#### PROFESSIONAL SERVICES AGREEMENT

This agreement is entered into between the Muskogee County Health Department, hereinafter referred to as Muskogee CHD, by virtue of the authority vested in it by Title 63, O.S. 1991, 1-206.1 and .

AGREEMENT PERIOD: Beginning the \_3rd day of August 2021 and terminating on the \_30 th day of \_June\_2022. This agreement shall not take effect until Muskogee CHD has in its possession a copy containing original signatures of both parties. The date of execution of this agreement need not correspond to the effective date, but the effective date shall be the controlling and commencement date.

#### GENERAL PURPOSE OF THIS AGREEMENT:

The purpose of this agreement is to provide Nursing services in support of the Muskogee CHD clinics.

Muskogee CHD shall pay a fee for the services at the rate of \$25.00 per hour; and State Rate for Travel per mile. A monthly invoice shall be submitted to the Muskogee CHD within thirty (30) days of the date services were rendered, indicating the date services were rendered and the number of hours of services performed on each date and the name of the person providing the service.

For the purposes of this agreement, all contacts and the invoice are to be directed to the Muskogee County representative, Tina Johnson <a href="mailto:tinaj@health.ok.gov">tinaj@health.ok.gov</a>.

It is understood between the parties that the Registered Nurse under no circumstances is to be considered an employee of either State Department of Health or Muskogee CHD and, therefore, not entitled to any benefits or other entitlement accruing to either State or County Health Department employees including workers compensation.

#### **DUTIES OF MUSKOGEE CHD**

Muskogee CHD shall provide such administration, supervision and guidance to Registered Nurse, as Muskogee CHD deems necessary and reasonable for the performance of this agreement.

#### AMENDMENT:

This agreement may be modified, changed or amended only by an instrument in writing, signed and Dated by the parties and appended hereto as an identifiable amendment hereof.

#### **CANCELLATION CLAUSE:**

This agreement is subject to termination upon 14 days advance written notice by either party. Written notice must be forwarded to one of the following addresses by certified mail:

Muskogee County Health Department 530 S 34<sup>th</sup> Street Muskogee OK 74403 The Registered Nurse shall maintain as confidential and privileged, all information, as required by statutes, codes of professional conduct and the rules of Muskogee CHD.

### **INVOICE INSTRUCTIONS:**

The County Administrator, or designate, is required to sign each invoice from the Nurse; and by doing so attests to the receipt of the services and verifies the accuracy of the invoice.

Representing the Muskogee County Health Department	Name of Registered Nurse Signatory:
Tina R. Johnson, Interim Regional Director	Hala Boydstin Signature
7/24/27 Date	s.s.# 447 74 0132
	ADDRESS: PO BOX 2637 MUSKESSE, OK 74402
	7/29/21 Date
APPROVED  ROLLAN, Olan	Keith Engl
Chair, Muskogee County Commissioners	2 day of Aug 202
Date	Chairman Killy (1)
Date	Member Aday
	Attest Day Of the Attest
	County Clerk
	0. ***
	OF OK OK

AMANDA HOOVER
Notary Public
State of Oklahoma

STATE OF OKLAHOMA	
COUNTY OF MUSKOGEE	

The undersigned Registered Nurse, of lawful age, being the first duty sworn on oath says that this agreement is true and correct. Affiant further states that she has made no payment, given or donated or agreed to pay, give or donate, either directly or indirectly, to any elected official, officer, or employee of the State of Oklahoma, of money or any other thing of value to obtain payment or the award of this agreement with the agency or any other state agency which would result in a substantial duplication of the final product required by the proposed agreement.

Name

Commission #

Subscribed and sworn to before

Seal

Commission Expires: 63/04/24

# (Rev. October 2018 Department of the Treasury Internal Revenue Service

## **Request for Taxpayer Identification Number and Certification**

Give Form to the requester. Do not send to the IRS.

▶ Go to www.irs.gov/FormW9 for instructions and the latest information.

	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.		
	Darla M. Boydstun		
	2 Business name/disregarded entity name, if different from above		
Print or type. See Specific Instructions on page 3.	3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check following seven boxes.  Individual/sole proprietor or C Corporation S Corporation Partnership single-member LLC  Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partne Note: Check the appropriate box in the line above for the tax classification of the single-member of LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single is disregarded from the owner should check the appropriate box for the tax classification of its own Other (see instructions) ►  5 Address (number, street, and apt. or suite no.) See instructions.  City, state, and ZIP code  M US COGER ON THE TAX CONTROL TAYLOTS	Trust/estate  rship)   wner. Do not check owner of the LLC is gle-member LLC that ler.	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):  Exempt payee code (if any)  Exemption from FATCA reporting code (if any)  (Applies to accounts maintained outside the U.S.)  Ind address (optional)
	7 List account number(s) here (optional)		
Pai	rt I Taxpayer Identification Number (TIN)		
	your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avup withholding. For individuals, this is generally your social security number (SSN). However, 1	0.0	urity number
reside	ent alien, sole proprietor, or disregarded entity, see the instructions for Part Ì, later. For other es, it is your employer identification number (EIN). If you do not have a number, see <i>How to ge</i>	447	-74-0132
	: If the account is in more than one name, see the instructions for line 1. Also see What Name		identification number
	ber To Give the Requester for guidelines on whose number to enter.	-	-
Par	t II Certification		
Unde	r penalties of perjury, I certify that:		
2. I ar Se	e number shown on this form is my correct taxpayer identification number (or I am waiting for m not subject to backup withholding because: (a) I am exempt from backup withholding, or (b rvice (IRS) that I am subject to backup withholding as a result of a failure to report all interest longer subject to backup withholding; and	I have not been no	otified by the Internal Revenue
3. I ar	m a U.S. citizen or other U.S. person (defined below); and		
	e FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reportir	O	
you hacqui	fication instructions. You must cross out item 2 above if you have been notified by the IRS that you ave failed to report all interest and dividends on your tax return. For real estate transactions, item 2 sition or abandonment of secured property, cancellation of debt, contributions to an individual reting than interest and dividends, you are not required to sign the certification, but you must provide you	does not apply. For ement arrangement	r mortgage interest paid, (IRA), and generally, payments
Sign Here		Date ► 7	29-21
Ge	neral Instructions • Form 1099-DIV (di	vidends, including	those from stocks or mutual

Section references are to the Internal Revenue Code unless otherwise

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

#### **Purpose of Form**

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

• Form 1099-INT (interest earned or paid)

- funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.

		JRCHASE ORI	DEN - CEAIN	<sup>71</sup> PO No			
Requisition No. 81	Federal Award			processing of this purcha	se request and the enc	umbering on the	
MUSKOGE	County, Oklahoma Requisitioning De	ent MUSKOGEF CC	\$3,80000				
Date Req. Rec. Aug 2,	earity, exterior in requisitioning by			-3-5000-2005 (MD2	2)		
Project No.	Date Material Needed:		Aug 2/202	MONA	unitioning County	X I I	
Suggested Vendors:				the 100 Degl	belong chang	DINCIAN	
NURSING SERVICES FO	R COVID OUTREACH CLINICS	****			•		
Purchasing Method Regula	r PO ⊠Blanket PO □Purchase Card/Veno	dor for p-card:	- Pro-Administrative Resignation & Science States and Science States				
Wethou -		7					
	d (if require <mark>d)</mark> rchasing Cooperative		Date: Aug 2, 2021 Fiscal Year 20 21 -2022 -2022				
County Purchasir	g Act		Appropriation Account: 1216-3-5000-2005 (MD2)  I hereby approve the Issuance and encumbrance of this purchase order.				
Public Competition	e Bidding Act	Purchasing Ager	nt		*******************************		
Issued To: DARLA BOYDSTUN, RN	appropriation accoun		umbrance has been enter brance is within the autho				
PO BOX 2637		appropriation.  Dated this 2ND	day of Al	JGUST	20 21		
MUSKOGEE, OK 74402  Shipped To:			-		-,		
MUSKOGEE CO HEALT	1 DEPT	County Clerk / De					
530 S 34TH MUSKOGEE, OK 74401				County. furnish an itemized invoi			
·	RE FOB DESTINATION UNLESS OTHERWISE NOTED.		of the purchase, and the	chased, it's unit price, the date of the purchase.	number or volume or e	ach item, it's	
Quantity Unit	Description	Unit Price	Amt To Be Encumbered	Adjust Amount	tment <u>Total</u>	Approved	
100 HOUR	NURSING SERVICE-AUGUST 2021	\$25.00	\$2,500.00		\$2,500.00		
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		TOTALS	\$2,500.00		\$2,500.00		
	CHARGE AND INVOICE TO:	This claim is approv		L BY GOVERNING E		members.)	
	POLLY IRIVING	District Attorney is a	approving officer for ex	penditures for that office,	, 19 O. S. § 215.37 G.		
	County Clerk		Date				
	County Clerk PO BOX 1008		Date				
	PO BOX 1008 Billing Address		Date	Chairman			
	PO BOX 1008  Billing Address  MUSKOGEE, OK 74402		Date	Chairman			
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hase order, and any discrepan	PO BOX 1008  Billing Address  MUSKOGEE, OK 74402	nis	Date	Chairman			
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Date Returned For F  COMPLETE WHI  I also certify that the maximu	Billing Address MUSKOGEE, OK 74402  City, State, Zip Code  deliving report and delivery documentation have been compared to the class have been reconciled as noted above. This purchase order is not for payment by the governing board.  Date  County Clerk / Deputy  illing For Consideration By The Governing Board  EN USED WITH BLANKET PURCHASE ORDER	Warrant Numb Amounts:  Pursuant to 62 O. S. payment of requisiti blanket purchase or approved invoice.	Per:	Chairman  Member  Member  AYMENT RECORD  ag Officer has the approvices against Governing Br by authorize payment of the second o	ng authority for pard approved		
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Copy 5 - Requesting Officer