



Independent Contractor Application

Applicant Information

Full Name: Last First M.I. DOB:

Address: Street Address Apartment/Unit # City State ZIP Code

Phone: Email

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

Position Applied for:

Are you a citizen of the United States? YES NO If no, are you authorized to work in the U.S.? YES NO
Have you ever worked for this company? YES NO If yes, when?
Have you ever been convicted of a felony? YES NO

If yes, explain:

Education

High School: Address:

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

College: Address:

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

Other: Address:

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

References

Please list three professional references.

Full Name: Relationship:
Company: Phone:
Address:

Full Name: _____ Relationship: _____
Company: _____ Phone: _____
Address: _____

Full Name: _____ Relationship: _____
Company: _____ Phone: _____
Address: _____

Previous Employment

Company: _____ Phone: _____
Address: _____ Supervisor: _____

Job Title: _____ Starting Salary:\$ _____ Ending Salary:\$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

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

Company: _____ Phone: _____
Address: _____ Supervisor: _____

Job Title: _____ Starting Salary:\$ _____ Ending Salary:\$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

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

Company: _____ Phone: _____
Address: _____ Supervisor: _____

Job Title: _____ Starting Salary:\$ _____ Ending Salary:\$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

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

Military Service

Branch: _____ From: _____ To: _____

Rank at Discharge: _____ Type of Discharge: _____

If other than honorable, explain: _____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

If this application leads to utilizing Nomad Nursing services, I understand that false or misleading information in my application or interview may result in my release.

Signature: _____ Date: _____

INDEPENDENT CONTRACTOR AGREEMENT

NOMAD NURSING, LLC

This Independent Contractor Agreement ("Agreement") is made and entered into this ____ day of _____, 20____ (the "Effective Date") by and between Nomad Nursing, LLC a Virginia LLC partnership and _____ ("Contractor")

WITNESSETH:

WHEREAS, Nomad Nursing runs an electronic bulletin board in which medical institutions advertise their needs for part-time or temporary licensed professionals (CNA, LPN, RN); and

WHEREAS, access to the Nomad Nursing bulletin board is limited to Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants who are duly licensed and in good standing to provide services as requested by such institutions, and who execute this independent Contractor Agreement; and

WHEREAS, Nomad Nursing also provides a billing and receivable collection service for Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants who execute this independent contractor agreement.

NOW THEREFORE, in consideration of the foregoing and the mutual covenants and premises contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Nomad Nursing and independent contractor hereby agree as follows:

1. Subject to independent contractors' satisfaction of the conditions set fourth below, Nomad Nursing hereby agrees that independent contractor may access to Nomad Nursing's electronic bulletin board for the purpose of securing part time or temporary employment at institutions listing available positions on the board.
2. Independent Contractor agrees during the term of this agreement to:
 - a. Maintain at all times, at the independent contractors' sole cost and expense, compliance with all professional licensing requirements, any and all ethical requirements of the independent contractor's profession and all federal, state and local laws, ordinances, regulations and rules relating to, governing or regulating the practice of the independent contractors profession, including, but not limited to VA/OSHA standards, Elder Abuse Regulations, etc.
 - b. Provides services at a level meeting contemporary community standard for persons with the independent contractors' professional experience, education, certification(s) and/or license(s).
 - c. Report and incidents to the facility supervisor where services are conducted, whether minor or major, client or customer problems or disagreements, scheduling and/or staff problems, equipment problems, VA/OSHA violations, etc.
 - d. Maintain in strict confidence all patient, client and customer information, including but not limited to, patient, client and customer names, locations, and individual patient information.
 - e. The independent contractor represents and warrants that he/she has never been terminated from previous employment or other engagement as a result of theft, misconduct, excessive tardiness or failure to follow the employer's or contractors' policies/procedures.
 - f. Comply with all other Nomad Nursing policies/procedures applicable to the services independent contractors agree to provide throughout the term of this agreement/ All such policies/procedures are hereby incorporated into this agreement.

3. Term of Engagement

The initial term of this agreement shall be one year, commencing on _____, 20____. Upon the expiration of the initial term, this agreement shall be automatically renewed for successive one-year terms unless otherwise terminated by Nomad Nursing or the independent contractor as provided for herein.

4. Fees

Nomad Nursing agrees to act as billing agent for independent contractors to bill for and collect payment for the services rendered by independent contractors to institutions listing on electronic bulletin board of Nomad Nursing. Nomad Nursing will bill for independent contractors' services at the rate agreed by the institution and will promptly remit funds as agreed to independent contractor when payment is received from the institution, independent contractor must obtain an authorized signature from the facility, the day the services were provided, and provide this signed authorization to Nomad Nursing to permit Nomad Nursing to prepare an invoice for independent contractor's services.

5. Insurance & Indemnification

During the term of this agreement, it is this independent contractor's responsibility to procure individual Workers Compensation Insurance. Upon obtaining insurance the independent contractor is to provide Nomad Nursing with a copy of the Certificate of Insurance evidencing the existence of such coverage. Each party shall indemnify and hold the other harmless from and against any and all liability including fines, claims, demands, suits or actions of any kind or nature arising by reason of the indemnifying parties acts or omissions in the course of performing its obligations under this agreement.

During the term of this agreement, it is the independent contractor's responsibility to procure individual Liability Insurance. Upon obtaining insurance the independent contractor is to provide Nomad Nursing with a copy of the Certificate of Insurance evidencing the existence of such coverage. Each party shall indemnify and hold the other harmless from and against any and all liability including fines, claims, demands, suits or actions of any kind or nature arising by reason of the indemnifying parties acts or omissions in the course of performing its obligations under this agreement.

OR

Workers Compensation and liability

It is understood and agreed that CONTRACTOR is not covered by Workers Compensation or liability insurance policies the Nomad Nursing may have and that CONTRACTOR is responsible for procuring and maintaining any liability insurance policy necessary to perform such services.

CONTRACTOR is responsible for any claims that may arise from CONTRACTOR'S services.

6. Benefits

Because the independent contractor will be providing independent professional healthcare services to medical institutions as an independent contractor and not as an employee of Nomad Nursing the independent contractor will not be entitled to participate in any benefit program (I.E, health insurance, educational benefits, sick days, vacation days, etc.) which Nomad Nursing may, from time to time, establish and maintain for the benefit of its employees. The independent contractor hereby releases and relinquishes any claim that he/she may now or may hereinafter have and forever discharges Nomad Nursing from any obligation to him/her in connection with an employee benefit program established or maintained by Nomad Nursing on behalf of its employees.

