ASAP MEDSTAFF
SOLUTIONS FOR JOB SEEKERS AND HIRING MANAGERS

AVAILABILITY FOR ASSIGNMENTS

As an employee of ASAP MedStaff, I understand that I will make myself available via phone at all time for possible assignments. Upon receiving a call from ASAP MedStaff, I will contact the office immediately.

It will be your responsibility to keep the ASAP MedStaff office aware of any situation that may cause you to not be available.

If I am schedule with a client and have a set schedule and the client changes their schedule, I understand that I need to contact the ASAP office immediately with the change or changes.

NO-CALL/NO-SHOW POLICY

I understand that when I accept an assignment I am obligated to fulfill the assignment in its entirety.

If I cannot be at work as scheduled, I am to follow the Attendance Policy Procedure which is to call the ASAP office (517-394-3358 or 866-394-3456). If you are not able to speak to someone at ASAP MedStaff please leave a detailed message. If you leave a message, you must also communicate via email to your main contact at the ASAP MedStaff office.

If I do not call according to the policy, or show up at a schedule assignment, I understand that there could be disciplinary action. **After 2 days of no-call/no-show, this will be considered a voluntary resignation from ASAP MedStaff.**

TIME SHEET POLICY

By law, ASAP MedStaff is obligated to keep accurate records for the time worked by its' employees. This is done by written documentation. Your time sheet is the only way the Payroll Department knows how many hours you have worked so that you may be paid for your time. The following guidelines must be adhered to for submittal of your time sheet.

- ✓ Time sheets MUST be received every Monday by 9am EST
- ✓ Time sheets MUST be filled out completely and legible
- ✓ Time sheets MUST have a signature and date by both employee and client
- ✓ Time sheets MUST be an accurate reflection of hours worked
- ✓ It is your responsibility to turn in your time sheet
- ✓ If you are working at multiple locations during one week you may submit multiple time sheets or clearly label the specific location by the day/hours worked

Failure to follow the above guidelines may result in your time sheet being denied and no paid out until the time sheet is complete and accurate.

Falsification of your time sheet is immediate grounds for discipline up to and including dismissal.

Signature: _____ Date: _____

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EVENT OF LOST, VOLUNTARY, OR NON-VOLUNTARY TERMINATION

I recognize that my employment assignment may require me to be responsible for clients' property, cash or other valuable assets. I will also recognize I may be required to handle confidential information. I accept this responsibility and acknowledge that I will use the utmost discretion and care as not to cause any harm, damage or loss of client's property, cash or other valuable assets.

I agree upon termination:

- I will deliver all confidential information to the appropriate employing entity supervisor
- I will not retain any confidential information
- I will return all company or client property in all respects

In the event of a dispute over damage or missing property:

- I will cooperate fully and completely with employing entity to bring the dispute to a resolution.
- If it determined that the lost has been willfully caused, I hereby authorize the company to deduct from my paycheck as needed to settle with the company or client's lost claim.
- If it determined the lost results through non-willful action or accident, I will not be held responsible.

I have read and understand this Agreement, including but not limited to all my future obligations pursuant to it.

RECEIPT OF EMPLOYEE HANDBOOK

I acknowledge the receipt of the ASAP MedStaff Employee Handbook made available to you at www.asapmedstaff.com/job-seekers/current-employees/ or email if requested. I understand that the Employee Handbook is intended to provide information regarding ASAP MedStaff's employment practices and policies it contains are subject to change at any time, with or without notice, at the discretion of ASAP MedStaff. This Handbook does not constitute a contract or obligation on part of ASAP MedStaff and does not guarantee my employment for any specific duration.

NOTICE OF RESIGNATION AGREEMENT

I agree that if I am on an assignment and accept other employment or choose to voluntarily terminate my employment, I will give a two (2) week notice in writing to ASAP MedStaff. If I am filling a Provider level position I will give a three (3) week notice in writing to ASAP MedStaff.

