EXCEL STAFFING SERVICES, INC.

PO Box 13251 Greensboro, NC 27415
Tel: 1- 800- 883- 9235
Fax: (336) 291-1011

DOH:__________________
ORIENTATION:__________________
TB DATE:__________________

EMPLOYEE SERVICE APPLICATION: CNA LPN RN (circle one)

NAME ______________________________________TAX ID/SS# ______ - ______ - _______

ADDRESS ______________________________________ PHONE ______ - ______ - _______

CITY ____ PHONE ______ - ______ - _______

STATE ___________________ ZIP _________________ PHONE ______ - ______ - _______

DATE OF BIRTH ______________________ ARE YOU A US CITIZEN? YES NO

HAVE YOU EVER BEEN AN EMPLOYEE WITH US? YES NO
IF YES, WHAT DATES? _________________________WHICH STATE(S)? ______________

PROFESSIONAL INFORMATION:
STATE(S) WHERE LICENSED _______________________ LICENSE # _________________
CPR CERTIFICATION? YES NO EXPIRATION DATE _________________
OTHER MEDICAL CERTIFICATION ____

EDUCATION:
HIGH SCHOOL/GED __________________________ DATE GRADUATED ______________
COLLEGE/TECH SCHOOL _____________________ DATE GRADUATED ______________

AVAILABILITY:
SHIFT PREFERENCE – 1ST _______ 2ND _______ 3RD _______ 12 HOURS? YES NO

EMPLOYMENT HISTORY: MUST BE FILLED OUT COMPLETELY
COMPANY NAME _______________________________ PHONE ______ - ______ - _______
ADDRESS ____
CITY ____________________________ STATE _________________ ZIP _________________
JOB TITLE ___________________________________ SUPERVISOR ____________________
REASON FOR LEAVING ____

COMPANY NAME _______________________________ PHONE ______ - ______ - _______
ADDRESS ____
CITY ____________________________ STATE _________________ ZIP _________________
JOB TITLE ___________________________________ SUPERVISOR ____________________
REASON FOR LEAVING ____

COMPANY NAME _______________________________ PHONE ______ - ______ - _______
ADDRESS ____
CITY ____________________________ STATE _________________ ZIP _________________
JOB TITLE ___________________________________ SUPERVISOR ____________________
REASON FOR LEAVING ____

The information on this application is accurate and subject to verification. I understand that any misleading or incorrect statements may render this application void. Special needs, shift variances, travel and other requirements determine what I will invoice Excel (per time slip/invoice) at a negotiated shift rate.

SIGNATURE ____ DATE _____________

CERTIFIED NURSING ASSISTANT TEST

IF YOU HAVE RECEIVED THIS CNA APPLICATION IN ERROR, PLEASE NOTIFY OUR OFFICE IMMEDIATELY

PLEASE ANSWER THE FOLLOWING STATEMENTS TRUE (T) OR FALSE (F).

_____ 1. NURSING PERSONNEL ARE NOT RESPONSIBLE FOR DOUBLE CHECKING TRAYCARDS TO AVOID SERVING THE WRONG TRAY TO A PATIENT.

_____ 2. AIDES SHOULD LET THE RESIDENT HELP HIMSELF WHENEVER IT IS POSSIBLE AND SAFE.

_____ 3. IT IS IMPORTANT THAT DIABETIC RESIDENTS EAT ONLY THOSE FOODS ORDERED BY THE DOCTOR OR DIETICIAN AND NOT EAT SUCH FOODS AS CANDY OR CAKES.

_____ 4. ALL RESTRAINTS MUST BE ORDERED BY THE DOCTOR.

_____ 5. IT IS UNPROFESSIONAL TO DISCUSS A RESIDENT'S CONDITION WITH OTHER RESIDENTS OR VISITORS.

_____ 6. IF YOU FIND A RESIDENT UNCONSCIOUS ON THE FLOOR YOU SHOULD PUT HIM/HER BACK TO BED.

_____ 7. IF A RESIDENT COMPLAINS OF GAS PAINS YOU SHOULD TELL THE NURSE.

_____ 8. YOU SHOULD GIVE AN ENEMA QUICKLY SO THE RESIDENT WON'T HAVE TO WAIT LONG.

_____ 9. IF YOU ARE EXERCISING A RESIDENT, AND HE/SHE COMPLAINS OF SHORTNESS OF BREATH, YOU SHOULD KEEP GOING BECAUSE HE/SHE PROBABLY JUST DOESN'T WANT TO EXERCISE.

_____ 10 . RANGE OF MOTION EXERCISES KEEP RESIDENTS FROM GETTING STIFF OR FROZEN JOINTS.

_____ 11. IF THE RESIDENT IS NPO FOR TEST TOMORROW MORNING, IT'S OK TO LET HIM/HER HAVE A GLASS OF WATER AFTER MIDNIGHT IF HE OR SHE IS THIRSTY.

_____ 12. IF A FOLEY CATHETER BAG COMES APART AND THE TUBING FALLS ON THE FLOOR, IT IS OK TO WIPE IT OFF AND PUT IT BACK TOGETHER.

_____ 13. EXTREME DEHYDRATION CAN LEAD TO DEATH.

_____ 14. A RESIDENT WHO IS INCONTINENT SHOULD BE CHECKED AT LEAST EVERY TWO HOURS.

_____ 15. A NORMAL BLOOD PRESSURE IS 80/50 FOR SOMEONE WHO IS ASLEEP.

_____ 16. A NORMAL HEART RATE SHOULD BE BETWEEN 60 AND 100 BEATS PER MINUTE.

_____ 17. A RESIDENT WHO HAS HAD A STROKE DOES NOT NEED ANY SPECIAL HELP.

_____ 18. IT IS OK TO LEAVE A RESIDENT UNATTENDED WHILE RUNNING HIS/HER BATH WATER.

_____ 19. YOU SHOULD PUT A HEATING PAD NEXT TO THE SKIN, WITHOUT A COVER FOR BEST RESULTS.

_____ 20. IF A RESIDENT SAYS, "I FEEL LIKE I'M GOING TO DIE", YOU SHOULD JUST IGNORE HIM/HER.

CNA SKILLS CHECKLIST

First Name ______________________ Last Name ______________________

Social Security Number ______________________ Date ______________________

It is **mandatory** that you read and fill out this form. The checklist is used to assess your experience and skills. Please provide an accurate self-assessment of your skills using the following guidelines.

