



4041 Powder Mill Road, Suite 107  
Beltsville, Maryland 20705  
Voice: 240-334-4333 Fax: 240-334-4335  
www.ISSNURSES.com

## Employment Application

May 22, 2008

Classification:  RN  LPN  CNA  GNA  Other:

First Name: MI: Last Name: Social Security Number:

Current Address: Street City State Zip Code

Home Telephone: Cellular Telephone: Other Telephone:

As a service to our staff and to facilitate communication between ISS and its employees, we provide email addresses to all of our staff. Below, please indicate what you would like your EMAIL address to be and provide an alternate EMAIL address where we can send your password and setup information. (Example: FirstName.LastName@ISSNURSES.com)

EMAIL Address: Alternate EMAIL Address:

Emergency Contact: Telephone: Other Telephone:

How did you hear about us?

- Newspaper – (Name):  Trade Publication – (Name):
- Personal Referral:  Other:

Have you been a defendant in a felony or misdemeanor case other than traffic violations?

YES  NO If YES, please explain:

Are you currently employed?  YES  NO If YES, may we contact your employer?  YES  NO

Do you have at least one year of acute care experience in the past two years?  YES  NO

What is your specialty? (i.e. Med/Surg, Critical Care, ER, etc.)

## Educational Background

Name and Location of School(s) Graduation Date Type of Degree

## License/Certificate Information

Professional License/  
Technical Certificate State Expiration Date

Have you ever been the subject of a malpractice claim?  YES  NO

If YES, please explain:

Have there been previously successful or currently pending challenges, revocation, denial, suspension, withdrawal, or restriction to any licensure, certification, or registration to practice in any jurisdiction, or the voluntary/involuntary relinquishment of such licensure, certification or registration?  YES  NO

If YES, please explain:

### Professional Certifications

(Include all certification, i.e., CCRN, NICU)

Type:	Expiration Date:
Type:	Expiration Date:
Type:	Expiration Date:
Type:	Expiration Date:

### Resuscitation Credentials

(Indicate credentials you possess by placing an expiration date next to the appropriate credential)

Credential	Expiration Date
ACLS	
BLS	
ENPC	
NRP	
PALS	
TNCC	
Other:	
Other:	

### References

(Please list three (3) supervisory references of individuals that have worked with you in the past that are in your same category of nursing)

Name:	Telephone Number:
Name:	Telephone Number:
Name:	Telephone Number:

The completion of this application authorizes Innovative Staffing Solutions, Inc. to contact the above named references in order to accurately evaluate your previous experience and suitability for the position for which you are applying.

You will be evaluated on the following criteria: Quality of Work, Productivity, Professionalism, Flexibility, Leadership Ability, Communication Skills, Attendance/Punctuality, and Clinical Skill Level.

It is understood that your completion of this application releases the above named references from any liability or claims which may arise as a result of any information provided pursuant to this reference request.

# Employment History

(Complete information regarding your employment history for the last 2 years. Begin with your present or most current position.)

Have you been asked not to return to a facility in which you were staffed by another agency?  YES  NO

If YES, which facility/facilities:

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Employment Dates: FROM: TO:

Hospital/Facility:

Address: Street City State Zip Code

Immediate Supervisor: Telephone: May we contact this person?  YES  NO

Specialty/Unit: Types of Patients:

Number of Beds: Supervisory experience?  YES  NO Was this an agency assignment?  YES  NO

Reason for leaving:

---

Employment Dates: FROM: TO:

Hospital/Facility:

Address: Street City State Zip Code

Immediate Supervisor: Telephone: May we contact this person?  YES  NO

Specialty/Unit: Types of Patients:

Number of Beds: Supervisory experience?  YES  NO Was this an agency assignment?  YES  NO

Reason for leaving:

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Hospital/Facility:

Address: Street City State Zip Code

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Address: Street City State Zip Code

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Reason for leaving:

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REFERENCE CHECK AUTHORIZATION

TO: \_\_\_\_\_

\_\_\_\_\_

ATTN: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

FAX: \_\_\_\_\_

I hereby release the above named previous or current employer and their agents from any liability or claims I may have which arise as a result of any information provided pursuant to this reference request.

