

## EXHIBIT A

### AGENCY EMPLOYEE – ACKNOWLEDGEMENT

Name: \_\_\_\_\_ Agency: \_\_\_\_\_ Date: \_\_\_\_\_

#### SECTION 1

*I acknowledge that I have read and will adhere to the Policies and Procedures provided within the Sinai Health System/Mount Sinai Hospital Medical Center Agency Employee Orientation.*

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

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#### SECTION 2

Please check one of the following:

\_\_\_\_\_ I am not currently, nor have I ever been, an employee of Sinai Health System or any affiliate.

\_\_\_\_\_ I was employed by Sinai from \_\_\_\_\_ to \_\_\_\_\_ as a Sinai employee at \_\_\_\_\_ (Facility Name).

\_\_\_\_\_ I worked at Sinai from \_\_\_\_\_ to \_\_\_\_\_ through \_\_\_\_\_ agency.

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

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#### SECTION 3

I understand that I may only work at Sinai Health System/Mount Sinai Hospital Medical Center through one healthcare staffing agency.

I declare that \_\_\_\_\_ is my preferred agency.

I am aware that I must notify my agency in writing, if I choose to change my preferred agency selection. I will at such time complete this form with the preferred agency I choose.

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