0 = No Experience
1 = Limited Experience
2 = Experienced
3 = Highly Skilled

DOCUMENTATION	**0**	**1**	**2**	**3**
Clinical Note				
PERSONAL CARE	**0**	**1**	**2**	**3**
Total Bed Bath				
Tub Bath				
Shower				
Sponge Bath				
Sitz Bath				
Hair Care				
Nail and Foot Care				
Skin Care				
Perineal Care				
Oral Care				
Denture Care				
Shave Patient				
Assist with Dressing				
Other: (List Below)				
GENERAL NURSING	**0**	**1**	**2**	**3**
Admit & Orient Patients				
Discharge Patients				
Vital Sign Monitoring				
Pulse Oximetry				
Urine Dipstick				
Blood Glucose Monitoring				
Wound Care				
Dressing Changes				
Pre-Operative Care/ Preparation				
Post-Anesthesia Care:				
- General				
- Spinal				
- Block				
Restraints - Apply / Monitor				
Isolation Techniques				
Advance Directives				
Postmortem Care				

VASCULAR	**0**	**1**	**2**	**3**
Apply Noninvasive BP Monitor				
Monitor Noninvasive BP Monitor				
Peripheral Pulses				
Discontinue Peripheral IV's				
Intake and Output				
Ultrasound Doppler				
RESPIRATORY	**0**	**1**	**2**	**3**
Open / Monitor Airway				
Assist with Intubarion (ETT)				
Assist with Extubation				
O2 Saturation Spot Checks				
O2 Saturation Monitors				
Incentive Spoirometry				
Nasal Cannula				
Face Masks				
Assist Care of Patient With:				
Asthma / COPD				
Pre / Post Thoracic Surgery				
Tracheostomy				
Chest Tubes				
NEUROLOGY	**0**	**1**	**2**	**3**
Neurological Evaluation				
Glascow Coma Scale				
Assist with Lumbar Puncture				
Seizure Precauctions				
Assist Care of Patient With:				
Open / Closed Head Injury				
CVA				
Spinal Cord Injury				
Craniotomy				
Drug Overdose / DTs				
GASTROINTESTINAL	**0**	**1**	**2**	**3**
Assist with Nutritional Evaluation				
Assist with Feedings				

CARDIAC	0	1	2	3
Use of Cardiac Monitors				
Telemetry				
Perform 12-lead EKG				
Assist with Code				
Assist Care of Patient With:				
Acute MI				
Congestive Heart Failure				
Pre / Post Cardiac Cath				
Pre / Post Cardiac Surgery				
Aneursym				
Permanent Pacemaker				
Temporary Pacemaker				

ORTHOPEDIC	0	1	2	3
Crutch Walking				
Cast Care				
Traction				
Assist Care of Patient With:				
Amputation				
Skeletal Traction				
Arthoscopy / Arthrotomy				
Total Hip Replacement				
Total Knee Replacement				

ACTIVITY	0	1	2	3
Postioning				
Transferring				
Walker				
Passive Range of Motion				
Active Range of Motion				
Walking with Assistance				
Walking with Supervision				
hoyer Lift				
Assist with Excerise Program				
Other: (List Below)				

Monitor NG Tube				
Gastrostomy Tube Monitor / Feed				
Ostomy Care				
Assist Care of Patient With:				
GI Bleed				
Abdominal Wounds				
Drains				

GENITOURINARY	0	1	2	3
Straight / Foley Cath Female				
Straight / Foley Cath Male				
Obtain / Instruct Clean Catch Urine				
Assist Care of Patient With:				
Shunts & Fistuals				
Renal Failure				
Nephrectomy				
Renal Transplant				
Mastectomy				
Hysterectomy				
Prostate Surgery				

OTHER	0	1	2	3
Assist Care of Patient With:				
Diabetes				
AIDS				
Multiple Trauma				
Burns				
Oncology				
Bone Marrow Transplant				
Liver Transplant				

Age-Appropriate Care: Ability to adapt care to incorporate normal growth and development, adapt method and terminology of client instructions as it relates to the age and comprehension level of the client, and to ensure a safe environment - reflecting specific needs of the client and various age groups.

AGE	0	1	2	3
Newborn / Infants (birth - 1 year)				
Toddler (1 - 3 years)				
Preschooler 3 - 5 years)				
School Age (5 - 12 years)				

AGE	0	1	2	3
Adolescents (12 - 18 years)				
Young Adults (18 - 39 years)				
Middle Adults (39 - 64 years)				
Older Adults (64+ years)				

The information I have provided above is true and accurate to the best of my knowledge, and I hereby authorize Excel Staffing Service, Inc to release this checklist to any entity that is contracted with Excel Staffing Service, Inc.

Print Name ______________________ Date ______________________

Independent Contractor Signature ______________________

SERVICE DESCRIPTION FOR CERTIFIED NURSING ASSISTANT
CONTRACT LABOR – PHYSICAL, SENSORY, & MENTAL REQUIREMENTS

PHYSICAL REQUIREMNTS (F) – Frequently used (O) – Occasionally used

REQUIREMENT	USED	COMMENTS
SIT	(O)	FEED, READ, AND TALK TO PTs.
STAND	(F)	INVOLVING PT. CARE
WALK, BEND, SQUAT	(F)	DAILY
LIFTING UNNASSISTED – UP TO 20 LBS	(F)	WORKING WITH EQUIPMENT
21-50 LBS	(O)	**OVER 50 LBS - ASSISTANCE NEEDED**
GRASPING USING BOTH HANDS	(F)	RENDERING PT. CARE AND PROCEDURES FOR PT. CARE
PUSHING/PULLING	(F)	WHEEL CHAIRS, CARTS
FINE MANIPULATING USING BOTH HANDS	(F)	DRESS PATIENTS, WRITE NOTATIONS, OPEN PACKETS, DOCUMENTATION
MOVE AROUND MACHINES	(O)	MACHINES IN PATIENTS ROOMS
MANIPULATING FEET USING BOTH FEET	(O)	USING FOOT LOCKS AND PEDALS ON BEDS, HOPPERS A HAMPERS
EXPOSURE TO DUST, FUMES, AND SHARP OBJECTS	(O)	DUST, CHEMICALS, SAFETY PINS, RAZORS, ETC.

