

Credentialing Internal Packet

LOCUM TENENS PROVIDER

Degree: MD DO PA-C ANP Midwife

IDENTIFYING INFORMATION				
Last Name:	First Name:	Middle Name:	Maiden Name:	Suffix:
Social Security Number:	NPI Number:	*Date of Birth	Birth City, State, Country	
Primary Specialty:	Secondary Specialty:	Other than English, please list all languages you speak:		
Are you able to work legally in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate the following: <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Visa or work authorization (You may be asked to provide proof of eligibility to work in the U.S.)				
<i>*Used for credentials verification purposes only. SBG Healthcare, LLC dba Epic Physician Staffing does not discriminate on the basis of age or other factors.</i>				
CONTACT INFORMATION				
Street Address:		Apt./Unit #	City:	State:
Zip Code:				
Home Phone:	Cell Phone:	Work Phone:	E-mail Address:	
ACTIONS, LIMITS, SANCTIONS (If yes, please provide a written description.)				
Have you ever been named in a malpractice claim(s) (including dismissed actions)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide a written description from your attorney.				
Has any monetary payment ever been made by you or on your behalf because of alleged medical malpractice? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Are there currently any pending medical malpractice claims or settlements? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Has your professional liability insurance coverage ever been denied, limited, or canceled by the action of any insurance company? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Has your current liability insurance carrier excluded any specific procedures from your insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No				
DISCIPLINARY ACTIONS (If yes, please provide a written description.)				
Have you ever been the subject of any investigation by any private, state, or federal health insurance program? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Other than any traffic violations, have you ever been charged with or convicted of a misdemeanor or felony or are you currently under indictment or charged with any alleged criminal activities? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Have you ever been censured by any committee of a state or county medical association with regard to professional conduct, ethics or fees?	[] Yes [] No
Have you ever been the subject of a licensing board inquiry?	[] Yes [] No
Have you ever withdrawn an application for medical licensure from a state licensing board?	[] Yes [] No
Have you ever withdrawn an application for medical staff membership at any facility?	[] Yes [] No
Have you ever been employed as a physician or provider where your employment was terminated by the employer?	[] Yes [] No
Have you ever been denied HMO, PPO, or other prepaid health plan participation?	[] Yes [] No
Are you currently engaged in any illegal drug activity?	[] Yes [] No
Have you ever been placed on probation or disciplined by any training program?	[] Yes [] No

(CONTINUED) DISCIPLINARY ACTIONS (If yes, please provide a written description.)

Have you ever been the subject of an administrative, civil, or criminal complaint or investigation regarding sexual misconduct?	[] Yes [] No
Have you ever voluntarily surrendered medical license, staff privileges, DEA registration or consented to a limitation of the same pending a review or investigation?	[] Yes [] No
Are there any other issues that should be disclosed that may have an adverse impact on your ability to deliver effective medical services?	[] Yes [] No
Have you ever been excluded from participation in from Medicare, Medicaid, or any other federal government programs?	[] Yes [] No
Have you ever been excluded from participation in a state Medicaid program?	[] Yes [] No
Have you ever been the subject of a state or federal investigation for a violation of fraud and abuse laws?	[] Yes [] No

UNDERGRADUATE EDUCATION

College or University:	Degree Awarded:	Honors:
From:	To:	Graduation Date:

MEDICAL EDUCATION

Medical School	Degree Awarded:	Phone Number:		
Address:	City:	State:	Zip Code:	Country:
From:	To:	Graduation Date:		

OTHER GRADUATE SCHOOL

College or University:		Degree Awarded:		Phone Number:	
Address:		City:	State:	Zip Code:	Country:
From:	To:	Graduation Date:			

INTERSHIP TRAINING

Institution Name:		Specialty:		Phone Number:	
Address:		City:	State:	Zip Code:	Country:
From:	To:	Program Chair:			
Program Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "NO", please provide written explain on separate sheet).					

RESIDENCY TRAINING

Institution Name:		Specialty:		Phone Number:	
Address:		City:	State:	Zip Code:	Country:
From:	To:	Program Chair:			
Program Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "NO", please provide written explain on separate sheet).					

Institution Name:		Specialty:		Phone Number:	
Address:		City:	State:	Zip Code:	Country:
From:	To:	Program Chair:			
Program Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "NO", please provide written explain on separate sheet).					

FELLOWSHIP OR PRECEPTORSHIP TRAINING

Institution Name:		Specialty:		Phone Number:	
Address:		City:	State:	Zip Code:	Country:
From:	To:	Program Chair:			
Program Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "NO", please provide written explain on separate sheet).					

Institution Name:		Specialty:		Phone Number:	
Address:		City:	State:	Zip Code:	Country:
From:	To:	Program Chair:			
Program Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "NO", please provide written explain on separate sheet).					

BOARD CERTIFICATION(S)

Name of Specialty Board:	Certification Date:	Re-certified?:	Expiration Date:
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

If not board certified, have you been accepted to take a specialty examination? [] Yes [] No

Date Scheduled: _____

If not board certified, how many times have you taken a specialty board examination and failed to pass?

WORK HISTORY
List all employment affiliations in month/year format since completion of post-graduate education. Please explain any gaps in employment greater than 30 days in writing. If you are affiliated with a hospital or organization as part of a job, please list it as well.

Practice / Facility Name:	Locum Tenens?: [] Yes [] No	Phone Number:
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Address:	City:	State:	Zip Code:	Country:
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From:	To:	Position Held:
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Practice / Facility Name:	Locum Tenens?: [] Yes [] No	Phone Number:
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Address:	City:	State:	Zip Code:	Country:
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From:	To:	Position Held:
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Practice / Facility Name:	Locum Tenens?: [] Yes [] No	Phone Number:
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Address:	City:	State:	Zip Code:	Country:
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From:	To:	Position Held:
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Practice / Facility Name:	Locum Tenens?: [] Yes [] No	Phone Number:
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Address:	City:	State:	Zip Code:	Country:
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From:	To:	Position Held:
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Practice / Facility Name:	Locum Tenens?: [] Yes [] No	Phone Number:
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Address:	City:	State:	Zip Code:	Country:
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From:	To:	Position Held:
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Practice / Facility Name:	Locum Tenens?: [] Yes [] No	Phone Number:
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Address:	City:	State:	Zip Code:	Country:
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From:	To:	Position Held:
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From:	To:	Position Held:
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Practice / Facility Name:		Locum Tenens?: <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone Number:	
Address:		City:	State:	Zip Code	Country:
From:	To:	Position Held:			

Practice / Facility Name:		Locum Tenens?: <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone Number:	
Address:		City:	State:	Zip Code	Country:
From:	To:	Position Held:			

Practice / Facility Name:		Locum Tenens?: <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone Number:	
Address:		City:	State:	Zip Code	Country:
From:	To:	Position Held:			

PROFESSIONAL LICENSES AND CONTROLLED SUBSTANCE PERMITS

Please list ALL current state medical licenses and state controlled substance permits.
Have you ever failed to pass any state board, national board (NMBE or NBOME), FLEX, or USMLE examination?
 Yes No

If "YES", please provide written explanation on a separate sheet.

State	License Number	Iss. Date	Exp. Date	Controlled Substance Reg. No	Iss. Date	Exp. Date

INACTIVE LICENSE(S)

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DEA REGISTRATION(S)

Registration Number:	Date Issued:	Date Expired:
Registration Number:	Date Issued:	Date Expired:
Registration Number:	Date Issued:	Date Expired:
Registration Number:	Date Issued:	Date Expired:

ECFMG / FMGEMS Yes No

Certificate Number:	Date Issued:
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MILITARY SERVICE Yes No

Branch:	Start Date:	End Date:
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PROFESSIONAL LIABILITY INSURANCE (please list all carriers and policy numbers for the past ten (10) years)

Present Carrier:		Policy Number:		Years With Company:	
From:	To:	Coverage Limits:			
Address:		City:	State:	Zip Code:	Country:
Previous Carrier:		Policy Number:		Years With Company:	
From:	To:	Coverage Limits:			
Address:		City:	State:	Zip Code:	Country:
Previous Carrier:		Policy Number:		Years With Company:	
From:	To:	Coverage Limits:			
Address:		City:	State:	Zip Code:	Country:
Previous Carrier:		Policy Number:		Years With Company:	
From:	To:	Coverage Limits:			
Address:		City:	State:	Zip Code:	Country:
Previous Carrier:		Policy Number:		Years With Company:	
From:	To:	Coverage Limits:			
Address:		City:	State:	Zip Code:	Country:
Previous Carrier:		Policy Number:		Years With Company:	
From:	To:	Coverage Limits:			
Address:		City:	State:	Zip Code:	Country:
Previous Carrier:		Policy Number:		Years With Company:	
From:	To:	Coverage Limits:			
Address:		City:	State:	Zip Code:	Country:
Previous Carrier:		Policy Number:		Years With Company:	
From:	To:	Coverage Limits:			
Address:		City:	State:	Zip Code:	Country:

REFERENCES (Please provide a minimum of THREE (3) clinical peer references whom you have worked with within the past 24 months, TWO (2) of whom are practicing in your same specialty.

Name: _____ Address: _____

Specialty: _____ City, State, Zip: _____

Phone: _____ E-mail Address: _____

Name: _____ Address: _____

Specialty: _____ City, State, Zip: _____

Phone: _____ E-mail Address: _____

Name: _____ Address: _____

Specialty: _____ City, State, Zip: _____

Phone: _____ E-mail Address: _____

Name: _____ Address: _____

Specialty: _____ City, State, Zip: _____

Phone: _____ E-mail Address: _____

Name: _____ Address: _____

Specialty: _____ City, State, Zip: _____

Phone: _____ E-mail Address: _____

Past and Pending Claims Information

Please complete a separate form for each incident reported

Patient Name: _____

first

last

Age: _____

Gender: _____

Date of incident: _____

Date of claim: _____

Nature of treatment and diagnosis at time of incident:

Allegations made against you:

Did the patient expire? Yes No

Disability: _____

Name of insurance carrier: _____

Policy number#: _____

Was the case settled? Yes No

Pending Suit dropped Dismissed Mediation/Arbitration

Amount of settlement: _____

Settled Trial

Name of other doctors and hospitals, if any, involved in the claim or suit:

To whom may we refer for further information about the claim: (if suit - name, address & phone number of defense attorney)

I hereby authorize release to any insurance company and its agents of information from my insurance carriers, their adjusting firms, and attorneys concerning my past or present claim matters in which I am involved.