Applicant Name (Please Print)

Social Security Number

5/22/2008

Applicant Signature

Date

Dates of Employment - From: \_\_\_\_\_

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

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

EXPECTATIONS

EVALUATION CRITERIA	EXCEEDS	MEETS	DOES NOT MEET
Quality of Work			
Productivity			
Professionalism			
Flexibility			
Leadership Ability			
Communication Skills			
Attendance/Punctuality			
Clinical Skill Level			

Reason for leaving: \_\_\_\_\_

Eligible for Rehire: [ ] Yes [ ] No

Additional Comments: \_\_\_\_\_

NAME: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

TITLE: \_\_\_\_\_ DATE: \_\_\_\_\_

Completed by: \_\_\_\_\_

Print Name

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



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REFERENCE CHECK AUTHORIZATION

TO: \_\_\_\_\_  
 \_\_\_\_\_

ATTN: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

I hereby release the above named previous or current employer and their agents from any liability or claims I may have which arise as a result of any information provided pursuant to this reference request.

Applicant Name (Please Print) \_\_\_\_\_

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

5/22/2008

Applicant Signature

Date

Dates of Employment - From: \_\_\_\_\_ To: \_\_\_\_\_

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

EXPECTATIONS

EVALUATION CRITERIA	EXCEEDS	MEETS	DOES NOT MEET
Quality of Work			
Productivity			
Professionalism			
Flexibility			
Leadership Ability			
Communication Skills			
Attendance/Punctuality			
Clinical Skill Level			

Reason for leaving: \_\_\_\_\_ Eligible for Rehire: [ ] Yes [ ] No

Additional Comments: \_\_\_\_\_

NAME: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

TITLE: \_\_\_\_\_ DATE: \_\_\_\_\_

Completed by: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Print Name



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## PHYSICAL EXAM/COMMUNICABLE DISEASE CLEARANCE

### INSTRUCTIONS:

This form must be completed and signed by a physician prior to your first assignment with Innovative Staffing Solutions, Inc. and annually thereafter. Please have the physician who has examined you within the past one (1) year complete this form and return it to Innovative Staffing Solutions, Inc. If an examination is necessary for the completion of this form, the expense of this examination will NOT be incurred by Innovative Staffing Solutions, Inc.

I certify that \_\_\_\_\_ has been examined by me on \_\_\_\_\_ and is in good health and able to work in his/her usual nursing occupation, and is free from any symptom indicating presence of communicable/contagious diseases.

Please fill in blanks that apply: (NEW HIRES ONLY)									
Measles - Disease	_____	Immunization	_____	Titer	_____	Pos.	_____	Neg.	_____
Mumps- Disease	_____	Immunization	_____	Titer	_____	Pos.	_____	Neg.	_____
Rubella - Disease	_____	Immunization	_____	Titer	_____	Pos.	_____	Neg.	_____
Varicella - Disease	_____	Immunization	_____	Titer	_____	Pos.	_____	Neg.	_____

PPD Skin Test: Date Administered: _____ Date Read: _____ Result: _____
NOTE: If positive, a chest x-ray and completion of TB Screening Questionnaire are required.
Chest X-Ray**: Date: _____ Result: _____ (Within 5 years of date of hire.)

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

\_\_\_\_\_

Physician's Telephone: \_\_\_\_\_



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**T B Questionnaire**

Employee Name: \_\_\_\_\_ Date: 5/22/2008

New ISS employees with a history of a positive reaction to a previous PPD shall provide a report from a physician indicating that X-rays of the chest taken within the previous 12 months were negative for TB or must have chest films made and read before starting any patient-related activities. All employees also must complete an annual TB Questionnaire. (This program is based on the U.S. Department of Health and Human Services, CDC Recommendations and Reports of October 28, 1994).

Positive TB skin test (PPD) Date:          Last Chest X-Ray Date:         

Please indicate if you are having any of the following problems for three to four weeks or longer:

	Yes	No
1. Chronic Cough lasting longer than three weeks.....	_____	_____
2. Chills that recur.....	_____	_____
3. Unexplained Weight Loss (over 10 lbs. in 2 months).....	_____	_____
4. Night sweats.....	_____	_____
5. Fever lasting several weeks.....	_____	_____
6. Coughing blood-streaked sputum.....	_____	_____
7. Fatigue – easily and ongoing.....	_____	_____
8. Shortness of Breath.....	_____	_____
9. Have you been recently diagnosed with diabetes, silicosis, HIV disease, renal disease or liver disease?.....	_____	_____
10. Have you recently been exposed to a family member or other person with active TB?.....	_____	_____
11. Have you ever received the BCG immunization?.....	_____	_____

If you checked YES to any of the above questions, are you currently being treated by a Physician?: Yes No (Circle one). Please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I UNDERSTAND THAT I MUST REPORT THE DEVELOPMENT OF ANY SYMPTOMS OF TB LISTED ABOVE TO A PHYSICIAN AND ISS IMMEDIATELY. A CHEST X-RAY MUST BE PERFORMED PRIOR TO WORKING AGAIN.**

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

\_\_\_\_\_  
 Physician Signature Date



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**ACKNOWLEDGEMENT OF CONFIDENTIALITY  
OF PATIENT HEALTH CARE INFORMATION**

I acknowledge the confidentiality of patient health care information (“Confidential Patient Information”) that I may receive or have access to in the course of providing patient care services at Innovative Staffing Solutions, Inc. (ISS) client facility. I shall maintain the confidentiality of Confidential Patient Information, and in doing so, shall comply with all applicable state and federal laws and regulations, including, without limitation, the privacy provisions under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the policies and procedures of each participating hospital where I may be assigned. My agreement to maintain the confidentiality of Confidential Patient Information shall survive the termination of my employment with ISS and the conclusion of any assignment.

Print Name:

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**Signature:**

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Date:

5/22/2008

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## Varicella Vaccination Declination/Waiver

Varicella (Chicken Pox) is a highly contagious disease in children, adolescents and adults caused by the Varicella/Zoster virus. Chicken Pox usually does not cause serious illness; however, it can cause serious complications including bacterial super infection, pneumonia and brain infections.

The Morbidity and Mortality Weekly Report of December 26, 1997 states that active immunization is strongly recommended because of special risks for health care workers.

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I, \_\_\_\_\_ understand that due to my occupation, exposure to persons carrying the Varicella infection in the form of Chicken Pox or Herpes Zoster puts me at risk to become infected. I have been informed about and encouraged to receive the vaccination series. At this time I have not received the vaccinations and I choose to decline vaccination. If in the future I want to receive Varicella immunization, I can receive the vaccination at no charge to me.

I know that I have had Chicken Pox in the Past \_\_\_\_\_ Yes \_\_\_\_\_ No.

If Yes, what Year? \_\_\_\_\_

5/22/2008

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**Employee Signature**

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Date



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## ISS POLICIES AND PROCEDURES

### Acceptance Agreement

I, \_\_\_\_\_, have received, read and understand the ISS Policy and Procedure Manual which cover the following topics:

- Scheduling
- Employee Cancellations
- Client Cancellations
- Late Arrivals
- Late Calls
- Payroll
- Timesheets
- Client Complaints
- Abuse and Neglect
- Drug and Alcohol-Free Workplace
- Compliance with Regulations
- Obligations to ISS

I agree to abide by these policies and procedures while employed with Innovative Staffing Solutions.

5/22/2008

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**Employee Signature**

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**Date**



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## HEPATITIS B VACCINE 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 (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

5/22/2008

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness Signature**

\_\_\_\_\_  
**Date**



**PAY SELECTION AGREEMENT**

**ISS offers three pay receipt options.  
You may choose paycard, check or personal direct deposit.**

Pay cards are available to every employee and are a convenient way to access your pay and ensure that your pay will be available each payday morning without being at work to pick up a paper check. To take advantage of the safety, dependability and convenience of pay cards, check the paycard option below and sign the authorization statement.

**Pay Card Option**

\_\_\_\_\_ I choose to have my pay deposited directly to my paycard. My Money Network pay card and information kit will be given to me by my manager. My net pay will be deposited onto the pay card each payday.

**Check**

\_\_\_\_\_ I would like an actual check generated. (Please circle one) **Mail or Pick-up**

**Direct Deposit Option**

\_\_\_\_\_ I choose to have my paycheck deposited directly into my checking/savings account. I have attached either a voided check or a photocopy of a check and signed the authorization statement.