SENSORY REQUIREMENTS

REQUIREMENT	COMMENTS/RELATED JOB DUTIES
CAN DISTINGUISH SMELLS	FOUL ODORS ARE OFTEN SYMPTOMATIC OF THE DISEASE PROCESS OR INFECTION
CAN HEAR NORMAL TONES SOFT TONES	PATIENTS CALLS AND CALL BELLS MUST BE ANSWERED HEARD FROM CLOSE AND FAR DISTANCES
CAN DISTINGUISH TEMPERATURES BY TOU OR PROXIMITY	BATH WATER FOR PATIENTS, TEMPERATURE OF EQUIPEMENT AND PATIENTS.
EYESIGHT: NORMAL OR CORRECTED AND ABLE TO DO CLOSE EYE WORK	OBSERVE PATIENTS, GIVE PATIENTS CARE THERMOMETERS, CHARTS, ETC.

MENTAL REQUIREMENTS

REQUIREMENT	COMMENTS/RELATED JOB DUTIES
READ, WRITE AND SPEAK	NECESSARY – TO COMMUNICATE WITH PTs., COMPREHEND NURSING SUPPLIES, CHARTS, DIET CARDS, ETC.
MEMORY AND RECALL	NECESSARY
POSITIVE ATTITUDE TOWARD THE ILL, ELDERLY, HANDICAPPED	NECESSARY
IS COHERENT	NECESSARY
CAN CONTROL EMOTIONS, CAN HANDLE STRESS	NECESSARY RELATES TO BOTH PHYSICAL AND MENTAL REQUIREMENTS, NOT GETTING ANGRY, etc.

TASKS

TASKS
ASSISTING PATIENTS WITH BATHING, ENSURING THAT WATER IS APPROPRIATE TEMPERATURE
ASSISTING PATIENTS TO AND FROM BATHROOM
RECORDING INTAKE AND OUTPUT INFORMATION
CHECKING VITALS AND WEIGHTS
ANSWERING PATIENT'S CALL LIGHTS AND REQUESTS
REPORTING OBSERVATIONS OF THE PATIENT TO NURSING SUPERVISOR

I have read and understand that the physical, sensory, and mental requirements outlined below are necessary of the services to be performed. I affirm I am able to perform the service without limitation and have not knowingly withheld any information relating to these requirements.

SIGNED **DATE**

PATIENT'S BILL OF RIGHTS-ELDER CARE ABUSE

I feel each resident should expect the highest quality of personal and professional care. In keeping with this philosophy, I support and adhere to the Patient's Bill of Rights. Because of the importance of these expectations in my role, I am attesting to the portions of the Patient's Bill of Rights highlighted below which affirm the rights of a resident:

1. To be treated with consideration, respect and full recognition of personal dignity and individuality.

2. To receive care, treatment and services which are adequate.

3. To receive respect and privacy of his or her personal and medical records.

4. To be free from mental and physical abuse.

5. To enjoy privacy in his or her room.

6. To associate and communicate privately with persons of his or her choice and send and receive his or her personal mail unopened.

7. To meet with and participate in activities of social, religious and community groups at his or her discretion.

No roster or rights can guarantee for the resident the kind of treatment they have a right to expect. It is very important that each of my actions is conducted with a main concern for the resident and the recognition of their dignity as a human being. Violations of the Patient's Bill of Rights may result in disciplinary action up to and including revocation of license, termination and jail.

By signing this, I state that I have read and understand the Patient's Bill of Rights.

SIGNATURE ______________________________________ DATE ___________

HEPATITIS B VIRUS VACCINE CONSENT OR DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus infection (HBV). At this time I choose the following:

Check one, then sign at the bottom.

☐ I have already received the vaccine and so I am declining at this time.

☐ I choose not to receive the vaccine at this time.

☐ I may chose to be vaccinated against Hepatitis B while working as an active Employee with Excel Staffing Services. I understand that I will be reimbursed for the cost of any shots in the Hep B series taken during the time I am working through Excel. In addition, I agree to request reimbursement while I am still actively accepting work and understand my request may be denied if it is made after I am terminated or inactivated for any reason.

SIGNATURE____

PRINT NAME _____________________________ **DATE** ____________

OSHA REGULATIONS AND GUIDELINES

In accordance with OSHA regulations, each contractor must review the Blood Borne Pathogen, Hazard Communications, Emergency Action Plan, Fire Prevention and Escape Routes.

Excel has notified each facility that they are responsible and must review their facility's specific plan with each contractor that works in that facility.

Please review all enclosed material, sign and date this sheet. Fax or mail this sheet back to Excel for your personnel file.

I ____ have reviewed and understand the presented material as stated. I have been given the opportunity to clarify any questions that I may have.

SIGNATURE ____________________________________ DATE ________________

STATEMENT OF EMPLOYEE
HEALTH STATUS AND INJURY HISTORY

NAME ____ TITLE _______________

Person to be notified in case of an emergency : ____________________________________
Telephone number(s): ____

Please answer the following by checking YES or NO. Use the space below to comment on any question you answered YES to.

1. Reactions to medications YES_____ NO _____

2. Skin rashes or eczema YES_____ NO _____

3. Back Trouble YES_____ NO _____

4. Back Injury YES_____ NO _____

5. Back Surgery YES_____ NO _____

6. Back Pain on lifting YES_____ NO _____

7. Knee Surgery YES_____ NO _____

8. Swollen Joints YES_____ NO _____

9. Rheumatism or arthritis YES______ NO _____

10. Dislocated shoulder YES_____ NO _____

11. Fracture of a bone YES_____ NO _____

12. Any other type of injury YES_____ NO _____

13. Work related injury claim within the past five years? NO _____
YES_____ Please explain nature of injury, place, and date: ________________________
____

Comments ____

____

____

____

SIGNATURE ______________________________________DATE_____________

EXCEL STAFFING SERVICES, INC.
P. O. BOX 13251
GREENSBORO, NC 27415
1-800-883-9235
FAX: 336-291-1011

INDEPENDENT PHYSICIAN, HEALTH CARE PROFESSIONAL AND VENDOR ACCESS AND CONFIDENTIALITY AGREEMENT

HP113-B

As a health care professional who treats patients and residents of facilities (hereafter referred to as "Health Care Professional"), you may have access to "confidential information." The purpose of this agreement is to confirm your understanding of and obtain your commitment to your duties regarding confidential information.