If you are printing this form, please sign on the signature line. To submit this form electronically, you must check the "I Agree" box, or use a digital signature. The Electronic Signatures Act (Public Law No: 106-229) went into effect on October 1, 2000 and gives electronic contracts the same weight as those executed on paper. By checking the "I Agree" button or using a digital signature, you are agreeing with the statements listed in the application you just completed and are placing your Electronic Signature on the Electronic Document.

Signature: _____

I agree

Print Name: _____

Date: _____



Credentialing with CMS and Managed Care for Hospital Billing Purposes

Provider Name: _____

CAQH Username: _____

CAQH Password: _____

CAQH # : _____

NPI Number: _____

NPPES Username: _____ (Username and Password used to create NPI)

NPPES Password: _____

Signature: _____

Date: _____

Health Attestation

Personal Health Information

1. Are you currently suffering from a condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner?

Yes No

2. Are you currently using illegal narcotics, illegal drugs, prescription drugs not prescribed to you, or intoxicating liquors to such an extent that your ability to practice medicine in a competent, ethical and professional manner would be impaired?

Yes No

I hereby attest the information provided above is accurate and true.

Provider Name

Date

Provider Signature



Direct Deposit Agreement Form

Provider Name:

Authorization Agreement

I hereby authorize SBG Healthcare to initiate automatic deposits to my account at the financial institution named below. I also authorize SBG Healthcare to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold SBG Healthcare responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until SBG Healthcare receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Credentialing Department.

Account Information

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____ Checking Savings

Signature

Authorized Signature (Primary): _____ Date: _____

Authorized Signature (Joint): _____ Date: _____

Please attach a voided check or direct deposit bank document and return this form to the Credentialing Department for processing.

Independent Contractor Biometric Data Collection Authorization Form

Epic Staffing Group, Inc. and its subsidiaries (The “Company”)

Some clients of the Company may collect, retain, and use biometric data for the purpose of verifying identity and/or recording time entries.

Biometric data is information generated by computer-based systems that scan an individual's hand, finger, face, retina or other physical characteristics and extract unique data points to create a unique mathematical representation. This representation is used to verify the individual's identity, for example, when the individual records their hours worked.

Providing biometric data may be required for engagements with some of the Company's clients, but is not required to secure or retain contract for services with the Company. Individuals are free to decline to provide biometric data to the Company without any adverse action by the Company.

If a client requires the collection of biometric data, the client will collect, use, and retain that data in accordance with the client's own policies and procedures. For more information about how our client uses, shares, and retains biometric data, to understand your privacy choices, including to revoke your consent or request to delete your biometric information, or to request a written copy of this disclosure, please contact the client directly.

By signing this Authorization Form, you agree to the collection, storage, and use of biometric data through a biometric timeclock or other system as described above.

Name: _____ Signature: _____ Date: _____

Independent Contractor Confidential Information Release Form

INDEPENDENT CONTRACTOR AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION ON SERVICE CONTRACT, BACKGROUND CHECK, EDUCATION VERIFICATION, EMPLOYMENT VERIFICATION, DRIVING RECORDS, MEDICAL RECORDS, AND RANDOM DRUG SCREENING

By affixing my signature hereunder, I authorize Epic Staffing Group, Inc. and its subsidiaries (“the Company”) to release any and all confidential employment, background check, driving records, education and medical information obtained in connection with my engagement and my service contract to any medical facility or entity with whom the Company has a staffing agreement, and to any other governmental or regulatory agency at such agency’s request, in connection with my placement at client facilities in accordance with applicable laws and regulations. For all other purposes, the Company shall keep my service contract and related records confidential and shall advise any medical facility or other entity to which records have been provided to also keep such records confidential. I hereby hold the Company harmless for any result(s) that arise with regard to the release of this confidential information by the Company.

Medical records information is confidential and the Company will instruct client facilities and/or other entities to treat the provided information confidential in accordance with applicable law as well.

- I AUTHORIZE THE COMPANY TO CONTACT PAST EMPLOYERS AND REFERENCES REGARDING MY EMPLOYMENT AND SERVICE HISTORY.
- I HEREBY RELEASE ALL PREVIOUS EMPLOYERS AND REFERENCES FROM ANY LIABILITY FOR FURNISHING THIS INFORMATION.
- I AUTHORIZE THE RELEASE OF INFORMATION CONTAINED IN THE BACKGROUND CHECK, EDUCATION VERIFICATION, EMPLOYMENT VERIFICATION & DRIVING RECORD, AND ACKNOWLEDGE RECEIPT OF THE DISCLOSURE AND AUTHORIZATION REGARDING BACKGROUND INVESTIGATION FOR CONTRACTING PURPOSES.
- I FURTHER AUTHORIZE THE RELEASE OF INFORMATION IN THIS APPLICATION & REFERENCE INFORMATION TO THE COMPANY AND ANY FACILITIES WHERE I MIGHT BE SENT ON ASSIGNMENT.
- I FURTHER AUTHORIZE THE RELEASE OF MEDICAL RECORDS INCLUDING LAB RESULTS TO THE COMPANY AND ANY FACILITIES WHERE I MIGHT BE SENT ON ASSIGNMENT.

My signature hereunder further indicates that I have read this CONFIDENTIAL INFORMATION RELEASE FORM in its entirety and understand and consent to its contents. I understand that I may view the background check maintained on me by the Company. I may also obtain a copy of this file, upon submitting proper identification and paying the costs of duplication services, by submitting a request by mail, by appearing at the Company office in person during normal business hours and on reasonable notice, or I may also receive a summary of the file by telephone after submitting a written request.

Name: _____ Signature: _____ Date: _____

Independent Contractor Education Information Release Form

By affixing my signature hereunder, I authorize Epic Staffing Group, Inc. and its subsidiaries (the "Company") to collect, verify, and release my education records for the purposes of education verification in connection with my contract for services and for other contracting purposes. This information will be used exclusively for evaluating my qualifications in relation to the requirements of my potential contract with the Company. I acknowledge that the Company complies with all Equal Employment Opportunity Commission (EEOC) regulations and will handle my education information in accordance with applicable privacy laws.

Education History:

Please provide details for each college or university attended:

Institution: _____ Degree Earned: _____

Major/Field of Study: _____ Date of Graduation: _____

Institution: _____ Degree Earned: _____

Major/Field of Study: _____ Date of Graduation: _____

Institution: _____ Degree Earned: _____

Major/Field of Study: _____ Date of Graduation: _____

I certify the information provided on this form is true and correct. I confirm that I have read and understood the terms of this authorization and voluntarily consent to the collection, verification, and release of my education information.

Full Name: _____ Signature: _____ Date: _____

Independent Contractor Medical & Drug Testing Authorization & Consent Form

I, the undersigned, hereby knowingly and voluntarily authorize and consent to submit to a drug and/or alcohol test as requested by Epic Staffing Group, Inc. and its subsidiaries (“the Company”) and/or its clients.

I consent to undergo required medical tests for credentialing purposes as required by the Company and / or its clients, including but not limited to vaccinations and / or titers, tuberculosis testing, and a physical.

I authorize the collection site, laboratory and medical review officer (MRO) to disclose the results of my medical, drug and/or alcohol tests to the Company, and I further the Company to disclose the results to designated representatives of their client where I will be working.

I acknowledge that the medical, drug and/or alcohol test results will be utilized by the client of the Company where I will be working to determine my eligibility for services, therewith.

I acknowledge that at the time of collection, a refusal to authorize the collection and testing of my urine by the collection site and laboratory, or a refusal to authorize the above disclosure of the test results will be treated as a positive drug and/or alcohol test. I further acknowledge that a positive drug and/or alcohol test may result in denial of my contract for services or termination.

In addition, I hereby knowingly and voluntarily release the Company, the client of the Company where I will be working, the collection site, the testing laboratory and their respective officers, directors, employees and agents from any and all claims, damages, losses, liabilities, costs and expenses, including attorney fees, arising from or relating to such collection and testing and any disclosure of the results thereof, including without limitation, the disclosure of any inaccurate or incomplete results, to the fullest extent permitted by law.

If the results of my test are positive after review and release from the MRO, I authorize the Company to disclose the results, including but not limited to the panels which I tested positive for, to their client for review to determine my eligibility to provide services, therewith. I understand that I have the right to a retest if an initial test indicates use of unlawful drugs and/or alcohol, and that I will have the opportunity to explain to the Company or their client that a positive test result is due to my legitimate use of prescription medication.

I understand that the test results will not be used for any other purpose than described in this form and the Company’s drug testing policy.

I acknowledge that I have the right to receive a copy of this authorization. I have read and understood the above Authorization & Consent in its entirety, and consent to medical, drug and/or alcohol testing under the terms discussed above and in the Company’s drug testing policy. I agree that a copy of this document is as valid as the original.

Name: _____ Signature: _____ Date: _____

Additional State Law Notices

If you live in, work in, or are seeking work for Epic Staffing Group, Inc. and its subsidiaries (“the Company”) in Washington State, Massachusetts, New Jersey, or Minnesota, please note the following information which we are required by state law to provide to you:

State of Washington applicants/employees only: If the Company requests an investigative consumer report (as defined by state law) from a consumer reporting agency, you have the right to receive a complete and accurate disclosure of the nature and scope of the investigation requested by the Company. You also have the right to request a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

Massachusetts applicants/employees only: If the Company requests an investigative consumer report (as defined by state law) from a consumer reporting agency, you have the right to have a copy of the report upon request.

