORS
- _____ PERMISSION FOR RELEASE OF INFORMATION
- _____ A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT



INDEPENDENT CONTRACTOR APPLICATION

Please complete all sections of this application even if you have submitted your resume. It is essential that we have complete information regarding both your training and experience. Your present employer will not be contacted for a reference without your consent. Reasonable accommodations will be made for applicants when requested.

- You may be required to provide proof of appropriate health status (if applicable based on position).
- You may be required to provide drug and/or criminal background screening (where required by policy, law, or client contract).

Military Caregivers of America, LLC is an equal opportunity employer and strives to comply with all applicable laws prohibiting discrimination based on race, color, sex, age, religion, national origin, ancestry, physical or mental disability, marital status, veteran status or any characteristic protected by law.

Date Available to Work _____ Today's Date _____

Personal Information

Name _____

Current Address _____

City _____ State/Zip _____

Phone (____) ____-____ Cell (____) ____-____ Best time to call _____

Email address _____

Social Security Number _____

Age 18 or Older? ____Yes ____No Sex? ____Male ____Female

Military Veteran? ____Yes ____No If yes, what branch? _____

If you are a veteran, have you been honorably discharged? ____Yes ____No

Speak/Understand Foreign Languages? ____Yes ____No

Currently Employed? ____Yes ____No Work for Another Agency? ____Yes ____No

Are you bound by a non-competition agreement of your current or previous employer? (Yes)____ (No)_____



Reliable Transportation? Yes No If yes, which ones? _____

Maximum number of miles you are willing to commute: _____ Please Initial: _____

Employment Status

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

If not a U.S. citizen, please indicate your immigration status.

(HI-B Visa) _____ (TN Visa) _____ (Resident Alien) _____ (Other) _____

Additional Information

How did you hear about us? _____

If referral, please indicate whom _____

Have you ever applied with us before? _____ If so, when? _____

Are any of your relatives employed by us? (Yes) _____ (No) _____

In which counties will you accept employment?

- Anne Arundel Carroll Charles Howard St. Mary's
- Baltimore City Calvert Frederick Montgomery Washington, DC
- Baltimore County Harford Prince George's Washington

Emergency Contact Information

Primary Emergency Contact (Name) _____ (Home #) _____
(Cell #) _____ Relationship to Applicant: _____

Secondary Emergency Contact (Name) _____ (Home #) _____
(Cell #) _____ Relationship to Applicant: _____



Medical Experience

Healthcare Discipline

Advanced Practice RN _____

RN _____

LPN II _____

LPN _____

CNA _____

PCA/HM _____

Other _____

Respite/Companion _____

Total Years of Experience: _____

Date Passed Boards: _____

Education

Please fill out at least one of the following education rows completely.

High School _____ City _____ State _____
Year Graduated _____ Degree Type _____

Nursing School _____ City _____ State _____
Year Graduated _____ Degree Type _____

College/University _____ City _____ State _____
Year Graduated _____ Degree Type _____

Other _____ City _____ State _____
Year Graduated _____ Degree Type _____

Clinical Experience

Please identify the amount of experience, in years, you have in each unit listed below.
Greater flexibility with float experience translates into more opportunity for assignments.

Critical Care _____
Cardiac Cath Lab _____
Emergency Room _____
Telemetry _____
Stepdown/ICU _____
Psychiatric Nursing _____
Inpatient Rehab _____
Neurology _____
Other _____

Medical Surgical _____
Neonatal ICU _____
Labor & Delivery _____
Post Partum _____
Operating Room _____
Geri-Psych _____
Orthopedics _____
Dialysis _____