Confidential information is valuable, sensitive, and protected by law and the facility policies. As a Health Care Professional, you are required to conduct yourself in a strict conformance to applicable laws and the facility policies and to abide by the duties described below governing confidential information.

You will be responsible for any alteration, destruction, misuse or wrongful disclosure of confidential medical information by you and for any failure by you to safeguard any authorization codes to access confidential information. You understand that your failure to comply with the duties described below and this agreement may also result in loss of privileges to access confidential information, loss of privileges to treat patients and residents at facilities and to legal liability.

As a Health Care Professional, you understand that you will have access to such confidential medical information that may include, but is not limited to, information relating to:

- Patients and residents (such as medical records, private conversations, admittance information, resident financial information, etc.)
- Other employees (such as salaries, employment records, disciplinary actions, etc.)
- Facility information (such as financial and statistical records, strategic plans, internal reports, memos, contracts, peer review information, communications, proprietary computer programs, source code, proprietary technology, etc.)
- Third party information (such as computer software programs, client and vendor proprietary information, proprietary technology, etc.).

As a condition of and in consideration of your access to such confidential information, you promise that:

1. You will use confidential information only as needed to perform your legitimate duties at facilities.

   a) You will only access confidential information needed to treat your patients and residents or fulfill your responsibilities.

b) You will not in any way divulge, copy, release, sell, loan, review, alter, or destroy any confidential information except as properly authorized within the scope of your professional activities as a Health Care Professional and treater of residents affiliated with facilities.

c) You will not misuse or fail to safeguard confidential information.

2. You will safeguard and will not disclose any authorization codes or keys you have that allow you to access confidential information. You accept responsibility for all activities undertaken using your authorization codes or keys.

3. You will report to the Facility Privacy Officer activities by any individual or entity you suspect may compromise the confidentiality of confidential information described in this agreement.

4. You understand that your obligations under this agreement will continue after termination of your privileges or permission to treat patients and residents of facilities. You understand that facilities may review, revise or terminate your privileges to access and use confidential information as reasonably warranted to protect confidentiality of such information.

5. You understand that you have no right to ownership interest in any confidential information referred to in this agreement. The facility may at any time revoke your key, access code, other authorization, or access to confidential information.

6. Health Care Professional shall indemnify and hold facilities harmless from and against all claims, liabilities, judgments, fines, assessments, penalties, awards, or other expenses, of any kind or nature whatsoever. This indemnification includes without limitation, attorneys' fees, expert witness fees, and costs of investigation, litigation or dispute resolution, relating to or arising out of any breach or alleged breach of this agreement by Health Care Professional.

7. You will respect ownership of proprietary software.

8. You will not operate any non-licensed software on any computer provided by any facility.

By signing this, I agree that I have read, understand and will comply with this agreement.

____ ____________________

Health Care Professional Date

____

Print Name

CONSENT FOR DRUG SCREENING

I ____ am aware that as a contract laborer, pre-employment drug testing is not necessary but that it may be requested that I voluntarily consent to a drug screening at my own expense. I hereby give my consent for this screening. Excel Staffing will give site location of where this service may be performed. I am also aware that I will be limited to the work offered if I do not have the test done before my shift is confirmed.

SIGNATURE ____

PRINT NAME ____________________________________ **DATE** _____________

DISCLAIMER

In the signing of this document, I acknowledge and agree that I am contracted to facilities by Excel Staffing. I also understand that I am not an employee of the facility and that I have no legal rights to any benefits provided by the facility to its employees. I further agree that I will not make any claims against said facilities for any wages or benefits including Worker's Compensation claims.

SIGNATURE____

PRINT NAME ______________________________ **DATE** __________

EXCEL STAFFING SERVICES, INC.
PO BOX 13251
GREENSBORO, NC 27415
TEL: 800-883-9235
FAX: 336-291-1011

REFERENCE REQUEST

Please send my reference request to:

Company Name ________________________________ Supervisor ____________________

Mailing Address ____

City ______________________________________ State _________ Zip ________________

Telephone Number (   ) _________ - _____________

For:
Applicant's Name ____ Job Title _________________

Tax ID/SS# ___________ - _________ - ______________

I hereby authorize the employer named above to provide any requested information to Excel Staffing Services, Inc. and release them from all liabilities in responding to inquiries in connection with my application.

Applicant's SIGNATURE **DATE**

(Applicants do not fill out this portion.) TO BE COMPLETED BY EMPLOYER

Dates of Employment: From ____________________ To __________________

Position Held: ____

Reason for Leaving: ____

Would you rehire? YES _______ NO _______

If no please explain: ____

____

Signature ____ Date _______________

Title ____

In placing an application with us for the position of ___________, the above applicant has given you as a reference. It would be appreciated if you will complete this form and return it to us in the enclosed self – addressed envelope. Thank you for your help.

EXCEL STAFFING SERVICES, INC.
PO BOX 13251
GREENSBORO, NC 27415
TEL: 800-883-9235
FAX: 336-291-1011

REFERENCE REQUEST

Please send my reference request to:

Company Name ___________________________________ Supervisor ______________________

Mailing Address ____

City ____ State _________ Zip ________________

Telephone Number (   ) _________ - _____________

For:
Applicant's Name ____ Job Title _________________

Tax ID/SS# ___________ - _________ - ______________

I hereby authorize the employer named above to provide any requested information to Excel Staffing Services, Inc. and release them from all liabilities in responding to inquiries in connection with my application.

Applicant's SIGNATURE **DATE**

(Applicants do not fill out this portion.) TO BE COMPLETED BY EMPLOYER

Dates of Employment: From ____________________ To __________________

Position Held: ____

Reason for Leaving: ____

Would you rehire? YES _______ NO _______

If no please explain: ____

____

Signature ____ Date ______________

Title ____

In placing an application with us for the position of ___________, the above applicant has given you as a reference. It would be appreciated if you will complete this form and return it to us in the enclosed self – addressed envelope. Thank you for your help.

