

# ACCESS THERAPIES

For Therapists

## REQUIRED DOCUMENTATION CHECKLIST

(ALL COPIES MUST BE CLEAR)

***The Documentation Below Must Be In Your File Prior To Any Assignment.***

### **Application Materials (forms provided in this document)**

1. Job Application must be completed in full. Please print or type neatly. You may include your resume, but it will not replace a complete job application.
2. Skills Checklist
3. Signed Job Description.
4. **Two** references and/or written references on letterhead or a performance evaluation with **one** other reference.
5. State Criminal Back Ground Check with in the last 6 months.

### **Medical Documentation (you may use the forms attached or provide clear, original copies with a Doctor's signature and an official stamp)**

6. A current physical or physician's statement within previous 12 months.
7. Hepatitis B documentation (vaccination series of three, titer, booster, or signed declination).
8. A TB screen current within 12 months or chest X-ray current within two years.

### **Licenses, Professional Certifications, and Resuscitation Credentials**

9. Clear copies of all current Physical/Occupational Therapy licenses and professional certifications.
10. Clear copy of a current CPR card.
11. Proof of eligibility to work within the United States (For example: a Social Security Card and a Driver's License, EAD, or Passport).

**All the above items must be in your *completed* file before your file is faxed to a facility for any assignment.**

***Thank you for applying with Access Therapies***

~~317-876-3963~~ Fax: 317-876-6754  
[www.Accesstherapies.com](http://www.Accesstherapies.com)

# ACCESS THERAPIES

## Therapist Professional Conduct Expectations

**Your professional conduct and clinical performance on ACCESS THERAPIES assignments is directly related to our ability to solicit new and interesting job opportunities for you. Toward that end, we expect that you will adhere to the following Professional Conduct Expectations while on assignment for ACCESS THERAPIES. Failure to meet these expectations could lead to your termination from the company.**

1. I will not discuss any elements of my compensation with anyone employed at the host facility.
2. I will not discuss any previous assignments worked for ACCESS THERAPIES with anyone employed at the host facility.
3. I will not recruit any therapies at the host facility.
4. I will communicate with the management, staff and patients of the host facility in a respectful manner at all times.
5. I will honor all terms of my agreement letter, including but not limited to beginning and ending assignment dates, housing arrangements, and travel arrangements.
6. I will honor the policies and procedures of ACCESS THERAPIES and the host facility.

I understand that by signing this agreement I have read, understood and intend to comply with these Professional Conduct Expectations.

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

# ACCESS THERAPIES

## **EMPLOYEE AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION ON EMPLOYMENT FILE, BACKGROUND CHECK, MEDICAL RECORDS, RANDOM DRUG SCREENING, AND PAYCHECK DEDUCTIONS:**

By affixing my signature hereunder, I authorize ACCESS THERAPIES to release any and all confidential employment, background check and medical information contained in my employment file to any medical facility or entity with whom ACCESS THERAPIES has a staffing agreement, and to any other governmental or regulatory agency at such agency's request. For all other purposes, shall keep my employment records confidential and shall advise any medical facility or other entity to ACCESS THERAPIES whom records have been provided to also keep such records confidential. I hereby hold ACCESS THERAPIES harmless for any result(s) that arise with regards to the release of this confidential information by ACCESS THERAPIES.

Medical records information is confidential and ACCESS THERAPIES will instruct client facilities and/or other entities to treat the provided information confidential as well. I consent to a urine, blood or breath sample for the purposes of an alcohol, drug, intoxicant, or substance abuse screening tests. Furthermore, I consent to the release of the test results for purposes of determining the fitness for employment or continued employment.

I authorize ACCESS THERAPIES to deduct from my paycheck for any of the following: unpaid single-supplement housing expenses being the cost incurred for rooming by oneself instead of sharing a room with a roommate, non-authorized housing expenses including but not limited to housing items taken from room(s) or other provided housing, telephone and fax charges to room left unpaid at time of departure, any other room service charges such as movie rentals or dry cleaning costs, any damage/destruction done to room or other housing, and any other expenses due and owing to ACCESS THERAPIES.

My signature hereunder further indicates that I have read the EMPLOYEE AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION ON EMPLOYMENT FILE, BACKGROUND CHECK, MEDICAL RECORDS, RANDOM DRUG SCREENING AND DEDUCTION FROM PAYCHECK POLICY in its entirety and understand its contents.