New Jersey applicants/employees only: If the Company requests an investigative consumer report (as defined by state law) from a consumer reporting agency, you have the right to have a copy of the report upon request.

Minnesota applicants/employees only: You have the right, upon written request, to receive a complete and accurate disclosure of the nature and scope of the consumer report. A consumer reporting agency must make this disclosure within five (5) days of receipt of your request or of the Company’s request for the report, whichever is later. **Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company.**

**NOTICE REGARDING BACKGROUND INVESTIGATION
PURSUANT TO CALIFORNIA LAW
(For California Applicants and Employees Only)**

Epic Staffing Group, Inc. and its subsidiaries (“the Company”) intends to obtain information about you from an investigative consumer reporting agency for employment purposes. Thus, you can expect to be the subject of “investigative consumer reports” obtained for employment purposes. Such reports may include information about your character, general reputation, personal characteristics, and mode of living. With respect to any investigative consumer report from an investigative consumer reporting agency (“ICRA”), the Company may investigate the information contained in your employment application and other background information about you, including but not limited to: your criminal history, sex offender registry status, driving history, education history, employment history, and professional licenses. The Company may also obtain comments from individuals who are knowledgeable about you. These reports may be used as a factor in making employment decisions. The Company uses third parties to conduct background checks. These third parties include (but are not limited to):

Staffing Backgrounds
4261 E University Dr., Ste 30-352
Prosper, TX 75078
800-935-9262

Universal Background Screening
PO BOX 743134
Los Angeles, CA 90074-3134
877-263-8033

First Advantage - Corporate Screening Services LLC
7271 Engle Rd., Ste 200
Cleveland, OH 44130
1-800-229-8606

HireRight
100 Centerview Dr., Ste 300
Nashville, Tennessee, 37214
866-521-6995

Under California Civil Code section 1786.22, you are entitled to find out from an ICRA what is in the ICRA’s file on you with proper identification, as follows:

- In person, by visual inspection of your file during normal business hours and upon reasonable notice. You also may request a copy of the information in person. The ICRA may not charge you more than the actual copying costs for providing you with a copy of your file.
- By requesting a copy be sent to a specified addressee by certified mail. ICRA’s complying with requests for certified mailings shall not be liable for disclosures to third parties caused by mishandling of mail after such mailings leave the ICRA’s.
- A summary of all information contained in the ICRA’s file on you (which is required to be provided by the California Civil Code) will be provided to you via telephone, if you have made a written request for telephone disclosure and the toll charge, if any, for the telephone call is prepaid by or charged directly to you.

“Proper Identification” includes documents such as a valid driver’s license, social security account number, military identification card, and credit cards. Only if you cannot identify yourself with such information may the ICRA require additional information concerning your employment and personal or family history in order to verify your identity.

The ICRA will provide trained personnel to explain any information furnished to you and will provide a written explanation of any coded information contained in files maintained on you. This written explanation will be provided whenever a file is provided to you for visual inspection.

You may be accompanied by one other person of your choosing, who must furnish reasonable identification. An ICRA may require you to furnish a written statement granting permission to the ICRA to discuss your file in such person's presence.

Please check this box if you would like to receive a copy of an investigative consumer report (as defined by relevant state law) at no charge if one is obtained by the Company.

**NOTICE REGARDING BACKGROUND INVESTIGATION
PURSUANT TO NEW YORK LAW
(For New York Applicants and Employees Only)**

TX Denton

You have the right, upon written request, to be informed of whether or not an investigative consumer report (as defined by state law) was requested from a consumer reporting agency. If a report was requested, you will be provided with the name and address of the consumer reporting agency to whom the request was made. You may also inspect and receive a copy of the report by contacting one of the third parties that the Company uses to conduct background checks. These third parties include (but are not limited to):

Staffing Backgrounds
4261 E University Dr., Ste 30-352
Prosper, TX 75078
800-935-9262

Universal Background Screening
PO BOX 743134
Los Angeles, CA 90074-3134
877-263-8033

First Advantage - Corporate Screening Services LLC
7271 Engle Rd., Ste 200
Cleveland, OH 44130
1-800-229-8606

HireRight
100 Centerview Dr., Ste 300
Nashville, Tennessee, 37214
866-521-6995

You are also now receiving a copy of Article 23-A of the NY Correction Law below:

NEW YORK CORRECTION LAW
ARTICLE 23-A

LICENSURE AND EMPLOYMENT OF PERSONS PREVIOUSLY
CONVICTED OF ONE OR MORE CRIMINAL OFFENSES

Section 750. Definitions.

751. Applicability.

752. Unfair discrimination against persons previously convicted of one or more criminal offenses prohibited.

753. Factors to be considered concerning a previous criminal conviction; presumption.

754. Written statement upon denial of license or employment.

755. Enforcement.

§ 750. Definitions. For the purposes of this article, the following terms shall have the following meanings:

(1) "Public agency" means the state or any local subdivision thereof, or any state or local department, agency, board or commission.

(2) "Private employer" means any person, company, corporation, labor organization or association which employs ten or more persons.

(3) “Direct relationship” means that the nature of criminal conduct for which the person was convicted has a direct bearing on his fitness or ability to perform one or more of the duties or responsibilities necessarily related to the license, opportunity, or job in question.

(4) “License” means any certificate, license, permit or grant of permission required by the laws of this state, its political subdivisions or instrumentalities as a condition for the lawful practice of any occupation, employment, trade, vocation, business, or profession. Provided, however, that “license” shall not, for the purposes of this article, include any license or permit to own, possess, carry, or fire any explosive, pistol, handgun, rifle, shotgun, or other firearm.

(5) “Employment” means any occupation, vocation or employment, or any form of vocational or educational training. Provided, however, that “employment” shall not, for the purposes of this article, include membership in any law enforcement agency.

§ 751. Applicability. The provisions of this article shall apply to any application by any person for a license or employment at any public or private employer, who has previously been convicted of one or more criminal offenses in this state or in any other jurisdiction, and to any license or employment held by any person whose conviction of one or more criminal offenses in this state or in any other jurisdiction preceded such employment or granting of a license, except where a mandatory forfeiture, disability or bar to employment is imposed by law, and has not been removed by an executive pardon, certificate of relief from disabilities or certificate of good conduct. Nothing in this article shall be construed to affect any right an employer may have with respect to an intentional misrepresentation in connection with an application for employment made by a prospective employee or previously made by a current employee.

§ 752. Unfair discrimination against persons previously convicted of one or more criminal offenses prohibited. No application for any license or employment, and no employment or license held by an individual, to which the provisions of this article are applicable, shall be denied or acted upon adversely by reason of the individual’s having been previously convicted of one or more criminal offenses, or by reason of a finding of lack of “good moral character” when such finding is based upon the fact that the individual has previously been convicted of one or more criminal offenses, unless:

- (1) There is a direct relationship between one or more of the previous criminal offenses and the specific license or employment sought or held by the individual; or
- (2) the issuance or continuation of the license or the granting or continuation of the employment would involve an unreasonable risk to property or to the safety or welfare of specific individuals or the general public.

§ 753. Factors to be considered concerning a previous criminal conviction; presumption. 1. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall consider the following factors:

- (a) The public policy of this state, as expressed in this act, to encourage the licensure and employment of persons previously convicted of one or more criminal offenses.
- (b) The specific duties and responsibilities necessarily related to the license or employment sought or held by the person.

- (c) The bearing, if any, the criminal offense or offenses for which the person was previously convicted will have on his fitness or ability to perform one or more such duties or responsibilities.
- (d) The time which has elapsed since the occurrence of the criminal offense or offenses.
- (e) The age of the person at the time of occurrence of the criminal offense or offenses.
- (f) The seriousness of the offense or offenses.
- (g) Any information produced by the person, or produced on his behalf, in regard to his rehabilitation and good conduct.
- (h) The legitimate interest of the public agency or private employer in protecting property, and the safety and welfare of specific individuals or the general public.

2. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall also give consideration to a certificate of relief from disabilities or a certificate of good conduct issued to the applicant, which certificate shall create a presumption of rehabilitation in regard to the offense or offenses specified therein.

§ 754. Written statement upon denial of license or employment. At the request of any person previously convicted of one or more criminal offenses who has been denied a license or employment, a public agency or private employer shall provide, within thirty days of a request, a written statement setting forth the reasons for such denial.

§ 755. Enforcement. 1. In relation to actions by public agencies, the provisions of this article shall be enforceable by a proceeding brought pursuant to article seventy-eight of the civil practice law and rules.

2. In relation to actions by private employers, the provisions of this article shall be enforceable by the division of human rights pursuant to the powers and procedures set forth in article fifteen of the executive law, and, concurrently, by the New York city commission on human rights.

**NOTICE REGARDING BACKGROUND INVESTIGATION
PURSUANT TO OKLAHOMA LAW
(For Oklahoma Applicants and Employees Only)**

Oklahoma Consumers Have the Right to Obtain a Security Freeze.

You have a right to place a "security freeze" on your credit report, which will prohibit a consumer reporting agency from releasing information in your credit report without your express authorization. A security freeze must be requested in writing by certified mail. The security freeze is designed to prevent credit, loans, and services from being approved in your name without your consent. However, you should be aware that using a security freeze to take control over who gets access to the personal and financial information in your credit report may delay, interfere with, or prohibit the timely approval of any subsequent request or application you make regarding a new loan, credit, mortgage, government services or payments, rental housing, employment, investment, license, cellular phone, utilities, digital signature, Internet credit card transaction, or other services, including an extension of credit at point of sale. When you place a security freeze on your credit report, you will be provided a personal identification number or password to use if you choose to remove the freeze on your credit report or authorize the release of your credit report for a period of time after the freeze is in place. To provide that authorization you must contact the consumer reporting agency by one of the methods that it requires, and provide all of the following:

- The personal identification number or password.
- Proper identification to verify your identity.
- The proper information regarding the period of time for which the report shall be available.
- Payment of the appropriate fee.