7. Employment Taxes

The parties acknowledge and agree that the independent contractor shall be providing independent professional healthcare services to Nomad Nursing's clients as an independent contractor and not as an employee. Accordingly, Nomad Nursing shall have no responsibility for the collection or payment of any federal, state or local payroll tax in connection with any fees paid to the independent contractor in pursuant to this Agreement. The independent contractor shall be responsible for any and all federal, state or local employment or other taxes incurred in connection with any fees paid to him/her in connection with this engagement. The independent further agrees to indemnify and

hold Nomad Nursing harmless from and against any and all liability, cost or expense incurred by Nomad Nursing including reasonable attorney's fees, in connection with any income or employment taxes, penalties or interest, tax audit, redetermination, appeal or litigation arising out of fees paid by Nomad Nursing to the independent contractor in connection with this agreement.

8. Independent Contractor

The parties acknowledge and agree that the independent contractor shall be at all times hereunder an independent contractor and not an employee of Nomad Nursing recognizing that the independent contractor is an shall be engaged in and independent healthcare profession, which may be subjected to licensing requirements. Nomad Nursing shall have no direct control over the methods or means by which the independent contractor shall perform services, and at times during this engagement, the independent contractor shall exercise his/her own independent professional judgement in connection with the performance of his/her services under this Agreement.

9. Termination

Either party may terminate this Agreement without cause upon thirty (30) days prior written notice to the other party.

10. Miscellaneous Provisions

- i. This agreement contains the entire understanding and agreement of the parties hereto respect the matters set forth herein. This agreement supersedes all prior or contemporaneous understandings, representations or agreements, whether written or oral.
- ii. This agreement may not be assigned without the prior written consent of the other party and which consent shall not be unreasonably withheld.
- iii. This agreement may not be modified, altered or amended except by a subsequent written instrument executed by the party against whom such modifications, alteration or amendment is sought to be enforced, which instrument shall specifically refer to this section of the Agreement.

IN WITNESS WHEREOF, NOMAD NURSING and the INDEPENDENT CONTRACTOR have executed this Agreement to be effective as of the date and year set forth above.

Signatures

Company:

_____ Printed Name of Representative

_____ Signature

_____ Date

Contractor:

_____ Printed Name

_____ Signature

_____ Date

Shift Assignment & Removal Acknowledgment

I, _____, acknowledge and understand that all shift assignments offered through Nomad Nursing are provided at the discretion of Nomad Nursing and/or its client facilities.

I understand and agree with that:

- Shift assignments are not guaranteed and may be changed, canceled, or reassigned at any time, with or without notice.
- Nomad Nursing reserves the legal right to remove me from a scheduled shift, future shift opportunities, shift-taking privileges, or GroupMe at its sole discretion, including but not limited to reasons related to facility requests, performance concerns, policy violations, or business needs.
- This acknowledgment does not create a contract for continued work, guaranteed hours, or ongoing shift availability.
- My relationship with Nomad Nursing is at-will, meaning either I or Nomad Nursing may end the working relationship at any time, with or without cause or notice, as permitted by law.
- I agree to comply with all Nomad Nursing policies, procedures, and facility-specific requirements as a condition of accepting shifts.

I acknowledge that I have read, understand, and agree to the terms outlined above and understand that failure to comply may result in removal from shift opportunities, GroupMe, or termination of my working relationship with Nomad Nursing.

Staff Member Name (Printed): _____

Signature: _____ Date: _____

Nomad Nursing Representative: _____

Signature: _____ Date: _____



Employment Eligibility Verification

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

USCIS

Form I-9

OMB No. 1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in Section 1, or specify which acceptable documentation employees must present for Section 2 or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address			Employee's Telephone Number
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.	Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):					
	<input type="checkbox"/> 1. A citizen of the United States					
	<input type="checkbox"/> 2. A noncitizen national of the United States (See instructions.)					
	<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)					
<input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any) _____						
If you check Item Number 4., enter one of these:						
USCIS A-Number		OR	Form I-94 Admission Number		OR	Foreign Passport Number and Country of Issuance
Signature of Employee				Today's Date (mm/dd/yyyy)		

If a preparer and/or translator assisted you in completing Section 1, that person **MUST** complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

Document Title 1	List A	OR	List B	AND	List C
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)	Additional Information				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)	Check here if you used an alternative procedure authorized by DHS to examine documents.				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.					First Day of Employment (mm/dd/yyyy):
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code		

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 	OR	<ol style="list-style-type: none"> 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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">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 	AND	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security <p style="margin-left: 20px;">For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.</p>
<p>Acceptable Receipts</p> <p>May be presented in lieu of a document listed above for a temporary period.</p> <p>For receipt validity dates, see the M-274.</p>				
<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee. 	OR	<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List B document. 	OR	<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.

Request for Taxpayer Identification Number and Certification

Give Form to the
requester. Do not
send to the IRS.

▶ Go to www.irs.gov/FormW9 for instructions and the latest information.

See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
2 Business name/disregarded entity name, if different from above
3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes. <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____ <small>Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.</small> <input type="checkbox"/> Other (see instructions) ▶ _____
4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <small>(Applies to accounts maintained outside the U.S.)</small>
5 Address (number, street, and apt. or suite no.) See instructions.
6 City, state, and ZIP code
7 List account number(s) here (optional)
Requester's name and address (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number												
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Employer identification number												
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Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What Is backup withholding, later.

BACKGROUND CHECK AUTHORIZATION

INFORMATION									
First		Middle		Last					
List our other names in the below row you have used within 10 years									
Date of birth			SSN						
Driver's License				State					
Day Phone				Cell Phone					
CURRENT ADDRESS									
City		State		Zip		Dates			-
PREVIOUS ADDRESS									
City		State		Zip		Dates			-
List the cities or towns you have lived in the past 10 years Use additional forms if necessary									
City		State		Zip		Dates			-
City		State		Zip		Dates			-
<p>I hereby authorize The Company or an agent of The Company to contact former employers, credit agencies, educational institutions, law enforcement agencies, city, state, county, and federal courts and military services to release information about my background including, but not limited to, information about my employment, education, consumer credit history, driving record, criminal record, and general public records history to the person or company with which this form has been filed.</p> <p>This releases the aforesaid parties from any liability and responsibility for collecting the above information. This release shall remain in effect for the length of my employment. I understand I have the right to obtain a free copy of this consumer report if the request is made in writing within 60 days of any adverse action/decision. If an investigative consumer report is conducted, I will be notified in writing within three days from request of said report. I believe, to the best of my knowledge, that all information I have provided is accurate true and correct and that I fully understand the terms of this release.</p> <p>Disclaimer: While the information contained in the reports provided has been obtained from public records data sources deemed reliable, its accuracy cannot be guaranteed due to potential human error in the actual recording of the record. Since this information is not owned by The Company, and since public records data on any one individual, group of individuals, company, or companies can be contained in more than one repository, The Company can only rely on its accuracy from the public records data sources presently available at the time of the search. This information is furnished for your exclusive use and accepted by you without any liability on the part of The Company, its sources, officers, agents or employees. Furthermore you agree to indemnify The Company, its sources, agents, and employees of any liability for the use of this information and shall agree that the right to obtain and the purpose for this information, for your exclusive use, is fully within the appropriate law or laws which apply to the permissible purpose of retrieving background information on an individual's criminal records history, credit history and / or workers compensation claim history.</p>									
Signature				Today's Date					
<input type="checkbox"/>	Yes, please send me a copy of the Consumer Report Obtained								