Preferences

Shift Preference: ____Days ____Evenings ____Nights ____Weekends

Employment History

Company #1

From (month/year) ____/____ To (month/year) ____/____

Hospital/Facility _____

Street Address _____

City _____ State _____ Zip _____

Agency (if a travel or per diem assignment) _____

Position _____ Charge Experience _____

Phone (____)-____-____

Supervisor Name and Title _____

Reason for Leaving _____

May we contact this employer? ____Yes ____No

Company #2

From (month/year) ____/____ To (month/year) ____/____

Hospital/Facility _____

Street Address _____

City _____ State _____ Zip _____

Agency (if a travel or per diem assignment) _____

Position _____ Charge Experience _____

Phone (____)-____-____

Supervisor Name and Title _____

Reason for Leaving _____



May we contact this employer? ____ Yes ____ No

Company #3

From (month/year) ____/____ To (month/year) ____/____

Hospital/Facility _____

Street Address _____

City _____ State _____ Zip _____

Agency (if a travel or per diem assignment) _____

Position _____ Charge Experience _____

Phone (____)-____-____

Supervisor Name and Title _____

Reason for Leaving _____

May we contact this employer? ____ Yes ____ No

Company #4

From (month/year) ____/____ To (month/year) ____/____

Hospital/Facility _____

Street Address _____

City _____ State _____ Zip _____

Agency (if a travel or per diem assignment) _____

Position _____ Charge Experience _____

Phone (____)-____-____

Supervisor Name and Title _____

Reason for Leaving _____

May we contact this employer? ____ Yes ____ No



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References

Reference #1

Name _____

Company _____

Address _____

City _____ State _____ Zip _____

Position _____ Relationship to You _____

Phone (____)-_____-_____

Reference #2

Name _____

Company _____

Address _____

City _____ State _____ Zip _____

Position _____ Relationship to You _____

Phone (____)-_____-_____

Reference #3

Name _____

Company _____

Address _____

City _____ State _____ Zip _____

Position _____ Relationship to You _____

Phone (____)-_____-_____



APPLICATION ACKNOWLEDGEMENT

I certify that the information in this application and any supporting documentation is true, accurate, current and complete. I understand that any misstatement, misrepresentation, omission, or falsification of facts on this application or supporting documentation may result in disqualification from further consideration or termination of the contractual agreement.

I authorize Military Caregivers of America, LLC to investigate my employment history, professional licensure, and credentials and to obtain any relevant information (including criminal background check) needed to make a decision regarding utilizing my services. I authorize Military Caregivers of America, LLC to contact any current or former employer, staffing companies through whom I have worked, state licensing boards, professional organizations, references, medical malpractice insurance carriers, educational institutions and any other sources of information about me to inquire about my background, education, work history, character, experience and clinical skills. I authorize Military Caregivers of America, LLC to disclose this application along with any information about me obtained through reference checks or during the course of the interview process for state, federal, contractual or accreditation audit purposes. I also authorize Military Caregivers of America, LLC to disclose any of my performance appraisals, disciplinary records or skills assessments for the same purposes as above. I release Military Caregivers of America, LLC and any individual or entity providing information to Military Caregivers of America, LLC from all liability for any damages resulting from disclosure of this information.

I also understand and agree that passing a medical examination and/or participating in a post-conditional offer medical screening may be required. If medical restrictions cannot be reasonably accommodated, my services may not be utilized as an independent contractor.

I consent that, subject to applicable state laws, Military Caregivers of America, LLC reserves the right to conduct pre-contractual drug screening or drug screening and testing for reasonable suspicion at any time during our contractual agreement or where warranted by circumstances, workplace conditions, or contractual requirements. Any violation of this policy shall result in termination of my services with Military Caregivers of America, LLC.

I understand and agree that nothing contained in this application or in granting of an interview creates an employment between Military Caregivers of America, LLC and myself. No promises regarding employment have been made to me. I acknowledge that the purpose of filling out all forms (including tax forms) at this



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pre-contract stage is solely for administrative purposes and it will not be used for a hiring decision for contracting. If any independent contractor relationship is established, I understand that my independent contractor agreement will be terminated “at will,” that I will have the right to terminate my independent contractor agreement at any time, and that Military Caregivers of America, LLC will retain a similar right to terminate my services at any time.