A consumer reporting agency must authorize the release of your credit report no later than three (3) business days after receiving all of the above items by any method that the consumer reporting agency allows.

A security freeze does not apply to a person or entity, or its affiliates, or collection agencies acting on behalf of the person or entity, with which you have an existing account that requests information in your credit report for the purposes of reviewing or collecting the account. Reviewing the account includes activities related to account maintenance, monitoring, credit line increases, and account upgrades and enhancements.

You have a right to bring civil action against anyone, including a consumer reporting agency who willfully or negligently fails to comply with any requirement of the Oklahoma Consumer Report Security Freeze Act.

A consumer reporting agency has the right to charge you up to Ten Dollars (\$10.00) to place a freeze on your credit report, up to Ten Dollars (\$10.00) to temporarily lift a freeze on your credit report, and up to Ten Dollars (\$10.00) to remove a freeze from your credit report. However, you will not be charged any fee if you are a victim of identity theft who has submitted, at the time the security freeze is requested, a copy of a valid investigative or incident report or complaint with a law enforcement agency about the unlawful use of your identifying information by another person, or if you are sixty-five (65) years of age or older for the initial placement and removal of a security freeze.

Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company.

Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street NW, Washington, DC 20552.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street NW, Washington, DC 20552.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
 - a person has taken adverse action against you because of information in your credit report;
 - you are the victim of identity theft and place a fraud alert in your file;
 - your file contains inaccurate information as a result of fraud;
 - you are on public assistance;
 - you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer

reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.

- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete, or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.
- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.
- **You may limit “prescreened” offers of credit and insurance you get based on information in your credit report.** Unsolicited “prescreened” offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt out with the nationwide credit bureaus at 1-888-567-8688.
- The following FCRA right applies with respect to nationwide consumer reporting agencies:

CONSUMERS HAVE THE RIGHT TO OBTAIN A SECURITY FREEZE

You have a right to place a “security freeze” on your credit report, which will prohibit a consumer reporting agency from releasing information in your credit report without your express authorization. The security freeze is designed to prevent credit, loans, and services from being approved in your name without your consent. However, you should be aware that using a security freeze to take control over who gets access to the personal and financial information in your credit report may delay, interfere with, or prohibit the timely approval of any subsequent request or application you make regarding a new loan, credit, mortgage, or any other account involving the extension of credit.

As an alternative to a security freeze, you have the right to place an initial or extended fraud alert on your credit file at no cost. An initial fraud alert is a 1-year alert that is

placed on a consumer's credit file. Upon seeing a fraud alert display on a consumer's credit file, a business is required to take steps to verify the consumer's identity before extending new credit. If you are a victim of identity theft, you are entitled to an extended fraud alert, which is a fraud alert lasting 7 years.

A security freeze does not apply to a person or entity, or its affiliates, or collection agencies acting on behalf of the person or entity, with which you have an existing account that requests information in your credit report for the purposes of reviewing or collecting the account. Reviewing the account includes activities related to account maintenance, monitoring, credit line increases, and account upgrades and enhancements.

- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS:	CONTACT:
<p>1.a. Banks, savings associations, and credit unions with total assets of over \$10 billion and their affiliates</p> <p>b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:</p>	<p>a. Consumer Financial Protection Bureau 1700 G Street NW Washington, DC 20552</p> <p>b. Federal Trade Commission Consumer Response Center 600 Pennsylvania Avenue NW Washington, DC 20580 (877) 382-4357</p>
<p>2. To the extent not included in item 1 above:</p> <p>a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks</p> <p>b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act.</p> <p>c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations</p> <p>d. Federal Credit Unions</p>	<p>a. Office of the Comptroller of the Currency Customer Assistance Group P.O. Box 53570 Houston, TX 77052</p> <p>b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480</p> <p>c. Division of Depositor and Consumer Protection National Center for Consumer and Depositor Assistance Federal Deposit Insurance Corporation 1100 Walnut Street, Box #11 Kansas City, MO 64106</p> <p>d. National Credit Union Administration Office of Consumer Financial Protection 1775 Duke Street Alexandria, VA 22314</p>
<p>3. Air carriers</p>	<p>Assistant General Counsel for Office of Aviation Protection Department of Transportation 1200 New Jersey Avenue SE Washington, DC 20590</p>
<p>4. Creditors Subject to the Surface Transportation Board</p>	<p>Office of Public Assistance, Governmental Affairs, and Compliance Surface Transportation Board 395 E Street SW Washington, DC 20423</p>
<p>5. Creditors Subject to the Packers and Stockyards Act, 1921</p>	<p>Nearest Packers and Stockyards Division Regional Office</p>
<p>6. Small Business Investment Companies</p>	<p>Associate Administrator, Office of Capital Access United States Small Business Administration 409 Third Street SW, Suite 8200 Washington, DC 20416</p>
<p>7. Brokers and Dealers</p>	<p>Securities and Exchange Commission 100 F Street NE Washington, DC 20549</p>
<p>8. Institutions that are members of the Farm Credit System</p>	<p>Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090</p>
<p>9. Retailers, Finance Companies, and All Other Creditors Not Listed Above</p>	<p>Federal Trade Commission Consumer Response Center 600 Pennsylvania Avenue NW Washington, DC 20580 (877) 382-4357</p>

Confidential Personal Information Policy

As a member of the Company’s workforce, you may have or receive access to information about individuals, including patients, staff members, and others, that is personal, private or confidential. This information may include any information about an individual, including health information, financial information, identification information, information about individuals’ preferences or personal lives, and other information that identifies or describes individuals (“Confidential Personal Information”). Confidential Personal Information may be in any form, whether electronic, paper, oral or otherwise. Confidential Personal Information may be sensitive in nature, and it is protected by law, regulation and strict Company policies.

As a condition of your access to Confidential Personal Information:

1. You may only access Confidential Personal Information which you have a legitimate need for within the scope of your work.
2. You may not in any way divulge, copy, release, sell, loan, review, alter, post online, destroy, or forward outside of the Company or the Company’s customer’s organization, any Confidential Personal Information unless expressly permitted by existing policy or as properly pre-approved in writing by an authorized officer of the Company or Company’s customer.
3. You may not utilize another user’s password in order to access any applicable system that contains Confidential Personal Information, nor may you reveal your computer credentials to anyone else for any reason. You are personally responsible and will be held accountable for all activities occurring under your computer credentials.
4. If you observe or have knowledge of unauthorized use, access or disclosure of Confidential Personal Information, you must report such events immediately to your supervisor or People Operations.
5. You may not seek to gain personal benefit or permit others to gain benefit personally through use, access or disclosure of Confidential Personal Information.
6. The information which with you have access to in the scope of your work, regardless of the medium on which it is stored (paper, computer, videos, recorders, etc.), the system which processes it (computers, voice mail, telephone systems, faxes, etc.), or the methods by which it is disseminated (electronic mail, face to face conversation, facsimiles, etc.) is the property of the Company or its customer, as applicable.
7. You may not retain or otherwise access Confidential Personal Information after you are no longer employed or engaged by the Company or its customer, as applicable, and if for any reason you do continue to retain or access Confidential Personal Information, you will delete or return it as soon as possible and your confidentiality obligations under this Policy will apply until the Confidential Personal Information is deleted or returned.



8. Your failure to maintain the confidentiality of Confidential Personal Information may result in corrective action, including, but not limited to, termination of employment or engagement with the Company, as well as potential civil or criminal penalties.
9. The Company and/or its customers may monitor system activity to identify inappropriate use, access or disclosure of Confidential Personal Information, and your inappropriate use, access or disclosure of Confidential Personal Information and can result in penalties up to and including termination of your employment or engagement and/or legal action being brought against you.
10. You must comply with the Company's customers' policies regarding maintaining the confidentiality of Confidential Personal Information.
11. You must comply with applicable data privacy laws, including but not limited to the Health Insurance Portability and Accountability Act ("HIPAA") and the General Data Protection Regulation ("GDPR"), as applicable.
12. The Company may inspect or monitor any Company-owned, leased or controlled computer, computer device, network, computer facility, storage device, voice mail or telephone system at any time for any reason, and the Company may divulge any information found during such inspections or monitoring to any party it deems appropriate for purposes of enforcing policies of the Company or its customers.
13. You should not consider electronic communications made using Company or Company's customer's devices or software systems to be either private or secure, nor have an expectation of privacy in anything you create, store, send or receive on any such computer or network.

I acknowledge that I have read, understood, and will abide by the above policy.

Employee Name: _____ Signature: _____ Date: _____

Anti-Harassment Standard

Epic Staffing Group, Inc. and its subsidiaries (the "Company") is committed to providing a workplace environment free from all forms of harassment, including sexual harassment. This includes ensuring that the contractors with which the Company engages are not engaging in improper harassment. This standard outlines the Company's commitment to preventing and addressing sexual harassment within the organization.

Sexual Harassment

Sexual harassment is a type of unlawful discrimination rooted in unwelcome verbal or physical behavior based on a person's gender. It encompasses behaviors and actions that are offensive, unwanted, or inappropriate, and it is strictly prohibited by local, state, and federal laws.

Sexual harassment may manifest in various forms, ranging from subtle comments to overt actions that create a hostile or offensive work environment. Examples of sexual harassment include:

- Unwelcome sexual advances or propositions
- Offensive comments about a person's gender or appearance
- Displaying or sharing sexually explicit material
- Making jokes or comments of a sexual nature
- Using derogatory language related to gender or sexual orientation

Complaint Process

If you believe you have experienced or witnessed sexual harassment, please report it promptly to People Operations or Company leadership, or submit an anonymous Epic Inform report using the following information:

- <https://safeline.com/SubmitReport> or 1-855-662-7233
- Company ID: 601010778

The Company prohibits retaliation against any individual who reports or participates in an investigation of sexual harassment.

