Guardian Angels Sitting Service

Family Name: _____
Hotel{ } Daily{ } Weekly{ } Monthly{ } Annual{ }
Job Address: Street_____
City: _____State: _____Zip: _____
Cell Phone: _____Hotel/ Home Phone: _____
Provider Name: _____

Provider Charges: (To be paid in cash to provider)
$_____ rate/hr
1. Date: ____/____/ Start Time: _____End Time_____Total # of hours: _____
Total: Mileage .25 x_____miles= _____total for transportation
Hourly _____ x _____ Hours + Mileage_____= Provider Total: $_____

2. Date: ____/____/ Start Time: _____End Time_____Total # of hours: _____
Total: Mileage .25 x_____miles= _____total for transportation
Hourly _____ x _____ Hours + Mileage_____= Provider Total: $_____

3. Date: ____/____/ Start Time: _____End Time_____Total # of hours: _____
Total: Mileage .25 x_____miles= _____total for transportation
Hourly _____ x _____ Hours + Mileage_____= Provider Total: $_____

4. Date: ____/____/ Start Time: _____End Time_____Total # of hours: _____
Total: Mileage .25 x_____miles= _____total for transportation
Hourly _____ x _____ Hours + Mileage_____= Provider Total: $_____

5. Date: ____/____/ Start Time: _____End Time_____Total # of hours: _____
Total: Mileage .25 x_____miles= _____total for transportation
Hourly _____ x _____ Hours + Mileage_____= Provider Total: $_____

6. Date: ____/____/ Start Time: _____End Time_____Total # of hours: _____
Total: Mileage .25 x_____miles= _____total for transportation
Hourly _____ x _____ Hours + Mileage_____= Provider Total: $_____

7. Date: ____/____/ Start Time: _____End Time_____Total # of hours: _____
Total: Mileage .25 x_____miles= _____total for transportation
Hourly _____ x _____ Hours + Mileage_____= Provider Total: $_____

Weekly Notes: Please be sure to include good and bad things that I can relay to the family each week. You can include some things that you did each day.

Authorization: (provider beginning work, authorization is automatically accepted in its entirety).
I have authorized the provider named above to care for my self or elderly friend or family member. I have given the provider clear instructions and provided them with emergency telephone numbers, medical information, allergy information, and any special conditions and/or instructions for my _____
I agree to pay Guardian Angels Sitting Service of Broward and Miami- Dade County LLC (the Agency) the Agency referral fee and the provider according to the attached fee schedule. I understand that neither I, nor the agency, are employers of this childcare provider and that they are independent contractors. I have willingly provided my credit card information in writing, by fax or over the phone and authorize Guardian Angels Sitting Service of Broward and Miami- Dade County LLC (the Agency) to automatically charge any amount incurred due to non-payment on my behalf, I have thoroughly read

and understand the information contained within this contract and agree to all membership terms.

Family Member's Signature: _____Date: _____

Emergency Information

Who to contact : _____
Phone # at location: _____Cell :_____
Friend Neighbor- Name: _____Phone number:_____
Allergies or Special Conditions:
_____

Medication Authorization

Doctor: _____ Phone number: _____
I authorize the provider to give my family member
Medication:
_____
Exact times: _____Intervals: _____
Dosage:
_____
I recognize that the childcare provider is not medically licensed and is administering this medication at my request and for my convenience.
Signature: _____

Poison Control: 1-800-222-1222

RATES: Minimum of (4) consecutive hours is required/ will be charged.
Elderly Companion Provider Rates: $15/hour. Cash is to be given to the provider at the time services are rendered.
Agency Referral: Daily/ Weekly/ Monthly/ Hotel: $8/ hour for each provider. Annual members: $4/ hour for each provider. Credit card on file will be charged for agency fees after service are completed
Holiday Rates: An additional $4/hour is to be given to the provider.
Cancellation: If services are cancelled within (24) hours the entire (4) hour minimum payment will be due for provider and agency.

This serves as a Receipt for Services:

Guardian Angels Sitting Service

I have provided _____hrs of care for:
Client Name: _____
For these services I, _____received $_____ (total for sitter)
And $_____ will be charged to credit card on file for agency fees).
Providers Signature: _____Date: _____