LLCP HEALTH CARE MANAGEMENT LLP TRAINING INSTITUTE

PROFILE FOR CONSULTATION COMPANY CONTACT & WAIVER NON-COMPETE CLAUSES & DATA FOR PUBLIC VIEW ON COMPANY WEBSITE DOMAIN:

LLCP HEALTH CARE MANAGEMENT LLP-CONSULTING & TEACHING INSTITUTE PROFILE/AND, OR FRANCHISE BUY-IN

NON-COMPETE AGREEMENT

POST YOUR RESUME HERE :(ATTACH BY UPLOADING YOUR COMPANY PROFILE, YOUR PICTURE OR ANY BROCHURES OR OTHER DATA YOU WISH TO INCLUDE IN YOUR PROFILE: hyperlink BY [INSERT]: ☐

HYPERLINK AND ATTACH HERE THIS PROFILE TO BELOW LINK BY [**INSERT/ATTACH**]:☐

UP LOAD THIS PROFILE AND, OR YOUR RESUME FOR POTENTIAL STUDENT/AGENCY OR WORKFORCE DEVELOPMENT "RETURN TO WORK" TO THE ATTENTION OF THIS WEB SITE ADMINISTRATOR WITHIN THE LINK PROVIDED AND ATTACHED WITHIN THIS SUBSCRIPTION AND MEMBERSHIP OR EMAIL AT THE WEB SITE LINK PROVIDED WITHIN THE EMAIL ADDRESS AT :

HTTP://WWW.LEGACYOFLIFECAREPROGRAMSHEALTH CAREMANAGEMENT.COM OR LEGACYOFLIFE16@YAHOO.COM

Please list your liability insurance carrier and bonding # in this box provided: ☐Yes, I have insurance

☐ No, but have applied for it

☐ Non-applicable-I am a student

☐Insurance Provider:

☐# Of Policy:

☐ Type of policy:

☐Provider Number:

☐Tax ID Number:

☐**Consultants are taxed when any services or products purchased at our PayPal web site location is used, or when LLCP pays for Consulting Services-you must have an active PayPal or other form of service available**

NON-COMPETE CLAUSE Policy:

Policy: For Hiring Consultants to Work with LLCP Health Care Management, LLP requires signing within this profile a Non-Compete Clause. In order to be listed as a Care Giver Provider Agency, Care Giver Applicant, Any Work force Development or Other Institute of Training and Educational Business, Recruitment, ET. El. All interested parties wishing to profile their business interests ***Must FIRST, Sign a Non-Compete Clause by checking the box in red. You must also sign the Profile Publish box and company Waiver box in red.***

DIRECTIONS:

IN ORDER TO BEGIN ANY BUSINESS, YOU MUST FIRST FILL OUT EACH BOXED IN AREA. CHECK THE BOXES INDICATED. UPLOAD YOUR COMPANY PROFILE DATA AT THE HYPERLINK. IF YOU HAVE NO HYPERLINK, USE THE EMAIL ADDRESS PROVIDED TO DOWN LOAD YOUR REQUIRED DATA. CHECK THE BOX NECESSARY IF YOU DESIRE TO COMPLETE THIS FORM WITH A CONSULT ASSIST, EMAIL IT TO PROVIDED COMPANY EMAIL ADDRESSES GIVEN. YOU MUST CHECK YOUR NON-COMPETE CLAUSE BOXES PROVIDED IN RED TO BE CONSIDERED FOR PROFILE DATA SUBMISSION. LLCP RESERVES THE RIGHT TO EVALUATE THIS AND ALL DATA PROVIDED FOR THIS PROFILE .