I understand and agree that Military Caregivers of America, LLC is under no obligation to contract with me or find placement on my behalf with one of its clients.

I understand and agree that this application is a continuous document and should any of the information which I have supplied herein changes, I am obligated to notify Military Caregivers of America, LLC of such changes immediately. Should I be hired as an independent contractor by Military Caregivers of America, LLC, my caregiver assignments, schedules, and/or work locations, are subject to change according to the needs of the business and the clients of Military Caregivers of America, LLC.

Applicant Name (print): _____

Signature of Applicant: _____ Date: _____

Military Caregivers of America, LLC is an Equal Opportunity Employer. Pursuant to Title VII of the Civil Rights Act of 1964 (42 U.S. C s200d et seq.) and 45 C.F.R. Part 80, Section 504 of the Rehabilitation Act of 1973, as amended (29 U. S. C s794) and 45 C. F. R Part 84, and the Age discrimination Act of 1975 (42 U. S. C s6101 et seq.) and 45 C. F. R. Part 91, the agency adheres to an equal opportunity policy for all persons seeking contractual employment, and for all persons employed by the agency. Military Caregivers of America, LLC does not discriminate on the basis of age, race, color, religion, military status, marital status, gender, gender preference, national origin, disability, or any characteristic protected by law.



PROFESSIONAL CREDENTIALS
AND CERTIFICATIONS

Name:

(Last) (First) (Middle Name)

Please list all credentials (CPR, ACLS, TNCC, CNOR, BLS, etc.) along with the expiration dates and attach a copy to this application.

Credential/ Certification	Expiration Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Professional Licensure

License #: _____ State _____

Have you ever held a nursing license under a different name? ____ Yes ____ No
If yes, please list name and location. _____

If you answer yes to any of the questions below, please attach a separate sheet with circumstances, dates and final outcome:

Have you ever been convicted of a crime other than a minor traffic violation? ____ Yes ____ No

Has your license or certification ever been investigated or suspended? ____ Yes ____ No

Have you ever been named as a defendant in a malpractice claim? ____ Yes ____ No



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REFERENCE INFORMATION

Independent Contractor's Name _____ Signature _____

Notice to Reference:

The applicant named above has applied to Military Caregivers of America, LLC for contractual employment and has given us your name as a professional reference. We would greatly appreciate it if you would verify employment dates as well as provide an evaluation of this applicant's past performance using the criteria outlined below. Please make any additional comments you feel would assist us in making our decision in hiring this applicant. Your comments will be kept in the strictest confidence. Thank you.

TO BE COMPLETED BY REFERENCE:

Employment Dates:

From (month/year) _____ / _____ To (month/year) _____ / _____

Hospital/ Facility _____ Number of Beds _____

Specialty/Units Worked _____ Average Patient Ratio _____

Position _____

Applicant Role in Unit _____ Advanced Practice RN _____ RN _____ LPN
 _____ Other (Explain) _____

Charge Experience? _____ Yes _____ No

Is this applicant eligible for rehire? _____ Yes _____ No
 (Explain) _____

Clinical Performance/ Attributes

	Exceeds Standards	Meets Standards	Does not Meet Standards*
Clinical Competence			
Critical Thinking Skills			
Quality of Work			
Quantity of Work			
Ability to Follow Directions			
Accepts Feedback			
Dependability			
Attitude			
Initiative			
Interpersonal Skills			

Print Name _____ Title _____

Signature _____ Date _____



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 _____ Other (Explain) _____

Charge Experience? _____ Yes _____ No

Is this applicant eligible for rehire? _____ Yes _____ No
 (Explain) _____

Clinical Performance/ Attributes

	Exceeds Standards	Meets Standards	Does not Meet Standards*
Clinical Competence			
Critical Thinking Skills			
Quality of Work			
Quantity of Work			
Ability to Follow Directions			
Accepts Feedback			
Dependability			
Attitude			
Initiative			
Interpersonal Skills			