<b>Bank Name</b>	<b>ABA/Routing #</b>	<b>Account #</b>	<b>Chkg./Svgs.</b>

\*\*\*\*\*

I recognize, acknowledge and accept that this service is being provided for my convenience. As such, I agree to hold the company, Innovative Staffing Solutions, Inc. (ISS), each participating bank and NACHA harmless from any claim incident to the operation of this plan, arising from any act or omission by the company and/or ISS, and their employees, including without limitation any claim based on alleged loss as a result of the rejection of any of his debits, because of insufficient funds arising from failure to credit deposits to my account.

I hereby authorize and request ISS to deposit any amount owed to me for wages by initiation of credit entries to my account at the financial institution (hereinafter "Bank") handling my choice indicated above. Further, I authorize Bank to accept and credit any credit entries indicated by ISS to my account. In the event that ISS deposits funds erroneously into my account. I authorize ISS to debit my account for an amount not to exceed the original amount of the erroneous credit. This authorization is to remain in full force and effect until ISS receives written notice from me of its termination in such time and in such a manner as to afford a reasonable opportunity to act on it.

WE will not process the direct deposit option without the following:

- For each checking account, you must attach a copy of a **voided check** as proof of the routing and account numbers for each account.
- For each savings account, you must attach a **printed statement** from the bank stating the correct routing and account numbers for each account.

The first paycheck following receipt of this form will usually be processed as a live check so that we may pre-note the account. Each subsequent paycheck will be direct deposited.

5/22/2008

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
Date

Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

Social Security Number:

\_\_\_\_\_

**Birth Date**

\_\_\_\_\_

Telephone Number:

\_\_\_\_\_

Fax:

\_\_\_\_\_

ALWAYS CHECK YOUR PAY STUB OR YOUR ACCOUNT TO VERIFY THAT YOUR DEPOSIT HAS POSTED.

+++++For Payroll Use Only +++++

Paycard ABA # 084003997 Paycard # \_\_\_\_\_

Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification: To be completed and signed by employee at the time employment begins

Last Name	First Name	Middle Initial	Maiden Name
Address (Street Name and Number)			Date of Birth (month/day/year)
			Social Security #

I am aware that federal law provides from imprisonment and/or fines for false statements or use of false documents in connection with completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- A citizen or national of the United States
- A Lawful Permanent Resident (Alien # A \_\_\_\_\_)
- An alien authorized to work until \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Alien # or Admission #) \_\_\_\_\_

Employee's Signature	Date (month/day/year)
	5/22/2008

Preparer and/or Translator Certification. (to be completed and signed if Section is prepared by a person other than the employee. ) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip code)	Date (month/day/year)

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List a OR examine one document from List B and one from List c, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

	List A	OR	List B	AND	List C
Document title:	_____		_____		_____
Issuing authority:	_____		_____		_____
Document #:	_____		_____		_____
Expiration Date (if any):	____/____/____		____/____/____		____/____/____
Document #:	_____		_____		_____
Expiration Date (if any):	____/____/____		____/____/____		____/____/____

CERTIFICATION – I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) app to be genuine and to relate to the employee named, that the employee began employment (month/day/year) \_\_\_\_/\_\_\_\_/\_\_\_\_ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name	Address	Date
Innovative Staffing Solutions, 4041 Powder Mill Road, Suite 402, Beltsville, MD 20705		5/22/2008

Section 3. Updating and reverification. To be completed and signed by employer.

A. New Name (if applicable)	B. Date of rehire	
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.		
Document Title: _____	Document # _____	Expiration Date (if any): ____/____/____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented documents(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date
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### EEO APPLICANT DATA RECORD

Name: \_\_\_\_\_ Date: 5/22/2008  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_

#### AFFIRMATIVE ACTION SURVEY

Government agencies require periodic reports on the sex, ethnicity, handicapped and veterans status of applicants. This data is for analysis and affirmative action only. Submission of information about a handicap is voluntary.