TO BE FILLED OUT BY THE COMPANY REQUESTING INFORMATION

Company Requesting Info: _____ Return Fax # _____

Name of Person to Return Info To: _____ Phone # _____

History Requested: Criminal Civil Credit DMV Social Security

**AUTHORIZATION FOR BACKGROUND CHECK &
SWORN DISCLOSURE STATEMENT**

Please Print

Last Name	First	Middle	Maiden	Social Security Number	
Current Mailing Address		Street, P.O. Box #, Apt. City		State	Zip Code
Nomad Nursing		8726 Seminole Trail		Ruckersville, Va	22968
Name of Agency	Street, P.O. Box #, Apt. City		State	Zip Code	

Please respond to all five (5) questions below:

1. Have you ever been convicted of or are you the subject of pending charges of any crime within the Commonwealth of Virginia? Yes (convicted in Virginia) Yes (pending in Virginia) No

If yes to convicted or pending, specify crime(s): _____

2. Have you ever been convicted of or are you the subject of pending charges of any crime outside the Commonwealth of Virginia? Yes (convicted outside Virginia) Yes (pending outside Virginia) No

If yes to convicted or pending, specify crime(s) and state, or other location: _____

3. Have you ever been the subject of a founded complaint of adult abuse or neglect within the Commonwealth of Virginia? Yes (in Virginia) No (in Virginia)

4. Have you ever been the subject of a founded complaint of adult abuse or neglect outside the Commonwealth of Virginia? Yes (outside Virginia) No (outside Virginia)

If yes, specify state, or other location: _____

5. In what states (other than Virginia) have you lived within the last five (5) years? _____

I hereby affirm that the information provided on this form is true and complete. I understand that the information is subject to verification and that making a materially false statement or affirmation is a Class 1 misdemeanor.

Signature Date

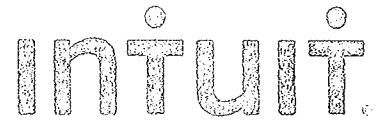


There will be a charge in the amount of \$45.00 per background check, that will be withdrawn from your first paycheck. Please acknowledge and give consent to withhold the above amount.

Signature:

Name/Date:

Intuit QuickBooks Payroll



Employee Direct Deposit Authorization

Instructions

Employee: Fill out and return to your employer.

Employer: Save for your files only.

This document must be signed by employees requesting automatic deposit of paychecks and retained on file by the employer. Do not send this form to Intuit.

Account 1

Account 1 type: Checking Savings

Bank routing number (ABA number):

Account number:

Percentage or dollar amount to be deposited to this account:

Account 2 (remainder to be deposited to this account)

Account 2 type: Checking Savings

Bank routing number (ABA number):

Account number:

Authorization: This authorizes Nomad Nursing LLC to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my (our) account(s) indicated below and to other accounts I (we) identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries. I agree that the ACH transactions authorized herein shall comply with all applicable U.S. Law. This authorization will be in effect until the Company receives a written termination notice from myself and has a reasonable opportunity to act on it.

Authorized signature:

Employee ID #:

Print name:

Date:



Virginia Department of Social Services
Adult Protective Services Program
801 E. Main Street
Richmond, VA 23219
Telephone: 804-726-7533

ACKNOWLEDGEMENT OF MANDATED REPORTER STATUS

(This is an optional form for employers of mandated reporters to document that their employees have been notified of their mandated reporter status. An acknowledgement form developed by the employer is also acceptable. If this form is used, page one should be retained by the employer. Page two listing indicators of adult abuse, neglect and exploitation should be retained by the employee).

I, _____, understand that when I am employed as a
(Employee Name)

(Type of Employment)

I am a mandated reporter pursuant to §§ 63.2-1603 through 1610 of the Code of Virginia. This means that I am required to report or cause a report to be made to Virginia Adult Protective Services (APS) either by calling the APS Hotline (1-888-83-ADULT) or the appropriate local department of social services whenever I have reason to suspect that an adult age 60 or over or an incapacitated adult age 18 and over and who is known to me in my professional or official capacity may be abused, neglected, or exploited. I understand that I must follow the reporting protocol, if any, of my employer, but my employer may not prohibit me from reporting directly to APS.

I understand that if I suspect a death of an adult age 60 or over or an incapacitated adult age 18 and over occurred due to abuse or neglect, I must report the death to the medical examiner and the law enforcement agency in the locality in which the death occurred.

I understand that I am immune from civil or criminal liability on account of any reports, information, testimony and records I release if the report is made in good faith and without malicious intent. My identity will be held confidential unless I authorize the disclosure or disclosure is ordered by the court.

I understand that if I fail to make a required report of suspected adult abuse, neglect, or exploitation, immediately upon suspicion, I may be subject to a civil money penalty imposed by the Commissioner of the Virginia Department of Social Services. If I am a law-enforcement officer, I understand the money penalty does not apply to me but that I will be referred to the court system for non-reporting of suspected adult abuse, neglect, or exploitation. If I am licensed, certified, or regulated by a health regulatory board, I may also be subject to administrative action or criminal investigation by the appropriate licensing, regulatory, or legal authority.

I understand that there is no charge when calling the Hotline number (1-888-83-ADULT or 1-888-832-3858) and that the Hotline operates 24-hours per day, 7 days per week, 365 days per year.

I affirm that I have read this statement and have knowledge and understanding of the reporting requirements, which apply to me pursuant to §§ 63.2-1603 through 1610 of the Code of Virginia.

Signature of Applicant/Employee

Date

Resident Rights

- (1) To be treated with respect and dignity
- (2) To equal access to quality care
- (3) To exercise his/her rights as a resident at facility and citizen/resident of United States
- (4) To be informed of and participate in his/her treatment
- (5) To choose activities, make choices about life in the facility, communicate with members of the community, receive visitors
- (6) To personal privacy and confidentiality of medical record
- (7) To voice grievances
- (8) To a safe, clean, comfortable, home-like environment
- (9) To be free from abuse, neglect, and misappropriation of property

Recognizing, Preventing, and Reporting Abuse

- (1) ALL allegations of abuse - verbal, physical, sexual, mental/emotional, involuntary seclusion, neglect, and misappropriation of the resident's property should be reported immediately and will be thoroughly investigated
- (2) Always protect residents from harm, if you think what you see or hear constitutes abuse, immediately place the resident in a safe environment, and inform a supervisor

HIPPA privacy and security/confidentiality

- (1) Share information only as it relates to the treatment and care of the resident, do not discuss resident information regarding a resident when in common areas of the center
- (2) Use HIPAA privacy feature on computers
- (3) Avoid leaving paper documentation that contains PHI in non-secure areas of the center
- (4) Do not take pictures of the resident
- (5) Do not post resident information on any form of social media

Infection Prevention & Control

- (1) Perform hand hygiene using soap and water when indicated, otherwise use alcohol-based hand rub located throughout the Center
- (2) Wear appropriate PPE as indicated when in the center and when providing direct patient care
- (3) Follow signage posted throughout the centers, including transmission-based precaution signs posted outside resident rooms
 - a. Droplet Precautions - GREEN
 - b. Contact Precautions Special Enteric - RED

Orientation Essentials for Agency Staff

- c. Special Droplet Contact Precautions - BLUE
- d. Contact Precautions - ORANGE
- e. Enhanced Barrier Precautions – YELLOW

Fire safety/Emergency Preparedness

- (1) There is an emergency preparedness binder at each nurse's station outlining the steps to take in the event of an emergency or natural disaster

Effective Communication

- (1) Identify yourself and use the resident's proper name each time you speak with them
- (2) Allow the resident extra time for processing and understanding
- (3) Avoid distractions, maintain eye contact if culturally appropriate
- (4) Speak slowly and clearly, listen carefully, sit face to face, and directly respond
- (5) Maintain a positive attitude and facial expressions with a pleasant and normal tone
- (6) Simplify questions, stick to one topic at a time
- (7) Be aware of body language
- (8) Eliminate assumptions, ask for clarification and adjust method when needed

Dementia

- (1) Expressions or indications of distress of residents with dementia are often attempts to communicate an unmet need. Examples of these include:
 - a. Aggressiveness
 - b. Wandering or elopement
 - c. Agitation
 - d. Yelling out
 - e. Delusions
- (2) Do not perceive these as challenging behaviors, always address the unmet needs first

I acknowledge that I have read and understand this information. I know I can ask a center manager if I have questions.

Staff Member Name:

Date:

Staff Member Signature:



Manual: Food and Nutrition

Policy: Hot Beverage Policy
Policy Title: Hot Beverage Delivery
Policy #: MP_7_

Effective Date: 2-19-25

Review Date:

Revision Date(s): 4/8/25

Pages: 1

Original Author:
Aramark

Departments Distribution:

Meal Distribution– Hot Beverage Considerations


Policy Statement

It is the center policy that hot beverages will be served at proper temperatures to allow for resident palatability as well as safety. Older adults have delayed response time, skin sensitivity, and pre-existing health conditions that can cause damage to skin if hot beverages come in contact with skin.

Action Steps

1. The Dining Service Director will ensure that coffee temperatures of hot beverages will arrive for service at a temperature range of 150 F or less.
2. When beverages have been reheated in a microwave the following must occur:
 - a. Time of microwaving should not exceed 2 minutes.
 - b. Using a sanitized (alcohol wipe) probe thermometer, the temperature must not exceed 140° before delivery of the hot beverage
 - c. The staff will be provided with a probe thermometer and alcohol wipes to sanitize the thermometer. Staff who take the temperature will have adequate training on the proper sanitizing and use of a probe thermometer.
 - d. If the temperature exceeds 150° the beverage shall remain under the direction of the person reheating until the beverage is less than 150 temperature range.
3. The hot beverage should be covered with a lid during transport back to the resident.

Date	Revision
October 2022	Original
February 2025	Reviwion

 <p>Manual: Food and Nutrition</p>	<p>Policy: Hot Beverage Policy Policy Title: Hot Beverage Delivery Policy #: MP_7_</p>	
<p>Effective Date: 2-19-25</p>	<p>Review Date:</p>	<p>Revision Date(s): 4/8/25</p>
<p>Pages: 1</p>	<p>Original Author: Aramark</p>	<p>Departments Distribution:</p>

References

1. AHCA Surveyor Guidance 2021, Surveyor Guidance For Identified Excessively Hot Tap Water Temperatures That May Cause Scald Burns In Health Care Facilities References
2. American Burn Association: Advanced Burn Life Support Instructor Manual. 1994. "Aging in American's Neighborhoods" American Society on Aging, San Francisco, CA, 1998 Calistro, A (1993).
3. 2024 Life Safety Hub • Built with [GeneratePress](#)
4. 2020-2025 . Dietary Guidelines for Americans and Older Adults: Toolkit for Senior Nutrition Programs



Section	Policy Number	Policy Name	Effective Date
Abuse/Neglect/Misappropriation/ Crime	701	Patient Protection	10/17/2023

POLICY

There is a zero tolerance for mistreatment, abuse, neglect, misappropriation of property, or any crime against a patient of the Health and Rehabilitation Center.

PROCEDURE

1. Patients of the Center have the legal right to be free from verbal, sexual, mental, and physical abuse, corporal punishment, involuntary seclusion including abuse facilitated or enabled through the use of technology, and free from chemical and physical restraints except in an emergency and/or as authorized in writing by a physician.
2. Any employee and/or covered agent of the Center, who willfully abuses including abuse facilitated or enabled through the use of technology, neglects, robs, exploits, or commits any crime, or participates in any criminal activity against any patient of the Center will be immediately subjected to corrective action, suspension, and/or termination as necessary.
3. All employees are responsible for immediately (no later than two hours after the allegation is made if the incident involves abuse or bodily injury, no later than 24 hours if the incident does not involve abuse or bodily injury) reporting to the Administrator, or in their absence, the Director of Nursing, or their immediate supervisor any and all suspected or witnessed incidents of patient abuse, neglect, theft, exploitation and/or mistreatment of a patient as well as any reasonable suspicion of a crime against a patient.
4. Any and all suspected or witnessed incidents of patient/ patient abuse, neglect, theft, and/or exploitation or any reasonable suspicion of a crime against a patient/patient Center brought to the attention of the Center’s Administration will result in internal investigation, appropriate and timely reporting to the State Survey Agency (SSA) and other legally designated agencies, as well as staff corrective action, suspension, and/or termination as necessary.
5. Failure by an employee to report any suspected or witnessed incident of mistreatment, abuse neglect, theft, exploitation, or reasonable suspected crime against a patient will result in corrective action.
6. There is no retaliation against an employee who makes a report or causes a report to be made for suspicion of allegation or abuse.



Section	Policy Number	Policy Name	Effective Date
Abuse/Neglect/Misappropriation/ Crime	703	Reporting Requirements/Investigations	02/05/2023

PROCEDURE

1. Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, **the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury.**
 - a. Notify the Adult Protective Services Agency, the local Ombudsman, and the appropriate local law enforcement authorities (police, sheriff's office, and/or medical examiner as deemed appropriate) for any incident of patient abuse, mistreatment, neglect, or misappropriation of personal property or other reasonable suspicion of a crime.
 - b. Notify within 24 hours the Department of Health Professions (DHP) for incidences involving nurse aides, RNs, LPNs, Physicians, or others licensed or certified by DHP.
2. The Administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigative protocol will include, but not be limited to, collecting evidence, interviewing alleged victims and witnesses, and involving other appropriate individuals, agents, or authorities to assist in the process and determinations.
3. The Administrator and/or Director of Nursing will assure notification of the incident to the Regional Director of Clinical Services and/or the Chief Nursing Officer and will provide an update to the status of the Center's immediate investigation and if deemed appropriate the plans for initiating the initial notification to the State Survey Agency and other appropriate agencies.
4. The Regional Vice President of Operations is to be notified as soon as reasonably possible of the allegation and the status of investigation. Notification by phone or voice mail is acceptable.
5. The Administrator must thoroughly investigate and file a complete written report of the investigation of the submitted FRI to the State Agency within five (5) working days of the incident. Upon completion of the internal investigation and prior to submitting any written follow-up investigative report to the State, copies of the completed investigative report must be submitted to the Regional Director of Clinical Services for review and consultation and to the Chief Nursing Officer for approval.