AUTHORITY FOR RELEASE OF INFORMATION

I authorize Excel Staffing Services, Inc. to perform a criminal history record information check in connection with my work, and to share the information with any / all facilities where I will accept work when required.

Last Name	First Name
Middle Name	Maiden Name
Social Security Number	Date of Birth
State You Currently Live In	County
Sex	Race

I hereby release said agency and persons from any and all liability, which may be incurred as a result of furnishing such information. In addition, as an Employee, I will submit a $20.00 **money order** to cover the cost of this criminal background check to be done. MS Resident's will have to send in a $50.00 money order along with a fingerprint card for a federal background check or a MS Fingerprint Clearance letter dated within the last two years as required by the state.

SIGNATURE **DATE**

- **NORTH CAROLINA- If you have lived in NC for less than 5 years or are a non-resident who wishes to work in NC you must submit a fingerprint card and $40.00 money order for a national database search through the State Bureau of Investigations.**

EXCEL STAFFING
PO Box 13251
Greensboro, NC 27415
1-800-883-9235
336-230-1103
Fax: 336-291-1011

Excel Staffing is a temporary help company, which provides temporary help employees to various nursing facilities. As a temporary employee hired as such with our company, you are required to contact our office after completion of your assignment.

CALLING THE ANSWERING SERVICE IS NOT CONSIDERED CONTACTING OUR OFFICE

You must contact our office and talk with our staffing professional to let us know you have completed your assignment.

Failure to contact our office for reassignment will mean that you have quit work without good cause. This may make you ineligible for benefits, including but not limited to unemployment benefits

______________________________ ____________________
Signature Date

EMPLOYMENT AGREEMENT

This Employment Agreement (the "Agreement") is made and entered into this ____ day of ______________, 20____, (hereinafter referred to as the "Effective Date") by and between Excel Staffing Service, Inc., a North Carolina corporation (the "Company"), and ____________________ (the "Employee"). The Company and the Employee are collectively referred to as the "Parties" in this Agreement.

WITNESSETH

WHEREAS, the Company has offered the Employee employment with the Company.

WHEREAS, prior to the offer of employment and prior to actually beginning work with the Company, Employee acknowledged and agreed that Employee would, as a condition of employment, sign this Agreement, containing the non-disclosure of confidential information and arbitration provisions set forth herein.

WHEREAS, as a condition precedent to the offer of employment and in consideration of the Company employing Employee; compensating Employee; providing Employee with certain employee related benefits; training Employee; and other good and valuable consideration, the receipt, adequacy, and sufficiency of which are hereby acknowledged and accepted, Employee has agreed to enter into this Agreement and has agreed to the provisions contained herein.

NOW, THEREFORE, for good and valuable consideration, the receipt, adequacy, and sufficiency of which are hereby expressly acknowledged and accepted, the Company and Employee, intending to be legally bound, hereby agree as follows:

ARTICLE 1
EMPLOYMENT

1.1 Employment At-Will. Both the Company and Employee acknowledge that the Employee's employment is "at will," and may be terminated by either party at any time, with or without reason, by giving notice to the other party. Nothing in this Agreement or in any written or oral communication constitutes an offer or agreement by the Company to employ Employee for any particular length of time nor by Employee to remain employed for any particular length of time.

1.2 Employee Duties and Responsibilities. Employee agrees to perform all duties and responsibilities assigned by the Company in a competent, diligent, and professional manner and to help advance and render profitable the interests, business, and goodwill of the Company.

1.3 Company Rules, Regulations, and Policies. Employee agrees, during his or her employment, to adhere to all rules, regulations, and policies that have been or that hereafter may be established by the Company for the conduct of its employees.

ARTICLE 2
COMPENSATION

2.1 Compensation. For all services rendered by Employee, in whatever capacity, during employment under this Agreement, Employee will be paid in accordance with the Company's normal payroll schedules and policies (and subject to any and all applicable federal, state, and local taxes and other statutory withholdings, payroll deductions, and other deductions allowed or required by law). Employee acknowledges that Employee's compensation is subject to change at any time at the Company's discretion.

2.2 Vacation. During Employee's employment under this Agreement, Employee will be eligible to accrue vacation time such as is allowed for other similar employees of Company pursuant to the Company's vacation policies then in effect. Any such vacation time shall accrue and shall be taken in accordance with the current Company vacation policies.

2.3 Other Benefits. Employee, if otherwise eligible, will be allowed to participate, following any applicable waiting periods, in Company-sponsored group benefit plans. Eligibility for participation in any Company-sponsored group benefit plans is determined in accordance with the terms of each plan, and each plan is subject to change in the Company's discretion.

ARTICLE 3
CONFIDENTIAL INFORMATION & COMPANY PROPERTY

3.1 Non-Disclosure of Confidential Information. Employee recognizes the interest of the Company in maintaining the confidential nature of its proprietary and other business and commercial information. In connection therewith, Employee covenants that during the Employee's employment with the Company and after employment has ended, Employee shall not, directly or indirectly, publish, disclose or use for the Employee's own benefit, or for the benefit of any business or entity other than the Company, data or information relating to the Company (whether constituting a trade secret or not), which is or has been disclosed to Employee or of which Employee became or becomes aware as a consequence of or through Employee's relationship with the Company and which has value to the Company and is not generally known to the Company's competitors (the "Confidential Information"). Confidential Information includes, but is not limited to, names, contacts, addresses, email addresses, and phone numbers of the Company's Clients and information regarding Clients' needs, projects, pricing, services, fee arrangements, costs, profits, financial data, method of doing business, techniques, developments, development plans, training materials, standard operating procedures, software code, improvements, inventions, and other business information relating to the Company that is not generally known. The Confidential Information shall not include any data or information that is voluntarily disclosed by the Company (except where such public disclosure has been made by Employee without authorization) or that has been independently developed or disclosed by others, or that otherwise enters the public domain through lawful means. Employee acknowledges that all Confidential Information and all embodiments thereof shall be and remain the sole property of the Company, and Employee shall, upon request of the Company, deliver to the

Company all Confidential Information and embodiments thereof, and all records, documents and other property of or pertaining to the Company, then in Employee's possession or control and shall not retain any copy or extraction thereof.