Print Name _____ Title _____

Signature _____ Date _____



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Hospital/ Facility _____ Number of Beds _____

Specialty/Units Worked _____ Average Patient Ratio _____

Position _____

Applicant Role in Unit ____ Advanced Practice RN ____ RN ____ LPN
 ____ Other (Explain) _____

Charge Experience? ____ Yes ____ No

Is this applicant eligible for rehire? ____ Yes ____ No
 (Explain) _____

Clinical Performance/ Attributes

	Exceeds Standards	Meets Standards	Does not Meet Standards*
Clinical Competence			
Critical Thinking Skills			
Quality of Work			
Quantity of Work			
Ability to Follow Directions			
Accepts Feedback			
Dependability			
Attitude			
Initiative			
Interpersonal Skills			

Print Name _____ Title _____

Signature _____ Date _____



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PHYSICIAN'S STATEMENT OF HEALTH

This nurse, _____, is free from infectious or contagious disease, and there is no cause to prevent the nurse from performing the tasks required by his/her profession.

Date: _____

Physician's Signature: _____

Physician's Printed Name: _____

Physician's Office Address: _____

Physician's Telephone Number: _____

Return this completed statement to Military Caregivers of America, LLC for submission with your application packet.



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TUBERCULIN SKIN TEST REPORTING FORM

Name (Please print):

Last	First	Middle Name
------	-------	-------------

Date of Test: _____

Date Read: _____
(have test read 48 to 72 hours after it is administered)

Read By (Printed Name): _____

Office Address: _____

Telephone Number: _____

Results: _____ 0mm/negative
 _____ mm/positive

- **If redness or swelling occurs, your test must be read by independent contractor's health nurse or a nurse certified in reading test.**



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HEPATITIS B VACCINATION STATUS

Name _____ Classification: _____

The hepatitis B vaccination will be made available to all independent contractors after independent contractors have received the required training, within 10 working days of initial assignment and to all who have occupational exposure, unless the independent contractor is exempted from having the Hepatitis B vaccination series for any of the following reasons:

(Check one)

- The antibody testing indicates me to be immune.
- The vaccine cannot be given for medical reasons.
- I have received the complete Hepatitis B Vaccination series previously.
- I would like the Hepatitis B Vaccination.
- I am currently receiving the Hepatitis Vaccination.

Signature

Date

Declination Statement

I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. I understand that due to my occupational exposure to blood and other potentially infectious materials, I may be at a higher risk of acquiring Hepatitis B. However, if in the future I continue to have occupational exposure to blood and other potentially infectious materials and want to be vaccinated with the Hepatitis B vaccine, I will receive the vaccination series at that time.

Signature

Date



**AUTHORIZATION OF BACKGROUND INVESTIGATION
 & RELEASE OF INFORMATION**

In consideration of my application for contract employment, I hereby authorize Military Caregivers of America, LLC (“MCA”) and/or its agents to make an independent investigation of my background and request any present or former employer, school, police department, financial institution, agency or other persons having personal knowledge about me, to furnish bearer with any and all information in their possession regarding me in connection with an application for contract employment with an MCA client; including consumer report information that may contain motor vehicle records.

I understand that MCA may release the results of my background investigation to any actual or potential MCA clients. Any background investigation results released by MCA shall be solely for the purpose of obtaining potential contract employment for me. I grant my permission to MCA to release the results of my background investigation and hereby agree to hold MCA harmless from any liability for the release of such results to MCA actual or potential clients.