The written follow-up investigative reporting document that is submitted must contain sufficient detail to demonstrate that a thorough investigation was conducted. It must include but is not limited to:

- a. Date of the occurrence.
- b. Name of the patient, staff, or individuals involved.
- c. Location of and description of the injury to the patient
- d. Location and description of the occurrence.
- e. Immediate action taken to protect the patient from further injury.



- f. Mechanisms in place to prevent recurrence of the incident, including date of review of Center policies and procedures.
 - g. Documentation of reports to Adult Protective Services, law enforcement, or the Department of Health Professions, as appropriate.
6. The Center Administrator's copy of all investigative reporting is to be retained for five (5) years from the date of the incident. These documents are to be destroyed by shredding at the end of the required retention period.
 7. Any substantiated incidences of abuse, neglect, exploitation, or crime require corrective action and will be taken through the Center's QAPI program to determine whether there is further need for systemic action.
 8. If an injury has occurred and there is potential for litigation, the Administrator is to assure the notification of the Regional Vice President of Operations and the Corporate Compliance Intermediary.



Section	Policy Number	Policy Name	Effective Date
Abuse/Neglect/Misappropriation/ Crime	702	Prevention/Screening/Training	02/05/2023

POLICY

The Administrator promotes the prevention of abuse (including verbal, sexual, mental, physical, corporal punishment, involuntary seclusion, or abuse facilitate or enable through the use of technology) and neglect and misappropriation of property by performing background checks on all employees and by advocating and enforcing patient rights and providing patients, families, and staff information on how and to whom they may report concerns, incidents, and grievances without fear of retribution.

PROCEDURE

1. Criminal background and reference checks are performed on all employees.
2. All employees receive training in orientation and are routinely in-serviced regarding the definitions of abuse, neglect, and misappropriation of property and their responsibility for understanding and preserving patient rights, protecting patients from abuse and neglect, and their responsibility to immediately report any cases of suspected or witnessed abuse or neglect. All employees during orientation receive a copy of the Resident Rights.
3. All employees are trained in orientation and are routinely in-serviced regarding mandated reporting requirements as well as reporting requirements under the Elder Justice Act for reporting any reasonable suspicion of a crime that has occurred against any individual who is a patient or any individual who is receiving care from the Center. The Center notifies covered individuals annually of their duty to report suspected crimes.
4. An employee poster detailing the reporting requirements and established time limits as well as the rights of employees to be free from retaliation for filing a complaint or a report of a crime to a law enforcement agency of jurisdiction and the State Survey Agency.
5. Patient Rights are posted in the Center in a central public location at eye level.
6. Patients are provided with a description of their legal rights, which include:
 - a. "The right to be free from verbal, sexual, mental and physical abuse, corporal punishment, involuntary seclusion, and free from chemical and, except in emergencies, physical restraints except as authorized in writing by a physician and with the consent of the Patient and/or legal representative for a specified and limited period of time or when necessary to protect the patient from injury to self or to others."
 - b. "The right to voice grievances and recommend changes in policies and services to the Health and Rehabilitation Center staff and to State and outside representatives of his/her choice, and to remain free from restraint, interference, coercion, discrimination, or reprisal."
7. Patient Rights and grievance proceedings are presented to the patient/responsible party both orally and in writing at the time of admission (The company *Admission Agreement Package* and *Resident Handbook*), and a hardbound Health and *Rehabilitation Center Resident Handbook Reference Guide* is made available in each patient's room as well as in the Center lobby for reference during the patient's length of stay.
8. All employees receive training on how to handle service concerns and/or grievances expressed by patients and/or families.
9. The Corporate Compliance intermediary's hotline number is posted in a highly visible area such as the lobby or direct care unit in the Center. It provides the name of the Administrator and a



statement of commitment to address concerns. This phone number is listed for patients and families so they can direct any unresolved or persistent issues to the corporate staff.

10. A poster with the current names, addresses, and telephone numbers of all pertinent state client advocacy groups (such as the state survey and certification agency, the state licensure office, the state ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit) is posted in the Center in an area that is readily accessible to patients and their families.
11. Volunteers engaged by the Center for scheduled activity programming are pre-screened and criminal background checks are secured.

Psychosocial Well-Being/Timely Call bell Response/Timely Incontinence Care

-Psychosocial well-being refers to the state of mental, emotional, and social health of an individual. It is a broad concept that encompasses various aspects of human life, including personal growth, happiness, life satisfaction, self-esteem, social functioning, and a sense of purpose in life.

-Resident's psychosocial can be affected not providing timely incontinence care, not responding to call bells timely, abuse or neglect and not upholding their resident rights.

-Call bell must be answered within 15mins. You cannot answer a resident's call bell and turn it off and not complete the care the patient asked for. If you inform a resident that you will be back, it must be timely, and you cannot clear the call bell.

-Incontinence care must be provided timely for all residents. Residents cannot remain in a soiled brief; this can cause skin impairments and affect a resident's psychosocial well-being. This is considered abuse and neglect.

In-Service Topic: Timely Incontinent Care & Resident Toileting Responsibilities

Purpose: To ensure all staff provide prompt, consistent, and individualized incontinent care and toileting assistance to every resident, preventing neglect, skin breakdown, and regulatory violations.

1. Importance of Timely Incontinent Care

Every resident has the right to be kept clean, dry, and comfortable.

Incontinent care must be completed as soon as soiling occurs and at minimum every 2 hours or per resident plan of care.

Failure to provide timely care can lead to:

Skin irritation, infection, or pressure injuries.

Odor and discomfort.

State survey citations for neglect.

Damage to our facility's reputation.

2. Checking the Kardex / Care Plan

Always review the Kardex or care plan at the start of your shift.

The Kardex identifies how each resident is toileted — whether they:

Need total assist, one-person or two-person assist.

Use a bedside commode, toilet, or are on a toileting schedule.

Require timed voiding, prompted toileting, or incontinence briefs.

Never assume a resident is independent. When in doubt, ask the nurse or review the Kardex again.

OVER=

3. Accountability & Communication

If you are unable to toilet or change a resident promptly, report it to the nurse immediately so help can be arranged.

Always document care as completed in the appropriate system or flow sheet.

During handoff, communicate when the resident was last toileted or changed.

4. Professional Standards

Follow the resident's care plan at all times.

Maintain resident dignity and privacy during toileting and incontinent care.

Wash hands before and after care.

Report any skin redness, odor, or irritation to the nurse immediately.

Key Takeaway:

💡 Always verify care instructions in the Kardex and perform *timely* toileting or incontinent care. Document accurately and never assume independence.

Harrisonburg Outside Food Policy

1. CNA warmed up outside food for a patient and then did not provide assistance with feeding and the resident acquired a burn
2. All residents who receive outside food that requires heating in the microwave have the potential to be affected. An audit will be conducted to determine which residents receive outside food and what residents require assistance from staff for eating. A list will be available on the unit. An audit of current residents that require assistance with eating will be completed and ensure it is on the care plan and Kardex.
3. The DON or designee will educate nursing staff on the policy for Outside Food, Guidelines for Microwave Use and to ensure that residents that require assistance with feeding are assisted with meals served from the kitchen as well as outside food. The CNA was provided with a 1:1 in-service on the policy of Outside Food, Guidelines for Microwave Use and providing assistance for residents that require assistance with feeding for meals and outside food. The Guidelines for Microwave use will be posted in Microwave areas. A reheating log and thermometer will be placed in all unit pantries.
4. The DON or designee will observe 2 residents that require assistance with feedings five times a week to ensure assistance is provided for 8 weeks. The DON or designee will audit the reheating logs on the units five times a week for 8 weeks to ensure staff are following the reheating of food or liquids was followed.
5. . Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI committee determines the problem no longer exists, the monitoring will be conducted randomly.
6. Date of Compliance: 10/17/25



POLICIES & PROCEDURES

[Nursing]

Section	Policy Number	Policy Name	Effective Date
General Nursing Care	#1017	Outside Food	1/29/2024

POLICY

Residents have the right to consume foods brought in from an outside source.

PROCEDURE

1. Prepared/ready-to-eat outside food that needs refrigeration may be placed in the refrigerator at the nurse's station, if there is space, for a short period of time, not to exceed three (3) days.
2. The items must be labeled and dated with the patient's name, room number, and the use-by-date.
3. Food that is sealed in original manufacturer's packaging may be kept until manufacturer's expiration date.
4. Food brought in that does not require refrigeration must be kept in a sealed container at the bedside.
5. Unit pantry refrigerators are only for refrigerated items designated for patients.
6. Unit pantries/nourishment rooms are for staff access only.
7. Microwaves are available in the nursing unit pantry for proper reheating of food for resident consumption. Team members will follow Guidelines for Microwave Use posted in the microwave area.
8. Nursing staff will clean microwaves as used.

Order from MFA Publications Manager

Guidelines for Microwave Use

- Manufacturer heating instructions should be followed when available.
- Cover all foods and liquids with a lid or plastic wrap to hold moisture and provide safe and even heating. Turn back a corner for steam to vent.
- Monitor food continuously while heating to avoid overheating.
- Stir food if possible to heat evenly.
- Allow food to “rest” for 2 minutes to evenly distribute heat.
- Stir or cut food to disperse heat.
- Verify temperature of food item prior to service to a resident. Open an alcohol wipe package with clean hands. Clean the thermometer stem by wiping with alcohol wipes prior to and after taking the temperature of each food. Take the temperature in the thickest part of the food item.
- Heat foods in microwave to 165°F
- Serve hot beverages between 140-155°F
- Do not serve food with visible steam to anyone requiring assistance or with slow physical response.
- Cover foods or beverage to prevent spills when delivering to resident.

*** Cooking times may vary because ovens vary in power and efficiency. ***

RESIDENT RIGHTS ANNUAL REVIEW

It is the policy at this Healthcare Center that all Residents shall have the following rights and privileges:

1. To be fully informed, both orally and in writing in a language that he/she understands, as evidenced by the Resident's written acknowledgment, prior to or at the time of admission and during his/her stay, of his/her rights and of all rules and regulations under state and federal laws governing Resident conduct and responsibilities;
2. To be fully informed, prior to or at the time of admission and during his/her stay, of services available in the Healthcare Center and of related charges, including any charges for services not covered under Titles XVIII or XIX of the United States Social Security Act or not covered by the Healthcare Center's basic per diem rate;
3. To be provided current information as to the application and utilization of benefits under Medicare and Medicaid;
4. To be provided, at the time of admission, a survey summary of the most recent findings and outcomes concerning Federal requirements;
5. To choose his/her attending physician and to be fully advised as to the way of contacting the physician responsible for his/her care;
6. To be fully informed by the physician of his/her medical condition unless medically contraindicated as documented by the physician in his/her medical record and to be afforded the opportunity to participate in the planning of his/her medical treatment, to refuse treatment, and to refuse to participate in experimental research, to practice self administration of drugs if determined by the interdisciplinary team that this practice is safe, and to be provided appropriate assessment and management of pain;
7. To be transferred or discharged only for medical reasons, or for his/her welfare or that of other Residents, or for non-payment for his/her stay except as prohibited by Titles XVIII or XIX of the United States Social Security Act, and to be given proper notice as outlined in federal and state law so as to ensure orderly transfer or discharge, and all such actions are documented in his/her medical record;
8. To be encouraged and assisted, throughout the period of his/her stay, to exercise his/her rights as a Resident and as a citizen and to this end may voice grievances and recommend changes in policies and services to Healthcare Center staff and to state and outside representatives of his/her choice, and to remain free from restraint, interference, coercion, discrimination, or reprisal;
9. To choose to manage his/her personal financial affairs, or to have access upon request to records of financial transactions made on his/her behalf and to be given at least a quarterly accounting of financial transactions made on his/her behalf should the Healthcare Center accept his/her written delegation of this responsibility to the Healthcare Center for any period of time in conformance with state law;
10. To be free from verbal, sexual, mental and physical abuse, corporal punishment, involuntary seclusion, and free from chemical and, except in emergencies, physical restraints except as authorized in writing by a physician and with the consent of the Resident and/or legal representative for a specified and limited period of time or when necessary to protect the Resident from injury to self or to others;
11. To be assured confidential treatment and the individual accessibility of his/her personal and medical records and to approve or refuse their release to any individual outside the Healthcare Center, except in case of his/her transfer to another Healthcare institution or as required by law or third-party payment contract;
12. To be treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment and in care for his/her personal needs;
13. Not to be required to perform services for the Healthcare Center that are not included for therapeutic purposes in his/her plan of care, and formally agreed upon by the Resident;
14. To have regular access to the private use of a telephone as well as stationery, postage and writing implements at the Resident's own expense;
15. To have immediate access and visitation rights and to communicate privately with persons of his/her choice, and send and receive his/her personal mail unopened, unless medically contraindicated as documented by his/her physician in his/her medical record;
16. To meet with and participate in activities of social, religious and community groups that do not interfere with the rights of other Residents at his/her discretion, unless medically contraindicated as documented by his/her physician in his/her medical record;
17. To organize and participate in Resident and family groups in the Healthcare Center;
18. To retain and use his/her personal clothing and possessions as space permits unless to do so would infringe upon rights of other Residents and unless medically contraindicated as documented by his/her physician in his/her medical record;
19. If married, to be assured privacy for visits by his/her spouse, and, if both are Residents in the Healthcare Center, to be permitted upon consent of both spouses to share a room with such spouse unless medically contraindicated as documented by the attending physician in the medical record;
20. To be properly notified before a change in Resident's room or roommate; and
21. To be afforded access to the formal results of the most recent survey of the Healthcare Center as well as the Healthcare Center's plans for correction.

Resident's Printed Name	Date	Witness's Signature	Date
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Resident's Signature	Date
----------------------	------

Post Test Questionnaire

1. You must report abuse and neglect within 2 hours of receiving a report from a patient True or False
2. All staff working in a nursing home are mandated reporters
True or False
3. Does the facility have to submit a report to the state survey agency when an allegation of abuse or neglect is reported by a patient? Yes or No
4. Who is the abuse coordinator? _____
5. If you make a resident feel sad or unimportant, this is an example of affecting someone's psychosocial well-being.
True or False
6. How many minutes is it considered a timely response to a call bell? 30 minutes 45 minutes 15 minutes
7. If a resident is incontinent, they should have to wait after they have told a staff member they are soiled to be changed or should the staff member change the resident immediately.
Wait or change immediately
8. Do the Residents have rights within the facility? Yes or No

Post-Test Questionnaire

1. Residents are permitted to be served coffee that is greater than 150F True or False
2. Residents are permitted to leave toiletries, air fresheners, and other personal hazardous items out for other residents to use
True or False
3. Hot beverages will have their temperature taken and recorded prior to leaving the kitchen True or False
4. A hot liquid assessment is completed only for residents who are cognitively impaired True or False
5. Patients deemed to have restrictions for hot beverages will be recorded for all staff to know interventions True or False
6. All personal items for residents should be stored in a location that does not allow other residents to see the items in plain sight True or False
7. Only resident rooms need to be monitored for hazardous materials True or False

Name & Position: _____



ALF Agency Checklist

1410 A North Augusta Street | Staunton, VA 24401

540-885-5454 | www.thelegacyatnorthaugusta.org

Staff Name: _____ Start Date: _____

- _____ Demographic Information
- _____ Identification (Photo ID, SS Card)
- _____ Copy of License
- _____ TB Screening
- _____ Background Check (criminal history records - Central Criminal Records Exchange)
- _____ Sworn Statement
- _____ ALF Staff Training Form Signed
- _____ Proof of Flu Vaccine (Reqd if no exemption)
- _____ Proof of Covid Vaccine (optional)
- _____ First Aid
- _____ CPR
- _____ CNA Duties Form Signed (facility form, if applicable)
- _____ CMA Duties Form Signed (facility form, if applicable)
- _____ Clinical Department Guide (copy given to staff)
- _____ Clinical Department Guide Acknowledgement of Receipt Signed
- _____ Memory Care badge (if applicable)
- _____ Orientation Checklist Reviewed

- _____ Agency checklist completed



RMA's and Nurses EVERY SHIFT

- Narcotic count** is done by oncoming/outgoing & sign count book, **call DON** for issues w/ count, initial errors!
- Check medication fridge temps** and **sign book** – no food in fridges.
- Receive report**-highlight, residents on isolation, recent falls, admissions, labs, etc .
- Pass medications- check MAR**
 - 5 rights EVERY TIME
 - **NEVER LEAVE medications. All medications MUST be observed when being taken.**
 - Document **after** medication is given.
 - If medication is missing, enter a progress note to include what you did to get the medication, contact MD to notify.
- Review TAR**
 - Every **TAR item must be documented completed or NOT completed & why!**
- Check mailbox** by concierge desk for new orders or communication following resident appointments.
- New orders** that come are entered into PCC- see resource book in care base for directions.
 - Once entered stamp with “entered” stamp and date and initial.
 - Place in “orders to be reviewed” folder.
- Night staff** to review “**Orders to be reviewed**” folder.
 - Review all orders for accuracy.
 - Stamp with “**reviewed**” folder.
 - Place in “**completed**” folder
- Night shift**
 - Restock medication carts qHS.
 - All open medications (eye drops, insulin, etc) have a date opened.
 - Check for expired medication.
 - **Reorder medications** needed or low
 - Make appointment packets for the residents with appointments the next day
 - Keep **care base clean**- sweep and empty trash.
 - Enter weights and vitals in PCC by the 5th of each month
- In PCC under UDA**- complete any change in condition or Fall risk rating
- Direct CNA and DCA**- Check **POC dashboard for alerts**- write progress note about the alert
 - Answer call bells timely
 - Be sure they are documenting their tasks in POC
- Give thorough report**
 - Note any resident falls, isolation, or new admissions.
 - Carry-over previous reports to next shifts until change is complete (fall is 72h, change of condition, etc).
 - Notify DON/On call of these things- **falls w/ injury, abuse concerns/allegations, res to res altercations, behaviors, family/res concerns not resolved by team/charge in community, any questions/support.**

Sign: _____ **Date:** _____ **Shift:** _____

Please complete and sign and leave in the communication binder in the care base along with your report sheet.



CNAs/DCAs

- Add your initials on the paper schedule hanging on the wall
- Receive report from off going team member**- ask about isolation, sick residents, special needs, fall risks
- Be sure you can **log into POC**- Alert your **RMA or Nurse** if unable to Log in **ASAP**. DO NOT SHARE LOG INS for documentation.
- Check in** with your Nurse/RMA, Charge Nurse for your break schedules- EVERYONE MUST HAVE A BREAK, scheduled!
- Review shower** schedule for your shift –
- Review Laundry** schedule for your shift – wash, fold and put away
- Ensure you have the messenger phone** for the floor you are working on. Make sure it is on and you know how to use it so you are able to answer residents' needs! If you need help, ask your RMA/nurse or Charge personnel. Use proper etiquette on the phones as well! Always!
- Document** all tasks in POC as you complete them. Don't wait until the end of the shift to document. You will be called in for incomplete documentation if not completed.
- Complete all showers, laundry** and be sure trash is removed from residents' apartments
- Make sure **Vitals and weights** are done for the month. These should be complete by the **5th of the month**
- Purposeful rounds include "seeing" that the resident is safe. At night listen for snoring or the rise and fall of the chest in Bed. If you are not able find the resident, alert nurse/RMA**
- Answer resident** needs timely throughout your shift. If you are going to be tied up for a while with a resident, alert your teammate so they can answer those that call while you are busy.
- TAKE TRASH OUT AT THE END OF EVERY SHIFT**

