Application for Employment

Global Medical & Health Services, LLC

600 Reisterstown Road, Suite 212

Pikesville, MD 21208

Phone: (410) 486-0516 Fax: (410) 486-0517

www.GlobalMedicalHealthServicesmd.com Email: gmhealthservices@yahoo.com

"Raising the Bar of Quality Healthcare"

Global Medical & Health Services, LLC
Credentialing Packet for the Independent Contractor

Contractor:_____ Date: _____

Department: (check all departments of interest)

☐ Residential ☐ Facility

Credentialing check off (all documents are required prior to accepting placement from the agency)

1. Completed application	
2. Resume	
3. Current Professional License Verification	
4. Current CPR Card	
5. Completed Background Release Form	
6. Independent Contractor Agreement	
7. New Hire Form	
8. Code of professional behavior/ Non-compete form	
9. References	
a) Professional	
b) Character	
10. Personnel Data Form	
11. I-9 Eligibility Form	
12. Orientation Checklist/Self-Assessment	
13. Driver's License	
14. Social Security Card	
15. Malpractice Insurance	
16. CJIS	

Medical Documentation:

1) Most Recent Physical (Put date)	
2) PPD/Chest X-ray	
3) Hepatitis B Series or declination form	
4) Drug Screen	

Other documentation as submitted by the contractor:

_____

_____

_____

Global Medical & Health Services, LLC

Application for Contract

Please Print Clearly Application for Contractor Agreement

Please answer all Questions. Resumes are not substitutions for a completed application.

I understand that neither this application nor any communication by a management representative is intended to create or does create a contract, offer, or promise of a contract for a definite term. I acknowledge that if offered a contract by GMHS, LLC, my contract is on an at-will basis in accordance with state law. This means the company is free to terminate my employment at any time, with or without cause or advance notice. In accordance with state law and acceptance of my contract is not for any specific time. Similarly, I am free to terminate my contract (as long as it does not conflict with the Non-compete clause of my contract) at any time for any reason. This at-will provision may be modified or waived only in, a written agreement signed by an authorized representative of the company and me. I agree to conform to the rules and regulations of the company, and I understand that the company has complete discretion to modify such rules and regulations at any time, except that it will not modify its policy of contract at-will or its arbitration policy, if any.

GMHS, LLC is an equal opportunity provider. Applicants are considered for contracts without regard to race, religion, sex, national origin, age, disability, or any other consideration made unlawful by applicable federal, state, and local laws.

Today's date:_____

Name:_____ Position applied for:_____

Telephone: __(____)_____ Alternate/Cell no.:__(____)_____

E-mail:_____

Present address:_____

_____

_____ How long have you lived here Yrs/ Mo

Previous address:_____

_____ How long did you live there Yrs/ Mo

Have you previously attempted to contract through this company? ☐ Yes ☐No

If yes, when did you apply?_____

Have you ever accepted a contract through this company? ☐ Yes ☐No If yes, provide dates.

_____

Instructions for answering the next two questions:

I. Hawaii applicants: Do not answer the following two questions
II. District of Columbia and Washington applicants: Limit any response to the past ten years.
III. Utah applicants: Limit any response to felony convictions only
IV. Arizona, District of Columbia, Illinois, Missouri, Rhode Island and Utah applicants: Do not respond to second question regarding arrests.
V. California applicants: Do not include misdemeanor marijuana-related convictions that are more than two years old or misdemeanor convictions for which probation was successfully completed or otherwise discharged and the case was judicially dismissed.
VI. Massachusetts applicants: Limit any response regarding misdemeanor convictions to the last five years and to those which were not a first offense for drunkenness, simple assault, and speeding, minor traffic violations or disturbing the peace.
VII. North Dakota and Oregon applicants: Regarding arrests, limit your response to pending charges that are less than one year old.
VIII. All applicants: Do not include convictions that were sealed, eradicated, erased, annulled by a court, or expunged, or convictions that resulted in referral to a diversion program.

Have you ever plead guilty or no contest to, or been convicted of any criminal offense other than applicable exceptions as listed above? ☐Yes ☐No

Have you ever been arrested for any matters for which you are out on bail or on your own recognizance pending trial? ☐Yes ☐No

Have you committed any crime or been convicted of, received probation before judgement, or entered a plea of nolo contendere to a felony or any crime involving moral turpitude or theft, or have any other criminal history that indicates behavior which was potentially harmful to your organizations' clients? ☐Yes ☐No

CRIMINAL OFFENSES ONLY: If you answered yes to either of the above two questions, please provide the dates and explain in accordance with the above instructions so that your individual circumstances can be considered.

