INDEPENDENT CONTRACTOR APPLICATION

All qualified applicants will receive consideration without regard to race, color, religion, sex, national origin, age, disability, or any other protected class status under applicable law.

PERSONAL INFORMATION

First Name	Last Name	Middle Name
Social Security Number		
Street Address	City / State	Zip Code
Home Phone	Cell Phone	Email
Emergency Contact Name	Emergency Contact Phone	
Driver's License Number	State Issued	Expiration Date
Make of Vehicle	Model of Vehicle	Year of Vehicle
Automobile Insurance Carrier	Policy Number	Expiration Date

Have you submitted an application with us before? ☐ Yes / ☐ No

If yes, when? _____

AVAILABILITY

Due to your status as an independent contractor and the nature of the business, no guarantee can be made as to the schedule or the amount of hours worked.

What date are you available to begin working as an independent contractor with A Good Care LLC?

_____

Please indicate your availability:

☐ Mornings ☐ Afternoons ☐ Evenings ☐ Overnights

☐ Weekdays ☐ Weekends

Please indicate the days of the week as well as the earliest and latest times that you are available for work. If you are flexible, please write "OPEN."

Day	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Earliest							
Latest							

PREFERENCES

Please indicate the counties in which you are willing to provide services:

☐ Pasco ☐ Hillsborough

Please indicate all services that you are willing to provide:

☐ Companionship
☐ Meal preparation
☐ Activities (games/crafts)
☐ Housekeeping (dusting/vacuuming)
☐ Laundry/ironing
☐ Medication reminders
☐ Errands/Shopping/Transportation*
☐ Personal Care
☐ Dementia/Alzheimer's Care

** In order to be able to provide transportation or run errands, you will be required to have a valid driver's license and current automobile insurance. A motor vehicle record check will be conducted, and proof of insurance will be required.*

Are you willing to provide service to a client with a pet? ☐ Yes / ☐ No If so, which kind: ☐ Cats ☐ Dogs

Are you willing to provide service to a client who smokes? ☐ Yes / ☐ No

EXPERIENCE

Please indicate all of the certifications you have received:

☐ Certified Nursing Assistant (CNA)
☐ Certified Home Health Aid (CHHA)
☐ Home Health Aid (HHA)
☐ CPR & First Aid
☐ Others (please specify) _____

Please indicate all caregiving experience you have:

☐ Caring for a family member.
☐ Hospice facility
☐ Hospital
☐ In-home care agency
☐ In-home hospice
☐ Private Duty
☐ Senior living facility

EDUCATION

Please note, our minimum level of education required is either a High School Diploma or a GED.

Please indicate the highest level of education completed:

☐ Grade School
☐ High School
☐ Associate degree
☐ Bachelor's Degree
☐ Post-Graduate Degree

School Type	School Name	City / State	Area of Study	Years Attended	Graduated?
High School					
Vocational/Technical					
Undergraduate					
Post-Graduate					

WORK HISTORY

Your application will not be considered unless all questions in this section are answered.

MOST RECENT POSITION:

Are you currently at this position? Yes / No **May we contact?** ☐ Yes / ☐ No

Duration: From_____ To _____

_____ _____ _____
Company Name City State

_____

__ Phone Number

_____ _____
Position Title Supervisor's Name

_____
Duties

$_____per_____(Hour/Week/Month/Year)

_____
Reason for Leaving

SECURITY

Please complete the attached Authorization to conduct a criminal and motor vehicle background check. Please note that we will only consider the applications of independent contractors who are licensed, bonded, and insured, and at least 19 years of age.

List states and counties of residence for the past seven years:

_____

Have you incurred any moving traffic violations? ☐ Yes / ☐ No

If so, please describe:_____

_____

Have you been convicted of a felony, misdemeanor, or other crime resulting in jail time?

☐ Yes / ☐ No

If so, please describe:

1. _____

Incident City/State Charge

2. _____

Incident City/State Charge

Have you appeared on a Sex Offender Registry in any state in the last 10 years? ☐ Yes / ☐ No

WORK REFERENCES (NO FAMILY MEMBERS)

Please provide three references. Do not include relatives. Your application will not be considered unless all three references are provided. If we are unable to reach any listed references, you will be asked to provide additional references.