3.2 Return of Company Materials. Employee agrees that, upon the termination of his or her employment with the Company for any reason, Employee will return to the Company's possession and control, all records, documents, files, price lists, customer lists, drawings, computer disks, brochures, pictures, videotapes, and other data compilations containing information of the Company of any type or description (including all copies thereof) which are then under Employee's control or in Employee's possession, whether developed and/or compiled by the Company, Employee, or others. Employee also agrees that Employee will sign, upon the termination of his or her employment for any reason, an affirmative representation that Employee has returned all such materials.

ARTICLE 4
CERTAIN REMEDIES

4.1 Injunctive Relief. Employee acknowledges that any breach of this Agreement, including without limitation Article 3 hereof, will cause immediate and irreparable harm to the Company and that the resulting damages will be exceedingly difficult to measure in full. Therefore, the Employee acknowledges that payment of damages to the Company in an action at law for breach of this Agreement would not adequately compensate the Company for the harm it suffered. The Employee and the Company therefore agree that, in addition to all of the remedies provided at law or in equity, this Agreement may be enforced by means of injunctive relief, including but not limited to a temporary restraining order and injunctions, and that all other available remedies at law or in equity, including but not limited to money damages, may be pursued for breach of this Agreement.

ARTICLE 5
NO CONFLICTING AGREEMENTS

5.1 No Conflicting Agreements. Employee agrees not to disclose to the Company or induce the Company to use any confidential or proprietary information belonging to any of Employee's previous employers, to any clients of Employee's former employers, or to others. Further, Employee represents and warrants to the Company that the performance of his or her job duties as may be assigned to him or her from time to time by the Company shall not violate, cause the breach of, or conflict with any prior agreement, contract, or understanding between him or her and any third party or otherwise violate any confidence of another, including but not limited to, any agreement prohibiting him or her from competing with such third party. In the event that the representation and warranty made by Employee above is not true, accurate, or correct, Employee agrees that he or she will indemnify and hold harmless the Company and its successors and assigns against any loss, damage, claim, or expense (including reasonable attorneys' fees based on the customary hourly rates then charged for their services) incurred by the Company or its successors or assigns that arise out of or are related to the breach of his or her representation and warranty to the Company as set forth above. The failure of either party at any time or times to require performance of any provision hereof shall in no manner affect the right, at a later time, to enforce such provision.

ARTICLE 6
ARBITRATION

6.1 Agreement to Arbitrate Disputes. Any controversy or claim arising out of the Employee's employment with the Company and/or termination of employment with the Company shall be settled by arbitration administered by the American Arbitration Association under the Employment Arbitration Rules and Mediation Procedures, as amended and in effect at the time the arbitration is initiated (the "Rules"), and judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. By way of example, such controversies and claims include those under federal, state, and local statutory or common law, such as claims for breach of contract, wrongful discharge, negligent retention, libel, slander, emotional distress and/or claims under Title VII of the Civil Rights Act of 1964, as amended, 42 U.S.C. § 2000e et seq.; the Civil Rights Act of 1991, as amended, 42 U.S.C. § 1981a et seq. ("CRA of 1991"); 42 U.S.C. § 1981 ("Civil Rights Act of 1866"); the Fair Labor Standards Act of 1938, as amended, 29 U.S.C. § 201 et seq.; the Equal Pay Act of 1963, 29 U.S.C. § 206(d)(1); the Americans with Disabilities Act, 42 U.S.C. § 12101 et seq.; the Rehabilitation Act of 1973, 29 U.S.C.A. § 794; the Family and Medical Leave Act of 1993, 29 U.S.C. § 2601 et seq.; the Age Discrimination in Employment Act of 1967, as amended, 29 U.S.C. § 621 et seq.; the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001 et seq. ("ERISA"); the Lilly Ledbetter Fair Pay Act; the Occupational Safety and Health Act; the North Carolina Wage and Hour Act; the North Carolina Persons with Disabilities Protection Act, N.C. Gen Stat. § 168A-1 et seq.; the North Carolina Equal Employment Practices Act, § 143-422.1 et seq.; and the North Carolina Retaliatory Employment Discrimination Act, as well as any state, local, or federal employment discrimination laws.

NOTICE: THE EMPLOYEE AND THE COMPANY UNDERSTAND THAT THEY WOULD HAVE HAD A RIGHT OR OPPORTUNITY TO LITIGATE DISPUTES THROUGH A COURT AND HAVE A JUDGE OR JURY DECIDE THEIR DISPUTES BUT HAVE AGREED INSTEAD TO RESOLVE DISPUTES THROUGH BINDING ARBITRATION, HAVE ELECTED ARBITRATION AS THEIR EXCLUSIVE FORUM, AND WAIVE ANY RIGHT TO TRIAL BY JURY IN A COURT OF LAW TO RESOLVE ANY DISPUTE.

Any arbitration initated under the terms of this Agreement shall be held in Guilford County, North Carolina, and shall be conducted and ruled upon by a single neutral Arbitrator selected using the listing process set out under the Rules. A copy of the most recent version of the Rules, as amended from time to time by the American Arbitration Association, is available from the Company for review upon request. The Arbitrator's decision, including the amount of any award, shall be final and binding upon the Parties. Together with the decision, the Arbitrator shall provide a written explanation of the decision and of any award. Any judgment upon an award made by the Arbitrator may be entered in any state or federal court having competent jurisdiction. All remedies available to the Employee or the Company in a court of law shall be available through arbitration unless they conflict with Section 6.2 of this Agreement.

The costs of the arbitration (filing fee, administrative fee, if any, and the Arbitrator's fee) shall be paid by the Company, however, the Employee and the Company will each pay his or her, or its own attorney's fees incurred in prosecuting or defending the arbitration. Nothing in

this arbitration provision shall prevent the Arbitrator from awarding the costs of the arbitration and/or attorney's fees to a prevailing party as allowed by law or by the Rules.

Nothing in this Agreement precludes the Employee or the Company from filing a complaint with a federal, state or other governmental administrative agency.

6.2 One-Year Limitation Period for Initiation of Arbitration. Any arbitration initiated under the terms of this Agreement must be initiated with the American Arbitration Association within one (1) year following the date of the incident complained of. If the applicable statute of limitations is less than one (1) year, no demand or request for arbitration shall be made after the date when such dispute would be barred by the applicable statute of limitations. Additionally, no demand or request for arbitration shall be made after the administrative deadline for filing such a claim has expired.