All Consultants or Business must carry own liability, professional and indemnity insurance and bonding for conducting LLCP Partnership business with us

I AGREE TO NON-COMPETE AGREEMENT ☐ *UPON CONSULTANT HIRING PERIOD OF A PERIOD OF THREE YEARS MINIMUM TIME FRAME ENFORCEMENT, POST TERMING AS A PARTNER OR CONSULTANT WITH LLCP HEALTH CARE MANAGEMENT, LLP, OR ITS' ENTERPRISES.* **-[CHECK THIS BOX]** ☐

I AGREE ☐ TO NON-COMPETE CLAUSES AND REGULATIONS WITHIN STATE OF TENNESSEE AND ALL OTHER STATES WITHIN USA, OR ITS' JURISDICTION, *TO ABIDE BY NON-COMPETE CLAUSES AND ENTER INTO THIS AGREEMENT WITH LLCP AGREEMENTS TO PARTICIPATE & PARTNER IN CONSULTING JOBS WHILE PERFORMANCE OF ROLES AND RESPONSIBILITIES FOR LLCP HEALTH CARE MANAGEMENT, LLP OR ITS' ENTERPRISES. I UNDERSTAND THAT THIS AGREEMENT MAY BE TERMED AT ANY TIME BY EITHER PARTY, AND REMAINS AN OPEN AGREEMENT WITHIN THE LEGAL MANDATES UNTIL VOIDED.* **-[CHECK THIS BOX]**

I AGREE ☐ TO ALLOW LLCP HEALTH CARE MANAGEMENT AND ITS' ENTERPRISES TO PROFILE SUBMITTED PROFESSIONAL, RESUME, OR OTHER SUBMITTED PERSONAL DATA, FOR THE REFERRAL DATA BASE AT THE PUBLIC WEB SITE PUBLICATION, AND TO POST ON THE COMPANY WEB SITE LINKS, UTILIZING MY PERSONAL AND PROFESSIONAL DATA TO SPONSOR AND ENDORSE THIS COMPANY'S SUPPORT. I UNDERSTAND THAT NO SOCIAL SERCURITY

I AGREE ☐ TO THIS NON-COMPETE WAIVER FOR ANY PERSONAL DATA/WAIVED WITHIN THIS COMPANY AGREEMENT TO PROFILE & PUBLISH MY INDIVIDUAL OR BUSINESS PROFILE TO THE PUBLIC FOR FEEDBACK AND REFERRAL RESOUCE TOOLS IN THE WEB SITE DOMAIN OF LLCP HEALTH CARE MANAGEMENT AND TRAINING INSTITUTE. I WAIVE THE BENEFIT OF ANY LEGAL ACTION ON MY PART, AND ADHERE TO ANY AND ALL JURISDICTION OF STATE'S STANDARDS OF FAIR PRACTICES AND WILL ABIDE BY THE STATE'S LAWS.

DATE:

TIME:

LLCP HEALTH CARE MANAGEMENT LLP TRAINING INSTITUTE

Please continue filling out this form:
Adding your comments in this boxed in area: (comment)

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TRAINING MADE EASY AT YOUR FINGER TIPS

PROFILE DATA INSERT FORMAT

NUMBERS OR OTHER PERSONAL PHONES, BIRTH DATES OR OTHER CONFIDENTIAL DATA WILL BE POSTED FOR PUBLIC VIEW. -[CHECK THIS BOX] ☐

(IN THE EVENT EITHER PARTY SHALL DECIDE TO DISPUTE ANY OF THESE WAIVED RIGHTS, THE MATTER WILL BE HANDLED WITHIN THE OBLIGATION OF EITHER PARTY TO AGREE AND REACH AN AMICIABLE DECISION. ANY OTHER ACTIONS WILL BE HANDLED BY OWN LEGAL REPRESENTATION AND LLCP HEALTH CARE MANAGEMENT WILL NOT CARRY THE LEGAL COMPENSATION ON THE PART OF THE OTHER PARTY TO DISAGREE OVER ANY DISPUTE). -[CHECK BOX HERE] ☐

☐PROFILE (ALL PERSONS FILLING OUT PROFILE DATA MUST BE VIABLE AND MEETING AGED ADULT STATUS-AGE 18-OR OLDER)
NAME:_____ **☐ AGE:** **TITLE:** **LEGAL STATUS TO MAKE DECIISONS:☐**