The scope of this report may contain information on my work history, criminal record (if any), education, credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living from public record sources or through personal interviews with your neighbors, friends, or associates. MCA makes no warranty regarding the truthfulness or accuracy of the background results obtained from other sources. I have the right to the results of the background investigation conducted. Additional rights specific to the state I reside or work in are listed below. Any requests for the results of my background investigation can be obtained by submitting a written request to Military Caregivers of America, LLC, P.O. Box 1734, Upper Marlboro, MD 20773-1734. I may also have a right to request additional disclosures regarding the nature and scope of the investigation. I am willing that a photocopy of this authorization be accepted with the same authority as the original and I specifically waive any written notice from any present or former employer who may provide information based upon this authorized request. I understand this authorization is to be a part of the written employment application which I sign.

Applicant name (Print): 	Print Maiden or Other Names Used: 	Date of Birth: (Identification purposes only) ____/____/____
Social Security # : (Identification purposes only) ____-____-____	Phone: (____)-____-____	Cell: (____)-____-____



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Present Address:	List all prior addresses within the Past 7 years: Address (1)
Address (2):	Address (3):

By signing below, I agree that a copy/fax/scan of this document shall be valid as an original and I certify that the facts and information in this form are true and correct. I also agree to the terms contained in this document, effective as of the date of my signature.

Signature: _____ Printed Name: _____ Date: _____



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ADDITIONAL RIGHTS REGARDING DISCLOSURE OF BACKGROUND INVESTIGATIONS

If you are a resident of any of the following states, please review the additional rights afforded to residents of that state.

California, Minnesota, or Oklahoma: If a consumer background report is ordered, would you like a free copy of the report mailed to your home? Yes No

California: A copy of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW has been provided to you.

Maine: If requested, you have the right to be informed if (1) the Company ordered a background report on you and if ordered (2) the name and address of the Consumer Reporting Agency (CRA) furnishing the report. You may request and receive from the Company, within five business days of our receipt of your request, the name, address and telephone number of the CRA's nearest office. In addition, you have the right to request and promptly receive from all such CRAs copies of any such investigative consumer reports.

New Jersey: If requested, you have the right to a copy of any background check report concerning you that the Company has ordered. You may contact the CRA for a copy.

Minnesota: If you submit a request to us in writing, you have the right to get from the Company a complete and accurate disclosure of the nature and scope of the consumer report or investigative consumer report ordered, if any.

New York: You have the right, upon written request, to be informed of whether or not a consumer report was requested. If a consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report. You have been provided a copy of Article 23-A of the New York Correction Law, in compliance with Article 25 Section 380-g of the New York General Business Law.

State of Washington: If the Company requests an investigative consumer report, you have the right, upon written request made within a reasonable period of time after your receipt of this disclosure, to receive from the Company a complete and accurate disclosure of the nature and scope of the investigation requested by the Company. You also have the right to request from the CRA a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.



MILITARY CAREGIVERS OF AMERICA, LLC'S SUBSTANCE ABUSE TESTING PROGRAM FOR INDEPENDENT CONTRACTORS

Introduction

Military Caregivers of America, LLC ("Company") is committed to promoting a safe and healthful work environment for all of its independent contractors. The Company is particularly concerned about alcohol and other drug abuse, since such abuse can have a serious effect on productivity and job performance, and may jeopardize the safety of the independent contractor.

In addition, the Company has an obligation to its clients to provide high quality services and to ensure client satisfaction. Substance abuse by Company independent contractors could result in serious mistakes in judgment and thereby compromise the high quality of our services and our clients' trust.

The Company consequently has established this Substance Abuse Testing Program ("Program") to:

- Insure a safe healthful working environment for all independent contractors
- Reduce substance abuse-related injuries and property damage
- Improve, if not insure, productivity and product quality
- Reduce substance abuse-related absenteeism and tardiness
- Refer independent contractors with substance abuse problems to appropriate care and assistance
- Deter individuals from bringing, possessing, using, distributing or having in their systems alcohol or other drugs on Company time or premises
- Help the Company maintain its position of leadership in the nursing referral agency industry.