6.3 Agreement Not to Bring, Join, or Participate in Class or Collective Actions. To the extent permitted by law, the Employee agrees that he or she will not bring, join, or participate in any class action lawsuits, collective action lawsuits, class arbitrations, or collective action arbitrations as to any claim, disputes, or controversy the Employee may have against the Company or any of the Company's owners, managers, officers, directors, employees, or assigns. The Employee agrees to the entry of injunctive relief to stop such a class action lawsuit, collective action lawsuit, class arbitration, or collective action arbitration to remove the Employee as a participant in such lawsuit or arbitration. The Employee also agrees to pay the attorneys' fees and court costs the Company incurs in seeking such relief. This Agreement does not constitute a waiver of any of the Employee's rights and remedies to pursue a claim individually (and not as a class) in binding arbitration as provided above in Articles 6.1 and 6.2.

ARTICLE 7
MISCELLANEOUS

7.1 Controlling Law. This Agreement shall be construed, interpreted, and enforced both as to substance and remedies, in accordance with the laws of the State of North Carolina.

7.2 Entire Agreement. This Agreement contains the entire agreement and understanding of the Parties with respect to the subject matter hereof. This Agreement shall not be modified or amended except by further written documents signed by both the Employee and the Company.

7.3 Severability. If any section, subsection, provision, term, paragraph, subparagraph or subpart of this Agreement shall, for any reason, be ordered or adjudged by any court of competent jurisdiction to be invalid or unenforceable, such judgment shall not affect, impair or invalidate the remainder of this Agreement but shall be confined in its operation to the provision or provisions regarding which such judgment shall have been rendered.

If any section, subsection, provision, term, paragraph, subparagraph or subpart of this Agreement is ordered or adjudged by a Court of competent jurisdiction to be invalid, unenforceable or unreasonable, such provision shall be reformed as provided for by law, and/or shall be deemed amended, to apply as to such maximum time, scope and territory or to such other extent as the adjudicating authority may determine or indicate to be reasonable, such amendment to apply only with respect to the operation of such provisions in the particular jurisdiction in which such adjudication is made.

7.4 Non-Waiver. No act or representation by either party shall constitute a waiver of any right under this Agreement, other than a writing expressly waiving a right. No waiver of any term or condition of this Agreement by any party shall be deemed a continuing or further waiver of the same term or condition or a waiver of any other term or condition of this Agreement.

7.5 Assignment. The rights and obligations of the Company under this Agreement may be assigned and delegated to any successor to or assignee of the Company's operations. The rights and obligations of Employee under this Agreement are personal and may not be assigned or delegated.

7.6 Opportunity to Review. Employee acknowledges that he or she has read and understands the provisions of this Agreement, has had the opportunity to review the Agreement with legal counsel prior to execution of the Agreement, and has elected to execute the Agreement based on his or her own free will and without any promise having been made to the Employee other than the promises by the Company set forth herein.

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

[THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK]

NOTICE: THE EMPLOYEE ACKNOWLEDGES THAT HE OR SHE HAS READ THIS AGREEMENT AND UNDERSTANDS THAT THIS AGREEMENT INCLUDES AN AGREEMENT TO ARBITRATE DISPUTES (ARTICLE 6.1), A MAXIMUM OF A ONE-YEAR LIMITATION PERIOD FOR INITIATION OF ARBITRATION (ARTICLE 6.2), AND A CLASS AND COLLECTIVE ACTION WAIVER (ARTICLE 6.3), ALL OF WHICH MAY BE ENFORCED BY THE PARTIES.

EMPLOYEE:

___________________________________(Signature)
____

Date: _______________________________

EXCEL STAFFING SERVICE, INC.

By: ____

Its: ____

Date: _______________________________

Form W-4 (2017)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

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

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

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

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

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

B Enter "1" if:
- You're single and have only one job; or
- You're married, have only one job, and your spouse doesn't work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

. . . **B** ____

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

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

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

F Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . **F** ____
(**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
- If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children.
- If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child. **G** ____

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

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2017

1 Your first name and middle initial	Last name	2 **Your social security number**

Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) | **5** |

6 Additional amount, if any, you want withheld from each paycheck . . . . . | **6** | $

7 I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . . ▶ | **7** |

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ▶ **Date** ▶

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

NC-4
Web
10-12

Employee's Withholding Allowance Certificate

North Carolina Department of Revenue

Social Security Number

Marital Status
○ Single ○ Head of Household ○ Married or Qualifying Widow(er)

First Name *(USE CAPITAL LETTERS FOR YOUR NAME AND ADDRESS)* M.I. Last Name

Address County *(Enter first five letters)*

City State Zip Code *(5 Digit)* Country *(If not U.S.)*

(See Form NC-4 Instructions before completing this form)

1. **Total number of allowances you are claiming**
   (From Line F of the Personal Allowances Worksheet on Page 2)

2. **Additional amount, if any, you want withheld from each pay period** .00
   (Enter whole dollars)

3. **I certify that I am not subject to North Carolina withholding because I meet the following two conditions:**
   - Last year I was entitled to a refund of all State income tax withheld because I had no tax liability; and
   - This year I expect a refund of all State income tax withheld because I expect to have no tax liability.

   ☐ Check Here

4. **I certify that I am not subject to North Carolina withholding because I meet the requirements of the Military Spouses Residency Relief Act and I am legally domiciled in the state of** ______________.
   ☐ Check Here

   (Enter state of domicile)

If line 3 or line 4 above applies to you, enter the year effective 20____ **and write "EXEMPT" here →** ______

5. **I certify that I no longer meet the requirements for exemption on line 3** ☐ **or line 4** ☐ *(Check applicable box)*
   Therefore, I revoke my exemption and request that my employer withhold North Carolina income tax based on the number of allowances entered on line 1 and any amount entered on line 2.
   ☐ Check Here

CAUTION: If you furnish an employer with an Employee's Withholding Allowance Certificate that contains information which has no reasonable basis and results in a lesser amount of tax being withheld than would have been withheld had you furnished reasonable information, you are subject to a penalty of 50% of the amount not properly withheld.