Individuals in NY may file complaints with the NY Commission on Human Rights (212-416-0197 or visit NYC.gov/HumanRights), the New York State Division of Human Rights (www.dhr.ny.gov), or the United States Equal Employment Opportunity Commission (www.eeoc.gov).

Prohibition of Retaliation

Retaliation against individuals who report sexual harassment or participate in an investigation is strictly prohibited by the Company. Retaliation may include, but is not limited to, adverse actions such as termination, demotion, or harassment.

Bystander Intervention

Bystander intervention encourages individuals to intervene when they witness behavior that may constitute sexual harassment. This can include directly addressing the situation, seeking help from supervisors or People Operations, creating distractions, or providing support to the individual being targeted. Engaging in bystander intervention contributes to creating a workplace environment where everyone feels safe, respected, and valued.

Responsibilities of Supervisory and Managerial Workers

Supervisory and managerial workers play a crucial role in preventing sexual harassment and retaliation. They are responsible for:

- Leading by example and promoting a respectful work environment
- Taking appropriate action to address and prevent sexual harassment
- Encouraging open communication and promptly addressing any concerns or complaints

Acknowledgment

The Company encourages all individuals to work together to uphold these principles and to create a culture of respect and professionalism. Failure to comply with this standard may result in termination of contract. I acknowledge that I have read, understood, and will abide by the above standard.

Name: _____ Signature: _____ Date: _____



A SAFE SPACE FOR YOU AND YOUR COLLEAGUES



Epic Staffing Group (Epic) is firmly committed to fostering a workplace that values transparency, trust, and the overall security of its employees, patients and clients. If you want to report any concerns of misconduct or voice out any issues affecting your safety and well-being, you can do so safely, anonymously, and securely through Epic Staffing Inform. Epic Staffing Inform is a safe space designed to empower you to speak up and be a positive contributor to our culture.

Submit a report through our Online Submission Form or by calling the number below.

We want you to feel heard. Epic Staffing Inform is available 24/7 for the safety and well-being of you and your colleagues.



epicstaffinggroup.ethicspoint.com



833-761-5890





REPORTING A CLINICAL INCIDENT

At Epic, your safety and well-being, as well as that of our patients, are our top priorities. If an incident or sentinel event occurs on assignment, please let us know by submitting an **Incident Self-Report Form**. Sentinel events should be reported **within 24 Hours** of the incident.

We take these matters very seriously and are intent on handling them with sensitivity, transparency, and respect for confidentiality. Our goal is to investigate these events thoroughly and take the necessary steps to prevent them from happening again.

Thank you for helping us maintain a safe environment for everyone.



**HELP TO PROMOTE A
CULTURE OF SAFETY**

Vendor Code of Conduct

At **Epic Staffing Group**, we believe that ethical conduct, responsible business practices, and unwavering commitment to excellence are the cornerstones of our success in providing exceptional healthcare staffing solutions. As a valued partner in our mission, we invite our vendors to join us in upholding the highest standards of integrity, quality, and compliance within our industry.

Our Vendor Code of Conduct is a testament to our dedication to maintaining the utmost ethical and professional standards in all our interactions. It serves to ensure that our vendors share in our commitment to deliver outstanding services while adhering to principles that safeguard the well-being of patients, healthcare professionals, and our organization alike.

To maintain a valued partnership, vendors are asked to comply with the following guidelines set forth by Epic Staffing Group.

Ethical Conduct:

- Conduct business affairs with the highest level of integrity, honesty, and transparency.
- Avoid conflicts of interest and disclose any potential conflicts promptly to Epic Staffing Group.

Compliance with Laws and Regulations:

- Comply with all applicable laws, regulations, and industry standards where they operate.
- Maintain compliance with labor laws, including minimum wage, working hours, and workplace safety standards.

Quality and Safety:

- Strive to deliver products and services that meet or exceed industry standards for quality and safety.
- Report all service, employee, or patient safety concerns promptly to Epic Staffing Group.

Fair Labor Practices:

- Respect the rights of all workers, including fair wages, working hours, and the freedom to associate and organize.
- Prohibit the use of child or forced labor in any form.
- Fully comply with all applicable slavery, forced labor and human trafficking laws, and do not engage in practices that are associated with forced labor or service for which the individual has not offered voluntarily.

Environmental Responsibility:

- Work to minimize the environmental impact of business operations, including reducing waste, conserving energy, and using sustainable materials when possible.

Confidentiality and Data Security:

- Safeguard any and all confidential information, PHI and/or data shared by Epic Staffing Group.
- Implement appropriate security measures to protect sensitive data from unauthorized access or disclosure.

Anti-Bribery and Anti-Corruption:

- Prohibit all forms of bribery, corruption, and unethical influence, including gifts and entertainment, to Epic Staffing Group employees or representatives.
- Maintain accurate records of financial transactions.

Non-discrimination and Diversity:

- Provide equal employment opportunities to all workers regardless of race, color, religion, gender, sexual orientation, national origin, disability, or other protected characteristics.
- Promote diversity and inclusion within the workforce.

Whistleblower Protection:

- Establish mechanisms for employees and vendors to report concerns regarding unethical or illegal behavior without fear of retaliation.

Continuous Improvement:

- Strive for continuous improvement in all aspects of business operations.
- Collaborate with Epic Staffing Group to identify opportunities for enhancing services.

Communication and Collaboration:

- Maintain open and honest communication with Epic Staffing Group, including promptly reporting any issues or concerns.
- Collaborate with Epic Staffing Group to address challenges and find mutually beneficial solutions.

Monitoring and Enforcement:

- Epic Staffing Group reserves the right to monitor and audit vendor compliance with this Code of Conduct.
- Non-compliance may result in corrective action, including the termination of the vendor relationship.

REPORTING VIOLATIONS

To report possible violations of these guidelines, vendors are encouraged to work with their primary Epic Staffing Group contact to bring about and/or resolve the concern. If the vendor wishes to escalate or keep the report anonymous, the following communication channels may be used;

See below for reporting procedures.

Epic Staffing Inform reporting procedure:

- You may submit a report by calling **833-761-5890**
- You may also submit a complaint or concern at epicstaffinggroup.ethicspoint.com

By engaging with **Epic Staffing Group**, you acknowledge your commitment to upholding these principles and complying with our Vendor Code of Conduct.

We expect our vendors to act as partners in our mission to provide exceptional healthcare staffing services while maintaining the highest ethical standards.

NAME (PRINT):

DATE:

SIGNATURE:

Patient Lifts



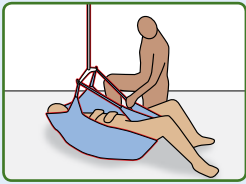
SAFETY GUIDE

Caregiver Safety Tips	1
Know Your Lift	2
Check Patient's Condition	3
Select Patient's Sling Size	4
Choose Sling and Sling Bar	5
Prepare Environment	6
Prepare Equipment	7
Place Patient in Sling	8
Perform Safety Check	9
Lift the Patient	10
Lower the Patient	11
Patient Lifts at Home	12–13
Sling Care	14
Patient Lift Care	15
Contact Information	16

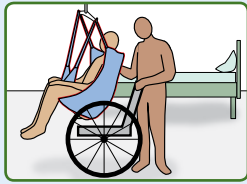
This guide provides general safety recommendations and is not a replacement for the manufacturer's instructions. Refer to manufacturer's instructions for specific use guidelines.

1 Caregiver Safety Tips

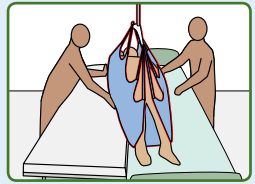
Using lifts for these activities may help caregivers avoid back injury:



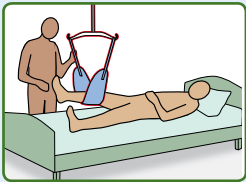
✓ Lifting from floor



✓ Bed-Chair transfer



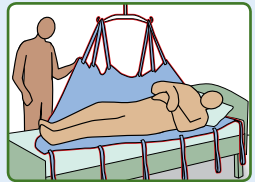
✓ Lateral transfer



✓ Lifting limbs

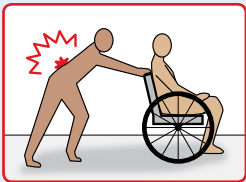


✓ Toileting/Bathing

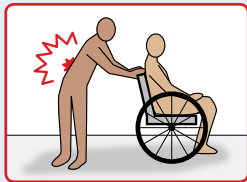


✓ Repositioning

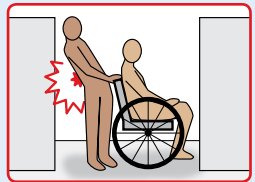
DO NOT push, pull or lift weight while...



Off-balance or leaning forward



Twisting and/or reaching



Entrapped in a confined space

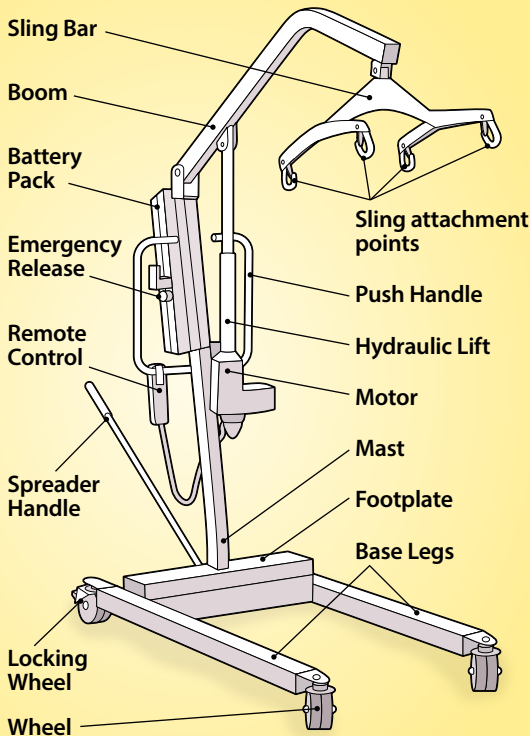
! Work as close to patient as possible to avoid stress of leaning.