_____

_____

Have you ever initiated an act of violence while on duty? ☐Yes ☐No
If yes, please provide and explanation: _____

_____

Education	School and Location	Course of Study	Graduate?	Number of years attended	Degree/Major
High School					
College					
Other					

Any other awards/certification that the agency should be aware of? _____

I authorize the Company or its agents to confirm all statements contained in this application and/or resume as it relates to the position I am seeking and to the extent permitted by federal, state, or local law. I agree to complete any requisite authorization forms for the background investigation.

I authorize and consent to, without reservation, any party or agency contacted by this employer to furnish the above-mentioned information. I hereby release, discharge and hold harmless, to the extent permitted by federal, state, and local law, any party delivering information to the Company or its duly authorized representative pursuant to this authorization from any liability, claims, charges, or causes of action which I may have as a result of the delivery or disclosure of the above requested information. I hereby release from liability the Company and its representative for seeking such information and all other persons, corporations, or organizations furnishing such information.

If hired by this Company, I understand that I will be required to provide genuine documentation establishing my identity and eligibility to be legally employed in the United States by this Company. I also understand this Company employs only individuals who are legally eligible to work in the United States for this Company.

THIS APPLICATION WILL BE CONSIDERED ACTIVE FOR A MAXIMUM OF SIXTY (60) DAYS. IF YOU WISH TO BE CONSIDERED FOR EMPLOYMENT AFTER THAT TIME, YOU MUST REAPPLY.

I CERTIFY THAT ALL OF THE INFORMATION THAT I HAVE PROVIDED ON THIS APPLICATION IS TRUE, ACCURATE AND COMPLETE.

Applicant Signature _____ Date_____/_____/_____

If the applicant is a minor, the foregoing release and consent must be signed by the applicant's parent or legal guardian. Signature by the applicant's parent or legal guardian constitutes acknowledgement by the applicant and the parent or legal guardian that the Company, to the extent permitted by federal, state, and local law, can test the applicant for controlled substances, conduct inspections of property without notice, and communicate screen results to Company personnel who need to know, the applicant, and the applicant's legal guardian.

_____ _____

Parent/Legal Guardian Witness

_____ _____

Date Date

UNDER MARYLAND LAW, AN EMPLOYER MAY NOT REQUIRE OR DEMAND, AS A CONDITION OF EMPLOYMENT, PROSPECTIVE EMPLOYMENT, OR CONTINUED EMPLOYMENT, THAT AN INDIVIDUAL SUBMIT TO OR TAKE A LIE DETECTOR OR SIMILAR TEST. AN EMPLOYER WHO VIOLATES THIS LAW IS GUILTY OF A MISDEMEANOR AND SUBJECT TO A FINE NOT EXCEEDING $100. I have read and understand the above statement.

_____ _____/_____/_____

Applicant's Signature Date

UNDER MASSACHUSETTS LAW, IT IS UNLAWFUL FOR AN EMPLOYER TO REQUIRE OR TO ADMINISTER A LIE DETECTOR TEST AS A CONDITION OF EMPLOYMENT OR CONTINUED EMPLOYMENT.

FEDERAL AND/OR STATE LAW MAY PROHIBIT THE USE OF POLYGRAPH OR SIMILAR TESTS AS WELL.

THIS APPLICATION MAY NOT BE APPLICABLE FOR ALL INDUSTRIES.

Global Medical & Health Services, LLC
Application for Contract

Work Experience:

Name: ________________________________ Social Security No:_____-___-______

Professional License No:________________________

Professional License State:______________________

Classification:

RN ☐ NP ☐ LPN ☐ PT ☐ PTA ☐ CNA ☐ CMA ☐ GNA☐

Name of Employer:	**List duties: Specify facility or Pediatric**
Address:	
Contact Person: (Print Full Name)	
Start Date:	
Still Employed ☐ **Yes** ☐ **No**	

Name of Employer:	**List duties: Specify facility or Pediatric**
Address:	
Contact Person: (Print Full Name)	
Start Date:	
Still Employed ☐ **Yes** ☐ **No**	

Name of Employer:	**List duties: Specify facility or Pediatric**
Address:	
Contact Person: (Print Full Name)	
Start Date:	
Still Employed ☐ **Yes** ☐ **No**	

GLOBAL MEDICAL & HEALTH SERVICES, LLC (GMHS)
INDEPENDENT CONTRACTOR AGREEMENT

The undersigned consultant acknowledges attainment for one or several of the following contractual services for GMHS, LLC:

☐Nursing Care Provider ☐NP ☐PT ☐Nursing Assessment Const. ☐Nurse Trainer

☐CNA ☐GNA ☐CMT

It is further acknowledged that:

1. The undersigned shall be deemed an independent contractor and is not binded for any length of time with GMHS, LLC for employment, partnership, joint venture or other agency associations.
2. The relationship between the undersigned independent contractor and GMHS, LLC is based on the independent consultant's decision to work at his/her own discretion with regards to self-scheduling on the available cases / positions.
3. Consistent with the foregoing, GMHS, LLC will not be responsible or held liable for the following: FICA, Medicare, Federal, State and any other required tax deductions. The undersigned independent contractor acknowledges his/her responsibility to pay all the above-mentioned tax liabilities.
4. The undersigned independent contractor further acknowledged that he/she is not entitled to any benefits bestowed on an employee of GMHS, LLC including: pension, profit sharing, unemployment insurance, workers' compensation, professional liability, overtime, pay bonuses, sick leave, vacation leave, family leave, tuition reimbursement and travel reimbursement.
5. The undersigned independent contractor accepts the above-mentioned terms for referral of services by GMHS, LLC and payment strictly for hours worked at the rate of $_____ per hour.

Signed on this (date) _____ day of (month) _____ of 20_____

_____	_____
Consultant Signature	GMHS, LLC Rep. Signature
_____	_____
Consultant Printed Name	GMHS, LLC Rep. Printed Name

600 Reisterstown Rd, Ste 212
Pikesville, MD 21208

Office: (410) 486-0516
Fax: (410) 486-0517

GLOBAL MEDICAL & HEALTH SERVICES, LLC
INTERVIEW AND HIRE APPLICATION

GMHS, LLC CODE OF CONDUCT

POSITION APPLIED FOR: _____

1. I will represent GMHS, LLC to the best of my ability on every assignment.

2. GMHS, LLC is my contractor and assigns me to various customers where services are required.

3. GMHS, LLC pay me at rate agreed to each assignment.

4. In consideration of GMHS, LLC introducing me to and providing me work with one or more of its' customers, I agree not to:

   - Work for each such customer through another agency for 75 days after the last day I worked for that customer through GMHS, LLC and, if so will forfeit all cost related to such transaction.
   - Work directly or indirectly for each such customer(s) for 75 days after that last day I worked that customer through GMHS, LLC.

5. I will not give my home phone number or address to my GMHS, LLC customer.

6. I understand that it is to my advantage to notify GMHS, LLC immediately when any of their customer contacts me.

I hereby certify that the information given on this application is true, correct and complete in every respect.

_____ _____

Independent Contractor's Signature Date

_____ _____

Interviewer's Signature Date

600 Reisterstown Road
Suite 212
Pikesville, Maryland 21208
www.globalmedicalhealthservicesmd.com

Phone: 410-486-0516
Fax: 410-486-0517
E-mail: gmhealthservices@yahoo.com

Find us on Facebook

Global Medical and Health Services. LLC

GMHS, LLC
Employment Reference Form

Authorization to provide professional reference information

Applicant name: _____RN LPN PT PTA CNA GNA CMT

Social Security Number: _____ - ____ - _____

Dear HR Agent for: _____ located at:

_____ Phone#: _____

_____ Fax#: _____

I have applied for a contract assignment with GLOBAL MEDICAL & HEALTH SERVICES, LL. Please provide the agency with the following information so that I may be considered for an assignment. While with your company, I held the position of: _____ and was employed from _____ to _____.

Signature of applicant: _____

	Outstanding	Good	Fair	Poor
Knowledge				
Appearance				
Personality				
Punctuality				
Performance				
Dependability				

*Pediatric experience (if applicable) [ ] Yes [ ] No [ ] N/A

Reason for separation from the company: _____

While employed through your agency was the above named individual ever accused of abuse or neglect with regard to your clients? [ ] Yes [ ] No

Would you rehire the applicant? [ ] Yes [ ] No

Name of individual completing this form _____Title: _____

Phone: _____

Signature: _____ Date: ___/___/___

Required information

GMHS, LLC

Personal Character Reference Letter / Form

Name: _____
(Referee's First and Last Name)

Address: _____
(Referee's street number and name)

_____ _____ _____
(City) (State) (Zip code)

Date: _____

To Whom It May Concern

Re: _____
(Employee's Name)

I have known the above referenced for the past _____ years, in the capacity of _____
(Friend, Priest, Relative, Pastor, etc.)

And have always found her/him to be kind, of good moral character, generous and responsible. Over the years (s)/he has always conducted her/himself to the highest standard.

I am sure that _____ will be a wonderful addition to any endeavor (s)/he desire in
(Employee's Name)

your establishment.

If I can be of further help, please do not hesitate to call me at (____) _____ - _____
(Referee's Phone#)

Thank you,

Signature: _____
(Referee's signature)

Print Name: _____
(REFEREE'S PRINTED FIRST AND LAST NAME)

Please fax back to: (410) 486-0517 or
E-mail at: gmhealthservices@yahoo.com or
Mail to: GMHS, LLC ▪ 600 Reisterstown Road, Suite 212 ▪ Pikesville, MD 21208

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E-mail: gmhealthservices@yahoo.com

Find us on Facebook

Global Medical and Health Services. LLC

Personal Data / Change Form

Name: _____

Address: _____

_____

Social Security #: _____

Phone #: _____

Mobile #: _____

Emergency #: _____

Exempts: _____

W2: _____

1099: _____ EIN: _____

GLOBAL MEDICAL & HEALTH SERVICES, LLC
600 REISTERSTOWN ROAD, STE 212, PIKESVILLE, MARYLAND 21208
PH: 410-486-0516 FX: 410-486-0517

I met face-to-face with: _____
(Applicant's name)

on _____ to discuss the positions of _____

Applicant's signature: _____

Name of Interviewer: _____

Pediatric Experience: _____

_____

FOR OFFICE USE ONLY

Assessment

	Punctuality	Appearance	Demeanor	Communication
Excellent				
Good				
Fair				
Poor				

Comments

_____

_____

_____

_____

Interview Results: [ ] Hired [ ] Not hired

Job Description Verification Form

I _____ have received a copy of my job description, and have read and fully understand my responsibilities. I have been given the opportunity to ask questions concerning my job description.

Print Name _____ Date _____

Signature _____ Date _____

GLOBAL MEDICAL & HEALTH SERVICES, LLC (GMHS)
CERTIFICATION OF PHYSICAL EXAMINATION

The Licensure Division for the State of Maryland requires that all employees and contractors have a physical examination completed prior to employment commencement. The regulation stipulates that person must be free of communicable diseases (including Hepatitis B and Tuberculosis) and have undergone a complete physical examination.

Employee's Release

I, _____, give the noted below physician my permission to
(Printed Employee Name)

release the information required by GMHS, LLC.

_____ _____
Employee's Name Date

Physician Verification

I certify that _____ was physically examined on _____ and is/was able to

___ Function without restriction as a health care worker,
___ Free of communicable diseases, including but not limited to Tuberculosis and Hepatitis B in their communicable form.
___ Is in good physical and mental health, and
___ The following tests were done with results being -

Tuberculin test: ___ Tine ___ PPD ___Chest X-Ray
(Check one)

Date: _____ Date Read / Result: _____

Chest X-Ray Date & Result: _____

Remarks: _____

_____ _____
(Printed Physician Name) *(Date)*

_____ _____
(Physician's Signature) *(Office Number)*

Physician's Address:
(Please Use Office Stamper)

Please mail or fax this completed form to:

GMHS, LLC
600 Reisterstown Rd, Ste 212
Pikesville, MD 21208
Fax: (410) 486-0517

GLOBAL MEDICAL & HEALTH SERVICES, LLC (GMHS)

CONSENT / DECLINE FORM FOR HEPATITIS B VACCINATION

GMHS, LLC, the agency I consent with, has provided me eduation about the Hepatitis B vaccine. I understand the effectiveness of the vaccine, the risk of contracting Hepatitis B due to exposure to blood and other potential infectious materials while working at the various sites that GMHS, LLC are currently under contract to service with staffing needs and the importance of taking active steps to reduce the risk.

I currently choose of my own free will, to hereby ☐ DECLINE / ☐ CONSENT being given the Hepatitis B vaccine. I do understand that if I decline the vaccination in the future I may receive it.

_____	_____	_____
Employee Name	*Signature*	*Date*

_____

Employee Address

_____	_____
Witness	*Date*

NOTE: Maintain this record for duration of employment plus 30 years

GLOBAL MEDICAL & HEALTH SERVICES, LLC

"Raising the Bar of Quality Healthcare"

www.globalmedicalhealthservicesmd.com Email: gmhealthservices@yahoo.com

Orientation Checklist

Nurse: _____ Classification: _____

Date: _____

RN Supervisor: _____

Specific Care	Self Assessment Component? Yes	Not	Competent	Incompetent	Supervisor Initial	Date Observed	Comments
ASSESSMENT							
Neurological	☐						
Respiratory	☐						
-Identify breath sounds	☐						
-Identify abnormal breath sounds	☐						
Identify Respiratory distress	☐						
Cardiovascular	☐						
Skeletal	☐						
Integumentary	☐						
Gastro-intestinal	☐						
Head-to-toe assessment	☐						
TUBE FEEDING							
GT feeding via pump infusion	☐						
Use of feeding pump	☐						
Medication via GT/JT/NGT	☐						
Providing GT/JT/NGT care	☐						
GT/NGT Insertion and Removal	☐						
ADMINISTERING **O_2 therapy**							
With humidity	☐						
Via mask	☐						
Nasal cannula	☐						
Tracheostomy tube collar	☐						
O2 concentrator	☐						
EQUIPMENT							
Pulse oximetry	☐						
Apnea monitor	☐						
Feeding pump	☐						
Nebulizer machine	☐						
Chest vest (chest physical therapy)	☐						
C-PAP machine	☐						
URINARY CARE							
Foley catheter care	☐						
Insertion of Foley catheter	☐						
Straight catheterization	☐						
Performing a douche	☐						
Giving an enema	☐						

RN Supervisor:

Specific Care	Self Assessment Component?		Demonstration					
	Yes	Not	Competent	Incompetent	Supervisor Initial	Date Observed		Comments
SUCTIONING								
Oral	☐							
Nasopharyngeal	☐							
Tracheostomy tube	☐							
TRACHEOSTOMY CARE								
Tracheostomy care (Stoma care)	☐							
Cleaning the inner cannula	☐							
Inserting the tracheostomy tube	☐							
Changing the tracheostomy ties	☐							
Replacing the tracheostomy collar	☐							
CARE OF CLIENT ON VENTILATOR								
Ventilator	☐							
CPAP	☐							
VITAL SIGNS								
Oral temperature	☐							
Rectal temperature	☐							
Axillary temperature	☐							
Ear (tympanic) temperature	☐							
Pulse- brachial	☐							
Pulse- radial	☐							
Pulse- apical	☐							
Respirations	☐							
Blood Pressure	☐							
ACTIVITIES								
Applying brace	☐							
Apply splints, ankle-foot-orthosis (AFO's)	☐							
Applying passive ROM	☐							
Use of : -Crib	☐							
-Stroller	☐							
-Wheelchair	☐							
-Hoyer lift	☐							
OSTOMY CARE								
Caring for colostomy/ileostomy	☐							
Irrigating colostomy/ileostomy	☐							
Care of the stoma	☐							
Applying ostomy bag	☐							
Teaching family about ostomies	☐							

Nurse initials: _____

RN Supervisor:

Specific Care	Self Assessment Component?		Demonstration					
	Yes	Not	Competent	Incompetent	Supervisor Initial	Date Observed		Comments
ACTIVITIES OF DAILY LIVING								
Bathing the client	☐							
Changing the diaper	☐							
Performing oral care and hygiene	☐							
Dressing the client	☐							
WOUND CARE								
Assessing & measuring a wound	☐							
Performing wet-to-dry dressing	☐							
Wound irrigation and debridement	☐							
Transparent wound dressing	☐							
Packing the wound	☐							
Applying bandage (paste bandage)	☐							
MEDICATION ADMINISTRATION								
Oral medication administration	☐							
Sublingual medication admin.	☐							
Buccal Med. Administration	☐							
Topical medication admin.	☐							
Ear medication administration	☐							
Eye medication administration	☐							
Nasal medication administration	☐							
Giving vaginal/ or rectal medication	☐							
Administering IM injection	☐							
Z-Tract intramuscular injection	☐							
Administering SQ & Intradermal Inj.	☐							
IV Therapy	☐							
Documenting medication admin.	☐							
Administering narcotics	☐							
Performing narcotics counts	☐							
WRITING NURSING NOTES								
Documenting clinical notes q 2 hr	☐							
Documenting family teaching	☐							
Obtaining Physician Orders	☐							
CLIENT LISTING/OTHER SKILLS								

Signature of Nurse: _____ Date: _____

Signature of RN Supervisor: _____ Date: _____

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Nurse initials: _____