AVAILABLE CONSULTING HOURS TO WORK: PER WEEK, MONTH, ETC:
(H)_____(YOU ARE CALLED PER JOB ASSIGNMENT ONLY)
(WK.)_____ **POSITION:_____**

Type of Professional Work Done: **Years of Experience:**

☐ **CARE GIVER, BUSINESS OF PROFESSION CERTIFICATI AND TEST RESULTS [CHECK THIS BOX]**

WHAT STATE: **(DEFINE WHAT STATE, AND YOUR LICENSE NUMBER)**
LICENSE #_____

EXPIRATION _____

siding over)

[CHECK THIS BOX] I AM A STUDENT ☐

[CHECK THIS BOX] I AM A PROFESSIONAL OR AGENCY PROVIDER, OR OTHER ☐

CHECK THIS BOX AND DEFINE WHAT IT IS YOU WHAT TO DO WITH THIS TRAINING OR PROJECT MANAGEMENT WORK WITH US?
_____

CHECK BOX HERE (RESPOND BY TYPING HERE):

☐ **CHECK THIS BOX | CHECK IF NOT GOOD STANING** ☐ **CHECK IF IN GOOD STANDING]**

Criminal Record: Have you ever been convicted of a crime against Seniors or Disabled Persons? ☐[Yes] ☐[No]
[CHECK EITHER BOX] This includes a misdemeanor (minor), or criminal act (found guilty or negligent) for which you have been convicted or acquitted[*found "not guilty"*])

(WHAT CRIMINAL ACTS WERE COMMITTED?(EXPLAIN)

"LLCP HEALTHCARE MANAGEMENT FOLLOWS ALL LAWS AND REGULATIONS FOR REPORTING OF ABUSE OR NEGLECT TO STATE AGENCIES WHO WILL INVESTIGATE ANY CRIMES COMMITTED AGAINST ELDERS OR DISABLED PERSONS-THIS COMPANY WILL NOT HIRE ANYONE FOUND GUILTY OF THESE ACTS. YOU WILL BE SUBJECT TO INVESTIGATION AND A BACKGROUND CHECK PRIOR TO WORKING OR PARTNERING WITH OUR COMPANY AND TRAINING INSTITUTE".

☐I ACCEPT THESE CONDITIONS FOR WORK
☐I DO NOT ACCEPT THESE TERMS FOR HIRING OR CONSULTING

(VOID THIS FORM IF NOT AGREEABLE TO THIS STATE AND FEDERAL MANADATE-YOU WILL BE TREATED WITH RESPECT AND VOIDED FROM THE PROFILE CONSIDERATION)

PRESENTING PROBLEMS:

LLCP HEALTH CARE MANAGEMENT DISCRIMINATION POLICY

LLCP DOES NOT DISCRIMINATE AGAINST ANY PERSON REGARDLESS OF ETHNIC ORIGIN, RELIGIOUS AFFILIATION, RACE, HANDICAP CONDITIONS, OR BELIEF DIFFERENT THAN WHAT THIS COMPANY REPRESENTS-ALL RIGHTS WILL BE RESPECTED WITHIN THIS FEDERAL AND LEGAL MANADATE. ALL STATE AND FEDERAL LAWS WITHIN WORKFORCE DEVELOPMENT ACTS, AND THE RIGHT TO WORK BOTH WITHIN THE AFFORDABLE CARE ACTS AND OTHER WORKFORCE ENTITIES OF LLCP HEALTH CARE MANAGEMENT, ORGANIZATIONAL STRUCTURE ABIDES BY THE FAIR LABOR ACT WITHIN ALL STATES* OF USA JURISDICITON IRREGARDLESS OF** NATIONAL ORIGINS OR AFFILIATIONS-WHICH INCLUDES THOSE OUTSIDE THE USA, WHO WORK WITHIN THE USA WHILE HOLDING GREEN CARDS OR VISA ***THIS COMPANY FOLLOWS WORKFORCE ENFORCEMENT WITH CHECKING ELIGIBILITY TO WORK WITHIN THE USA AND ITS TERRITORIES.