The Company has committed substantial resources to make this Program effective for every independent contractor, whether regular or temporary. The safety and livelihood of too many others depend on having a drug-free place of work.

General Provisions

Except as otherwise provided in this Program, the Company prohibits the use, possession and/or distribution of alcohol and other drugs (hereafter collectively referred to as "drugs", unless otherwise noted) by anyone on its premises or time, on its clients'



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premises or time or at its outside events. The Company also prohibits independent contractors from reporting to their assignments under the influence of a drug or having in their systems (even if because of use off Company premises and time) any drug in excess of (1) the appropriate concentration level established by the U.S. Department of Health and Human Services ("DHHS") or the U.S. Department of Transportation ("DOT") (in the case of alcohol) or (2), in the case of a substance for which neither of those agencies has established such a level, the appropriate concentration level accepted as reasonable by the medical community. The use and possession of legally-prescribed drugs is permitted on the Company's premises and time provided the drug is contained in the original prescription container and has been prescribed by a medical practitioner for the current use of the person in possession of the drug. Possession of lawfully-acquired over-the-counter drugs also is permitted, but use of any such drug must be consistent with the manufacturer's instructions. Alcoholic beverages are permitted on the Company's premises and time only when in sealed and unopened containers or when otherwise authorized by the President. The permissibility of legally- prescribed drugs, lawfully-acquired over-the-counter drugs and alcohol on clients' premises depends on the clients' policies, which the Company will enforce.

In order to enforce and to monitor compliance with this Program, the Company has contracted with one or more clinics and testing laboratories to collect and to test urine, breath and blood samples for the presence of drugs, as explained below. **The Company also may have testing conducted in accordance with the requirements of clients or applicable law, even if not specifically mentioned in this Program and even if different from the testing provided for in this Program.**

Vendors

Vendors who will be working on Company time or premises for an extended period will be required to subject their employees, who are assigned Company work, to the prohibition and testing provisions of this Program.

Types of Testing to be Conducted

Pre-employment testing

All candidates being considered for independent contracting work with the Company will be required to undergo and to pass a drug test as a condition of hire. No candidate whose test result is positive will be considered further for independent contracting, and no future application for employment by the candidate will be considered for at least a year.



Reasonable suspicion testing

Any independent contractor whom the Company reasonably suspects may be in violation of this Program or the program of a client to whom the independent contractor has been assigned will be required to undergo a drug test. A reasonable suspicion is one based upon observable and articulable conduct, appearance or work performance of the independent contractor identified. Involvement by an independent contractor in a work-related incident resulting in \$1,500 or more in property damage (estimated or actual) or injury to any person requiring more than first aid will constitute grounds for reasonable suspicion in the event the independent contractor shows at least one additional indicator of potentially being in violation of this program.

Whenever feasible, an independent contractor required to submit to reasonable suspicion testing will be observed by the Company's Coordinator or Assistant Coordinator of Healthcare Services or management employee, and Company will complete a form detailing the reason(s) for suspicion of violation of the Substance Abuse Policy. (See attachment.) An independent contractor to be tested based upon reasonable suspicion will be suspended from work pending the Company's receipt of notice of the test result.

Sample Collection and Testing

Consent and Release

Prior to sample collection, an independent contractor identified for testing will be required to sign a consent and release form authorizing and agreeing to collection and testing of a sample, or samples, of his/her urine, blood or breath. Examples of such forms are attached, though any form chosen by the Company, its client to whom the independent contractor has been assigned, its clinic(s), or its laboratory(ies) may be used.

Sample collection

Urine, blood and breath samples will be collected by the Company's clinic(s), which will follow chain-of-custody procedures and procedures that protect independent contractor confidentiality and privacy and protect the collected sample(s) from adulteration, substitution and misidentification.

Sample testing

All urine and blood sample testing will be conducted by a laboratory certified by the U.S. Department of Health and Human Services ("DHHS"), and all initial positive urine and



blood test results will be confirmed by a second, reliable testing method.

Testing for alcohol content will be by blood analysis or breathalyzer.

Any independent contractor blood- or urine-tested under this Program who questions the accuracy of a positive test result may submit a written request for a retest to the Company's Managing Director within three (3) working days of the independent contractor's receipt of notice of the result. A portion of the original specimen, or a "split" sample, will have been preserved for such testing, which will be conducted at the independent contractor's own expense by the same laboratory or a different

DHHS-certified laboratory of the independent contractor's choice applying the same concentration cut-off levels as were applied during the first test.

Medical Review Officer

No test result will be reported to the Company as positive until the Company's medical review officer ("MRO") has confirmed that the result reflects a violation of this Program. The MRO will be a physician chosen by the Company and may contact any tested independent contractor for information the MRO deems necessary to a determination that the independent contractor's test result was or was not positive. The MRO also may order a retest of the independent contractor's original sample(s) or split sample.

Reinstatement, Assistance and Discipline

After reasonable suspicion testing

In the event an independent contractor's reasonable suspicion test result is negative while he or she is on suspension pending the Company's receipt of notice of the result, the independent contractor will be immediately reinstated and paid any wages and benefits that would have been paid had the independent contractor's work hours not been interrupted by the test and/or suspension. However, if the suspension was in part or in whole for misconduct, whether associated with the circumstances that led to the initial testing or not, the independent contractor will not be made whole for, or reinstated during, any part of the suspension that was for the misconduct.

In the event an independent contractor's reasonable suspicion test result is positive, the independent contractor will be removed from his/her assignment. The independent contractor also may be disciplined, up to and including discharge, for any misconduct related to, or any damage or injury caused by, his or her substance abuse in accordance with the Company's discipline policy.



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After retesting at independent contractor's request

If the result of a retest requested by an independent contractor under this Program is negative, the Company will reimburse the independent contractor for the cost of the test, and the independent contractor will be reinstated and made whole if he or she was suspended pending the Company's receipt of notice of the first test result. However, if the suspension was in part or in whole for misconduct, whether associated with the circumstances that led to the initial testing or not, the independent contractor will not be made whole for, or reinstated during, any part of the suspension that was for the misconduct.

Upon refusal to sign/cooperate

An independent contractor who refuses to execute a consent and release form, who attempts to adulterate or to substitute a sample or otherwise to interfere with the sample collection or testing processes, or who refuses to cooperate with the Company's MRO or to provide the MRO with information he or she requests will be treated as having tested positive and as having been insubordinate.

Confidentiality

The Company and its clinic(s)/laboratory(ies) will keep confidential, to the extent reasonable and feasible, all test results and test-related information.



CONSENT TO BREATH AND/OR BLOOD TEST

I hereby voluntarily consent to a breath or blood test, including the collection of a sample or samples of my breath and/or blood, pursuant to Military Caregivers of America, LLC's ("the Company's") Substance Abuse Testing Program ("Program"). I acknowledge that I have been given notice of the Program and that I understand it. I further consent to the disclosure of the test result(s) and any test-related information by and between the Company, the Company's testing laboratory, its medical review officer, and its appropriate supervisory and managerial personnel.

Date: ____/____/____

Signed: _____

CONSENT TO URINALYSIS

I hereby voluntarily consent to a urine test, including the collection of a sample of my urine, for the purpose of urinalysis pursuant to Military Caregivers of America, LLC's ("the Company's") Substance Abuse Testing Program ("Program"). I acknowledge that I have been given notice of the Program and that I understand it. I further consent to the disclosure of the test result(s) and any test-related information by and between the Company's medical clinic, testing laboratory, medical review officer, and appropriate supervisory and managerial personnel.

Date: ____/____/____

Signed: _____

CONSENT TO SUBSTANCE ABUSE TESTING PROGRAM

I hereby acknowledge I have received a copy of Military Caregivers of America, LLC's ("the Company's") Substance Abuse Testing Program, have had the chance to review it and ask any questions I have about it, understand it, and must abide by it as a condition of employment with the Company.

Name _____

Address _____

Signature

Date Signed



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PERMISSION FOR RELEASE OF INFORMATION

I, _____ do hereby authorize Military Caregivers of America, LLC to release the following information, as applicable, from my personnel file to any Military Caregivers of America, LLC's client. I hereby release Military Caregivers of America, LLC from any and all liability associated with such release.

The information shall include, but not be limited to:

- Licenses
- Certifications
- Skills checklists/ Exam results
- Clinical Competencies
- US citizenship status
- Health status, including immunizations/vaccines, and TB results
- In-services
- Graduation date, school or degree received

Independent Contractor's Signature

Date



A Summary of Your Rights under the Fair Credit Reporting Act

The Federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, D.C. 20552 or phone (202)435-7000.**

You must be told if information in your file has been used against you. Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.

You have the right to know what is in your file. You may request and obtain all the information about you in the files of a consumer reporting agency (your “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:

- a person has taken adverse action against you because of information in your credit report;
- you are the victim of identity theft and place a fraud alert in your file;
- your file contains inaccurate information as a result of fraud;
- you are on public assistance;
- you are unemployed but expect to apply for employment within (60) days.

In addition, all consumers are entitled to one free disclosure every (12) months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

You have the right to ask for a credit score. Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.

You have the right to dispute incomplete or inaccurate information. If you identify information in your file that is incomplete or inaccurate, and report it to the



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consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.

Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information. Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within (30) days. However, a consumer reporting agency may continue to report information it has verified as accurate.

Consumer reporting agencies may not report outdated negative information. In most cases, a consumer reporting agency may not report negative information that is more than (7) years old, or bankruptcies that are more than (10) years old.

Access to your file is limited. A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

You must give your consent for reports to be provided to employers. A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.

You may limit “prescreened” offers of credit and insurance you get based on information in your credit report. Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at (1-888-567-8688).

You may seek damages from violators. If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

Identity theft victims and active duty military personnel have additional rights. For more information, visit: www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For more information about your federal rights, contact:



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TYPE OF BUSINESS:	CONTACT:
<p>The FTC works to prevent fraudulent, deceptive and unfair business practices. In addition, provide consumer spot, stop, and avoid scams and fraud.</p>	<p>Federal Trade Commission (FTC) 600 Pennsylvania Ave., NW Washington, DC 20580 1-877-382-4357</p>
<p>The Office Comptroller charters, regulates and supervises all national banks. In addition, Federal branches/agencies of foreign banks.</p>	<p>Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney St. Suite 3450 Houston, TX 77010-9050 1-800-613-6743</p>
<p>Federal Reserve System is the central bank of the U.S. Formulates and administers credit and monetary policy.</p>	<p>Federal Reserve System 20th St and Constitution Ave NW Washington, DC 20551 1-888-851-1920</p>
<p>NCUA charters and supervises Federal credit unions and insures savings in federal and most state-chartered credit unions across the country and National Credit Union Share Insurance Fraud.</p>	<p>National Credit Union Administration (NCUA) 1775 Duke Street Alexandria, VA 22314-3428 1-800-755-1030/1-703-518-6300</p>
<p>FDIC responds to questions about Federal deposit insurance coverage and handles complaints & inquiries about FDIC-Insured state banks which are “not” members of the Federal Reserve System.</p>	<p>Federal Deposit Insurance Corporation (FDIC) Consumer Response Center 1100 Walnut St. Box # 11 Kansas City, MO 64106 1-877-275-3342</p>
<p>DOT is responsible for planning and coordinating federal transportation projects. It also sets safety regulations for all major modes of transportation</p>	<p>Department of Transportation (DOT) 1200 New Jersey Ave, SE Washington, DC 20590 1-855-368-4200/1-202-366-4000</p>