I understand that my employment is "at will" and may be terminated by me or ACCESS THERAPIES at any time, with or without prior notice, for any lawful reason or no reason. I further understand no contract is intended by me or ACCESS THERAPIES and as such my employment is not governed by any contractual relationship with ACCESS THERAPIES. I certify that the facts contained in this application are true and accurate. I understand that any misrepresentation or omission of facts is cause for dismissal. I authorize the employer to investigate any and all statements contained herein and request the persons, firms, and/or corporations named above to answer any and all questions relating to this application. I release all parties from all liability, including but not limited to, the employer and any person, firm or corporation who provides information concerning my prior education, employment or character.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*ACCESS THERAPIES does not discriminate in respect to hiring, firing, compensation, and all other terms and conditions of privileges of employment on the basis of race, color, national origin, ancestry, sex, age, pregnancy or related medical conditions, marital status, religious creed, or disability.*

**PT SKILLS/PROFICIENCY CHECKLIST**

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

1=no experience    2=familiar with    3=experienced in    4=able to teach and supervise

<b>WORK SETTINGS</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>MODALITIES</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Rehabilitation Hospital					Acupuncture				
General Acute Care					Hot Packs				
Rehabilitation Unit in Hospital					Neuromuscular Reeducation				
Pediatric Rehab. Hospital/Clinic					Myofascial Release Techn.				
Sports Medicine Clinic					Fluidotherapy				
Childrens Hospital					Hydrotherapy				
School System					Whirlpool				
Home Health Care					Hubbard Tank				
Outpatient Clinic					Therapeutic Pool				
Nursing Home					Biofeedback				
Private Practice					TENS				
Psychiatric Hospital					Muscle Stimulation				
Physician Office					Ultrasound				
					Diathermy				
					Cryotherapy				
<b>ORTHOPEDICS</b>									
ROM					Traction (Mechanical)				
Back School					Cervical				
Back Syndromes					Lumbar				
Hip Fractures					Cervical Traction (Manual)				
Total Hip/Total Knee					Massage				
Hand Injury					Wound Dressing/Debridement				
TMJ Dysfunction					Paraffin				
Arthritis Programs					Vasopneumatic Devices				
Mobilization Techniques					Easy Street				
Gait Training					Continuous Passive Motion				
Manipulation Techniques									
Post-surgical mgmt. tendon/muscle release					<b>PEDIATRICS</b>				
					Learning Disabled				
					Spina Bifida				
					Balance Disorders				
<b>NEUROLOGIC</b>									
Stroke Rehab					Early Intervention				
Coma Management					NICU Treatment				
Head Trauma					Neurodevelopmental Testing				
Spinal Cord Injury					DDST				
Functional Splinting					Orthotics				
Adaptive Equipment					Equipment Assessment				
Neuromuscular Rehabilitation					Adaptive ADL				
					Mental Retardation				
<b>PROSTHETICS/ ORTHOTICS</b>									
AK Prosthetics					Cerebral Palsy				
BK Prosthetics									
UE Prosthetics					<b>SPORTS MEDICINE</b>				
Orthoplast					Strength/Endurance Training				
Resting Splints					Lido Back				
AFO/PLS					Kin Com				
Static Splinting					Biodex				
Dynamic Splinting					Cybex				
Serial/Inhibitory Casting					Orthotron/Kinetron				
<b>SPORTS MEDICINE</b>									
Taping/Strapping					<b>OTHER</b>				
Nautilus					Symptom Magnification Assessment				
Bracing/Joint Immobilization					Cardiac Rehabilitation				
					Chest Physiotherapy				
<b>ADAPTIVE EQUIPMENT</b>									
Assessment					Burn Management				
Fabrication					Inservice Education				
Wheelchair					Geriatrics				
Seating					HHA supervision				
Ordering					PTA supervision				
<b>WORK HARDENING</b>									
Job Site Evaluation									
Functional Capacity Evaluation									
Work Capacity Evaluation									

**Access Therapies**  
 8590 Georgetown Road  
 Indianapolis, IN 46268  
 1-317-876-3963

OT SKILLS CHECKLIST

**OT SKILLS/PROFICIENCY CHECKLIST**

Name:

1=no experience    2=familiar with    3=experienced in    4=able to teach and supervise

<b>WORK SETTINGS</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>		<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Rehabilitation Hospital					Neurodevelopmental therapy				
General Acute Care					Myofascial therapy				
Rehabilitation Unit in Hospital					Joint mobilization				
Pediatric Rehab. Hospital/Clinic					Energy conservation/ work simplification				
Sports Medicine Clinic					Instruct in body mechanics				
Childrens Hospital					Blood pressure monitoring				
School System					Heart rate monitoring				
Home Health Care					Purposeful activities- crafts/leisure				
Outpatient Clinic					Perceptual retraining				
Nursing Home					Cognitive retraining/ compensatory activities				
Private Practice					Desensitization/resensitization				
Psychiatric Hospital									
Physician Office									
<b>ASSESSMENT/EVALUATION</b>					W/C measurements/fitting				
Client initial assessment					W/C operations				
Client D/C assessment					Behavior modification techniques				
Functional evaluations					Dysphagia treatment				
ADLs					Universal Precautions				
Range of motion									
Muscle strength					<b>SPECIALTY AREAS</b>				
Sensation					Spinal Cord Injury				
Cognition					Procedures for post-CVA rehab				
Perception					Orthopedics				
Coordination					Neurological disease				
Driving evaluation					Pediatric experience(0-3yr)				
Swallowing					Pediatric experience (3+yr)				
Vocational Skills					Head trauma				
Leisure skills					HHA supervision				
Mental status					COTA supervision				
Neonatal/developmental assessment					Burn management				
Functional capacity for work					Inservice education				
Oral motor skills					Geriatrics				
Needs for adaptive/home equipment					Total hip/ total knee				
Evaluation for environmental control system					Hand rehab				
<b>PROCEDURE/INSTRUCTION</b>					<p><b>Access Therapies</b>  <b>8590 Georgetown Road</b>                      Indianapolis, IN 46268                      1-317-876-3963</p>				
Development of care plan									
Charting/documentation									
Upper extremity therapeutc exercise									
Oral motor stimulation									
Neonatal infant stimulation									
Fabrication of splints									
Environmental adaptations									
ADL training									

## SLP SKILLS/PROFICIENCY CHECKLIST

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

1=no experience    2=familiar with    3=experienced in    4=able to teach and supervise

WORK SETTINGS	1	2	3	4		1	2	3	4
Rehabilitation Hospital					Esophageal speech/treat-				
General Acute Care					ment of laryngectomy				
Rehabilitation Unit in Hospital					Perceptual retraining				
Pediatric Rehab. Hospital/Clinic					Language remediation/				
Sports Medicine Clinic					language development				
Childrens Hospital					Behavior modification				
School System					Swallowing therapy (Peds)				
Home Health Care					Swallowing therapy (Adults)				
Outpatient Clinic					Aural rehabilitation				
Nursing Home					Sign language				
Private Practice									
Psychiatric Hospital					<b>SPECIALTY AREAS</b>				
Physician Office					Procedures for post-CVA rehab				
					Neurological disease				
<b>ASSESSMENT/EVALUATION</b>					Spinal Cord injury				
Client initial assessment					Pediatric experience (0-3yr)				
Client D/C assessment					Pediatric experience (3+yr)				
Auditory comprehension					Head trauma				
Language expression					HHA supervision				
Written expression					Inservice education				
Articulation					Geriatrics				
Visual comprehension					Other (list)				
Reading comprehension									
Non-verbal communication									
Oral motor skills									
Swallowing									
Voice									
Hearing									
Attention span									
Selective attention									
Memory									
Thought organization									
Problem solving/reasoning									
Needs for adaptive/home equipment									
<b>PROCEDURE/INSTRUCTION</b>									
Development of care plan									
Speech/articulation therapy									
Oral motor therapy/techniques									
Dysphagia treatment									
Cognitive retraining/compensatory									
Neonatal infant stimulation									
Environmental adaptations									
Augmentative communication									
Energy conservation									

**Access Therapies**  
**8590 Georgetown Road**  
 Indianapolis, IN 46268  
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RN	_____	LPN	_____
QMA	_____	PT	_____
PTA	_____	OT	_____
COTA	_____	OTHER	_____

**Personal Information**

Name		Date
Social Security #	Are you 18 years or older?	
Present Address		
City	State	Zip
Home Phone ( )	Alternate Phone ( )	
Certification Received From		
License Received By Waiver	Endorsement	State Exam
License #	Date Expires	
CPR Expiration	Last Physical Exam	Last TB
Have you been convicted of a felony or a misdemeanor within the last 5 years?		Yes No
Describe		
Date of Birth	Driver's License #	State
Person to be notified in case of an emergency		Phone # ( )

**Physical**

Do you have any physical limitations that preclude you from performing any work for which you are being considered.
Yes No
If yes, what can be done to accommodate your limitation
Please describe
Describe any major illness(es) in the past 5 years
Describe any history of chemical dependence

**Employment Desired**

Position	Date you can start	Salary Desired
Are you employed now?	If so, may we contact your present employer?	
By whom were you referred to us?		

**Education**

	Location	Attended	Graduate?
Vocational			
Hospital			
College/University			
Post Graduate			

**Personal References**

<b>Name</b>	<b>Name</b>
<b>Address</b>	<b>Address</b>
<b>Phone# ( )</b>	<b>Phone# ( )</b>

**Work History**

<b>Employer</b>	<b>Address</b>
<b>Position</b>	<b>From To</b>
<b>Supervisor</b>	<b>Phone#</b>
<b>Leaving Date</b>	<b>Reason for Leaving</b>

<b>Employer</b>	<b>Address</b>
<b>Position</b>	<b>From To</b>
<b>Supervisor</b>	<b>Phone#</b>
<b>Leaving Date</b>	<b>Reason for Leaving</b>

<b>Employer</b>	<b>Address</b>
<b>Position</b>	<b>From To</b>
<b>Supervisor</b>	<b>Phone#</b>
<b>Leaving Date</b>	<b>Reason for Leaving</b>

**Experience**

Area	Experience in last 3 years	Area	Experience in last 3 years	Area	Experience in last 3 years	Area	Experience in last 3 years
Alcohol Detox		Labor & delivery		Oncology		Psychiatric	
Burns		Medical Floor		Operating Room		Rehabilitation Care	
Cardiac Care		Medications		Orthopedics		Surgical Floor	
Doctor's Office		Neurological		OB/GYN		Urology	
Home Healthcare		Nursery		Pediatrics		Private Duty	
Intensive Care		Nursing Home					

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal. I authorize investigation of all statements contained herein and the references listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release all parties from all liability for any damage that may result from furnishing same to you. I understand and agree that, if hired, my employment is for no definite period and may, regardless of the date of payment of my wages and salary be terminated at any time without prior notice. I understand that I am not to transport patients in my automobile, nor am I to drive patients in the patient's automobile without written consent from the Access Therapies Office.

I agree, I will not seek or accept employment, either directly or indirectly in any capacity from any client of Access Therapies to whom I have been assigned for at least 90 days after the last day of that assignment. I further understand that I cannot be paid until I present a time slip signed by both the client and me to the Access Therapies office.

Signature of Applicant

Date

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# ACCESS THERAPIES

## PREVENTING AND ADDRESSING SEXUAL HARASSMENT AND UNLAWFUL DISCRIMINATION

The Company is committed to working with Client healthcare facilities to provide a work environment that is free of harassment and discrimination. In keeping with this commitment, we do not tolerate any form of sexual harassment or any other form of unlawful discrimination.

Harassment based on race, sex, national origin, disability, sexual orientation; religion or other protected characteristic is a violation of state and federal laws. State and federal laws define sexual harassment to include unwelcome sexual advances, requests for sexual favors, and other verbal, visual, or physical conduct of a sexual nature. Any person who commits such a violation may be subject to personal liability as well as disciplinary actions, up to and including termination.

Sexual harassment of employees by supervisors, co-workers or clients/customers is strictly prohibited. Such conduct is unlawful when:

- ◆ Submission to the conduct is made a term or condition of employment;
- ◆ Submission to or rejection of the conduct is used as the basis for an employment decision affecting an employee; or
- ◆ The conduct has the purpose or effect of unreasonably interfering with an employee's work performance, or creating an intimidating, hostile, or offensive work environment.

Examples of sexual harassment include unwelcome sexual flirtations, advances or propositions; verbal abuse of a sexual nature; subtle pressure or requests for sexual favors; unnecessary touching of an individual; a display in the workplace of sexually suggestive objects or pictures; sexually explicit or offensive jokes; or a physical assault.

If at anytime on your assignment you believe that you are being subjected to discrimination or harassed in any way, please express your assessment of remarks made or actions taken as "harassment," or "discrimination" and the facts of the incident(s) to your direct supervisor, the house supervisor, or, if you prefer, the assignment facility's Human Resources department.

In many situations, individuals are insensitive to the offensiveness of their words or behaviors, but will cease the offensive behavior when its impact is brought to their attention. Try this approach, bearing in mind that what is acceptable in one environment may not be acceptable in another.

While working as a Traveler you may find environments that are less tolerant of "kidding around" and "teasing" than you have been used to, or you may find yourself uncomfortable

in an environment that is far more tolerant of “kidding around” or “teasing” than you have worked in before. In this situation, make your discomfort known through the appropriate chain of command at the healthcare facility.

If the situation is not resolved to your satisfaction, please report the facts of the incident(s) to the Clinical Liaison who will immediately investigate any complaint and work with the assignment facility to define and initiate appropriate preventive and/or corrective action(s).

No Traveler or corporate staff employee will be retaliated against for making a complaint or bringing inappropriate conduct to the Company’s attention, for preventing unlawful practices, or for participating in an investigation, proceeding, or hearing conducted by any governmental agency.

***TRAVELERS:***

- 1. Be aware that as a Traveler you will be viewed as a “newcomer,” and may not ever become part of the facility’s social “family.” Be especially conscious of this status in your words and actions, taking care never to say or do anything that could be viewed as “in poor taste” or construed as harassing behavior. Always keep in mind that what is acceptable in one environment may not be acceptable in another, and that often one person’s “kidding around” or “teasing” is another person’s “harassment.”*
- 2. Show respect to everyone by refusing to participate in or tolerate inappropriate behavior.*

I have read, understood and intend to comply with these Professional Conduct Expectations.

\_\_\_\_\_  
Nurse Associate Signature

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

# ACCESS THERAPIES

## AGE SPECIFIC JOB REQUIREMENTS

JCAHO mandates that caregivers and other facility employees are competent to provide age appropriate care and services. As a result our Client facilities require that we document your competencies for all age groups for whom you provide care.

The following highlights some of the most important caregiver actions related to the age of the patient. Identify the age groups of your patients.

### Neonates

Provide protective environment.

- ◆ Cuddle and hug the baby.
- ◆ Use pacifier and bottle as distractions.
- ◆ Position babies in supine position for sleep.
- ◆ Ensure warmth.
- ◆ Involve parents in decision making process.
- ◆ Provide parents with information about support services available to aid them to meet the needs of their baby post-discharge.

### Infants

- ◆ Keep parents in infant's line of vision within safety limits.
- ◆ Give infant a familiar object for comfort.
- ◆ Limit the number of strangers present.
- ◆ Remove equipment used and keep rail up after procedure.
- ◆ Position infant in supine position for sleep.
- ◆ Involve parents in decision-making processes.
- ◆ Do not allow infant to routinely use a bottle as a sleeping aid.
- ◆ Provide parents with information about support services available to help them to meet the needs of their child post-discharge.

### Toddlers

- ◆ Explain what you'll do before beginning.
- ◆ Use firm, direct approach.
- ◆ Give one direction at a time.
- ◆ Prepare the child immediately before procedures.
- ◆ Allow choices when possible.
- ◆ Distract the toddler from focusing on pain or procedures.
- ◆ Use play as a means of preparation and explanation of procedures.
- ◆ Allow for religious/cultural beliefs as expressed by parents.
- ◆ Include parents in education of the toddler.
- ◆ Emphasize aspects of procedures that will require cooperation.
- ◆ Provide parents with information about support services available to help them meet the needs of their toddler post-discharge.

## **Pre-school and school-age patients**

- ◆ Explain procedure and equipment using correct terminology.
- ◆ Plan for duration of education and play sessions appropriate to child's tolerance.
- ◆ Educate using games, rewards and praise.
- ◆ Allow child to have as much control over the environment as possible.
- ◆ Explain unfamiliar objects.
- ◆ Involve child whenever possible.
- ◆ Plan procedures in advance to reduce child's waiting time.
- ◆ Allow for expressions of religious/cultural beliefs as expressed by the parents.
- ◆ Include parents in the child's education.
- ◆ Provide parents with information about support services available to help them meet the needs of their child post-discharge.

## **Adolescents**

- ◆ Include reasons in explanation of procedures.
- ◆ Encourage questions regarding the patient's fears.
- ◆ Provide privacy – especially for adolescents.
- ◆ Involve in decision making and planning.
- ◆ Expect resistance from the patient.
- ◆ Allow for religious/cultural beliefs.
- ◆ Include parents in the patient's education as appropriate to the family dynamic and medical condition of the patient.
- ◆ Provide parents and the adolescent with information about support services available to help them meet their needs after the patient's discharge.