STUDENTS/PROFESSIONALS:

IDENTIFY ANY HANDICAPING OR OTHER CONDITIONS WHICH MAY HINDER YOUR PERFORMANCE, WHICH MAY REQUIRE ACCOMODATION OR ADAPTIVE EQUIPMENT NEEDS HERE:

[BEGIN TYPING HERE]:

MY ACCOMODATION PLAN (DESCRIBE HOW WE MAY ASSIST YOU WITH YOUR PERFORMANCE LEVELS:[BEGIN TYPING HERE]:

LLCP HEALTH CARE MANAGEMENT LLP TRAINING INSTITUTE

CONTINUE:

_____
_____
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_____

PLEASE INITIAL BELOW THAT YOU ACKNOWLEDGE PRESENTING PROBLEMS

☐ THIS AREA REQUIRES YOUR INITIALS:_____

ANY PERSONAL ALLERGIES:

LIST PRESCRIBED PHARMACY MEDICATIONS TAKEN DAILY:[PLEASE BE MADE AWARE WE DO SCREENING OF DRUG TESTING ONCE YOU BECOME A PARTNER/CONSULTANT-AT YOUR EXPENSE WITHIN AGREEMENTS DONE WITH YOU]-[**THIS IS NOT A COMPANY EXPENSE**]-OTHER: [STUDENTS ARE REQUIRED TO HAVE RANDOM TESTING DONE PER THEIR COST DURING INSTITUTIONAL TRAINING DURING FACE-TO-FACE TRAINING OUT SIDE THE PARAMETERS OF NON-INCLUSIVE ON-LINE COURSE WORK TAKEN, ***EXCLUDED FROM OUR POLICY***-THOUGH WE ENCOURAGE YOU TO HAVE A DISCUSSION WITH YOUR POTENTIAL HIRING EMPLOYMENT REGARDING THEIR REQUIREMENTS]

List Allergies, medications here:

☐ THIS AREA REQUIRES YOUR INITIALS:_____

REQUIRED SIGNATURES OF REPRESENTATIVE OR STUDENT:(NAME)

☐ Sign_____

OTHER PROBLEMS:

☐ Defined: Fill out below in green box:

☐ **[CHECK BOX HERE]**

LLCP HEALTH CARE MANAGEMENT, LLP
931-215-2182
LEGACYOFLIFE16@YAHOO.COM

LLCP HEALTHCARE MANAGEMENT, LLP

Problems, Defined: (begin typing):

Hyperlink: you must have adobe in order to go into this document to complete it! (Please complete your reference form and attach to this document prior to submission

Linda R Smith blank reference sheet.pdf

LLCP HEALTH CARE MANAGEMENT LLP TRAINING INSTITUTE

☐ DATE	☐ TIME	☐ CALL BACK	☐ RETURNING YOUR CALL
		☐ **URGENT**	☐ **PERSONAL DATA**

☐ **PROFILE NAME**		☐ **CALLER**	
(H)FROM [ ] TO [ ] **(WK.)FROM[ ]TO [ ]** ☐ RESUME:☐PROVIDED LINK ATTACHED		☐ **ANY PRESENT OR PAST CAREER ASSESSMENTS:_____**	☐ **FULL TIME** ☐ **P/T TEMP**
☐ **CEU/CERTIFICATION AND TEST RESULTS**	☐ **DATE:**	**DISCUSS:**	
☐ **PROGRESS**	☐ **SEEN OR FOLLOWED UP PHONE CONSULT**		
☐ **DOES PROFILER HAVE ANY OTHER PRESENTING PROBLEMS?**		☐ **REVISED NEEDS AND A NEW ADDED DISABILITY PLAN:**	
EXPLAIN:		**EXPLAIN:**	
		☐ **NEW ALLERGIES:**	
	☐ **INITIAL:**	☐ **NEW PHARMACY PRESCRIPTIONS:**	☐ **INITIAL:**
☐ **ONSET DATE**		☐ **PROBLEM**	☐ **Explain:**

PROFILE ENDED: PROVIDE EMAIL LINK TO YOUR PAYPAL AT: LINK YOUR BUSINESS ADDRESS HERE: