



## **ACKNOWLEDGEMENT FORM** ANNUAL MANDATED TOPICS

I hereby acknowledge receipt and understanding of the following Mandated Topics from American Medical Staffing.

Topics Included:

- ❖ Fire Safety
- ❖ Electrical Safety
- ❖ Infection Control/Universal Precautions
- ❖ Hepatitis C
- ❖ Hepatitis B
- ❖ HIV Testing and Related Information
- ❖ Age Specific Care
- ❖ Sexual Harassment
- ❖ Pain Management
- ❖ Patient Abuse
- ❖ Multi-Cultural Aspects and Spiritual Diversity of Patient Care
- ❖ HIPAA Privacy Regulations
- ❖ National Patient Safety Goals
- ❖ Patient Rights
- ❖ Domestic Violence
- ❖ Restraints
- ❖ Blood Glucose Monitoring & Management
- ❖ Advance Directives
- ❖ Agency Administrative Policies and Procedures
- ❖ Emergency Preparedness Plan
- ❖ Prevention of Medical Errors
- ❖ Back Safety
- ❖ Workplace Violence

I understand that as an employee of *Company Name*, at any client facility, it is my responsibility to protect the confidentiality of the patients' medical information. Failure to maintain patient confidentiality may lead to discharge or other disciplinary action.

I have read and understand the above policy.

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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Social Security #



## EMPLOYMENT APPLICATION

Name \_\_\_\_\_

Home Tel. (     ) \_\_\_\_\_

Street Address \_\_\_\_\_

Cellular (     ) \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Beeper/Pager (     ) \_\_\_\_\_

Social Security No. \_\_\_\_\_

E-Mail \_\_\_\_\_

Position Applying For: \_\_\_\_\_

Other (Specify): \_\_\_\_\_

### WORK HISTORY:

**Current or Last Employer** \_\_\_\_\_

Tel. (     ) \_\_\_\_\_

Street Address \_\_\_\_\_

Supervisor \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Job Title \_\_\_\_\_

Salary \_\_\_\_\_ Dates Worked – From \_\_\_\_\_ To \_\_\_\_\_

Name Used While Employed \_\_\_\_\_

Reason for Leaving \_\_\_\_\_

Duties \_\_\_\_\_

May We Contact This Employer To Obtain Reference?  Yes  No

**Prior Employer** \_\_\_\_\_

Tel. (     ) \_\_\_\_\_

Street Address \_\_\_\_\_

Supervisor \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Job Title \_\_\_\_\_

Salary \_\_\_\_\_ Dates Worked – From \_\_\_\_\_ To \_\_\_\_\_

Name Used While Employed \_\_\_\_\_

Reason for Leaving \_\_\_\_\_

Duties \_\_\_\_\_

### EDUCATION:

**Name of High School** \_\_\_\_\_

Check Highest Grade Completed:

Street Address \_\_\_\_\_

1      2      3      4      5      6

City, State, Zip \_\_\_\_\_

7      8      9      10      11      12

**Name of College or Nursing School** \_\_\_\_\_

Name Used While Attending \_\_\_\_\_

Street Address \_\_\_\_\_

Degree/Course/Certificate \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Date Received \_\_\_\_\_

Were You Ever Convicted Of A Crime?  Yes  No

If Yes, Please

Explain \_\_\_\_\_

\* Criminal conviction (s) will not automatically disqualify an applicant from employment with American Medical Staffing.



PLEASE READ AND SIGN

I hereby authorize American Medical Staffing, and also authorize and request each former employer and person, firm or corporation given as a reference to answer all questions that may be asked and give all information that may be sought in connection with this application specifically concerning my work, skill or my professional action in any transaction. My employment with American Medical Staffing will not begin until such references are received.

I agree, in consideration of your employing me that I will not seek or accept employment from any client of American Medical Staffing without first obtaining permission from American Medical Staffing and I agree to remain on the American Medical Staffing' payroll for an additional 350 hours or the terms agreed upon by all parties. I understand that if I am in violation of this agreement, I am subject to legal action and monetary damages.