Know Your Lift

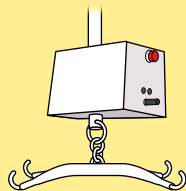
2

! Patient falls from lifts may cause injuries, including head trauma, fractures and death.

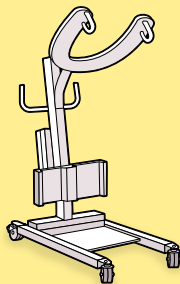
Receive training and practice before operating a lift.



Floor-Based, Full-Body Sling Lift



Overhead Full-Body Sling Lift



Sit-to-Stand Lift

A floor-based, full-body sling lift is featured throughout this guide; however the information applies to all patient lifts.

Check Patient's Condition

Before using a patient lift, check:

Patient's physical capabilities

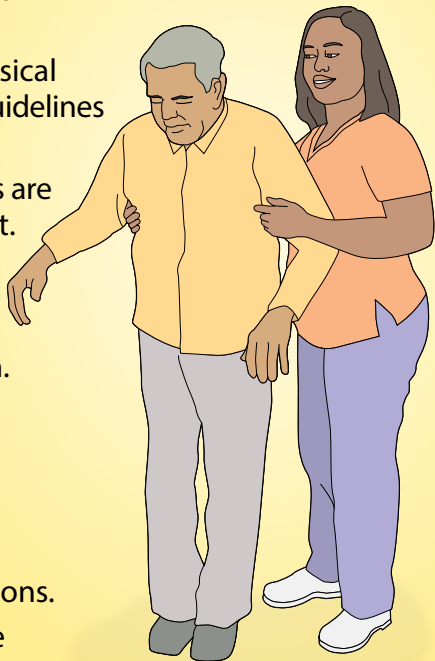
- ✓ Check to see if patient can assist with transfer.
- ✓ Check patient's weight and physical condition; use manufacturer's guidelines to make sure lift is appropriate.
- ✓ Determine how many caregivers are required to safely lift the patient.

Patient's medical condition

- ✓ Make sure you have correct lift and sling for patient's condition.
- ✓ Ensure the lift will not make the patient's condition worse.

Patient's mental status

- ✓ If alert, ensure patient is able to understand and follow instructions.
- ✓ Make sure patient is ready to be placed in a lift.



The use of a patient lift should be avoided if the patient is agitated, resistant or combative.

Select Patient's Sling Size

4

1 Assess patient's size, weight and hip measurement.

2 Choose size of sling based on manufacturer recommendation for patient's measurements. Choosing correct sling size is critical for safe patient transfer.

SLING TOO LARGE:

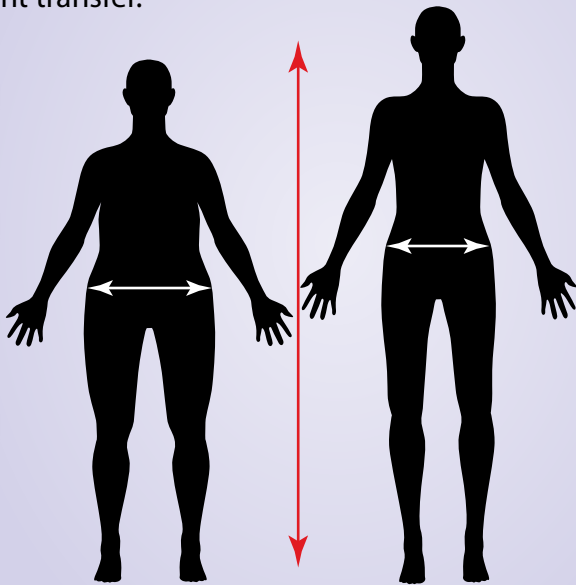
Patient may slip out.

SLING TOO SMALL:

Patient may fall out.
Sling may worsen patient's condition.

IF BETWEEN SIZES:

Smaller size may keep patient more secure.



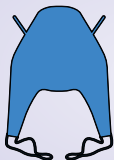
! Using the wrong sling or attaching the sling incorrectly may cause an accident that can result in serious injury or death.

Choose Sling and Sling Bar

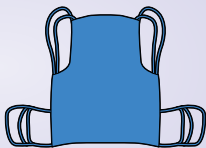
**! Only use a sling specifically designed for your lift.
! Using the wrong sling may cause serious injury.**

To increase patient safety, use the correct type and size of sling for your patient. Select sling and sling bar based on manufacturer recommendations for the following criteria:

- ✓ Type of transfer task
- ✓ Patient's medical condition
- ✓ Patient's size and weight
- ✓ Pressure sensitivity
- ✓ Need for full back support
- ✓ Need for head support
- ✓ Need for padding
- ✓ Patient's preferred or medically appropriate position



U-shaped



Full-Body

Some medical conditions such as stroke, orthopedic conditions, amputations or certain wounds may affect sling choice.

Sling Bars

- ✓ Use a sling bar that is appropriate for the patient's size.
- ✓ Choose sling bar/sling combination that will place patient at a safe angle.
- ✓ Only use sling with correct clip or loop attachment type for the sling bar.

Prepare Environment

Determine number of caregivers needed:

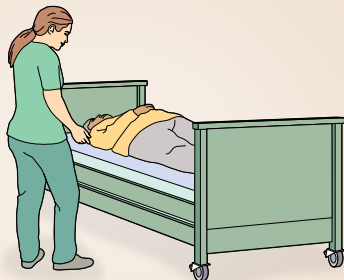
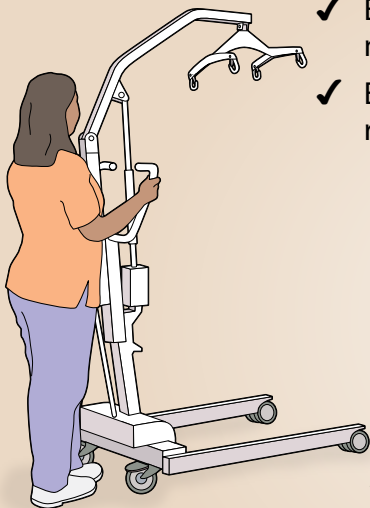
- ✓ Most lifts require two or more caregivers to safely operate lift and handle patient.

Position lift and receiving surface:

- ✓ Move lift base legs near or around patient's device. Base legs are usually more stable in full open position.
- ✓ Position lift and receiving surface at correct height to transfer patient easily.

Clear path for lift:

- ✓ Ensure there is space for lift to pivot and move freely to receiving area.
- ✓ Ensure lift is able to fit under or around receiving surface and through doorways.



For thick carpet, consider choosing a lift with larger wheels or placing a plastic floor mat over carpet.

Prepare Equipment

! Do not use lift to transport patient unless lift is specifically designed for transport.

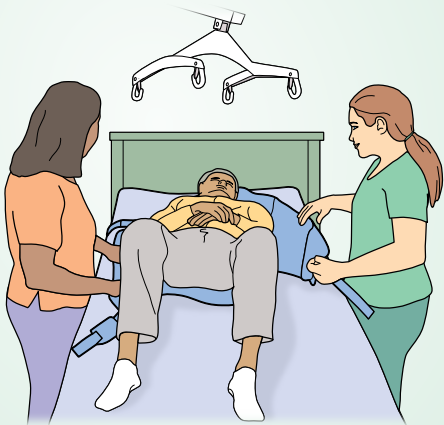
- ✓ Ensure battery is charged for transfer.
- ✓ Test lift controls before bringing lift to patient.
Make sure the emergency release feature works.
- ✓ Ensure receiving surface is stable and locked.
- ✓ Ensure slings, hooks, chains, straps and supports are available, appropriate and correctly sized.
- ✓ Check lift and sling weight limits. Ensure patient's weight does not exceed the limits.
- ✓ Examine sling and attachment areas for tears, holes and frayed seams.
DO NOT USE sling with any signs of wear.



Place Patient in Sling

! Using the wrong sling or attaching the sling incorrectly may cause serious injury to the caregiver or patient.

- 1** Place patient in sling.
 - ✓ Position center of sling under patient's spine.
 - ✓ Place leg straps flat under patient; do not let material fold.
 - ✓ Make sure sling opening is not large enough to let patient slip out or too small to let patient fall out.
- 2** Lower sling bar down to patient. Do not let sling bar hit patient.
- 3** Attach sling straps to sling bar as directed by manufacturer.
 - ✓ Use matching loops from each side to ensure sling is balanced. Choose loops that provide best angle and position for patient.
 - ✓ Ensure all clips or loops are secure and will stay attached as patient is lifted.
 - ✓ Ensure straps are not twisted.
 - ✓ Ensure patient's head and/or back is supported, if needed.



Perform Safety Check

Before lifting the patient, perform safety check:

- ✓ Examine all hooks and fasteners to ensure they will not unhook during use.
- ✓ Double-check position and stability of straps and other equipment before lifting patient.
- ✓ Ensure clips, latches and bars are securely fastened and structurally sound.



For electric lifts, make sure batteries are always charged.

Lift the Patient

10

! Do not leave patient unattended while in lift. Never keep patient suspended in sling for more than a few minutes.

1 Lift patient two inches off the surface to make sure patient is secure. Check the following:

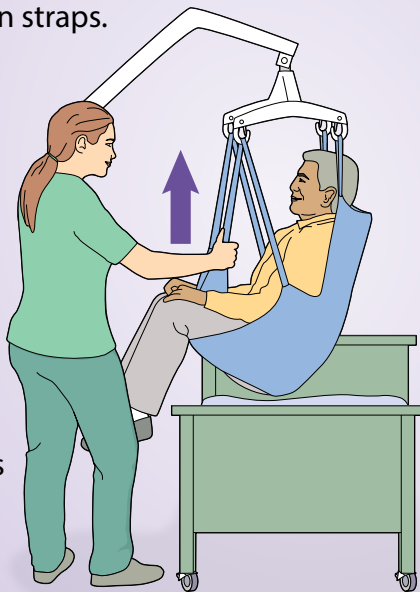
- ✓ Sling straps are confined by guard on sling bar and will not disengage.
- ✓ Weight is spread evenly between straps.
- ✓ Patient will not slide out of sling or tip backward or forward.

2 Check patient's comfort:

- ✓ Make sure sling does not pinch or pull patient's skin.
- ✓ Ask if patient is comfortable.
- ✓ Look for non-verbal signs of discomfort.

3 Slowly lift patient, only as high as necessary to complete transfer. Check the following:

- ✓ Patient is still comfortable.
- ✓ Sling will not hurt patient's skin.



Lower the Patient

- 1 Use gentle hands-on pressure to guide patient as you slowly move lift toward receiving surface.

! Holding or supporting patient's weight while in sling may cause straps or hooks to detach from lift.

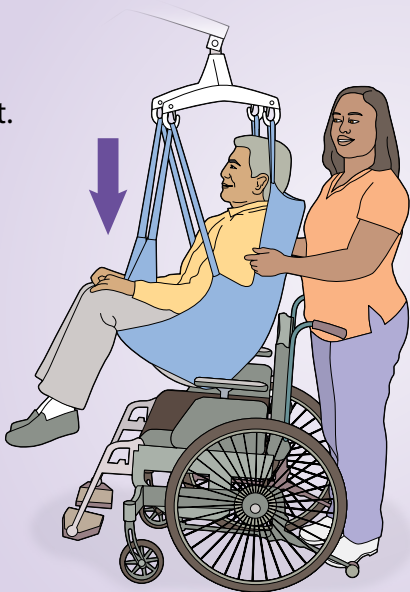
- 2 Slowly lower patient toward receiving surface. Move patient's body into correct position on receiving surface before releasing patient's weight.

- 3 Release patient's weight.
Do not let sling bar hit patient.

- 4 Detach sling from lift using manufacturer's instructions.

- 5 Carefully remove sling from patient's body, if necessary.

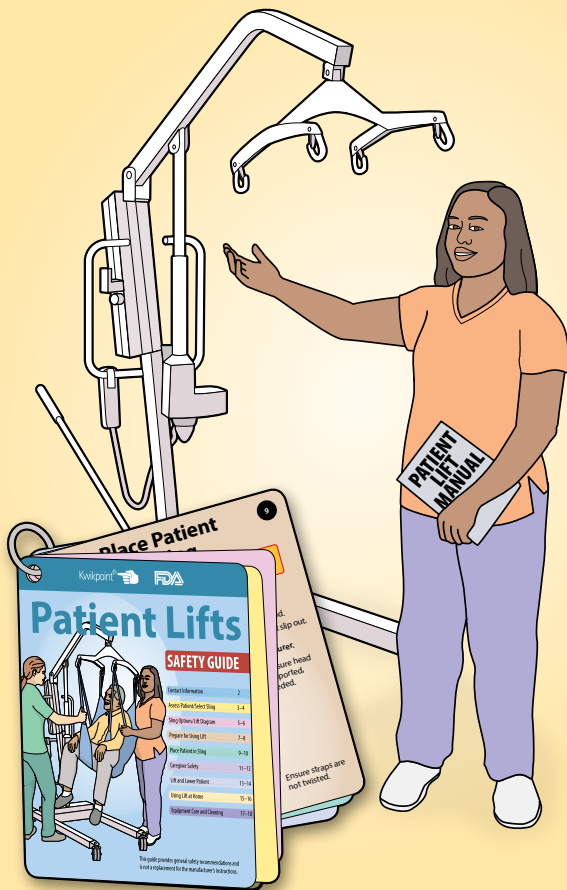
- ✓ Be careful not to hurt patient's skin.
- ✓ Ensure that seated patients do not fall forward as sling is removed.



If power fails, use the emergency release to lower patient manually.

Patient Lifts at Home

12

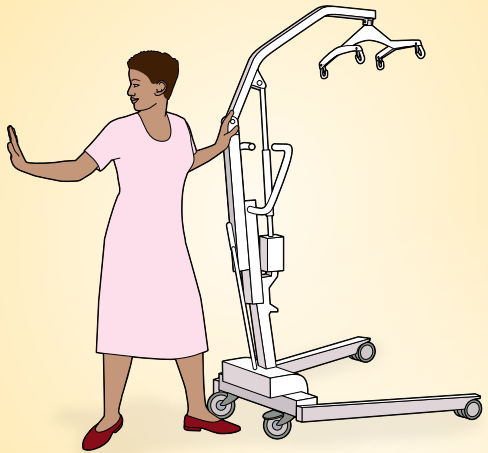


- ✓ Get training from a qualified medical professional before operating a patient lift at home.
- ✓ Keep manufacturer's instructions close to your lift and always follow them.
- ✓ Have a back-up plan in case your lift stops working properly.
- ✓ When selecting a lift for home use, ensure you have the required number of caregivers needed to operate the lift.

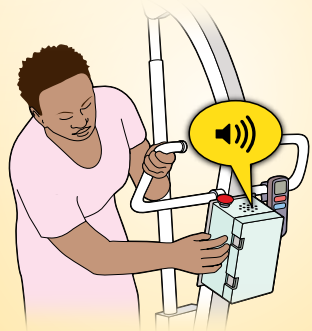
Patient Lifts at Home

! Never operate a lift by yourself if the lift requires more than one person for operation.

- ✓ Keep children and pets away from lift.



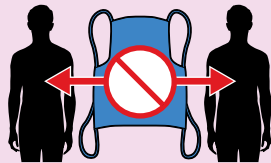
- ✓ Make sure you recognize and understand the alarms and error messages. Always follow through when you hear an alarm.
- ✓ Call your supplier or manufacturer if you need help or have a problem with the device.



Sling Care

14

Do not share slings between patients unless slings are properly washed and disinfected.



! Disinfect slings after every use.



Follow manufacturer sanitation and wash instructions. Remove metal or plastic reinforcements if required.



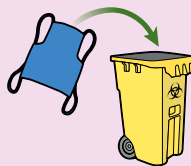
Disinfect and scrub areas that contact patient's skin.



Air dry only.
Do not machine dry.



Do not bleach.
Do not iron.



Throw away used disposable slings.

**! Do not use slings that are frayed, ripped or have holes.
! If sling shows signs of wear, replace it immediately.**

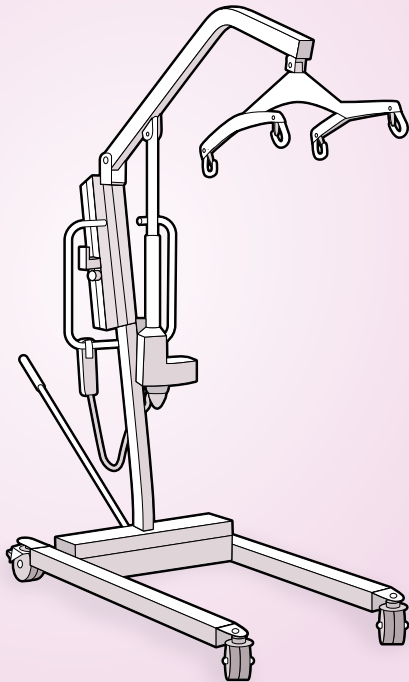
Patient Lift Care

Follow manufacturer instructions to clean and disinfect lift.
Always clean lift before and after each patient use.

- ✓ Disinfect all lift surfaces.



- ✓ Wipe off traces of disinfectant.



- ✓ Clean motor casings and ceiling tracks if using an overhead lift.

Contact Information

CARE PROVIDER

Name:

Phone:

LIFT MANUFACTURER

Name:

Phone:

Web Site:

SUPPLIER

Name:

Phone:

Web Site:

If you have problems operating your lift, contact the manufacturer or supplier.

If you experience an injury, quality problem, or use error when using a patient lift, we encourage you to file a voluntary report at **1-800-FDA-1088** or online through MedWatch, the FDA Safety Information and Adverse Event Reporting program at www.fda.gov/Safety/MedWatch.

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INTRODUCTION

OSHA currently estimates that roughly 5.6 million healthcare workers in the United States are at risk of exposure to blood borne pathogens through “needle-stick” or sharps-related incidents every day– of this 5.6 million, approximately 1000 workers a day are actually affected. When handling sharps on a daily basis it can be easy to forget that holding a needle is just the same as having a weapon of infection. Should you accidentally stick yourself or somebody else, the chance of becoming infected with HIV is 1 in 300, the chance of becoming infected with Hepatitis C is 1 in 50, and the chance of becoming infected with Hepatitis B is 1 in 5. Fortunately, there are safety guidelines in place which, if followed, greatly reduce the chances of an accident.



WHAT IS A “SHARP”? In the medical field, a sharp is a reference to any tool with a point or edge that has the capability to break the skin. Examples of sharps include:

- Lancets: small devices with a sharp point or blade used to retrieve blood for testing.
- Needles: sharp, hollow tubes used for injection
- Syringes: instruments used to withdraw fluid or inject medication into the body
- Auto-injectors: pre-filled syringes
- Infusion sets: tubing systems with an attached needle used for delivering medication



PREPARATION – Setting up your work station properly is vital. Before working with the patient, ask yourself:

- Is this area properly lit so that I can clearly see what I am doing?
- Are the tools that I will need to complete this task within view and easily accessible?
- Is there a sharps disposal container nearby?
- Is the patient aware of and approve the upcoming procedure?

PROCEDURE – There are many “Do’s and Don’ts” to keep in mind - not just while performing the task at hand, but before and after the procedure as well.

Make sure you **DO**:

- Use needles with sheaths or caps if you have access to them.
- Inspect the sharp(s) for any irregularities before use.
- Be aware of bystanders and other healthcare workers in the area.
- Use verbal cues when relocating or handling sharp(s).
- Replace the sheath or cap immediately following use.



DO NOT, under any condition:

- Leave the room without disposing of the sharp(s) yourself.
- Continue working on the task if you are distracted in any way.
- Attempt to complete a task by yourself if you suspect you may need assistance.
- Place the sharp(s) on the bed, or anywhere other than your designated work space.
- Try to remove the needle without a needle clipper.
- Dispose of the sharp(s) in a trash can or recycle bin.

PROPER DISPOSAL – Your facility should provide enough FDA-approved sharps disposal containers for every work space to have one within clear view. Sharps disposal containers are required to be clearly labeled and:

- Have walls made of rigid, leak resistant plastic
- Be equipped with a puncture proof lid that prevents anything from falling out
- Remain stable and upright during storage and use



DAMAGE CONTROL - In the unfortunate case that you are stuck by a used needle or sharp of any kind, do not panic. There are two simple steps that you can take to defend yourself against infection - the same steps which should also be followed if at any time, any bodily fluid comes into contact with open skin, or a mucous membrane such as your eyes, nose, or mouth.

1. Immediately wash the affected area with a skin disinfectant (ie: hand sanitizer, rubbing alcohol) or soap and water.
2. Seek medical assistance by calling your local hospital or physician.

In addition to those two steps, the incident must be recorded in the sharps injury log within 14 days of the occurrence, as directed under Cal OSHA code 5193c(2) which states that the following information shall be provided:

- Date and time of the exposure
- Type and brand of sharp involved
- A description of the incident

OVERVIEW

Although there are many cases of needle-related injuries among healthcare workers in the U.S, many accidents could be avoided if certain safety guidelines were applied and practiced regularly. There is no reason for you not take responsibility and apply the education you have received towards protecting yourself and those around you.

DO NOT PUT LOOSE SHARPS IN THE TRASH



7 BILLION

SHARPS ARE DISCARDED IN THE TRASH EVERY YEAR.

Up to 850,000 people are injured every year by sharps that are not discarded properly. Used sharps can cut people, infect them and spread disease.

Sources: www.safeneedledisposal.org, and www.calpsc.org.

USE A SHARPS CONTAINER

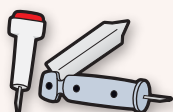
These are sharps



Syringes



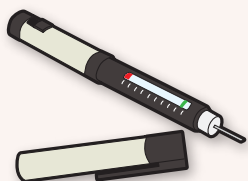
Needle connectors



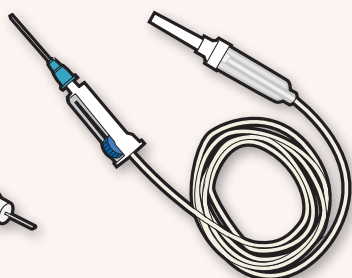
Lancets



Needles



Auto injectors



Infusion sets

WARNING

Needle stick injury can expose you to infectious diseases such as Hepatitis and HIV.

TO AVOID INJURY...



Do not force sharps into container



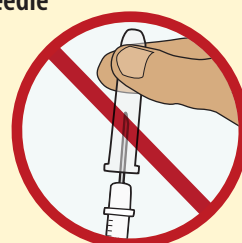
Do not put fingers inside container



Do not remove needle



Do not bend or break needle



Do not recap needle

KEEP YOUR COMMUNITY SAFE

DO NOT throw loose sharps in trash



DO NOT put sharps in recycling



DO NOT flush sharps down toilet

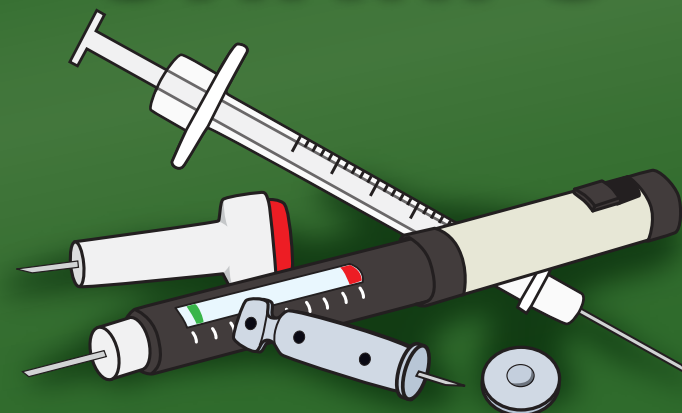


KEEP OUT of reach of children

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BE SMART WITH SHARPS



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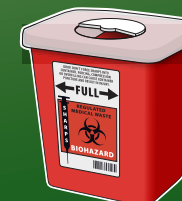
GET A SHARPS CONTAINER

FREE sharps containers may be available from your doctor, hospital, health insurance or medication supplier.

You can also buy a sharps container from your pharmacist or online.



Portable travel containers



Sharps container with vertical drop slot



Sharps container with horizontal drop slot

In some areas it is illegal to dispose of sharps in the trash.

Please follow your community guidelines.

Report problems associated with sharps and sharps disposal containers to the FDA (800-FDA-1088).



For information about rules and laws in your community, contact the Coalition for Safe Community Needle Disposal at 800.643.1643. For more information on sharps visit fda.gov/safesharpsdisposal.

Use a Sharps Container

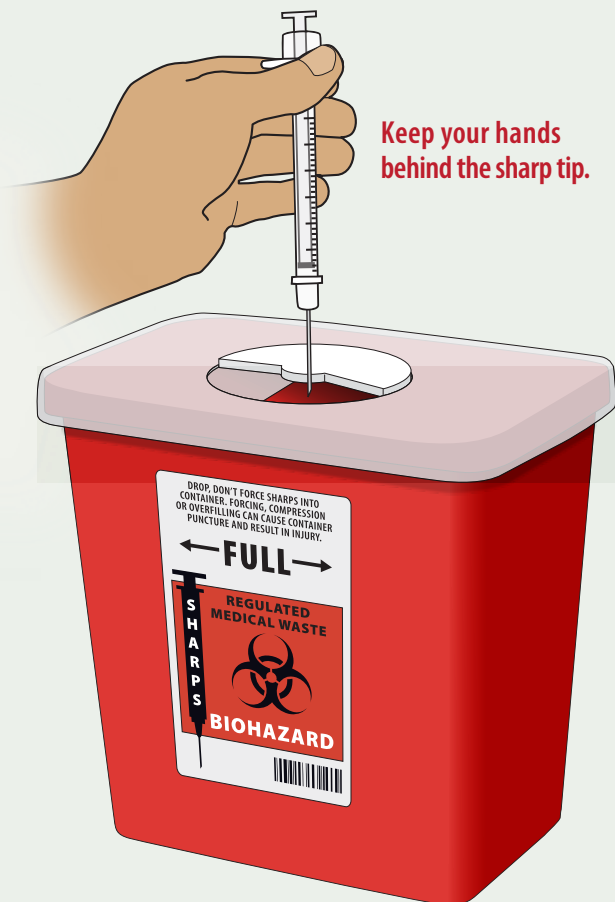
1 Visually check sharps container for hazards before handling. Read all labels.

MAKE SURE
container is not overfilled
or damaged.

CHECK
that container is large
enough to fit your sharp.



2 Put sharp in container immediately after use.



Discard a Sharps Container

Stop using sharps container when 2/3 full or filled to FULL line.



1 Close sharps container as instructed on label.

Different containers have different closures.



2 Bring sharps container to a sharps disposal program.



Find a program through your local waste or public health department, your doctor, veterinarian, hospital or pharmacist.

TYPES OF SHARPS DISPOSAL PROGRAMS:

- | | |
|--|--|
|  Mail-back program |  Drop box or supervised collection site |
|  Special waste pick-up service |  At-home needle destruction device |
|  Syringe exchange program (SEP) |  Hazardous waste collection site |

For information about rules and laws in your community, contact the Coalition for Safe Community Needle Disposal at 800.643.1643. For more information on sharps visit fda.gov/safesharpsdisposal or safeneedledisposal.org.

If You Cannot Get a Sharps Container...

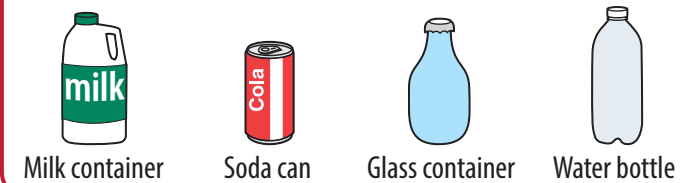
FDA RECOMMENDS ALWAYS USING FDA-CLEARED CONTAINERS

If you do not have a sharps container, use an empty household container with these features:



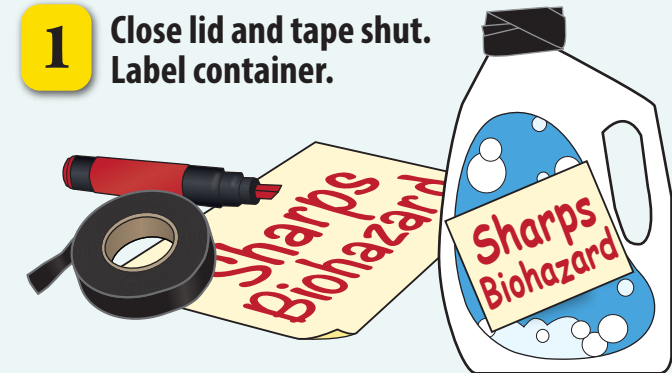
DO NOT USE

These containers can break or puncture easily.



Dispose of a household sharps container when it is 2/3 full:

1 Close lid and tape shut. Label container.



2 Bring container to a sharps disposal program.

If you cannot find a disposal program, put container in center of full trash bag and discard in regular trash.*



* In some areas it is illegal to dispose of sharps in the trash. Please follow your community guidelines.