Employee's Signature ______________________________ Date ______________

I certify, under penalties provided by law, that I am entitled to the number of withholding allowances claimed on line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on line 3 or 4, whichever applies.

(Employer: Complete below only if sending to the North Carolina Department of Revenue. Submit the original and keep a copy for your records.)

Employer's Name *(USE CAPITAL LETTERS)* **FEIN**

Employer's Address County *(Enter first five letters)*

City State Zip Code *(5 Digit)* Country *(If not U.S.)*

EXCEL STAFFING
PO BOX 13251
GREENSBORO, NC 27415
PHONE: 1-800-883-9235 EXT 5
FAX: 336-291-1011

Effective December 1, 2010 there will be a $5.00 check-processing fee deducted from all payroll checks that are issued.

I ______________________________ am aware of the non-refundable check-processing fee, which would be deducted from all payroll checks that are issued to me. I also understand there are no fees if I receive my payroll by direct deposit.

______________________________ ____________

Print Name Date

____

Sign Name

DON'T FORGET!

$$$$ 50 $$$$
<u>$$$$ EASY MONEY $$$$</u>

WE JUST WANTED TO REMIND YOU TO KEEP THOSE REFERRALS COMING! FOR EVERY NURSE OR CNA YOU REFER WHO APPLIES AND WORKS 40 HOURS, YOU WILL RECEIVE A $50 BONUS.

THESE BONUSES ARE UNLIMITED!
SO, BE SURE TO GIVE A COUPON TO EVERYONE YOU KNOW WHO WOULD LIKE TO WORK WITH EXCEL.

FOR MORE INFORMATION, TO REQUEST ADDITIONAL COUPONS, OR TO CHECK ON A REFERRAL, CALL THE RECRUITING DEPARTMENT AT 1-800-883-9235 EXT 5.

****

Referred by: your name, address & phone #	Applicant's name, address, & phone #
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

**This coupon must be attached to your referral's application in order to qualify for this bonus.

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSITS
(ACH CREDITS)

___________________________________ ______________________________
COMPANY **COMPANY ID NUMBER**

I (WE) hereby authorize EXCEL STAFFING SERVICE, INC. hereinafter called COMPANY, To initiate credit entries and/or correction entries to our _______Checking _____Savings Account (select one) indicated below at the depository named below, hereinafter called DEPOSITORY, to credit the same to such account.

___________________________________ ___________________________________
DEPOSITORY NAME **BRANCH**

___________________________________ ___________________________________
CITY **STATE**

___________________________________ ___________________________________
BANK TRANSIT NUMBER **ACCOUNT NUMBER**
(FIRST 9 DIGITS OFF CHECK BOTTOM)

This authorization is to remain in full force until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY reasonable opportunity to act upon it.

_________________________________ ____________________________________
NAME(S) **TAX ID OR SOCIAL SECURITY NUMBER**

_________________________________ ___________________________________
SIGNATURE **DATE**

_________________________________ ___________________________________
SIGNATURE **DATE**

Attention Applicants

Please complete the following and RETURN with the application

Applicant Name: ____

City & State: ____

How did you hear about our company?

Name of Newspaper: ____

Name of Radio Station: ______________________________________

Name of TV Station: ____

Name of Friend: ____

Phonebook: ____

Name of Company Representative: ______________________________

Other: ____

We thank you for taking the time to fill this out and it helps us to provide better customer service in the future.

Thank You

Recruiting Department

EXCELL STAFFING SERVICES, INC PO Box 13251 Greensboro, NC 27415 Tel: 1- 800- 883- 9235
Fax: (336) 230 -1160

Thank you for your interest in Excel Staffing

Enclosed you will find an application packet and information about our Blood Borne Pathogens/Exposure Control Policies. Please be sure to read through the information before filling out your application. This is important information you may keep for your records. It is not necessary to mail it back with your application.

Also, please be sure to **SIGN EVERY PAGE** in your application packet that requires a signature. It is important we have all records in your file signed and dated.

Finally, be sure to include a copy of the following:

- ✓ Drivers License **(Clear and Visible Copy)**
- ✓ Social Security Card or Proof Of Citizenship
- ✓ Current TB Skin Test Results, Chest X-ray, or Health Screening **(Must be on Letterhead of Facility with Date Given and Date Read)**
- ✓ Nursing License **(RNs & LPNs)**
- ✓ CPR Card Front and Backside. **(Talk to your recruiter if you are not currently certified.)**
- ✓ Kentucky State Licensed CNAs **(Must also include a copy of their listing letter)**
- ✓ Mississippi Nurses and CNA's **(Must include a copy of a Federal Fingerprint Background Check)**
- ✓ **NC residents who have lived in the state less than 5 years or non-residents who wish to work in NC must submit a fingerprint card and $40 money order for SBI national processing as required by the state.**
- ✓ **All other states submit a $10 money order for criminal background check**

*Your name must be entered into our system as it appears on your social security card, even if it is not the same as the name you are currently using. To update your file at any time send the personnel department a copy of your new social security card.

Can I Fax My Application?

Sure! If you choose to fax your application packet, call immediately after sending it to verify it printed out on our end. (You may get a confirmation that it went through even if we did not get it.)

WHAT HAPPENS AFTER I SEND MY APPLICATION?

A recruiter will call you as soon as we receive your application. Please list all valid phone numbers where you can be reached. Normally we can process your application the day it is received so you may begin accepting shifts. It is important we are able to contact you because:
1. If your application is complete, you need to check in with us to activate your file.
2. If there are documents missing from your application your recruiter needs to inform you of what to do in order to complete the application process. Applications that are lacking are kept on file for up to three months. Please attempt to turn in missing forms as soon as possible.

After your application has been processed, you will receive a packet in the mail. It includes a name badge and time slips.

WHAT ARE THE BONUSES BEING OFFERED?

Currently we are offering two bonuses. The first is a Referral Bonus available to you when you refer a nurse or CNA and he or she in turn works at least forty hours.

The second is a $250 PERFECT ATTENDANCE BONUS! This is awarded to anyone who works a minimum of 40 shifts within an eight-week period and has no cancellations. It is available every eight weeks.

To retrieve either bonus, simply call our accounts payable and let us know you are eligible. We will be happy to research your information and the bonus will be sent with your next paycheck.