I also understand that if I am in possession of company property, I will be responsible for returning this on or before my last day of work.

Signature: _____ Date: _____

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RELEASE & CONSENT FORM FOR SUBSTANCE ABUSE TESTING

Certain clients of ASAP Staffing require that employees assigned to it successfully pass a substance abuse test. As a condition for consideration for assignment with ASAP Staffing, I voluntarily authorize any laboratory designated by ASAP MedStaff or its clients to conduct a test for the purpose of determining the presence of drugs in my system. I also understand that I may be subject to random drug screens as dictated by ASAP Staffing or by its clients. Failure to complete the drug screen when directed may result in dismissal from my assignment.

I consent to the release by the laboratory designated by ASAP Staffing or its clients of the results of the drug and alcohol test.

I hereby release and forever discharge ASAP Staffing, its clients, and the laboratory and the employees of them, of and from any and all lawsuits, proceedings, claims or causes of action arising from the test or tests, and from any action or inaction of ASAP Staff or its clients based on the results of the test.

I understand the meaning of this release and consent form, and I have had the opportunity to raise any questions about it before signing. My signature below is completely voluntary, without coercion or duress of any kind, and I am signing this release and consent form solely as a condition for consideration for assignments with ASAP Staffing.

Signature: _____ Date: _____

RELEASE OF INFORMATION CONSENT

In the course of doing business, our clients may request to have access to information contained in your employee file. This release allows us to share all information contained in your employee file with any client that may consider you for placement. This information may include but is not limited to drug screen results, TB testing results, criminal history reports or a social security number.

Some of our clients are required to keep duplicate employee information on site to comply with accreditation organizations in which they participate.

Signature: _____ Date: _____

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HBV WAIVER/AGREEMENT

I, _____, understand that due to my occupational exposure to blood, body fluids and other infectious materials I may be at risk of acquiring the Hepatitis B Virus (HBV) infection. I am **taking advantage of / declining** (circle choice) the opportunity to be vaccinated at this time. The complete vaccination process includes three injections over a 6-7 month time period. I understand that there could be side effects to taking the HBV series. If I choose to decline the vaccination, I understand that I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I want to receive the Hepatitis B Vaccination, I will be reimbursed for the series at its completion and the records are provided to ASAP MedStaff for my file. I will not hold ASAP MedStaff or any staff members responsible for my **choosing / declining** (circle choice) to take the Hepatitis B Vaccine or for its possible side effects.

I am declining because I have already received the Hepatitis B Vaccination - **YES NO**

I can provide documentation of the vaccination to ASAP MedStaff- **YES NO**

I cannot provide documentation, the date I received the series was on/about_____

Signature: _____ Date: _____

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BLOODBORNE PATHOGENS INFORMATION SHEET

Numerous pathogens are carried in blood and body fluids, most notable Hepatitis B, Hepatitis C and HIV which causes AIDS. Each of these pathogens can also be transmitted sexually. There is no current cure to Hepatitis B or the HIV virus. Both can be prevented using safe sexual practices and the use of Universal Precautions.

Universal Precautions include the following;

1. Wear gloves if touching blood, body fluids, soiled linens, non-intact skin or mucous membranes.
2. Wash hands immediately after contact with blood or body fluids
3. Use a mouthpiece when performing mouth-to-mouth resuscitation
4. Cover draining lesions
5. Put sharps in puncture proof containers; don't recap needles
6. Wear gloves, gown, mask and goggles when performing a procedure where splashing may occur
7. Clean blood or body fluids spills with 1-part bleach and 10-parts water, wearing gloves

Gloves should be worn while performing the following tasks;

1. Bathing
2. Oral Care
3. Toileting/changing diapers
4. Touching soiled linens
5. Administering eye drops
6. Performing dressing changes
7. Performing Accuchecks with a glucometer
8. Giving injections
9. Starting IV's
10. Cleaning blood and body fluid spills
11. Obtaining blood by venipuncture or through an IV
12. Suctioning

Gowns should be worn when;

1. Articles that are soiled with blood or body fluids may touch your clothing
2. There is a danger of being splashed with blood and/or body fluids

Masks/Goggles should be worn when;

1. Performing a procedure that causes spraying or splashing of body fluids
2. If an exposure occurs, contact ASAP MedStaff immediately and fill out an incident report.

Heptavax is a vaccine given to prevent Hepatitis B. It consists of three injections – an initial injection, an injection one month later, and a third injection five months after the second. It is important that the employee complete all three injections, as it is thought that protection does not occur until after the third injection. Heptavax is offered to employees at any time. Please contact us for details.

I have read the above information regarding Bloodborne Pathogens.

Signature: _____ Date: _____

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HIPPA PRIVACY RULES

HIPPA PRIVACY

The Health Insurance Portability and Accountability Act (HIPAA) is a law enacted by the Federal government with three parts that address the privacy, security, and health information.

HIPPA TERMS

Acknowledgment: A patient's written statement that he or she has received the Notice of Privacy Practices.

Authorization: A patient's written permission to use and disclose health information for reasons other than treatment, payment and health care operations

Business Associate: A person or entity that conducts activities on behalf of a covered entity that involve access to or creation of PHI but is not part of the covered entity's workforce.

Covered Entity: A health plan, healthcare clearinghouse or healthcare provider that electronically transmits health information in connection with a billing transaction.

Disclosure: The release, transfer or providing of access to information outside the entity holding information.

Healthcare Operations: Any of the following activities of a covered entity: fundraising activities, quality assessment and improvement activities, insurance activities; business planning, development and management activities; licensing and audits; evaluating healthcare professionals and plans; and training healthcare services provided to an individual.

Minimum Necessary: The least amount of protected health information (PHI) an individual needs to perform his or her job or to achieve the purpose for which PHI is needed.

Notice of Privacy Practices: A notice given to patients to make them aware of the types of uses and disclosures an entity may make of their PHI.

Protected Health Information (PHI): Health information, including contact information that identifies an individual or provides enough information that there is a reasonable basis to believe it could be used to identify the individual.

Use: The sharing, examination, or analysis of PHI by an entity that maintains such information.

Workforce: Employees, volunteers, students and other people whose conduct while performing work for a covered entity is under the direct control of such entity, whether or not they are paid by the covered entity.

What does HIPPA Privacy apply to? HIPPA Privacy Rules apply to the protection of a patient's health information. The HIPPA Privacy Rules and stricter Michigan law dictates how and when Protected Health Information (PHI) can be used or disclosed; whenever written, verbal or electronic.

HIPPA Privacy Rules require more restrictions of the use of disclosure of patient information. HIPPA Privacy regulations also include consequences, such as penalties and fines, for non-compliance.

Conversation: Use caution when discussing patient information in public areas, on the phone or in voice messages.

Patient Records: Share information responsibly, whether by copy or other means.

Technology: Protect your password as well as access to your computer and fax machines. Limit the use of speakerphones when the potential of PHI disclosure may exist.

What if you become aware of a HIPPA violation? Immediately report it to your supervisor.

Signature: _____ Date: _____

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PAYROLL INFORMATION

Direct Deposit and/or Money Network Service Selection

ASAP MedStaff offers two ways to receive your pay check. You may chose Direct Deposit or the Money Network Service. You can also do a combination of both options. If you chose to take advantage of our Direct Deposit option please provide a VOIDED check to us for the account you wish to deposit into. More information can be found on the document below. Please note that your selection(s) must be marked and initialed on the Employee Pay Selection Record document.

It takes 2-3 weeks to establish these services, your first check will be mailed to you.

Please write your name and address here:

_____

_____

_____

Online Access to Payroll

You can access your pay stub history and W2 conveniently online. On page 9 of this packet you will find the quick-start guide to getting started with this online service. Please review the information in the guide and let us know if you have any questions.

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Employee Pay Selection Record

ASAP Staffing, LLC ("**Employer**") offers two options to receive your pay, Direct Deposit or the Money Network® Service. You may also split your pay between the two options. Please review these options and make your selection below.

Option 1: **DIRECT DEPOSIT** Employer will pay all, or a portion, of my net pay as selected below ("**Direct Deposit**") into the account (the "**Account**") at the financial institution with the routing and account numbers and account type (collectively, "**Account Information**") I have provided separately to Employer according to Employer's procedure.

Option 2: **MONEY NETWORK SERVICE** Employer will pay all, or a portion, of my net pay as selected below using the Money Network Service (the "**Service**") and I may use either of the following options:

Money Network™ Check. The Money Network Check ("**Check**") is a paycheck that I can easily complete on or after each payday morning wherever I am, eliminating the need to pick up my paycheck, wait for it to be mailed, or pay for it to be cashed. The Check can be deposited into my personal bank account or cashed for free at Money Network check-cashing partners.

Money Network Payroll Debit Card. The Money Network Payroll Debit Card ("**Card**") provides a dependable, safe, optional, and convenient way to receive and access my pay on and after each payday morning with the following features: (i) eliminates the need to pick up my paycheck, wait for it to be mailed, or pay for it to be cashed; (ii) immediate, worldwide access wherever the Card is accepted for ATM cash withdrawals, bank-branch withdrawals, and store purchases (including "cash back"); (iii) money transfers to a personal or joint checking account; and (iv) free balance inquiries by phone or online. There is no monthly service charge for the Card as long as I am employed by Employer. Many Card transactions are free (and I need never incur a fee to access 100% of my wages, to the penny, using the Service), but there are fees for other transactions. The Terms and Conditions, fee schedule, and other disclosures related to the Service are included in the Service's Welcome Packet. Once I have consented to those terms and contracted for the Service by activating my Service account by following the instructions in the Welcome Packet, I may begin to use the Service.

I HEREBY ELECT TO HAVE MY PAY DISTRIBUTED AS INDICATED:
(*REQUIRED:* MAKE <u>ONE</u> CHOICE BY CHECKINGTHE A, B, OR C BOX AND WRITING YOUR INITIALS ABOVE YOUR SELECTION BELOW)

A ☐ Initials	*OR*	B ☐ Initials	*OR*	C ☐ Initials
DIRECT DEPOSIT		**MONEY NETWORK SERVICE**		**<u>BOTH</u> DIRECT DEPOSIT AND MONEY NETWORK SERVICE (SPLIT-DEPOSIT)** I have provided split-deposit instructions ("**Split Deposit Instructions**") separately to Employer according to Employer's procedure.

I authorize Employer to pay me by Direct Deposit and/or the Service, according to the selection I checked and initialed above. In case of payment of funds to which I am not entitled, I authorize Employer to withdraw such funds from the Account and/or the Service. Unless I am already paid by Direct Deposit, I acknowledge that, in order to choose Direct Deposit, I must submit a fully completed Employee Pay Selection Record ("**PSR**") and Account Information (defined above). The PSR and Account Information must be submitted to Employer within three (3) business days (thirty (30) days in Michigan) of receiving notice to do so. **If I fail to satisfy these requirements to be paid by Direct Deposit, I agree that I will be paid using the Service. <u>However, I understand that I can change my pay selection at any time</u>** in the future by submitting a new PSR and Account Information according to Employer's procedure (subject to the time it takes Employer to implement the change). My election will remain in effect unless Employer and/or Program Manager cancels this arrangement. To help the government fight the funding of terrorism and money laundering activities, Federal law requires financial institutions to verify and record identity information before opening an account such as the account provided when you enroll in the Service. To permit this identification so that my pay to be placed in such an account, I authorize Employer to share my name, address, date of birth, Social Security Number, identification documents, and related personal information with Money Network and the issuing bank.

Signature*	Printed Name*	Date*	EMPLOYER USE ONLY Employee ID Number

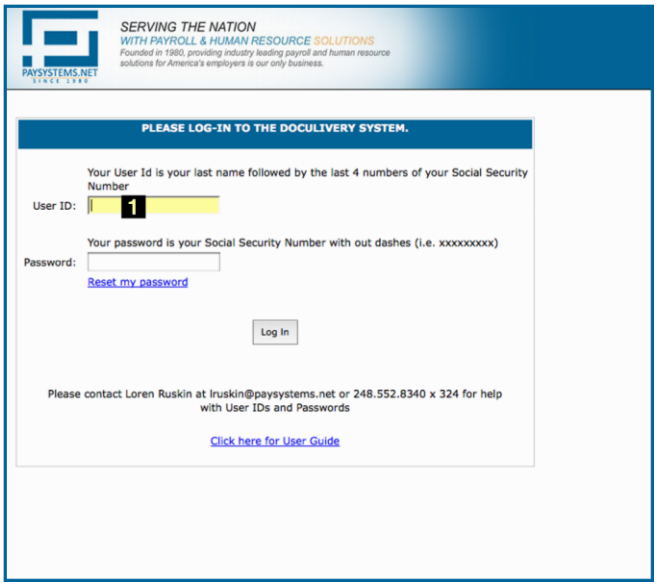
* ***Required***

5/22/2013

This guide provides all of the quick-start information needed to get connected, and start accessing your electronic pay stubs in no time at all. Follow the quick and easy steps outlined below to begin accessing your online documents quickly and easily.

Getting Started

1. Point your internet browser to: **www.doculivery.com/paysystems**



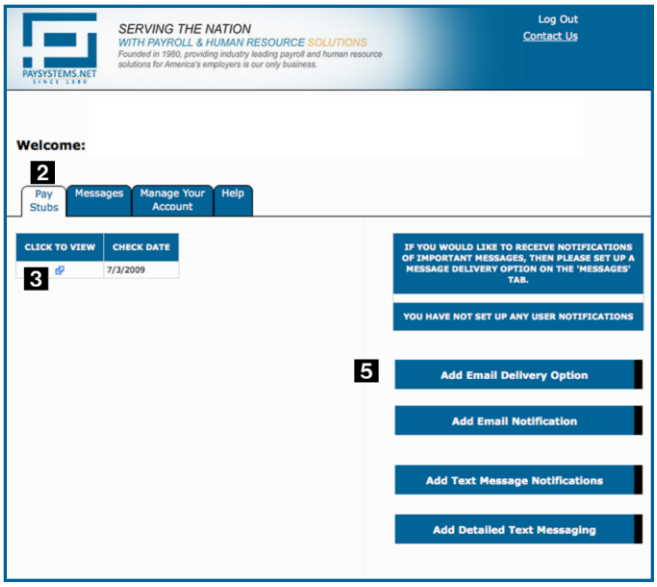
2. Enter your initial login ID and Password. **1** You will be required to change your password upon initial login.

   Your initial USER ID is: *your last name in capital letters followed by the last four numbers of your Social Security Number.*

   For example, if your last name is Smith, and your Social Security Number is 123-45-6789, then your USER ID is: SMITH6789

   Your initial PASSWORD is: *the last four digits of your Social Security Number.*

   For example, if your Social Security Number is 123-45-6789, then your PASSWORD is: 6789



3. Once you have logged in and changed your password, please make a note of your new password for future reference.

4. Once logged in, you will see the main screen which is organized by tabs. Click on the Pay Stubs tab **2** to see a list of all pay dates for which you have a pay stub. To see the entire pay stub for a particular date click on the view icon in the Click To View column on the left side of the screen. **3**

Setting up Notification Options

1. Click on the Pay Stubs tab **2**. On the right side of the screen, select the appropriate bar **5** to setup email or text message notifications.