



# VisionQwest Healthcare Group

Dear Caregiver

Thank you for choosing VisionQwest Healthcare. We look forward to working together with you. Our company is very flexible, and works hard to get you the hours you desire at the facilities you request. In addition to completing the hiring packet we will need copies of the following forms to complete your contractor file:

- Driver's License and SS Card (for I-9)
- Current License (if applicable)
- Current BLS (If applicable)
- Current ACLS/PALS/NRP (If applicable)
- Copy of Immunization record (Proof of MMR)
- Copy of TB (PPD Skin test) within one year
- Proof of Professional Liability Insurance (if applicable)

The application process can seem overwhelming at first, but all of the documents required are the same that are needed for hospital employment. We have built a good reputation for our meticulous record keeping and meeting stringent nurse hiring requirements which has allowed us to gain more hospital contracts and offer more shifts with fewer cancellations. We are honored that you have decided to join our team and allowing us to represent you in the healthcare industry. If you have any questions please feel free to contact our office 818.547.0497 Ext 2.

Sincerely,

**Michael Lodge**

VisionQwest Healthcare



# VisionQwest Healthcare Group

## Application

Thank you for applying for a position with our Company. We appreciate the time you are giving to complete this application. It is important that you fully and accurately complete this form yourself and indicate the position(s) for which you wish to be considered. The following must be filled out completely for your application to be considered.

Name: \_\_\_\_\_  
Last First Middle

Have you ever used another name?  Yes  No If yes, what: \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_\_ Other Telephone: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Have you ever used another Social Security Number?  Yes  No

Present Address: \_\_\_\_\_  
No. Street City State Zip

Mailing Address: \_\_\_\_\_  
(If different) No. Street City State Zip

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### Per Diem Assignment Desired:

Position applying for: \_\_\_\_\_

If hired, on what date can you start work? \_\_\_\_\_ Salary desired? \_\_\_\_\_

### References:

How did you hear about our company? \_\_\_\_\_

List below three persons not related to you who have knowledge of your work performance within the last three years. If this does not apply to you, then provide three school or personal references that are not related to you.

Name	Address	Phone	Years Known
1.) _____	_____	_____	_____
2.) _____	_____	_____	_____
3.) _____	_____	_____	_____



# VisionQwest Healthcare Group

## Education and Training

Name and State	Degree Obtained	Date Graduated
High School: _____	_____	_____
College/University: _____	_____	_____
Vocational/Business: _____	_____	_____

## Employment History:

List below all present and past employment, starting with your most recent employer:

Are You Employed Now?  Yes  No    May we contact your present employer?  Yes  No

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

No.	Street	City	State	Zip
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Telephone: (\_\_\_\_) \_\_\_\_\_ Your Supervisor's Name: \_\_\_\_\_

Position Held: \_\_\_\_\_

Date of Employment: From: \_\_\_\_\_ To: \_\_\_\_\_

Earnings: Starting: \_\_\_\_\_ / Ending: \_\_\_\_\_

Exact Reason for Leaving: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

No.	Street	City	State	Zip
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Telephone: (\_\_\_\_) \_\_\_\_\_ Your Supervisor's Name: \_\_\_\_\_

Position Held: \_\_\_\_\_

Date of Employment: From: \_\_\_\_\_ To: \_\_\_\_\_

Earnings: Starting: \_\_\_\_\_ / Ending: \_\_\_\_\_

Exact Reason for Leaving: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

No.	Street	City	State	Zip
-----	--------	------	-------	-----

Telephone: (\_\_\_\_) \_\_\_\_\_ Your Supervisor's Name: \_\_\_\_\_

Position Held: \_\_\_\_\_

Date of Employment: From: \_\_\_\_\_ To: \_\_\_\_\_

Earnings: Starting: \_\_\_\_\_ / Ending: \_\_\_\_\_

Exact Reason for Leaving: \_\_\_\_\_



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## License Information

Answer the following questions if applying for a professional position:

Are you licensed for the job applied for?  Yes  No Type of license (RN/LVN/CAN/Other: \_\_\_\_\_) Issuing state: \_\_\_\_\_ License/certification number: \_\_\_\_\_ / Expiration Date \_\_\_\_\_ Has your license ever lapsed, been revoked or suspended?  Yes  No If yes, state reason(s), date of lapse, revocation or suspension and date of reinstatement: \_\_\_\_\_