## **Adults**

- ◆ Include reasons in explanation of procedures.
- ◆ Encourage questions regarding the patient's fears.
- ◆ Provide privacy.
- ◆ Involve in decision making and planning.
- ◆ Allow for religious/cultural beliefs.
- ◆ Bring significant others into the patient's education.
- ◆ Provide for mobility of the patient.
- ◆ Provide information to patient and members of the patient's support network about available services to help meet the patient's and their needs post-discharge.

## **Geriatrics**

- ◆ Include reasons in explanation of procedures.
- ◆ Encourage questions regarding patient's fears.
- ◆ Provide privacy.
- ◆ Speak distinctly.
- ◆ Focus light directly on objects.
- ◆ Slow the pace of explanations and presentations.
- ◆ Ensure warmth.
- ◆ Involve in decision making and planning.

- ◆ Provide for mobility of patient.
- ◆ Change patient positions slowly due to decreased circulatory force.
- ◆ Involve patient or designated individual in decisions involving treatment plan.
- ◆ Consider ability to chew, taste, see, hear, and think and remember in seeking patient's cooperation and in patient teaching.
- ◆ Provide information about support services to help caretakers and other family members meet the patient's and their needs post-discharge.

I have read, understood and intend to comply with these professional conduct expectations.

\_\_\_\_\_  
Nurse Associate Signature

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date



Client Name
Employee Name

Client Name
Employee Name

WEEK ENDING DATE	CLASSIFICATION	LICENSE NO.

WEEK ENDING DATE	CLASSIFICATION	LICENSE NO.

DAY	DATE	TIME STARTED	TIME FINISHED	REGULAR HOURS	OVERTIME HOURS	CLIENT OVERTIME APPROVAL
MON						
TUES						
WED						
THUR						
FRI						
SAT						
SUN						

DAY	DATE	TIME STARTED	TIME FINISHED	REGULAR HOURS	OVERTIME HOURS	CLIENT OVERTIME APPROVAL
MON						
TUES						
WED						
THUR						
FRI						
SAT						
SUN						

TOTAL HOURS TO NEAREST 1/4 HOUR			
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TOTAL HOURS TO NEAREST 1/4 HOUR			
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I Certify that the hours shown above represent my Total Hours Worked and that they were properly verified by the Client or by an authorized representative

I Certify that the hours shown above represent my Total Hours Worked and that they were properly verified by the Client or by an authorized representative

<b>EMPLOYEE'S SIGNATURE:</b>
------------------------------

<b>EMPLOYEE'S SIGNATURE:</b>
------------------------------

**CLIENT AGREEMENT**

I certify that the named employee has worked the hours listed on this time sheet in a satisfactory manner. Client agrees to terms of net upon receipt and to pay interest on unpaid accounts over 30 days at the rate of 22% per annum, together with all collection and litigation costs, plus interest and reasonable attorney fees.

I certify that the named employee has worked the hours listed on this time sheet in a satisfactory manner. Client agrees to terms of net upon receipt and to pay interest on unpaid accounts over 30 days at the rate of 22% per annum, together with all collection and litigation costs, plus interest and reasonable attorney fees.

Client agrees to pay 4 hours of wages for the last minute cancellations. Late calls will be charged the full 8 hours shift rate.

Client agrees to pay 4 hours of wages for the last minute cancellations. Late calls will be charged the full 8 hours shift rate.

Client understands Access Therapies is not an employment agency and that its employees are assigned to render temporary service and not to become employed by client. Client agrees that in the event the named employee is employed by client within 90 days from the last day of work recorded here, client shall pay to Access Therapies no less than \$4,500 as a separation expense.

Client understands Access Therapies is not an employment agency and that its employees are assigned to render temporary service and not to become employed by client. Client agrees that in the event the named employee is employed by client within 90 days from the last day of work recorded here, client shall pay to Access Therapies no less than \$4,500 as a separation expense.

<b>SIGNATURE OF AUTHORIZED CLIENT ONLY:</b>
---

<b>SIGNATURE OF AUTHORIZED CLIENT ONLY:</b>
---

24 HOUR SERVICE - DEDICATED TO SERVING YOU

24 HOUR SERVICE - DEDICATED TO SERVING YOU