Full Name	Phone Number	Relationship	Number of Years Known
1.	Home/Cell: Work:		
2.	Home/Cell: Work:		
3.	Home/Cell: Work:		

CERTIFICATION & RELEASE: I certify that I have read and understand the contents of this application and that the answers provided are complete and true to the best of my knowledge. I understand that any false or misleading information, omissions, or misrepresentations of fact in this application may result in rejection of my application or termination at any time during any contracting relationship with A Good Care, LLC. I authorize A Good Care, LLC and/or its agents, including consumer-reporting bureaus, to verify any of this information including, but not limited to, criminal history and motor vehicle driving records. I authorize all persons, private and public entities, and law enforcement authorities to release any information concerning my background and hereby release any said persons, private and public entities, and law enforcement authorities from any liability for any damage whatsoever for issuing this information. I release A Good Care, LLC from any liability which might result from making such investigations. I also understand that the use of illegal drugs is prohibited during any contracting relationship with A Good Care, LLC. I am willing to submit and consent to drug testing to detect the use of illegal drugs prior to and during any contracting relationship with A Good Care, LLC. I understand that this application is not an independent contractor agreement. My signature below acknowledges that I have read, understand, and agree to the above information. I also understand that I will not be an employee of A Good Care, LLC. I further understand that due to the nature of the business, no amount of work can be guaranteed.

_____ _____

Applicant Signature Printed Name

_____

Date

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

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

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► S

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

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.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

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)
- Form 1099-DIV (dividends, including those from stocks or mutual 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.*

AUTHORIZATION FOR BACKGROUND CHECK

After carefully reading this Authorization, I authorize A Good Care, LLC to order my background report, including investigative consumer reports. I understand that A Good Care, LLC may rely on this authorization to order additional background reports, including investigative consumer resorts, during any contracting relationship, without asking me for my authorization again as allowed by applicable law.

I also authorize the following agencies and entities to disclose to any background check entity and its agents all information about or concerning me, including but not limited to: my past or present employers or contracting clients, educational institutions, including colleges and universities, law enforcement and all other federal, state, and local agencies, federal and state courts, the military, credit bureaus, testing facilities, motor vehicle records agencies, all other private and public sector repositories of information, and any other person, organization, or agency with any information about or concerning me. The information that can be disclosed to any background check entity and its agents includes, but is not limited to, information concerning my employment or contracting history, earnings history, education, credit history, motor vehicle history, criminal history, military service, professional credentials, and licenses, and substance abuse testing.

I agree that A Good Care, LLC may rely on this authorization to order background reports, including investigative consumer reports, from companies other than a background check entity without asking me for my authorization again as allowed by law. I also agree that any copy of this form is valid like the original. I certify that all the information I provided is true and correct.

Last Name:_____First:_____ Middle:_____

_____

Signature

If you live or work in California, Minnesota, or Oklahoma: Check here if you would like a free copy of your background report:_____

INDEPENDENT CONTRACTOR AGREEMENT

This Agreement is made between A Good Care LLC ("Agency) &_____("Contractor) effective _____, 20___, under the following terms and conditions:

I. **Documentation for Service**. Will be submitted weekly Varies by the client.
II. **Payment:** will be weekly on Tuesday via direct deposit.

III. Independent Contractor Status. This agreement shall be binding upon the parties, their successors, assigns and personal representatives. Time is of the essence on all undertakings. This agreement shall be enforced under the laws of the State of Florida.

Title VI of the Civil Rights Act of 1964 requires that the organization may not refuse, limit or terminate services to patients on the basis of race, color, or national origin. To that end, this organization has adopted a policy of providing equal services regardless of race, color, or national origin, and based solely on an individual's documented medical necessity and clinical status.

Acknowledgement of information to Contractors

I ACCEPT THAT I HAVE RECEIVED LAWS AND RULES GIVEN TO INDEPENDENT CONTRACTORS, AS REQUIRED.

LAWS AND RULES INCLUDE:

- Rule 59A-18.005 Registration Policies
- Rule 59A-18.005(6) regarding health statements and communicable disease
- Rule 59A-18.0081 Certified Nursing Assistant and Home Health Aide
- Sections 400.506, 400.484, 400.462, 400.488, 408.809, and 408.810(5), F.S. with telephone numbers
- Rule 59-18.018 Emergency Management Plans

Tax Exempt Form

I, _____
Hereby acknowledge that I am an independent contractor/SUB-CONTRACTOR; therefore, I am responsible for Social Security and taxes. I also acknowledge that I will receive an IRS 1099 Form for the preceding year by the agency February 1st, of service. As an independent contractor, I am not eligible for any benefits such as vacations, disability or unemployment and will not be covered by Worker's Compensation, Liability Insurance. The Contractor agrees to bear all responsibility for the actions related to themselves and their employees or personnel under this Agreement. In addition, the Contractor agrees to obtain comprehensive liability insurance coverage in case of bodily injury, personal injury, property damage, contractual liability, and cross-liability.

DATE: _____

CONTRACTOR SIGNATURE: _____

Contractor Statement of Commitment & Confidentiality Statement

I HAVE READ AND UNDERSTAND THE AGENCY'S PERSONNEL POLICY MANUAL. IN COMPLIANCE WITH THOSE POLICIES, I AGREE TO CONFORM TO THE FOLLOWING:

- I have read and understand the agency's' job description appropriate to my level of performance. I will not accept assignments beyond my designated performance level as determined by the agency.
- I will immediately contact the agency regarding any areas of discrepancy between the clients' assessment of the assignment requirements and my understanding of my specific performance level as designated by the agency.
- I will abide with the agency's Standard Code of dress as described in the Personnel Policy Manual. I must wear all the required personal protection equipment.
- I will always maintain professionalism in the home to which I am assigned.
  I will not arrive accompanied by anyone of personal reasons.
  I will not make or accept personal telephone calls in the clients' home.
  I will not smoke in a clients' home.
- I will arrive on time for the assignments I have accepted. In the event of an emergency which may cause me to be late, I will notify the agency of the situation and expected arrival.
- I will notify the agency immediately if I am unable to arrive for my assignment within my due time or if I am unable to meet my assignment commitment. I understand that the agency will then contact the client. I also understand that not calling the agency when I am unable to meet my assignment commitment will be grounds for termination immediately.
- I must report all accidents to agency immediately, no matter how slight it might be.
- It has been explained to me that I am being offered employment with the understanding that I have personal transportation at my disposal to be used for travel to and from the patient assignments. I further understand that I am responsible for auto liability insurance coverage.
- I will not accept any money or gifts from the agency's clients. I will receive payment for services rendered directly from the agency.

Disclosure of confidential information gained through your contacted assignments is stated as an act of prohibited conduct subject to formal disciplinary action. Any information concerning a patient’s illness, family, financial condition or personal peculiarities is strictly confidential. When a patient’s history or condition is reviewed, it must be done in privacy with only those persons involved with the care of the patient. Any other information coming to you in the course of your work concerning another person or employee is also considered confidential and may not become the topic of conversation with others.

When assigned a patient by the agency directly, at the moment of termination of assignment, for whatever reason, the agency will be responsible for notifying the client of the new changes. You are not allowed to contact the client or family member to notify of change nor are you allowed to offer a transfer to any other agency you might also be contracted with. Doing so can lead to legal repercussions.

At the commencement of contract, you will be given an identification badge, which must be worn at all times during the assignment accepted. At the moment of termination of contract, for whatever reason, this identification badge must be returned to the agency within a week of termination. Failing to do so will incur a charge of $10.00 from final paycheck.

CONTRACTOR SIGNATURE: _____

DATE: _____

Office Hours and Weekend Policy

At **A Good Care Agency**, we prioritize the well-being of our clients and the professionalism of our caregivers. To ensure smooth operations and effective communication, the following job policy regarding office hours and weekends is established:

1. **Office Hours:**
   - The standard office hours are Monday to Friday from 9:00am to 4:00pm.
   - During office hours, caregivers should contact the office for any non-emergency matters, scheduling concerns, or administrative assistance.
   - **After Hours calls only emergency calls** Any problem with your visit/shift may be made to the coordinator 813-995-3029 whenever necessary.

2. **Weekends:**
   - The agency office will be closed on weekends (Saturday and Sunday).
   - Caregivers are expected to be responsible and self-sufficient during weekends, providing necessary care to clients without direct supervision from the office.

3. **Emergency Situations:**
   - In the event of an emergency during weekends or outside office hours, caregivers must follow the agency's emergency protocol.
   - Caregivers should first take all necessary actions to address the emergency, ensuring the safety and well-being of the client.

4. **Contacting Client Families:**
   - If a caregiver encounters an emergency situation that requires immediate attention and intervention, they are required to contact the designated emergency contact within the client's family as specified in the client's care plan.
   - Caregivers should inform the client's family of the emergency, the steps taken, and any immediate needs or concerns.

5. **Reporting to the Agency:**
   - Caregivers must report any emergencies or critical incidents to the agency at the earliest opportunity during the next business day.
   - The agency will provide necessary support and guidance to caregivers following the report of an emergency.

6. **Communication Protocols:**
   - Caregivers are expected to maintain open communication with the agency during regular office hours for non-emergency matters.
   - The agency will provide caregivers with contact information for emergency situations, and caregivers should use this information responsibly.

By signing below, I acknowledge that I have read, understood, and agree to comply with the policies outlined in the "Office Hours and Weekend Policy" of **A Good Care Agency.**

CONTRACTOR SIGNATURE: _____

DATE: _____

NON-COMPETE AGREEMENT

1. Purpose

This agreement, when countersigned below, shall constitute an agreement regarding certain confidential and proprietary information and trade secrets.

("Confidential Information") relating to the business of **A Good Care LLC** hereinafter referred to as the "Company" and _____ hereinafter referred to as the "Recipient" (collectively referred to as the "Parties"), as of the date executed by the Company (the "Effective Date").

Recipient shall strictly maintain the confidentiality of the Proprietary Information. Proprietary information may be shared between the Parties for use in scoping, estimating, and completing projects as well as for the everyday business practices for the Company and its clients/customers.

Job Policy

As an independent contractor of A Good Care, LLC. I understand that the job I am being hired to perfom belongs to A Good Care, LLC. I also understand that it is illegal for me to transfer or attempt to transfer any case to another agency or take ownership of any job that I am employed as an independent contractor.

I understand and have read this document that if I, as an independent contractor, HHA, CNA, CAREGIVER OR STAFF working with A GOOD CARE , LLC take a client/patient or take a client to another agency that A GOOD CARE, LLC., has contracted me to provide service for, the agency can take me to court for lost income that may be up to or equal to $10,000.00 not including the agencies court and legal fees regarding the patient/client that have removed from their agency, and again I am informed that all court an legal fees that the agency A GOOD CARE, LLC., may have regarding the case will be my responsibility. also am hereby informed that once an investigation has been done on why the patient/client has left A GOOD CARE, LLC., either by case manager, patient, AHCA Background Clearinghouse Screening that the patient was moved to the agency listed on the AHCA website proving that you are employed with the agency that the client/patient has been transferred to, my last two (2) weeks that I have worked with that client/patient will be mailed to my address on file which can take up to three (3) months from the date last worked with client/patient.
If after the investigation there is proof that I have done this with other agencies, my information will be sent to AHCA details of the moving of clients/patients to other agencies for personal monetary gains.

In consideration of the employment opportunity provided by **A GOOD CARE LLC**. I, intending to be legally bound, agree to the following:

1. **Term of agreement.** This agreement is effective on the effective date and shall remain in effect throughout the term of your employment/contract with the agency **A GOOD CARE LLC.**, and for a period of two (2) years thereafter.

2. **Limitations of this Agreement**. This agreement is not a contract employment/independent contractor. Neither the agency**, A GOOD CARE LLC**., or I, are obligated to specific term of employment. This agreement is limited to the subject matter of covenants not to complete or solicit as described in this agreement.

3. **Covenant not to compete.** I agree that at no time during my term of my employment/contract with the agency **A GOOD CARE LLC**., will I engage in any business activity which is competitive with the agency nor work for any agency which competes with the agency **A GOOD CARE LLC**., For a period of two (2) years immediately following the termination of my employment/contract, I will not, for myself or on behalf of any other person or business enterprise, engage in any business activity which competes with the agency **A GOOD CARE** within 50 miles of the facility in which you were employed/contracted.

4. **Non-solicitation**. During the term of my employment, and for a period of two (2) years immediately thereafter, I agree not to solicit any employee/independent contractor or independent contractor of the agency on behalf of any other business enterprise, nor shall I induce any employee or contractual or other relationship with the agency.

5. Return of Materials (if apply)

Upon termination or expiration of the Agreement, or upon written request of the Company, the Recipient shall promptly return to the Company all documents and other tangible materials representing the Company's Confidential Information and all copies thereof. The Company shall notify immediately the Recipient upon discovery of any loss or unauthorized disclosure of the Confidential Information.

6. Remedies

Should the Recipient breach any of the provisions of this Agreement by unauthorized use, or by disclosure of the Confidential Information to any unauthorized third party to the Company's detriment or damage, the Recipient agrees to reimburse the Company for any loss or expense incurred by the Company as a result of such use or unauthorized disclosure or attempted disclosure, including without limitation court costs and reasonable attorney's fees incurred by the Company in enforcing the provisions hereof. Recipient further agrees that any unauthorized use of or disclosure of the Confidential Information will result in irreparable damage to the Company and that the Company shall be entitled to an award by any court of competent jurisdiction of a temporary restraining order and/or preliminary injunction against such unauthorized use or disclosure by the Recipient without the need to post a bond. Such remedies, however, shall not be deemed to be the exclusive remedies for any breach of this Agreement but shall be in addition to all other remedies available at law or equity.

7. Choice of Law

This Agreement shall be governed by and construed in accordance with the laws of the State of Florida without reference to its conflicts of laws principles. Any disputes arising from or related to the subject matter of this Agreement shall be heard in a court of appropriate jurisdiction of the Company's principal office and the parties hereby consent to the personal jurisdiction and venue of these courts. If any provisions of this Agreement or its applications is held to be invalid, illegal or unenforceable in any respect, the validity, legality or enforceability of any other provisions and applications herein shall not in any way be affected or impaired.

CONTRACTOR SIGNATURE: _____

Acknowledgement

I certify that I have read and fully understand the questions asked in this application and that all answers given by me are true, accurate, and complete. I also understand that the omission, concealment, or misrepresentation of any fact on this application or during any interview for consideration as a contractor may be cause for my immediate dismissal/termination as a contractor.

I give **A GOOD CARE, LLC**., permission to use any information in this application to enable it and its agents to verify the information contained in this application. I also authorize present and former employers, educational institutions I have attended, credit agencies, all references, and any other persons to answer all questions asked by **A GOOD CARE, LLC**., with regard to any of the subjects covered by this application. I also understand that in connection with my background investigation, that my contracting may be contingent on the results of such investigation. I release **A GOOD CARE, LLC.,** and its agents, and all affiliated entities, as well as any person or situation that provides any information about me, from any and all liability whatsoever resulting from any such investigation or the disclosure of such information.

In consideration of my being considered for contracting by **A GOOD CARE, LLC**., I agree to abide by all rules and regulations, which I understand are subject to change at any time for any reason without prior notice. I also understand that if contracted, I will be contracted at will and for no definite period of time. I understand that either **A GOOD CARE, LLC**., or I can terminate my contract at any time, with or without cause and with or without advance notice. I further understand that no communication, whether oral or written, by any representative of **A GOOD CARE, LLC.,** at any time, can constitute a contract for hire. No representative or agent of **A GOOD CARE LLC**., has the authority to enter into any agreement for contracting for any specific period of time or to make any agreement contrary to the foregoing.

I am willing to submit to a physical examination, including the analysis for the detection of the use of unlawful drugs or substances in accordance with the applicable laws. If I receive an offer for contracting, I agree that my continued contract may be contingent on the results.

I understand that **A GOOD CARE, LLC**., is not involved in the day-to-day supervision or decision concerning patient care . This remains with the professional as part of professional practice. The professional fully indemnifies **A GOOD CARE LLC**., against any and all liability and responsibility associated with his or her professional duties. The professional maintains his or her license as required by law, professional liability coverage and other responsibilities as found under state prime contract law.

I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.

CONTRACTOR SIGNATURE:_____

DATE: _____