Have you ever, under your name or another name, been convicted of (or pleaded guilty or nolo contendere to) a Felony or Misdemeanor? ....  Yes  No

Have you ever, under your name or another name, been convicted of a crime, which resulted with your being in prison and released from prison or paroled? ....  Yes  No

(Do not identify convictions for marijuana-related offenses that are more than two years old; or convictions for which the criminal record has been expunged, sealed or eradicated by the court; or, misdemeanor convictions for which any probation has been completed and the case dismissed by the court.)

If yes, explain each conviction fully, when, where and of what you were convicted and disposition of the case(s):

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Are you currently under arrest, or released on bond or your own recognizance, pending trial for a criminal offense? .....  Yes  No

If yes, state the nature of the crime charged, and when and where trial is pending:

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### **The following section is for employment within the healthcare industry in California**

Please answer the following only if:

1. The position for which you are applying will provide you access to patients. Have you ever been arrested for a sex related crime?  Yes  No If Yes, Please Explain:

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2. The position for which you are applying will provide you access to drugs or medications. Have you ever been arrested for a drug related crime?  Yes  No Please Explain:

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# VisionQwest Healthcare Group

## Authorization

### Personally completed this form honestly and accurately

By my signature below, I promise that I have personally completed this application. I declare under penalty of perjury that the information provided in this application (and accompanying resume, if any) is true and complete, and I understand that any false information or significant omissions may disqualify me from further consideration for per diem assignments, and may be justification for my dismissal from per diem assignments if discovered at a later date. I understand that any job offer is conditional based on the satisfactory review of my qualifications including any and all background or drug screening which may be required.

### Drug and Alcohol screening

I give permission for a pre-assignment / employment drug/alcohol screening exam, and, if the company makes a conditional job offer, I give permission for a complete assignment / employment physical and mental examination. I also consent to the appropriate release of any and all medical information, as may be deemed necessary. (See separate Agreement)

### Authorization to obtain information

I voluntarily and knowingly authorize any present or past employer; supervisor; administrator; educational institution; law enforcement agency; state, local, or federal agency; credit bureau; collection agency; private business; military branch; the national personnel records center; personal reference; and/or other persons; to give records or information they may have concerning my criminal history, motor vehicle report, educational history, licensing, employment (including character, earnings history and reasons for termination) or any other information requested by the company requested to determine my eligibility for per diem assignment.

### Release

I voluntarily waive all recourse and release any company, individual or organization from liability for complying with any request from the company or agents of the company (including any consumer reporting agency) to obtain any information from any source whatsoever relating to my application for per diem assignments. I further release the company or any individual within the company regarding the use any information received which may have bearing on my application for per diem assignments.

### Notification and compliance with rules

I agree to immediately notify the company if I should be convicted of a crime while my application is pending, or during my assignment if hired. If I become assigned, in consideration of my per diem assignment, I agree to comply with the rules, regulations, policies and procedures of the company.

**I certify that all of the information provided by me on this Application is true and accurate.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_



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## Hepatitis B Vaccine

OSHA requires all health care workers at risk to have the opportunity to have the Hepatitis B Vaccination offered to them by their employer.

1. If you have completed the vaccination series, please indicate such at the appropriate statement, date and sign the bottom of this letter.
2. If you are in the process of receiving the series, please indicate, date and sign at the bottom of this letter. Please indicate if you require a dose of the vaccine while working on this contract. VisionQwest Healthcare will provide it to you at no cost.
3. If you decline to have the Hepatitis B Vaccine indicate this at the bottom of this letter, sign and date.

**\*\*\*Please Choose Only One\*\*\***

I understand the OSHA guidelines and have completed the Hepatitis B Vaccine series

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I understand the OSHA guidelines and need #\_\_\_\_ or booster, in the series. Please make arrangements with us to receive this dose of the vaccine.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I understand the OSHA guidelines and DECLINE the Hepatitis B Vaccination.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



# VisionQwest Healthcare Group

## Education Acknowledgment Form

This is to acknowledge that I have received training a copy of VisionQwest Healthcare's Contractor / Employment Manual which contains information and verification of procedures related to the following:

Blood borne Pathogens and Universal Precautions  
Latex Allergies  
Hospital and Fire Safety  
Emergency Preparedness  
Security and Workplace Violence  
Tuberculosis Education  
HIPAA Education  
Patient Rights  
Risk Management  
Age Specific Competency  
Use of Restraints  
Abuse Reporting  
Sexual Harassment  
Conscious Sedation  
Advance Directives  
Organ Donation  
Medication Errors  
Preventing Workplace Injuries  
JCAHO National Patient Safety Goals

I understand that the above mentioned materials provide guidelines and summary information about the company's policies and procedures. I also understand that it is my responsibility to read, understand, become familiar with, and comply with the standards that have been established.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_



# VisionQwest Healthcare Group

## Certified Nursing Assistant / Caregiver Assignment Description

### Summary

Perform a variety of nonprofessional nursing duties in the direct care of patients under the direct supervision of an RN/LPN.

### Duties and Responsibilities

- Prepare patients, equipment and supplies for specific procedures and provide manual assistance as required.
- Obtain and record patient data for medical records noting and informing RN/LPN of information collected.
- Administer treatment and personal care procedures to patients including, but not limited to, feeding, bathing, shaving, changing clothing, cleaning bed-making, assisting with ambulation, enemas, skin care, and bowel and bladder elimination; provide such additional care as required to meet the personal needs and comfort of assigned patients.
- Participate in teaching activities by reinforcing teaching instructed by RN and/or physician as needed.
- Assist physician and nurses with physical examinations by helping position patients, changing non-sterile dressing and weighing patients.
- Note and reports any changes in patient's condition to the RN or LPN.
- Take and records vital signs, record I&O, applies ice bags, administer douches and enemas.
- Turn and position patients, set up and feed patients as necessary, provide patients with fresh drinking water.
- Perform finger sticks for blood glucose testing with appropriate training.
- Assist with admission, discharge, and transportation of patients.
- Follow standard precautions and use personal protective equipment as required.
- Perform other related duties incidental to the work described herein.
- Collect, deliver and conduct routine tests on patient specimens.
- Clean assigned area; stock and replenish supplies and equipment as required.



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- Participate in own professional development by maintaining required skills validation and attending educational offerings. Supports the development of other staff and formal learners.
- Perform other related duties incidental to the work described herein.

## **Education**

Preferred Completion Certified Nurse Aide education program approved by the California Board of Nursing with a High School diploma or equivalent preferred.

## **Experience**

A minimum of two years current experience

## **Degrees, Licensure, and/or Certification**

Preferred Current Certified Nursing Assistant license in the state of Illinois and current BLS

## **Knowledge, Skills, and Abilities**

- Working knowledge of procedures and techniques involved in administering routine and special treatments to patients.
- Working knowledge of sanitation, personal hygiene and basic health and safety precautions applicable to work in a hospital
- Working knowledge of infection control procedures and safety precautions
- Able to withstand prolonged standing and walking with the ability to move or lift at least 50 pounds
- Ability to understand English and follow oral and written instructions
- Ability to document and communicate pertinent information
- Ability to establish and maintain effective working relationships with patients and hospital staff

## **Essential Job Functions**

- Assist with walking and light exercise
- Plan and prepare meals, followed by clean-up
- Monitor food expiration dates, make future meals
- Make beds and change linens, as needed
- Light housekeeping to include dusting and vacuuming
- Assist with bathing, dressing and grooming



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- Laundry and ironing
- Take out garbage
- Run errands (pickup prescriptions, dry cleaning)
- Engage in physical and mental exercises
- Provide medication reminders
- Escort on appointments (hair salon, physical therapy, etc)
- Escort to religious services or events
- Maintain calendar and organize mail
- Engage in activities (games, memory books)
- Companionship

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## Employment Verification Form

I, \_\_\_\_\_ (Print Name) Voluntarily and knowingly authorize VisionQwest Healthcare to contact the following employers listed in the "Company" box below to give records or information they may have concerning my present or prior employment (including character, earnings, history and reason for termination) and any other information requested by VisionQwest Healthcare to determine my eligibility for employment. **Candidate - please complete the highlighted areas only below.**

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Company: (Print current or prior employer name here)	Company: (Print prior employer name here)	Company: (Print prior employer name here)
Phone:	Phone:	Phone:
Position Held:	Position Held:	Position Held:
Dates of Employment:	Dates of Employment:	Dates of Employment:
Attendance: Good Fair Poor	Attendance: Good Fair Poor	Attendance: Good Fair Poor
Eligible for Re-hire Yes No	Eligible for Re-hire Yes No	Eligible for Re-hire Yes No
Contact /Title	Contact /Title	Contact /Title
Info Verified by:	Info Verified by:	Info Verified by:



# VisionQwest Healthcare Group

## Work Experience Checklist

Clinical Skill		Dates of Experience (mm/YYYY) i.e. 01/2000 – 06/2005
I&O	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Vital Signs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Acute Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Private Duty	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hospice	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nursery	<input type="checkbox"/> Yes <input type="checkbox"/> No	
CPR	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Blood Glucose Monitor	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# VisionQwest Healthcare Group

## Reference Inquiry Form

To: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I have applied for employment at VisionQwest Healthcare. I authorize you to release all information requested below by VisionQwest Healthcare, including information concerning my character, habits, abilities, and reason(s) for leaving your company. The following information may help in identifying my records:

Name:		Social Security Number:	
Position:		Dates of Employment:	
Applicant's Signature:			

	Excellent	Good	Standard	Fair	Poor
Job Performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to Work with Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					
Signature of person completing this Form				Date:	



# VisionQwest Healthcare Group

## Reference Inquiry Form

To: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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Name:		Social Security Number:	
Position:		Dates of Employment:	
Applicant's Signature:			

	Excellent	Good	Standard	Fair	Poor
Job Performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to Work with Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					
Signature of person completing this Form				Date:	



# VisionQwest Healthcare Group

## Reference Inquiry Form

To: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I have applied for employment at VisionQwest Healthcare. I authorize you to release all information requested below by VisionQwest Healthcare, including information concerning my character, habits, abilities, and reason(s) for leaving your company. The following information may help in identifying my records:

Name:		Social Security Number:	
Position:		Dates of Employment:	
Applicant's Signature:			

	Excellent	Good	Standard	Fair	Poor
Job Performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to Work with Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					
Signature of person completing this Form				Date:	



# VisionQwest Healthcare Group

## Medical Release

\_\_\_\_\_  
Applicant Name

RN \_\_\_\_\_  
Position

Based on qualifications presented on your application form and/or in your job interview, you are hereby, offered a job with our organization conditional upon submitting to our standard medical review and the verification of your answers to the following questions. Your job offer cannot and will not be rescinded unless a medical review reveals that you cannot perform the essential functions of the job (with accommodations if requested), or you present a hazard to yourself or others. False or misleading statements are also grounds for rescinding this offer. This form must be accurate and complete for us to process. This information is considered personal and medical in nature and will be treated as such by handling it confidentially in strict compliance with the American with Disabilities Act.

### PHYSICIAN'S STATEMENT

I have examined the individual named above, and to the best of my knowledge, he/she is in good physical and mental health, free of any communicable diseases, and is able to perform in his/her profession at full capacity.

Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

	<u>Date Taken</u>	<u>:Results</u>
Mumps	_____	: _____
Rubella	_____	: _____
Rubeola	_____	: _____
Varicella	_____	: _____
Hepatitis-B	_____	: _____
TB Test	_____ Read On _____	: _____
Chest X-Ray	_____	: _____

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Physician: \_\_\_\_\_



# VisionQwest Healthcare Group

## ACKNOWLEDGMENT OF INDEPENDENT CONTRACTOR

This Acknowledgment of Independent Contractor (the "Agreement") is made and effective this [DATE],

**BETWEEN:** **VisionQwest Healthcare Group** (the "Company"), a corporation organized and existing under the laws of the State] of California, with its head office located at:

500 N Central, Suite 740, Glendale, CA 91203

**AND:** \_\_\_\_\_ (the "Contractor"), a professional licensed individual organized and existing under the laws of the State of California with address located at:

\_\_\_\_\_

**NOW, THEREFORE,** in consideration of the mutual agreements and covenants herein contained the Contractor hereby acknowledges that it has been retained by the Company, for purposes of:

- ( ) Per Diem RN / ( ) Per Diem LVN / ( ) Per Diem CNA
- ( ) Per Diem Other \_\_\_\_\_

In consideration of the foregoing, the Company agrees to pay the undersigned payment as follows:

The Contractor is required to submit their time sheet to VisionQwest Healthcare Accounts Payable Department at the end of their shift on the 15<sup>th</sup> and last day of the month. Payables will be made bi-weekly in accordance to the Company's contract with the client facility. The Healthcare per diem contractor will be paid on or before the 10<sup>th</sup> and 25<sup>th</sup> of each month. Per diem meaning a Contractor as base pay rate for temporary or contract worker.

### 1. TERMS

- a. The undersigned shall be deemed an independent contractor and is not an employee, partner, agent, or engaged in a joint venture with Company.
- b. Consistent with the foregoing, the Company shall not deduct withholding taxes, FICA or any other taxes required to be deducted by an employer as I acknowledge my responsibility to pay same as an independent contractor.
- c. I further acknowledge that I shall not be entitled to any fringe benefits, pension, retirement, profit sharing or any other benefits accruing to employees. Contractor is required to provide their own insurance to cover workers comp and professional liability insurance if applicable.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date first above written.

#### COMPANY

#### CONTRACTOR

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Print Name and Title

\_\_\_\_\_  
Print Name and Title



# VisionQwest Healthcare Group

## **CLIENT PROTECTION AGREEMENT**

This Client Protection Agreement (Agreement) is made as of this \_\_\_\_\_ by and between VisionQwest Healthcare Group (Company) and \_\_\_\_\_ (Contractor). In consideration of per diem assignment by the Company, the agreement of Contractor to work for the Company, and the mutual promises contained in this Agreement, Contractor and the Company agree as follows:

1. **Definition of Terms.** As used in this Agreement, the following terms will have the indicated meanings:
  - (a) "Company" includes VisionQwest Resource Group, Inc. and its division VisionQwest Healthcare Group and affiliates and all joint ventures and partnerships of which the Company or any of its divisions, subsidiaries and affiliates is a member or participant.
  - (b) "Client" means any customer or client of the Company, or any person or entity, or any affiliate of the foregoing, to whom the Company furnishes services and/or personnel in any manner.
2. **Prohibited Activities.** Contractor will provide services to a Client(s) of the Company, in this respect:
  - (a) During the time Contractor is providing services to a Client, Contractor **will not**, in any way, try to obtain employment with the Client or attempt to become a consultant to, or independent contractor to the Client.
  - (b) If Contractor is requested (or it is suggested to Contractor) that Contractor accepts employment with a Client, or become a consultant to or independent contractor to the Client, then Contractor will notify the Company with 24 hours of such suggestion or request.
  - (c) For a period of six months following termination of per diem assignment with the Company, Contractor shall not become an employee or Client or an independent contractor or consultant to a Client or provide any services to a Client.

**ANY VIOLATION OF THIS SECTION SHALL BE GROUNDS FOR A 15% PAYMENT OF YOUR ANNUAL GROSS SALARY TO VISIONQWEST HEALTHCARE AND IMMEDIATE TERMINATION.**

3. **Effective Date and Term.** This agreement, no matter when signed by Contractor, is effective from the first date of Contractor's per diem assignment with the Company, and shall survive the termination of Contractor's per diem assignment with the Company. Unless specifically provided differently in a separate written agreements signed by an authorized agent of the Company, Contractor's per diem assignment by the Company is at will, and can be terminated at any time by the Company with or without cause.
4. **No Right to Continuing Assignment.** No provision of this Agreement shall be construed as giving Contractor any right to be retained in the per diem assignment of the Company.



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## 5. Miscellaneous.

- (a) If any arbitration, litigation, dispute resolution, or other legal proceeding occurs between the parties relating to this Agreement, the prevailing party shall be entitled to recover (in addition to any other relief awarded or granted) its reasonable costs and expenses (including attorneys' fees) incurred in the proceeding and any appeal therefrom. No waiver, amendment, or modification of this Agreement shall be effective unless in writing and signed by the party against whom the waiver, amendment, or modification is sought to be enforced. No failure or delay by either party in exercising any right, power, or remedy under this Agreement shall operate as a waiver of the right, power, or remedy. No waiver of any term, condition, or breach of this Agreement shall be construed as a waiver of any other term, condition, or breach.
- (b) The section and paragraph headings of this Agreement are intended as a convenience only, and shall not be used to interpret its provisions. Where the context of this Agreement requires, singular terms shall be considered plural and plural terms shall be considered singular.
- (c) This agreement is intended to benefit and is binding on (a) the successors and assigns of Company, and (b) the heirs and legal successors of Contractor.
- (d) The validity, construction, and performance of this Agreement are governed by the laws of the State of California.
- (e) This Agreement, including all referenced attachments, constitutes the complete and final agreement between the parties, and supersedes all prior negotiations, agreements, and understandings between the parties concerning its subject matter but does not amend, cancel or supersede any employment contract between Company and Contractor.
- (f) Contractor represents that Contractor has no agreements with or obligations to any other party that would interfere with Contractor's compliance with this Agreement.
- (g) If Contractor breaches or threatens to breach any provision of this Agreement, in addition to any other rights and remedies Company may have, Company shall be entitled to temporary and permanent injunctive relief to prevent the breach or threatened breach without the necessity of proving actual damages or posting any bond or undertaking.
- (h) The words "shall" and "will" are used interchangeably in this Agreement and have the same mandatory meaning.
- (i) All Conditions in this Agreement are also covenants.
- (j) Any provision of this Agreement which is invalid, illegal or unenforceable in any jurisdiction will, as of that jurisdiction, be ineffective to the extent of such invalidity, illegality or unenforceability without affecting any remaining provision of this Agreement in such jurisdiction.



# VisionQwest Healthcare Group

- 6. Notices.** All notices to be given hereunder will be personally delivered (including sent by courier such as Federal Express, United Parcel Service, and Express Mail of the U.S. Postal Service, as long as a signed receipt for delivery is obtained) and sent by certified U.S. mail, postage prepaid, to the parties at the addresses set forth following the signatures of the parties, or to such other addresses as the parties may from time to time designated by notice given in accordance with this Section 7.12. Notices will be deemed given when received if personally delivered (including via any courier service); three days after mailing, or if by certified mail, postage pre-paid with return receipt requested, three days after mailing.
- 7. Acknowledgment of Reading and Understanding.** Contractor acknowledges that Contractor has read and understands this Agreement, and has received a copy of it.

This Agreement is executed as of the date set out in the first paragraph of this agreement.

**Contractor**

VisionQwest Healthcare Group  
A Division of VisionQwest Resource Group, Inc.  
A California Corporation

\_\_\_\_\_  
Signature

\_\_\_\_\_  
By:

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Title

Address:

500 N. Central, Suite 740  
Glendale, CA 91203

Please fill out:      W-9  
                                 I-9



# VisionQwest Healthcare Group

## What Happens Now?

Thank you for applying with VisionQwest Healthcare. Once we get your application, we begin the process of putting together your employee file, and completing a background check. In the meantime, please return to our office the following checked items:

- Proof of MMR
- Proof of Tb (PPD Skin Test)
- Proof of Varicella titer
- Completed Urine Drug Screen
- Completed Competency Exams (Age Related, Universal Precautions, CNA Competency Exam)
- Completed Skills Checklist
- Two References
- Copy of License
- Copy of CPR / ACLS / PALS / NRP
- Other: \_\_\_\_\_

Once your chart is complete, we will contact you to determine a start date. You can pre-book up to one year in advance, or call us an hour before a shift and inform us if you would like to work. You can also specify how frequently or infrequently you would like to be contacted by us.

### Contact Information:

VisionQwest Healthcare  
500 N. Central, Suite 740  
Glendale, CA 91203  
818.547.0497 Ext 2 (office)  
310.861.5558 (fax)

Once again, thank you, and please feel free to contact us at any time and let us know what we can do better to serve you.