I understand that this employment application is not a contract and that if hired, my employment with American Medical Staffing can be terminated with or without cause, and with or without notice, at any time, at the option of American Medical Staffing I also understand that any and all benefits received pursuant to employment with American Medical Staffing may be changed or eliminated at will without prior notice.

I consent to having a background check done on my history, including a social security number verification, and I understand that my employment might hinge on this check, including termination if after I am hired, American Medical Staffing acquires information that precluded my hire.

I understand that all applicants are required to undergo screening for the presence of illegal drugs or alcohol as a condition of employment at American Medical Staffing. I will be required to voluntarily submit to a urinalysis test at a laboratory chosen by the company and by signing this consent agreement. I release American Medical Staffing from liability. I understand that with positive test results I will be denied employment at this time, but I may initiate another inquiry with American Medical Staffing, after 6 months. American Medical Staffing will not discriminate against applicants for employment because of past abuse of alcohol/drugs. Neither will American Medical Staffing tolerate the current abuse of alcohol/drugs. I may also be asked to voluntarily submit to urinalysis tests for Cause/Post Incident Screening, Post Accident Screening and at the request of any client prior to starting an assignment.

I authorize American Medical Staffing to copy and forward my personnel file contents to any and all agencies which require this of American Medical Staffing. I hereby certify that all of the above information is true and correct. I understand that any misrepresentation or false information given on this application will result in rejection or termination of employment.

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

FOR OFFICE USE ONLY – DO NOT WRITE BELOW

**INTERVIEW COMMENTS**

Interviewed By: \_\_\_\_\_ Position: \_\_\_\_\_ Office: \_\_\_\_\_

Interviewer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**APPLICANT DATA SHEET**

Name: \_\_\_\_\_ RN \_\_\_ LPN \_\_\_ CNA

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Beeper: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Best Time & Number to be reached: \_\_\_\_\_

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

Geographic Preferences: \_\_\_\_\_

Preferred Work Setting: \_\_\_\_\_ Hospital \_\_\_\_\_ MD Office \_\_\_\_\_ Clinic  
\_\_\_\_\_ Nursing Home Other \_\_\_\_\_

Specialty Areas Desired: \_\_\_\_\_ ER \_\_\_\_\_ OR \_\_\_\_\_ Med Surg \_\_\_\_\_ Telemetry  
\_\_\_\_\_ PACU \_\_\_\_\_ NICU \_\_\_\_\_ ICU \_\_\_\_\_ CCU \_\_\_\_\_ PICU  
\_\_\_\_\_ LTC / Sub-A \_\_\_\_\_ Cardiology \_\_\_\_\_ Renal \_\_\_\_\_ Psych  
\_\_\_\_\_ OB Other \_\_\_\_\_

Employment Desired: \_\_\_\_\_ Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ Per Diem

Availability: \_\_\_\_\_ Shift 1 \_\_\_\_\_ Shift 2 \_\_\_\_\_ Shift 3 \_\_\_\_\_ Mon \_\_\_\_\_ Tues \_\_\_\_\_ Wed  
\_\_\_\_\_ 12 Hour AM \_\_\_\_\_ 12 Hour PM \_\_\_\_\_ Thurs \_\_\_\_\_ Fri \_\_\_\_\_ Sat \_\_\_\_\_ Sun

Desired amount of hours per week: \_\_\_\_\_ Available to begin on: \_\_\_\_\_

Preference Pay Rates: Hourly \_\_\_\_\_ Salary \_\_\_\_\_

Years of Experience: \_\_\_\_\_

**Referral Program:**

Nurse Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Nurse Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Nurse Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





## **Drug Testing Consent Form**

I have applied for employment with American Labor Solutions. As a condition for my application being considered, I understand and agree to undergo substance screening. I understand that if my test results are positive, I shall not be considered further by American Labor Solutions.

I hereby authorize any physician, laboratory, hospital or medical professional retained by American Labor Solutions for screening purposes to conduct such screening and to provide the results to a American Labor Solutions, and I release American Labor Solutions and any person affiliated with American Labor Solutions and any such institution or person conducting the screening, from liability therefor.

Applicant's signature: \_\_\_\_\_

Applicant's name: \_\_\_\_\_

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



**ASSIGNED EMPLOYEE CONFIDENTIALITY AND PRIVACY AGREEMENT**

As a condition of my assignment by \_\_\_\_\_ (the “Agency”) to \_\_\_\_\_ (the “Facility), I hereby acknowledge and agree as follows:

I will not use, disclose, or in any way reveal or disseminate to unauthorized parties any information I gain through contact with materials or documents that are made available through my assignment at the Facility or that I learn about during such assignment.

I will not disclose or in any way reveal or disseminate any information pertaining to the Facility or its operating methods and procedures that come to my attention as a result of this assignment.

Under no circumstances shall I remove copies or documents from the premises of the Facility.

I have read the attached “Summary of HIPAA Privacy Rules for Temporary Personnel” and understand it. During my assignment at the Facility, I will abide by the principles described in this attached summary, as well as any privacy policy provided to me by the Facility. In particular, I will not use, disclose or in any way reveal or disseminate any protected health information which I learn in connection with any assignment, except in accordance with such principles and privacy policy.

I understand that I shall be responsible for any direct or consequential damages resulting from any violation of this Agreement.

The obligations of this Agreement shall remain in effect even after my employment by American Medical Staffing has ended.

Assigned Employee:

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

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

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



**REFERENCE REQUEST**

The following employment information must be provided to American Medical Staffing, in accordance with their stringent pre-employment requirements. I hereby authorize the release of my employment and performance records. I respectfully request your prompt response to this request for my employment information, as my future employment is dependent on your contribution.

**Employer Contact Information**

Facility Name: \_\_\_\_\_ Unit: \_\_\_\_\_

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

Contact Name: \_\_\_\_\_ Title \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail \_\_\_\_\_

**Employee Information**

Name of Applicant (printed): \_\_\_\_\_

Name Used while employed \_\_\_\_\_ Position \_\_\_\_\_

Social Security # \_\_\_\_\_ Dates of Employment: From: \_\_\_\_\_ to \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_ Date \_\_\_\_\_

**This portion is to be completed by the Employer**

	EXCELLENT	GOOD	AVERAGE	POOR
Quality of work / Competency	_____	_____	_____	_____
Attendance / Punctuality	_____	_____	_____	_____
Professional Conduct	_____	_____	_____	_____
Cooperation /Relationships	_____	_____	_____	_____

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

Eligible for Rehire: \_\_\_\_\_ YES \_\_\_\_\_ NO      Still Currently Employed: \_\_\_\_\_ YES \_\_\_\_\_ NO

Name(printed) \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_ Contact Phone Number \_\_\_\_\_

Signature \_\_\_\_\_

*The staff of American Medical Staffing recognizes the many tasks you must accomplish daily. We appreciate the moments you spent completing this request. Your comments directly impact our ability to achieve our goal to continuously provide qualified healthcare professionals to facilities such as yours.*

Please return this document to our offices via mail or fax to:

**American Medical Staffing**  
 4595 Broadmoor Ave., SE, Ste. 150  
 Grand Rapids, MI 49512  
 Phone: 616-871-9696 / Fax: 616-656-1003



**REFERENCE REQUEST**

The following employment information must be provided to American Medical Staffing, in accordance with their stringent pre-employment requirements. I hereby authorize the release of my employment and performance records. I respectfully request your prompt response to this request for my employment information, as my future employment is dependent on your contribution.

**Employer Contact Information**

Facility Name: \_\_\_\_\_ Unit: \_\_\_\_\_

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

Contact Name: \_\_\_\_\_ Title \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail \_\_\_\_\_

**Employee Information**

Name of Applicant (printed): \_\_\_\_\_

Name Used while employed \_\_\_\_\_ Position \_\_\_\_\_

Social Security # \_\_\_\_\_ Dates of Employment: From: \_\_\_\_\_ to \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_ Date \_\_\_\_\_

**This portion is to be completed by the Employer**

	EXCELLENT	GOOD	AVERAGE	POOR
Quality of work / Competency	_____	_____	_____	_____
Attendance / Punctuality	_____	_____	_____	_____
Professional Conduct	_____	_____	_____	_____
Cooperation /Relationships	_____	_____	_____	_____

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

Eligible for Rehire: \_\_\_\_\_ YES \_\_\_\_\_ NO      Still Currently Employed: \_\_\_\_\_ YES \_\_\_\_\_ NO

Name(printed) \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_ Contact Phone Number \_\_\_\_\_

Signature \_\_\_\_\_

*The staff of American Medical Staffing recognizes the many tasks you must accomplish daily. We appreciate the moments you spent completing this request. Your comments directly impact our ability to achieve our goal to continuously provide qualified healthcare professionals to facilities such as yours.*

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**HEPATITIS B STATUS DECLARATION**

Do not sign both the Acceptance and Declination portions of this form. If you have any uncertainty regarding your current status, please contact your American Medical Staffing representative for clarification.

If you are unable to provide the required Vaccination Information at this time,  
Please sign the Declination Portion of this document.

**Hepatitis B Declination**

I understand that my occupation may result in exposure to blood or other potentially infectious materials, and that I may be at risk of acquiring Hepatitis B virus (HBV) infection. I understand that my failure to receive this vaccine may subject me to the risk of acquiring Hepatitis B disease or, I am in the process of receiving inoculations for Hepatitis, but I have not completed them yet. Therefore, for now I decline and I will furnish you proof of my inoculations when they are completed.

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

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

**Hepatitis B Acceptance**

I have already received 3 vaccinations required for Hepatitis B Vaccination Series and I am able to provide the vaccination records as proof of these inoculations at this time.

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

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



## TB Questionnaire

EMPLOYEE NAME: \_\_\_\_\_ SPECIALTY \_\_\_\_\_

### STEP I

If you have had a positive PPD in the past, go to step II. If you receive PPD's on an annual basis, complete **Step I ONLY**.

DATE OF LAST PPD: \_\_\_\_\_ RESULTS OF LAST PPD IN MM: \_\_\_\_\_

### STEP II

Since you have had a positive/sensitive PPD and are no longer required to have an annual chest x-ray, the following is to be completed annually and maintained in the personnel file. However, you must have the results of at least one XRAY on File.

DATE OF LAST XRAY: \_\_\_\_\_

Please read and put a checkmark in the correct Yes/No space if you are experiencing any of the following symptoms or if any of the following apply to you:

	YES	NO
1. Unplanned loss of weight(>10% of body weight).....	___	___
2. Night sweats.....	___	___
3. Fever lasting several weeks .....	___	___
4. Frequent coughing in the absence of a cold or flu.....	___	___
5. Coughing blood-streaked sputum.....	___	___
6. Unusual tiredness or weakness lasting weeks .....	___	___
7. Pain in chest when taking a breath.....	___	___
8. Have you been recently diagnosed with diabetes, silicosis, HIV disease, renal disease or liver disease?.....	___	___
9. Have you been recently been exposed to a family member or others with active TB?.....	___	___

If you checked YES to any of the above question, are you currently treating with a physician?: (Circle one) YES NO Please explain: \_\_\_\_\_

IF YOU DEVELOP ANY OF THE SYMPTOMS LISTED ABOVE, PLEASE CONTACT YOUR PHYSICIAN AND AGENCY **IMMEDIATELY**. A CHEST X-RAY **MUST** BE PERFORMED PRIOR TO WORKING AGAIN.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



**PHYSICAL EXAMINATION**

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

**PPD, Mantoux, TB Tine Test**

Result \_\_\_\_\_ Date Placed \_\_\_\_\_ Date Read \_\_\_\_\_

*If result is positive please attach the Chest X- Ray Report*

**Titre / Immunization Records**

*Please specify immunity status as well as the source used to verify this status. Immunization records and or Titre results must be attached.*

	<i>Immune Status</i>	<i>Titre</i>	<i>Vaccination Record</i>
Measles	_____	_____	_____
Mumps	_____	_____	_____
Rubella	_____	_____	_____
Varicella	_____	_____	_____
Rubeola	_____	_____	_____

*\*Rubeola Immunity must be verified if patient DOB is after 11/1/57*

Hepatitis B Vaccination Dates

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Diphtheria Tetanus Vaccination Date \_\_\_\_\_ (if applicable)

**Statement of Health**

The above named is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation of addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

Date: \_\_\_\_\_ Physician Name: \_\_\_\_\_

Please Print

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

Physicians Signature \_\_\_\_\_

**THIS FORM MUST BE COMPLETED AND RETURNED WITH REQUIRED ATTACHMENTS PRIOR TO ACTIVE EMPLOYMENT!**





PLEASE HAVE SIGNED BY YOUR SUPERVISOR  
AND FAX BACK TO:

**(616) 656-1003**

BY 9am MONDAY OF EVERY WEEK.

(TIMESLIPS RECEIVED AFTER THIS DEADLINE WIL LBE PROCESSED IN THE NEXT WEEK'S PAYROLL)

Client Name		Week Ending Friday	
Address:	City		
Position	<input type="checkbox"/> RN <input type="checkbox"/> LPN		

Nurse Name	<input type="checkbox"/> HOLD MY CHECK <input type="checkbox"/> MAIL MY CHECK
Social Security Number / / / / / / / / /	Available for Work? <input type="checkbox"/> YES <input type="checkbox"/> NO
Nurse Signature X	When Available?

**IMPORTANT FOR NURSE:** BY EXECUTING THIS FORM, NURSE AGREES TO TERMS AND CONDITIONS ON REVERSE SIDE AND CERTIFIES THAT THIS FORM IS TRUE AND ACCURATE AND THAT NO INJURIES WERE SUFFERED.

DAY		DATE	STARTED	Hours to Nearest Quarter Hour		REG HOURS
				FINISHED	LESS LUNCH	
Saturday						
Sunday						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Minimum Four (4) Hours Per Employee Per Day*			REGULAR			
Client: Please Write Total Hours In Words To The Nearest Quarter Hour:  ▶			Hours		Minutes	
			Total Time:			
Please Print Name (Client)			Title			
Authorized Signature (Client):			Is This Nurse Continuing This Assignment?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

**IMPORTANT FOR CLIENT:** BY EXECUTING THIS FORM CLIENT CERTIFIES THAT HOURS SHOWN ARE CORRECT, WORK WAS PERFORMED SATISFACTORILY AND THAT CLIENT AGREES TO THE TERMS AND CONDITIONS ON THE REVERSE SIDE OF THIS FORM. PLEASE DRAW LINE THROUGH UNUSED SPACES ABOVE.



### CLIENT INFORMATION

Client named on the reverse side, or their representative, hereby agrees that:

1. The Agency Nursing Division herein called (“Agency”) incurs substantial recruiting, screening, administrative and marketing expenses in connection with the temporary employee (“Nurse”) named on reverse side. Client agrees that if Client hires Nurse within one (1) year after this date, without an agreement from Agency, Client will pay Agency’s liquidated damages of 30% of yearly salary of Nurse.
2. Client certifies that the time set forth as hours worked is correct and that the work was performed in a satisfactory manner (**MINIMUM OF FOUR (4) HOURS UNLESS OTHERWISE AGREED TO BY CLIENT AND AGENCY**)
3. Client confirms the prior agreement between Agency and Client with respect to the services performed hereunder and any future services.
4. Client as not and shall no in the future without prior written permission from Agency in each instance (i) entrust Nurse with unattended premises, cash, negotiable instruments, or other valuables or authorize Nurse to operate machinery or motor vehicles; (ii) assign Nurse to perform work other than that described at the time Client placed the job order.
5. Agency insurance does not cover fees or damage caused by Nurse operating Clients owned or leased motor vehicles and Client therefore accepts full responsibility for claims, including the defense thereof, involving bodily injury, property damage, fire, theft, collision, cargo damage or public liability damages sustained if incurred as a result of Nurse driving such vehicles or arising out of moving violation by Client or paragraph 4(i) or 4(ii) above.
6. Agency is not responsible for claims made under its liability or bond insurance policies unless such claims are reported to Agency in writing by Client within 30 days after occurrence.
7. Agency is not responsible for claims for damage to property within Agency or Nurse’s care, custody and control.
8. In the event of Client’s non-payment of Agency’s invoices, Client agrees to be responsible for all collection expenses, including attorney’s fees, interest and court costs.
9. Client accepts the obligation to discuss all matters concerning Nurse, including, within limitation, Nurses job assignment, wages and payroll procedures with Agency and not with Nurse directly.
10. Client shall indemnify and hold Agency, its subsidiaries, affiliates and agents, including the employer of records, harmless from any and all claims and damages arising out of Client’s violation of employment laws, including, without limitation, OSHA and EPO and immigration laws.

### NURSE INFORMATION

1. **Recording your time.** Report all time to the nearest ¼ hour. Do not show odd minutes.
2. **Overtime.** All authorized work you perform in excess of 40 hours per week (Monday-Sunday) will be at time and ½ half the regular rate. You are permitted to work overtime only if the Client requests and approves such work. Approval must be obtained from us by the Client before overtime can be authorized.
3. **Lunch.** Your lunch period will be determined by the supervisor to whom you are assigned. If you work a full day, the law requires you to take a minimum of ½ hour for lunch.
4. **Absence-Call Us At Once.** We will contact the Client. If you will be out a number of days, it will be up to the Client to decide on replacing you or awaiting your return.
5. **Future Assignments.** If you do not contact us after each assignment, we will assume you are not available for work.



Please provide the following documents to our offices at the time of your appointment.

1. Current State Nursing License; we must see the original.
2. Copy of current Professional Liability Insurance (1,000,000 / 3,000,000)
3. Current Physical Form ( within the last 12 months)
4. Lab results regarding the following Titres  
Measles, Mumps, Rubella, Rubeola, Varicella
5. Documents Verifying ability to work in the United States
6. Current BCLS (ACLS and PALS when applicable)
7. Current negative PPD or Chest X-Ray report
8. Professional Reference contact information for 2 employers
9. Copy of Degree

We appreciate your attention to the documents on this list as they are required for employment with American Medical Staffing.

# Form W-4 (2008)

**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 2008 expires February 16, 2009. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** You cannot claim exemption from withholding if (a) your income exceeds \$900 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/multiple 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 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. 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

payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 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. 919 for details.

**Nonresident alien.** If you are a nonresident alien, see the Instructions for 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 your projected total tax for 2008. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

## 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 are single and have only one job; or   
 • 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 \$1,500 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 \$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). See Pub. 972, Child Tax Credit, for more information.   
 • If your total income will be less than \$58,000 (\$86,000 if married), enter "2" for each eligible child.   
 • If your total income will be between \$58,000 and \$84,000 (\$86,000 and \$119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have 4 or more eligible children. **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 have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed \$40,000 (\$25,000 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.

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

Form <b>W-4</b>	<b>Employee's Withholding Allowance Certificate</b>	OMB No. 1545-0074 <b>2008</b>
<b>► 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.</b>		
1 Type or print your first name and middle initial.	Last name	2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <b>Note.</b> If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 <b>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.</b> ► <input type="checkbox"/>
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 2008, and I certify that I meet <b>both</b> of the following conditions for exemption. • Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability <b>and</b> • This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> 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 (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)

### Deductions and Adjustments Worksheet

**Note.** Use this worksheet *only* if you plan to itemize deductions, claim certain credits, or claim adjustments to income on your 2008 tax return.

- 1** Enter an estimate of your 2008 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2008, you may have to reduce your itemized deductions if your income is over \$159,950 (\$79,975 if married filing separately). See *Worksheet 2* in Pub. 919 for details.) 1 \$ \_\_\_\_\_
- 2** Enter: 

{	\$10,900 if married filing jointly or qualifying widow(er) \$ 8,000 if head of household \$ 5,450 if single or married filing separately	}	. . . . .	2	\$ _____
---	--	---	-----------	---	----------
- 3** **Subtract** line 2 from line 1. If zero or less, enter “-0-” 3 \$ \_\_\_\_\_
- 4** Enter an estimate of your 2008 adjustments to income, including alimony, deductible IRA contributions, and student loan interest 4 \$ \_\_\_\_\_
- 5** **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 8* in Pub. 919) 5 \$ \_\_\_\_\_
- 6** Enter an estimate of your 2008 nonwage income (such as dividends or interest) 6 \$ \_\_\_\_\_
- 7** **Subtract** line 6 from line 5. If zero or less, enter “-0-” 7 \$ \_\_\_\_\_
- 8** **Divide** the amount on line 7 by \$3,500 and enter the result here. Drop any fraction 8 \_\_\_\_\_
- 9** Enter the number from the **Personal Allowances Worksheet**, line H, page 1 9 \_\_\_\_\_
- 10** **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10 \_\_\_\_\_

### Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

**Note.** Use this worksheet *only* if the instructions under line H on page 1 direct you here.

- 1** Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1 \_\_\_\_\_
  - 2** Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you are married filing jointly and wages from the highest paying job are \$50,000 or less, do not enter more than “3.” 2 \_\_\_\_\_
  - 3** If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter “-0-”) and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3 \_\_\_\_\_
- Note.** If line 1 is *less than* line 2, enter “-0-” on Form W-4, line 5, page 1. Complete lines 4–9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.
- 4** Enter the number from line 2 of this worksheet 4 \_\_\_\_\_
  - 5** Enter the number from line 1 of this worksheet 5 \_\_\_\_\_
  - 6** **Subtract** line 5 from line 4 6 \_\_\_\_\_
  - 7** Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here 7 \$ \_\_\_\_\_
  - 8** **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed 8 \$ \_\_\_\_\_
  - 9** Divide line 8 by the number of pay periods remaining in 2008. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2007. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 \$ \_\_\_\_\_

**Table 1**

**Table 2**

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above
\$0 - \$4,500	0	\$0 - \$6,500	0	\$0 - \$65,000	\$530	\$0 - \$35,000	\$530
4,501 - 10,000	1	6,501 - 12,000	1	65,001 - 120,000	880	35,001 - 80,000	880
10,001 - 18,000	2	12,001 - 20,000	2	120,001 - 180,000	980	80,001 - 150,000	980
18,001 - 22,000	3	20,001 - 27,000	3	180,001 - 310,000	1,160	150,001 - 340,000	1,160
22,001 - 27,000	4	27,001 - 35,000	4	310,001 and over	1,230	340,001 and over	1,230
27,001 - 33,000	5	35,001 - 50,000	5				
33,001 - 40,000	6	50,001 - 65,000	6				
40,001 - 50,000	7	65,001 - 80,000	7				
50,001 - 55,000	8	80,001 - 95,000	8				
55,001 - 60,000	9	95,001 - 120,000	9				
60,001 - 65,000	10	120,001 and over	10				
65,001 - 75,000	11						
75,001 - 100,000	12						
100,001 - 110,000	13						
110,001 - 120,000	14						
120,001 and over	15						

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The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