Free time-PLEASE DO NOT SIT IN CAREBASE UNLESS YOU ARE DOUMENTING

- Assist other CNAs/DCAs in the building with resident care/break coverage.
- Assist residents with walking in the hallway for exercise.
- Help keep our community clean
- Restock supplies in residents' rooms as needed.
- Keep your personal phone in your pocket or in the care base to use during breaks.
- NEVER use your video/facetime while at work, even on break. This can become a resident privacy issue.
- NEVER SLEEP in our building even if you are on break!**
- At the end of your shift, give report- pass on any laundry that needs to be complete, any resident needing special assistance, etc.
- Turn in your community phone and keys.
- Make sure **ALL your tasks** for your shift are documented and showing green!
- Check out with your RMA/Nurse

Additional responsibilities for Night shift 7pm-7am

Once report is received from day shift:

- Complete Purposeful rounds on all resident
- Assist residents to bed – memory care residents will need motivation to get to bed
- Ensure all laundry, folded, and put away
- Restock supplies (briefs, wipes, gloves) in resident rooms
- Continue purposeful rounds (hourly in memory care)
- Remove all trash from resident rooms, care bases and kitchen, put trash bags in trash cans
- Clean common areas, care base (clean dining room and put away dishes in Memory care)


Memory care

Early morning:

- Help all residents to get up for the day
- Be sure they have been toileted and are in clean dry clothes
- Help them brush teeth and hair- residents will require motivation and encouragement
- Make beds for all residents- have residents help if they are able
- Orient residents to time, day, and season

Purposeful Rounding and the 6 P's

- "Potty" (toileting)
 - Toileting while unattended is the most common unsafe behavior leading a resident or guest to fall
- Pain
 - Use the appropriate scale for the resident or guest
 - Report any findings to nurse
 - Treat pain & assess effectiveness
- Positioning
 - Make sure to evaluate the resident or guest for comfort and proper alignment
- Personal items or Possessions
 - Remote control
 - Magazines or books
 - Phone
 - Tissues
- Partaking
 - Offer food and drink
- Parting question – Is there anything else I can help with?

 We CARE

Sign: _____

Date: _____

Shift: _____

Please complete and sign and leave in the communication binder in the care base along with your report sheet.

Virginia Tuberculosis (TB) Screening and Risk Assessment Tool

For use in individuals 6 years and older

Use this tool to identify asymptomatic **individuals 6 years and older** for latent TB infection (LTBI) testing.

- The symptom screen and risk factor assessment may be conducted by a licensed healthcare provider (MD, PA, NP, RN, LPN). If a symptom or risk factor for TB is identified, further evaluation should also be performed by a licensed healthcare provider (MD, PA, NP, RN, LPN), however an RN or an LPN conducting evaluations must have an order by healthcare personnel with prescriptive authority consistent with Virginia professional practice acts for [medicine](#) and [nursing](#).
- Re-testing should only be done in persons who previously tested negative and have new risk factors since the last assessment.
- A negative Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA) does not rule out active TB disease.

First screen for TB Symptoms: None (If no TB symptoms present → Continue with this tool)

Cough Hemoptysis (coughing up blood) Fever Weight Loss Poor Appetite Night Sweats Fatigue

If TB symptoms present → Evaluate for active TB disease

Check appropriate risk factor boxes below.

TB infection testing is recommended if any of the risks below are checked.

If TB infection test result is positive and active TB disease is ruled out, TB infection treatment is recommended.

- Birth, travel, or residence in a country with an elevated TB rate ≥ 3 months
 - Includes countries other than the United States (U.S.), Canada, Australia, New Zealand, or Western and North European countries
 - IGRA is preferred over TST for non-U.S.-born persons ≥ 2 years old
 - Clinicians may make individual decisions based on the information supplied during the evaluation. Individuals who have traveled to TB-endemic countries for the purpose of medical or health tourism < 3 months may be considered for further screening based on the risk estimated during the evaluation.

- Medical conditions increasing risk for progression to TB disease
Radiographic evidence of prior healed TB, low body weight (10% below ideal), silicosis, diabetes mellitus, chronic renal failure or on hemodialysis, gastrectomy, jejunioileal bypass, solid organ transplant, head and neck cancer

- Immunosuppression, current or planned
HIV infection, injection drug use, organ transplant recipient, treatment with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥ 15 mg/day for ≥ 1 month) or other immunosuppressive medication

- Close contact to someone with infectious TB disease at any time

- None; no TB testing indicated at this time

Patient Name _____

Date of Birth ____/____/____

Name of Person Completing Assessment _____

Signature of Person Completing Assessment _____

Title/Credentials of Person Completing Assessment _____

Assessment Date ____/____/____



National Lutheran Communities & Services

Notes

Acknowledgement Form for Clinical Agency Team Members Orientation to community. Team member is responsible for information listed below.

Employee Name: _____

Job Title: _____

Date: _____

- Infection Control Basics
- Handwashing
- Personal Protective Equipment
- Communication
- Residents' Rights
- Behavioral Health
- Code of Conduct for NLCS
- Health Insurance Portability and Accountability Act
- Dementia Care
- Activities of Daily Living
- iPhones
- Language Link
- Krames
- Policy Stat
- Point Click Care
- Point of Care

Employee Name (print): _____

Employee Signature: _____

Coach Signature: _____

Coach Name (print): _____

SWORN STATEMENT OR AFFIRMATION
FOR ADULT FACILITY EMPLOYEES

To the Applicant:

Section 63.2-1720 of the Code of Virginia requires that any person desiring work at a licensed assisted living facility or licensed adult day care center provide the hiring facility or center with a sworn disclosure statement or affirmation disclosing any criminal convictions or pending criminal charges, whether within or outside the Commonwealth of Virginia.

The law prohibits licensed assisted living facilities and licensed adult day care centers from hiring any individuals convicted of a barrier crime. However, applicants convicted of one misdemeanor barrier crime not involving abuse or neglect may be hired if five years has elapsed since the conviction.

Any person making a false statement on this form regarding any criminal offense shall be guilty of a Class 1 misdemeanor.

Further dissemination of the background check information provided on this form is prohibited other than to the Commissioner's representative or a federal or state authority or court as may be required to comply with an express requirement of law for such further dissemination.

Please Print

1. _____
Last Name First Middle Maiden Social Security Number

Address Street/P.O. Box/Apt. # City State Zip Code

2. Have you ever been convicted of a law violation(s) but excluding offenses committed before your eighteenth birthday that were finally adjudicated in a juvenile court or under a youth offender law? ___ yes ___ no

If yes, list all and explain _____

3. Are you the subject of any pending criminal charges? ___ yes ___ no

If yes, explain _____

4. I hereby affirm that the information provided on this form is true and complete, and I agree and understand that any falsification of information herein, regardless of time of discovery, may cause forfeiture on my part to any employment offered by this facility. I understand that all information on this form is subject to verification.

Applicant's Signature _____ Date: _____

NOTE TO LICENSEE: This form must be retained for all compensated employees.