**Check one**  Male  Female

**Check one** of the following race/ethnic groups:  White  Black  Hispanic  
 American Indian/Alaskan Native  
 Asian/Pacific Islander

**Check** if any of the following are applicable:  Vietnam Era/Gulf War Veteran  
 Disabled Veteran  
 Handicapped Individual



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CRIMINAL BACKGROUND CHECK RELEASE AND AUTHORIZATION

The purpose of this form is to notify you that a Consumer Report and/or an Investigative Consumer Report will be conducted on you in the course of consideration for employment or promotion. This report is being provided by Inquiries, Inc.- Post Office Box 67 Easton, MD 21601 - Phone 410-819-3711. I hereby authorize your company or any agent of your company to contact any and all corporations, former employers, credit agencies, educational institutions, law enforcement agencies, city, state, county, and federal courts and military services to release information about my background including, but not limited to, information about my employment, education, consumer credit history, driving record, criminal record, and general public records history to the person or company with which this form has been filed. This release also authorizes the client to request a pre-employment and/or random selection 5 or 10 panel Urine Based drug screen. This releases the aforesaid parties from any liability and responsibility for collecting the above information. This release shall remain in effect for the length of my employment. I understand I have the right to obtain a free copy of this Consumer Report if; (1) Any adverse action/decision is made based on the information in the consumer report, & (2) If the request is made in writing within 60 days of the adverse action. I believe to the best of my knowledge that all information I have provided is accurate true and correct and that I fully understand the terms of this release.

Please write clearly

NAME: (Last) (First) (Middle)

List any maiden or other name used in the last seven (7) years:

Date of Birth: / / Social Security Number:

Drivers License # State Sex Race

Professional License held\* State License #

List your current mailing address as well as any other cities or towns you have lived in the past seven (7) Years:

Address:

City State Zip Code DATES: / / to / / /
City State Zip Code DATES: / / / to / / /
City State Zip Code DATES: / / / to / / /
City State Zip Code DATES: / / / to / / /

\*\*\*APPLICANT - DO NOT WRITE BELOW THIS LINE\*\*\*

FAX TO: 410-819-3670

TO BE COMPLETED BY COMPANY REQUESTING INFORMATION:

Company Name: Innovative Staffing Solutions

Telephone Number: 240-334-4333

Fax Number: 240-433-4335

PLEASE START OUR STANDARD BACKGROUND CHECK

While the information contained in the reports provided has been obtained from public records data sources deemed reliable, its accuracy cannot be guaranteed due to potential human error in the actual recording of the record. Since this information is not owned by Inquiries, Inc. and since public records data on any one individual, group of individuals, company, or companies can be contained in more than one repository Inquiries, Inc. can only rely on its accuracy from the public records data sources presently available at the time of the search. This information is furnished for your exclusive use and accepted by you without any liability on the part of Inquiries, Inc. its sources, officers, agents or employees. Furthermore you agree to indemnify Inquiries, Inc, its sources, agents, and employees of any liability for the use of this information and shall agree that the right to obtain and the purpose for this information, for your exclusive use, is fully within the appropriate law or laws which apply to the permissible purpose of retrieving background information on an individuals criminal records history, credit history and / or workers compensation claim history.

# Form W-4 (2006)

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

**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 2006 expires February 16, 2007. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** You cannot claim exemption from withholding if (a) your income exceeds \$850 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-

earner/two-job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

**Head of household.** Generally, you may 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 line E below.

**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. 919, How Do I Adjust My Tax Withholding, 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 payment using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax.

**Two earners/two 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. 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.

**Nonresident alien.** If you are a nonresident alien, see the instructions from Form 8233 before completing this Form W-4.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to our projected total tax for 2006. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

**Recent name change?** If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 to initiate a name change and obtain a social security card showing your correct name.

## Personal Allowances Worksheet (Keep for your records)

- A** Enter "1" for yourself if no one else can claim you as a dependent . . . . . **A** \_\_\_\_\_
- You are single and have only one job; or
- B** Enter "1" if: . . . . . **B** \_\_\_\_\_
- You are married, have only one job, and your spouse does not work; or
  - Your wages from a second job or your spouse's wages (or the total of both) are \$1,000 or less
- 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 \$1,500 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): . . . . . **G** \_\_\_\_\_
- If your total income will be less than \$55,000 (\$82,000 if married), enter "2" for each eligible child.
  - If your total income will be between \$55,000 and \$84,000 (\$82,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have four or more eligible children.
- H** Add line 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 have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$35,000 (\$25,000 if married) see the Two-Earner/Two-Job 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.

----- Cut 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 review by the IRS. Your employer may be required to send a copy of this form to the IRS

OMB No. 1545-0074

**2006**

<b>1</b> Type or print your first name and middle initial.	Last Name	<b>2</b> Your social security number
Home address (number and street or rural route)		<b>3</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> 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		<b>4</b> If your last name differs from that shown on your social security card, check here <input type="checkbox"/> You must call 1-800-772-1213 for a new card.
<b>5</b> Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	<b>6</b> Additional amount, if any, you want withheld from each paycheck	
<b>7</b> I claim exemption from withholding for 2006, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> <li>• Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and</li> <li>• This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.</li> </ul> If you meet both conditions, write "Exempt" here . . . . .		<b>7</b>

**Employee's signature**  
(Form is not valid unless you sign it.) X

Date 5/22/2008

<b>8</b> Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) Innovative Staffing Solutions, 4041 Powder Mill Road, Suite 402, Beltsville, MD 20705	<b>9</b> Office code (optional)	<b>10</b> Employer identification number (EIN)
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<b>D-4</b> 	<b>GOVERNMENT OF THE DISTRICT OF COLUMBIA</b> <b>OFFICE OF TAX AND REVENUE</b> <b>Employee's Withholding Allowance Certificate</b>
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1. **WHO MUST FILE** – Every new employee who resides in or is domiciled in the District of Columbia and from whom tax is required to be withheld, must fill out Form D-4 and file it with his/her employer. If you are not liable for D.C. taxes because you are a nonresident or are not domiciled in the District of Columbia, you must file Form D-4A (Certificate of Nonresidence in the District of Columbia).
2. **WHEN TO FILE** – File Form D-4 whenever you start new employment. Once filed with your employer, it will remain in effect until an amended certificate is filed. An employee may file a new withholding allowance certificate at any time if the number of withholding allowances to which he or she is entitled increases. However, an employee must file a new certificate with 10 days if the number of withholding allowances previously claimed decreases.
3. **WHAT TO FILE** – After completing Form D-4, detach the bottom portion and file it with your employer. Keep the top portion for your records.

**D-4 WORKSHEET INSTRUCTIONS**


- A. thru D – Choose the appropriate category.  
 E. Enter a "1" or "2" for each category of Age or Blindness, depending on the number of allowances you are claiming for yourself or your spouse or both.  
 The age and blindness allowance does not apply to dependents.  
 F. Dependents – Enter the number of dependents you are entitled to claim and who are not claiming themselves on a separate District of Columbia Individual Income Tax return.  
 G. Additional Withholding Allowances – You may claim additional allowances, the number of which is determined by taking the excess of your estimated itemized deductions over your applicable standard deduction and dividing it by the current allowable personal exemption amount/

**D-4 WORKSHEET TO FIGURE YOUR WITHHOLDING ALLOWANCES**

A.	SINGLE: If you claim an allowance for yourself only, and if no one else claims you as a dependent enter the figure "1".....	
B.	HEAD OF HOUSEHOLD: If you are single, or married and not living with your spouse and maintain a household for yourself and a qualifying person, enter the figure here.....	
C.	MARRIED FILING JOINTLY: If you claim an allowance for yourself and your spouse, and an allowance for your spouse is not claimed on another certificate, enter figure "2".....	
D.	MARRIED FILING SEPARATELY: If you claim an allowance for yourself only, enter the figure "1".....	
E.	AGE AND BLINDNESS: (Applicable only to you and your spouse, but NOT to dependents) AGE – If you or your spouse will be 65 years of age or older at the end of the year, enter the figure "1"; if both will be 65 or older, enter the figure "2".....	
F.	DEPENDENTS: Enter the number of dependents for whom allowances are claimed.....	
G.	Additional withholding allowances. (See Instruction G above).....	
H.	Add the number of allowances you indicated on the worksheet and enter the TOTAL here and on line 1 of Form D-4 below.....	

**D-4 EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE INSTRUCTIONS**

1. Print or type your full name, current address and social security number. Under Title V, Sec. 1(a) of the D.C. Income and Franchise Tax Act, each employee is required to furnish his/her employer with their social security number on Form D-4. Your social security number is necessary for the identification of your tax account with the District of Columbia and will be used only for tax administration purposes.
2. Be sure to check the proper Filing Status Box. This enables your employer to use the correct income tax withholding table.
3. Enter on line 1 of the allowance certificate below the total number of allowances claimed on line H of the worksheet above.
4. In some instances, even if you claim zero withholding allowances, you may not have enough tax withheld. You may, upon agreement with your employer, have more tax withheld by filling in a dollar amount on line 2 below.
5. You may claim an exempt status on line 3 below, only if you qualify for an exempt status on Federal Form W-4.
6. Be sure to sign and date Form D-4  
 Separate along this line and give the bottom part to your employer. Keep the top portion for your records.

<b>D-4</b> 	<b>EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE</b>		Government of the District of Columbia <b>OFFICE OF TAX AND REVENUE</b>
	Type or print your full name (Last, First, M.I.)		
	Home address	Your Social Security Number	Error! Reference source not found.

**Filing Status** (Check only one) -  Single  Head of Household  Married Filing Jointly  Married Filing Separately

<b>1</b>	Total number of allowances you are claiming (from line H of the Worksheet above)
<b>2</b>	Additional amount, if any, you want deducted each pay period <span style="float: right;">\$</span>
<b>3</b>	<p>I claim exemption from withholding because (check boxes below that apply):</p> <p>a <input type="checkbox"/> Last year I did not owe any District income tax and had a right to a full refund of ALL income tax withheld from me</p> <p style="text-align: right;">YEAR <span style="border: 1px solid black; display: inline-block; width: 40px; height: 20px; vertical-align: middle;"></span></p> <p><b>AND</b></p> <p>b <input type="checkbox"/> This year I do not expect to owe any District income tax and expect a full refund of ALL income tax withheld from me.</p> <p>If both a and b apply, enter the year this is effective and the word "EXEMPT" hear. _____</p> <p>c If you entered "EXEMPT" on line 3b, are you a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate or, if claiming exemption from withholding, that I am entitled to claim the exempt status

Employee's signature X  
5/22/2008

Date

EMPLOYER: Keep this certificate with your records. If 10 or more exemptions are claimed OR if you suspect this certificate contains false information please send a copy to  
Office of Tax Revenue, 941 N. Capitol St., NE, Washington, D.C. 20002 Att: Compliance Administration

FORM  
**MW 507**

**Employee's Maryland Withholding Exemption Certificate**

Print your full name		Your social security number	
Address (including ZIP code)		County of residence (or Baltimore City)	

**1. Total number** of exemptions you are claiming from worksheet below 1.

\_\_\_\_\_

**2. Additional withholding pre pay period under agreement with employer** 2.

\_\_\_\_\_

**3. I claim exemption from withholding because I do not expect to owe Maryland tax. See instructions below and check boxes that apply.**

a. Last year I did not owe any Maryland income tax and had a right to a full refund of all income tax withheld

**AND**

b. This year I do not expect to owe any Maryland income tax and expect to have the right to a full refund of all income tax withheld. (This includes seasonal and student employees whose annual income will be below the minimum filing requirement.)

If both a and b apply, enter year applicable \_\_\_\_\_ (year effective) Enter "EXEMPT" here 3.

\_\_\_\_\_

**4. I claim exemption from withholding because I am domiciled in one of the following states. Check state that applies.**

District of Columbia  Pennsylvania  Virginia  West Virginia

I further certify that I do not maintain a place of abode in Maryland as described in the instructions on page 2/

Enter "EXEMPT" here 4.

\_\_\_\_\_

**Employee's signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Employer's name and address (including zip code) (For employer use only) Innovative Staffing Solutions, 4041 Powder Mill Road, Suite 402, Beltsville, MD 20705	Federal employer identification number
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**Worksheet and instructions**

**Line 1**

**a. Number of personal exemptions (total exemptions on lines A, C and D of the federal W-4 or W-4A worksheet).** a.

\_\_\_\_\_

**b. Number of additional exemptions for dependents over 65 years of age.** b.

\_\_\_\_\_

**c. Number of additional exemptions for certain items, including estimated itemized deductions, alimony payment, allowable child care expenses, qualified retirement contributions, business losses and employee business expenses for the year.** c.

\_\_\_\_\_

**d. Number of additional exemptions for taxpayer and/or spouse at least 65 years of age and/or blind.** d.

\_\_\_\_\_

**e. Total – add lines a through d and enter here and on line 1 (Form MW 507).** e.

\_\_\_\_\_

**EXEMPTIONS FOR DEPENDENTS** To qualify as your dependent, you must be entitled to an exemption for the dependent on your federal income tax return for the corresponding tax year.

**ADDITIONAL EXEMPTIONS FOR DEPENDENTS OVER 65 YEARS OF AGE** An additional exemption is allowed for dependents who are 65 years of age or older.

**ADDITIONAL EXEMPTIONS** You may claim additional exemptions for certain items, including estimated itemized deductions, alimony payments, allowable child care expenses, qualified retirement contributions, business losses and employee business expenses for the year. One additional withholding exemption is permitted for each \$2,400 of estimated itemized deductions or adjustments to income that exceed the standard deduction allowance.

**NOTE:** Standard deduction allowance is 15% of Maryland adjusted gross income with a minimum of \$1,500 and a maximum of \$2,000 for each taxpayer.

# FORM VA-4

COMMONWEALTH OF VIRGINIA  
DEPARTMENT OF TAXATION

## PERSONAL EXEMPTION WORKSHEET

- 1. If you wish** to claim yourself, write "1" ..... \_\_\_\_\_
- 2. If you are married** and your spouse is not claimed on his or her own certificate, write "1"..... \_\_\_\_\_
- 3. Write the number** of dependents you will be allowed to claim on your income tax return (do not include your spouse)..... \_\_\_\_\_
- 4. Subtotal Personal** Exemptions (add lines 1 through 3)..... \_\_\_\_\_
- 5. Exemptions** for age
- (a) If you will be 65 or older on January 1, write "1"..... \_\_\_\_\_
- (b) If you claimed an exemption on line 2 and your spouse will be 65 or older on January 1, write, "1"..... \_\_\_\_\_
- 6. Exemptions** from blindness
- (a) If you are legally
- (b) If you claimed an exemption on line 2 and your spouse is legally blind, write "1"..... \_\_\_\_\_
- 7. Subtotal exemptions** for age and blindness (add lines 5 through 6)..... \_\_\_\_\_
- 8. Total of Exemptions** – add line 4 and line 7..... \_\_\_\_\_

-----  
-----  
Detach here and give the certificate to you employer. Keep the top portion for your records  
**FORM VA-4 EMPLOYEE'S VIRGINIA INCOME TAX WITHHOLDING EXEMPTION CERTIFICATE**

Your social security number	Name
Street Address, City, State ZIP Code	

### COMPLETE THE APPLICABLE LINES BELOW

1. If subject to withholding, enter the number of exemptions claimed on:
- (a) Subtotal of Personal Exemptions – line 4 of the Personal Exemption Worksheet..... \_\_\_\_\_
- (b) Subtotal of Exemptions for Age and Blindness – line 7 of the Personal Exemption Worksheet..... \_\_\_\_\_
- (c) Total Exemptions – line 8 of the Personal Exemption Worksheet..... \_\_\_\_\_
2. Enter the amount of additional withholding requested (see instructions)..... \_\_\_\_\_
3. I certify that I am not subject to Virginia withholding. I meet the conditions set forth in the instructions (check here)..... \_\_\_\_\_

<b>Signature</b>	5/22/2008 Date
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EMPLOYER: Keep exemption certificates with your records. If you believe the employee has claimed too many exemptions, notify the Department of Taxation, P.O. Box 1115, Richmond, Virginia 23218-1115, telephone (804) 367-8037.

Applicant Record Sheet  
Thursday, May 22, 2008

Applicant Name: ,

Applicant Category:

Applicant Specialties:

Applicant S.S. #:

Applicant Address:

Applicant Telephone:

Applicant Cellular:

Applicant EMAIL:



4041 Powder Mill Road, Suite 107  
Beltsville, Maryland 20705  
240-334-4333 Fax: 240-334-4335  
[www.ISSNURSES.com](http://www.ISSNURSES.com)

## SUMMARY OF EXPERIENCE

Employee Name:

Educational Background

Employment History

-  
-  
-