

# Independent Contractor Registration

Personal Data

<b>Name: (as shown on your income tax form)</b>			
Last:	First:	M:	
<b>Address:</b>			
Street:	City:	State:	Zip:
<b>Date Of Birth:</b>		<b>Social Security or EIN number:</b>	
<b>Telephone:</b>			
Home:	Cell:	Other:	
<b>Emergency Contact:</b>			
Name:		Relationship:	Phone:
<input type="checkbox"/> Please check here if you haven't maintained continuous residency in the state of Florida for the past 5 years.			
Business Name if different than above name:		Business Address if different than home address:	

Educational Background

<b>License Information:</b>		<b>License Number:</b>
Please Circle One <b>RN</b> <b>LPN</b> <b>CNA</b> <b>HHA</b>		
License Expiration Date/ Renewal Information		License Date:
School Name:	School Phone Number:	School Address:

Employment History/ Work Experience

Company Name:	Phone Number:	Address:	
Dates Of Experience:	Position:	<b>May we contact: Yes / No</b>	
Company Name:	Phone Number:	Address:	
Dates Of Experience:	Position:	<b>May we contact: Yes / No</b>	
Company Name:	Phone Number:	Address:	
Dates Of Experience:	Position:	<b>May we contact: Yes / No</b>	

Personal References:

Name:	Company	Title:	Phone Number:
Name:	Company	Title:	Phone Number:
Name:	Company	Title:	Phone Number:

**Registrant Acknowledgement**

**I certify** that the information in this registration is accurate, current, & complete. I understand that misstatements or omissions may result in disqualification from further consideration.

**I authorize** the investigation of my past work experience, credentials, and license verification, & to obtain any relevant information including a criminal background check. I authorize the disclosure of this registration along with any information about me obtained through the reference checks or during the course of the registration process for state, federal, contractual, or accreditation audit purposes. I release any individual or entity providing information from all liability for any damage from the disclosure of this information.

**I understand** that passing a medical examination &/or screening is required.

**I also understand** that I will be responsible for any Federal Taxes & agree that Workmans Compensation Insurance is not required by law, and therefore will not be part of my contract.

**Registrant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Pursuant to Title VII of the Civil Rights Act of 1965 (42 U.S.C., §20000 et seq.) and 45 C.F.R. Part 80, §504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §6101 et seq.) and 45 C.F.R. Part 91, we adhere to an equal opportunity policy for all persons seeking admission as patients/ clients or seeking employment/registration. We offers equal admission, employment, registration and advancement opportunities to qualified individuals without regard to race, color, religion, sex, age, national origin, marital status, disability or any other category protected by any applicable local, state or federal law, ordinance or regulation.