

REQUIRED DOCUMENTATION CHECKLIST

(Please ensure that all copies submitted are legible)

Application Material (forms provided)

- | | |
|--|--|
| <input type="checkbox"/> Employment Application | <input type="checkbox"/> Medical History Questionnaire |
| <input type="checkbox"/> Two (2) written references | <input type="checkbox"/> N95 Respirator Medical Evaluation |
| <input type="checkbox"/> Pre Employment Inquiry Release | <input type="checkbox"/> TB Screening |
| <input type="checkbox"/> I-9 Form (Section 1 only) | <input type="checkbox"/> Hepatitis B Screening |
| <input type="checkbox"/> W-4 Form | <input type="checkbox"/> Influenza Vaccine Attestation |
| <input type="checkbox"/> Age-Related Competency Checklist | |
| <input type="checkbox"/> Clinical Skills Competency Checklist(s) | |

REQUIRED Medical Documentation

- Current health examination or physician's statement
- Hepatitis B Documentation (proof of vaccination series, titer, booster, or signed declination)
- A negative PPD skin test or Chest X-ray
- Proof of immunity to Rubeola (Measles), Rubella (German Measles) and Mumps (physician signed MMR record or positive titers)
- Proof of immunity to Varicella
- 10 panel Drug Screening
- N95 Respirator Fit Testing Results
- Influenza and/or H1N1 Vaccination history

Licenses, Professional Certifications, Resuscitation Credentials & Miscellaneous

- Current Resume
- Current California nursing license or Certification – (front and back)
- CEUs – for permanent license holders
- Clear copy of a current BLS (CPR) card – Must be AHA or ARC – (front & back)
- Clear copy of a current ACLS, PALS, NRP, CCRN, NALS, etc. (front & back)
- Proof of eligibility to work within the United States (Social Security Card and a valid Driver's License, or current USA Passport)
- Passport sized recent photograph

*****All requested documentation and completed forms must be received by RNS prior to the commencement of any assignment.*****

CORPORATE OFFICE

1006 McKeever Avenue – Hayward, CA 94541
Tel 800.704.4401 – Fax 888.704.4402
rns@rnsonline.com

SACRAMENTO

1555 River Park Drive – Suite 206 – Sacramento, CA 95815
Tel 800.704.4401 – Fax 888.704.4402
rns@rnsonline.com



EMPLOYMENT APPLICATION - HEALTHCARE PROFESSIONAL

Name _____ RN LVN CNA
(Last) (First) (Middle Initial) OTHER: _____

Social Security No. _____ - _____ - _____ Birth Date _____
MM/DY/YR

Current Address _____
(Number) (Street) (City) (State) (Zip)

Permanent Address _____
(Number) (Street) (City) (State) (Zip)

Current Phone (____) _____ Permanent Phone (____) _____ Cell Phone (____) _____

Email Address: _____

Emergency Contact _____ Relationship _____ Phone(____) _____

Date available to start work ____/____/____

Shift Preference: _____ AM / PM to _____ AM / PM

Can you work rotating shifts? Yes No

CLINICAL EXPERIENCE*

| Clinical Area | Years Experience | Clinical Area | Years Experience | Clinical Area | Years Experience |
|---------------|------------------|---------------|------------------|---------------|------------------|
| | | | | | |
| | | | | | |

*You must have a minimum of 1 year experience in each clinical area you are submitted to.

Clinical Area(s) preferred _____

LICENSE(S)

| State | Number | Expires | State | Number | Expires |
|-------|--------|---------|-------|--------|---------|
| | | | | | |
| | | | | | |

CERTIFICATION(S)

| Name | Date Taken | Expires | Name | Date Taken | Expires |
|------|------------|---------|------|------------|---------|
| | | | | | |
| | | | | | |

EDUCATION

| SCHOOL | CITY/STATE | MO/YR GRADUATED | DEGREE |
|--------|------------|-----------------|--------|
| | | | |
| | | | |

EMPLOYMENT HISTORY

List your most recent employment first. You must account for all times from present to the month/year you passed the State Boards and received your License. Use additional sheets if necessary. Do not omit any positions. If there was a problem, explain on a separate sheet. Enter the Agency name if you worked as a PRN or Travel Nurse. Explain all breaks in employment and provide verification information.

Employment Date From ____/____/____ (mm/dd/yr) to ____/____/____

Hospital Facility _____ Agency (if used) _____ Full-time Part-Time

Address _____ City _____ State _____ Zip _____

Immediate Supervisor _____ Phone _____ May we contact this employer? Yes No

Specialty / Unit _____ Types of Patients _____

Number of Beds _____ Charge Experience? Yes No Eligible for rehire? Yes No

Reason for leaving? _____

Employment Date From ____/____/____ (mm/dd/yr) to ____/____/____

Hospital Facility _____ Agency (if used) _____ Full-time Part-Time

Address _____ City _____ State _____ Zip _____

Immediate Supervisor _____ Phone _____ May we contact this employer? Yes No

Specialty / Unit _____ Types of Patients _____

Number of Beds _____ Charge Experience? Yes No Eligible for rehire? Yes No

Reason for leaving? _____

Employment Date From ____/____/____ (mm/dd/yr) to ____/____/____

Hospital Facility _____ Agency (if used) _____ Full-time Part-Time

Address _____ City _____ State _____ Zip _____

Immediate Supervisor _____ Phone _____ May we contact this employer? Yes No

Specialty / Unit _____ Types of Patients _____

Number of Beds _____ Charge Experience? Yes No Eligible for rehire? Yes No

Reason for leaving? _____

Employment Date From ____/____/____ (mm/dd/yr) to ____/____/____

Hospital Facility _____ Agency (if used) _____ Full-time Part-Time

Address _____ City _____ State _____ Zip _____

Immediate Supervisor _____ Phone _____ May we contact this employer? Yes No

Specialty / Unit _____ Types of Patients _____

Number of Beds _____ Charge Experience? Yes No Eligible for rehire? Yes No

Reason for leaving? _____

Employment Date From ____/____/____ (mm/dd/yr) to ____/____/____
Hospital Facility _____ Agency (if used) _____ Full-time Part-Time
Address _____ City _____ State _____ Zip _____
Immediate Supervisor _____ Phone _____ May we contact this employer? Yes No
Specialty / Unit _____ Types of Patients _____
Number of Beds _____ Charge Experience? Yes No Eligible for rehire? Yes No
Reason for leaving? _____

Employment Date From ____/____/____ (mm/dd/yr) to ____/____/____
Hospital Facility _____ Agency (if used) _____ Full-time Part-Time
Address _____ City _____ State _____ Zip _____
Immediate Supervisor _____ Phone _____ May we contact this employer? Yes No
Specialty / Unit _____ Types of Patients _____
Number of Beds _____ Charge Experience? Yes No Eligible for rehire? Yes No
Reason for leaving? _____

Explanation of any breaks:

Have you ever been convicted of a crime other than a traffic violation? _____
If yes, please list conviction and explain:

(Note: Conviction is not an automatic bar of employment. Each case will be considered on its own merits.)

I represent that the information provided in this employment application (and all accompanying documents, if any) is true and complete. I understand that any false information or significant omissions may disqualify me from any further consideration for employment and may be justification for dismissal from employment if discovered at a later date. I agree to immediately notify RNS, Inc., if I should be convicted of any crime while my job application is pending, or while employed with RNS.

I authorize investigation of all statements contained in this application and authorize any individual or entity to provide information and opinion to RNS Inc. as part of the investigation. I understand and hereby authorize that a separate criminal background check may be conducted by, or on behalf of RNS, Inc. I release RNS, Inc. and any individual, or entity providing information to RNS, from any legal liability for the damages from the disclosure of this information.

I understand and agree that, if I am hired, my employment is "at-will" which means that it is for no definite period of time and may be terminated by me or RNS at any time for any reason.

Signature _____ Date _____
Printed Name _____

CONFIDENTIAL INFORMATION DISCLOSURE AND RELEASE

I hereby authorize RNS Incorporated (“RNS”) to release any and all confidential employment, background, and/or medical information contained in my employment file to (i) any medical facility or entity with whom RNS has a contractual agreement to provide temporary nurse staffing services, (ii) any potential client facility of RNS for whom I may be assigned, or (iii) any other governmental or regulatory agency at such agency’s request. I agree to release RNS from any liability with regards to the release of confidential information by RNS.

I hereby authorize RNS to contact past employers and references regarding my employment history, and to conduct background and education verifications as may be required by its client facilities prior to the commencement of my employment with RNS. I agree to release RNS, all previous employers, and references from any liability for furnishing this information.

I hereby authorize RNS to collect from my physician and/or previous employer(s) any and all health screenings and/or lab information that may be required for the employment of health care professionals. This information includes, but is not limited to: health physicals, TB skin tests, chest X-rays, vaccinations, titers, illness history, drug screenings, and N95 mask fittings. I agree to release RNS, and anyone providing said information to RNS at my request from any liability for furnishing this information.

As a condition of my employment with RNS, I also understand and agree to undergo a standard 10-12 panel drug screening prior to the commencement of my employment, and on an as-needed basis thereafter. I hereby authorize any physician, laboratory, hospital or medical professional retained by this employer or by myself, to conduct such screening and to provide the results to RNS. I agree to release RNS, any person affiliated with RNS, and any institution or person conducting the screening from any liability with regards to said screening.

I understand that all confidential employment, background, and medical information collected by RNS will be held in strict confidence and will not be disseminated improperly.

Employee Signature

Date

Printed Name

Last 4 Digits of SSN

Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. **ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

| | | | |
|--|-------|--|--------------------------------|
| Print Name: Last | First | Middle Initial | Maiden Name |
| Address (Street Name and Number) | | Apt. # | Date of Birth (month/day/year) |
| City | State | Zip Code | Social Security # |
| I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form. | | I attest, under penalty of perjury, that I am (check one of the following): <input type="checkbox"/> A citizen or national of the United States <input type="checkbox"/> A Lawful Permanent Resident (Alien # A _____) <input type="checkbox"/> An alien authorized to work until ___/___/___ (Alien # or Admission #) _____ | |
| Employee's Signature | | | Date (month/day/year) |

Preparer and/or Translator Certification. (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

| | |
|---|------------|
| Preparer's/Translator's Signature | Print Name |
| Address (Street Name and Number, City, State, Zip Code) | |
| Date (month/day/year) | |

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s)

| List A | OR | List B | AND | List C |
|---------------------------------------|----|-------------|-----|-------------|
| Document title: _____ | | _____ | | _____ |
| Issuing authority: _____ | | _____ | | _____ |
| Document #: _____ | | _____ | | _____ |
| Expiration Date (if any): ___/___/___ | | ___/___/___ | | ___/___/___ |
| Document #: _____ | | _____ | | _____ |
| Expiration Date (if any): ___/___/___ | | _____ | | _____ |

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) ___/___/___ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)

| | | |
|--|---|-----------------------|
| Signature of Employer or Authorized Representative | Print Name | Title |
| Business or Organization Name | Address (Street Name and Number, City, State, Zip Code) | Date (month/day/year) |

Section 3. Updating and Reverification. To be completed and signed by employer.

| | |
|-----------------------------|--|
| A. New Name (if applicable) | B. Date of rehire (month/day/year) (if applicable) |
|-----------------------------|--|

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title: _____ Document #: _____ Expiration Date (if any): ___/___/___

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

| | |
|--|-----------------------|
| Signature of Employer or Authorized Representative | Date (month/day/year) |
|--|-----------------------|

Form W-4 (2011)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2011 expires February 16, 2012. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using

Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

| | | | |
|----------|--|----------|---------------|
| A | Enter "1" for yourself if no one else can claim you as a dependent | A | <u> </u> |
| B | Enter "1" if: { <ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. } | B | <u> </u> |
| C | Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) | C | <u> </u> |
| D | Enter number of dependents (other than your spouse or yourself) you will claim on your tax return | D | <u> </u> |
| E | Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) | E | <u> </u> |
| F | Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.) | F | <u> </u> |
| G | Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children | G | <u> </u> |
| H | Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶ | H | <u> </u> |
| | For accuracy, complete all worksheets that apply. { <ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. } | | |

----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

| | | |
|--|--|---|
| Form W-4 Department of the Treasury Internal Revenue Service | <h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p> | OMB No. 1545-0074 2011 |
| 1 Type or print your first name and middle initial. Last name | | 2 Your social security number |
| Home address (number and street or rural route) | | 3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. |
| City or town, state, and ZIP code | | 4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/> |
| 5 | Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) | 5 <u> </u> |
| 6 | Additional amount, if any, you want withheld from each paycheck | 6 \$ <u> </u> |
| 7 | I claim exemption from withholding for 2011, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶ | 7 <u> </u> |
| Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete. | | |
| Employee's signature (This form is not valid unless you sign it.) ▶ | | Date ▶ |
| 8 | Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) | 9 Office code (optional) 10 Employer identification number (EIN) |

MEDICAL HISTORY QUESTIONNAIRE

Name _____ SSN _____

Date of Birth _____ Weight _____ Height _____

Drug Allergies? Y or N If yes, please specify: _____

Other Allergies? Y or N If YES, please specify: _____

Date of Last Physical Exam _____ Name of Physician _____

Address _____

City _____ ST _____ Zip _____

Any misrepresentation or falsification will result in denial of medical claims as well as possible termination of employment.

Any questions answered "yes" will not necessarily disqualify you for employment. We will not discriminate on the basis of physical handicaps.

1. Have you ever been denied Life Insurance? Y N
2. Have you ever been denied Health Insurance? Y N
3. Have you ever used barbiturates, heroin, opiates or other narcotics except as prescribed by a physician? Y N
4. Are you currently being treated for alcoholism or other substance abuse? Y N
5. Have you ever been a patient in a mental institution? Y N
6. Have you ever been refused employment because of your physical, mental or other health related conditions? Y N
7. Have you ever had any industrial or occupational disease, injury or ailment? Y N
8. To your knowledge, have you ever been exposed to toxic substances in previous employment? Y N
9. Are you unable to perform certain body motions or assume certain body positions? Y N
10. Do you have vision impairments? Y N
11. Have you received or do you have a pending application for disability or reimbursement for medical expenses? Y N
12. Do you intend to apply for compensation for disability or reimbursement for medical expenses? Y N
13. Do you have an existing disability because of injury? Y Y
14. Have you had a rapid weight gain or loss exceeding 15 lbs. during the last 12 months? Y N
15. Do you smoke? Y N
16. Do you use any other type of tobacco? Y N
17. Do you have diabetes? Y N
18. Are you or any member of your family disabled or suffering from heart disease, stroke, or ARC (AIDS-related condition)? Y N

19. Have you had any of the following?

- | | | | | | |
|-------------------------|---|---|-----------------------------|---|---|
| Operations | Y | N | Stomach Problems..... | Y | N |
| Fractures..... | Y | N | Respiratory Problems..... | Y | N |
| Head Injury | Y | N | Circulatory Problems..... | Y | N |
| Neck Injury..... | Y | N | Epilepsy / Seizures..... | Y | N |
| Back Injury | Y | N | Mental Disease | Y | N |
| Other Injuries | Y | N | Jaundice | Y | N |
| Chronic Back Pain | Y | N | Rheumatism / Arthritis..... | Y | N |
| Tuberculosis | Y | N | Skin Disease | Y | N |
| Heart Problems..... | Y | N | Hernia..... | Y | N |

Please give details below for any questions (1-19) where you have answered “Yes”.

| <i>Condition</i> | <i>Details</i> | <i>Onset Mo/Yr</i> | <i>Duration</i> | <i>Result</i> |
|------------------|----------------|--------------------|-----------------|---------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Additional Comments:

PLEASE READ AND SIGN

I hereby certify that there are no misrepresentation and/or falsifications concerning my present or past health. I authorize all physicians, practitioners, hospitals and other institutions to supply information relative to my health. I release said liability concerning the issuing of this information. I am fully aware that any misstatement of material facts may cause rejection of my application and/or will disqualify me from holding a job with the company and will result in denial of payment of medical claims.

I MAKE THESE REPRESENTATIONS FREELY AND VOLUNTARILY.

SIGNATURE _____

DATE _____

INFORMATION ABOUT HEPATITIS B VACCINE

THE DISEASE

Hepatitis B is a viral infection caused by Hepatitis B virus (HBV) which causes death in 1% to 2% of patients. Most people with Hepatitis B recover completely, but approximately 5% to 10% become chronic carriers of the virus. Most of these people have no symptoms, but can continue to transmit the disease to others. Some may develop chronic active Hepatitis and Cirrhosis. HBV also appears to be a causative factor in the development of liver cancer. Thus, immunization against Hepatitis B can prevent acute Hepatitis and also reduce sickness and death from chronic active Hepatitis, Cirrhosis and liver cancer.

THE VACCINE

Hepatitis B vaccine is produced from the plasma of chronic HBV carriers. The vaccine consists of highly purified, formalin-inactive Hepatitis B antigen (viral coating material). This process inactivates all known animal and human viruses, including hepatitis and the proposed AIDS virus. It has been extensively tested for safety and efficiency in large scale clinical trials with human subjects. A high percentage of healthy people who receive two doses of vaccine and a booster achieve high levels of surface antibody (anti-HPs) and protections against Hepatitis B. Persons with immune system abnormalities, such as dialysis patients, have less response to the vaccine, but over half of those receiving it do develop antibodies. Full immunization requires three doses of vaccine over a six-month period although some persons may not develop immunity even after three doses. However, persons who have been infected with HBV prior to receiving the vaccine may go on to develop clinical Hepatitis in spite of immunization. The duration of immunity is unknown at this time.

POSSIBLE VACCINE SIDE EFFECTS

The incidence of side effects is very low. No serious side effects have been reported with the vaccine. A few persons experience tenderness and redness at the site of injection. Low-grade fever may occur. Rash, nausea, joint pain and mild fatigue have also been reported. The possibility exists that more serious side effects may be identified with more extensive use.

HEPATITS B (HBV) VACCINE INFORMED CONSENT

I, _____, hereby acknowledge that I have been given a copy of the fact sheet concerning Hepatitis B and the HBV vaccine. I have also been given the opportunity to ask questions and to seek further information on the benefits and risks of this vaccine. (EMPLOYEE: Please complete and sign the section below that best describes your status with the Hepatitis B Vaccine.)

HEPATITIS B (HBV) VACCINE AUTHORIZATION & DOCUMENTATION

I, _____, realize that the Hepatitis B (HBV) immunization must be given in three (3) separate injections. I will be responsible for presenting myself to the directed facility listed below on the prescribed dates in order to complete the entire series and to receive the follow-up titer testing two months post-vaccine. All injection documentation should be completed by the facility that administered the injection(s) in the spaces provided, or must be attached. *FEMALE EMPLOYEES SHOULD NOT RECEIVE THE HBV VACCINE IF THEY ARE PREGNANT OR SUSPECT A POSSIBLE PREGNANCY.* My signature below indicates that I have authorized- _____ (Facility/hospital) to administer the HBV vaccine to me.

Employee Signature _____ Date _____

INITIAL DOSE: Date _____ Lot _____

Given By: _____

Comments: _____

1 MONTH DOSE: Date _____ Lot _____

Given By: _____

Comments: _____

6 MONTH DOSE: Date _____ Lot _____

Given By: _____

Comments: _____

PREVIOUS HEPATITIS B (HBV) VACCINE / TITER INFORMATION

I, _____, have already received the Hepatitis B Vaccine. My last injection was given on _____ (date). I _____ DID _____ DID NOT receive follow-up titer testing post-vaccine. (Proof of injections and/or titer must be attached.)

Employee Signature _____ Date _____

HEPATITIS B (HBV) VACCINE DECLINATION

I, _____, understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination at that time.

Employee Signature _____ Date _____

Respirator Medical Evaluation

This questionnaire is used in determining whether you have any medical condition that may affect your ability to wear a respirator. Most employees will be approved to wear respirators based on the information obtained from this questionnaire. In some cases, more information may be requested. Fit testing of the respirator is also required and will be done separately. All medical information is considered confidential. This information will be included in your employee health file. Access to your employee health file will be in accordance with the OSHA standard, 1910.1020 (*Access to Employee Exposure and Medical Records*) and HIPAA.

| |
|--|
| Name |
| Have you ever worn a respirator before? <input type="checkbox"/> Yes <input type="checkbox"/> No Manufacturer: _____ Type/Model #: _____ Size: _____ |
| Type of Respirator To Be Used <input type="checkbox"/> N95 Particulate Respirator <input type="checkbox"/> Powered Air Purifying Respirator <input type="checkbox"/> Other : _____ |

All questions are mandatory per OSHA standard, 1910.134 and must be answered by every employee who has been selected to use any type of respirator. Please circle "yes" or "no" to each question.

- | | | |
|---|-----|----|
| 1. Do you currently smoke tobacco, or have you smoked tobacco in the last month..... | Yes | No |
| 2. Have you ever had any of the following conditions? | | |
| a. Seizures (fits):..... | Yes | No |
| b. Diabetes (sugar disease):..... | Yes | No |
| c. Allergic reactions that interfere with your breathing:..... | Yes | No |
| d. Claustrophobia (fear of closed-in places):..... | Yes | No |
| e. Trouble smelling odors (except when you had a cold):..... | Yes | No |
| 3. Have you ever had any of the following pulmonary or lung problems? | | |
| a. Asbestosis:..... | Yes | No |
| b. Asthma:..... | Yes | No |
| c. Chronic bronchitis:..... | Yes | No |
| d. Emphysema:..... | Yes | No |
| e. Pneumonia:..... | Yes | No |
| f. Tuberculosis:..... | Yes | No |
| g. Silicosis:..... | Yes | No |
| h. Pneumothorax (collapsed lung):..... | Yes | No |
| i. Lung cancer:..... | Yes | No |
| j. Broken ribs:..... | Yes | No |
| k. Any chest injuries or surgeries:..... | Yes | No |
| l. Any other lung problems that you've been told about:..... | Yes | No |
| 4. Do you currently have any of the following symptoms of pulmonary or lung illness? | | |
| a. Shortness of breath:..... | Yes | No |
| b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:..... | Yes | No |
| c. Shortness of breath when walking with other people at an ordinary pace on level ground:..... | Yes | No |
| d. Have to stop for breath when walking at your own pace on level ground:..... | Yes | No |
| e. Shortness of breath when washing or dressing yourself:..... | Yes | No |
| f. Shortness of breath that interferes with your job:..... | Yes | No |
| g. Coughing that produces phlegm (thick sputum):..... | Yes | No |
| h. Coughing that wakes you early in the morning:..... | Yes | No |
| i. Coughing that occurs when you are lying down:..... | Yes | No |
| j. Coughing up blood in the last month:..... | Yes | No |

- | | | |
|---|-----|----|
| k. Wheezing:..... | Yes | No |
| l. Wheezing that interferes with your job:..... | Yes | No |
| m. Chest pain when you breath deeply..... | Yes | No |
| n. Any other symptom that you think may be related to lung problems:..... | Yes | No |
5. Have you ever had any of the following cardiovascular or heart problems?
- | | | |
|--|-----|----|
| a. Heart attack:..... | Yes | No |
| b. Stroke:..... | Yes | No |
| c. Angina:..... | Yes | No |
| d. Heart failure:..... | Yea | No |
| e. Swelling in your legs or feet (not caused by walking):..... | Yes | No |
| f. Heart arrhythmia (heart beating irregularly):..... | Yes | No |
| g. High Blood Pressure:..... | Yes | No |
| h. Any other heart problem that you've been told about:..... | Yes | No |
6. Have you ever had any of the following cardiovascular or heart problems?
- | | | |
|--|-----|----|
| a. Frequent pain or tightness in your chest:..... | Yes | No |
| b. Pain or tightness in your chest during physical activity:..... | Yes | No |
| c. Pain or tightness in your chest that interferes with your job:..... | Yes | No |
| d. In the past two years, have you noticed your heart skipping or missing a beat:..... | Yes | No |
| e. Heartburn or indigestion that is not related to eating:..... | Yes | No |
| f. Any other symptoms that you think may be related to heart or circulation problems:... | Yes | No |
7. Do you currently take medication for any of the following problems?
- | | | |
|-------------------------------------|-----|----|
| a. Breathing or lung problems:..... | Yes | No |
| b. Heart trouble:..... | Yes | No |
| c. Blood pressure:..... | Yes | No |
| d. Seizures (fits):..... | Yes | No |
8. Has your wearing a respirator caused any of the following problems? (If you have never used a respirator, check the following space: _____ and go to question 9)
- | | | |
|---|-----|----|
| a. Eye irritation..... | Yes | No |
| b. Skin allergies or rashes..... | Yes | No |
| c. Anxiety that occurs only when you use the respirator..... | Yes | No |
| d. Unusual weakness or fatigue:..... | Yes | No |
| e. Any other problem that interferes with your use of a respirator..... | Yes | No |
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire:.....
- | | | |
|--|-----|----|
| | Yes | No |
|--|-----|----|

NOTE: If you experience any discomfort, or shortness of breath when wearing a respirator, immediately leave the high-risk area and then remove your respirator. If symptoms persist for longer than 15 minutes, please report to RNS Incorporated, and Employee Health Services or the Administrative Nursing Supervisor (ANS) at the facility you are working at. Do not continue to wear the respirator until you have been indicated to do so by the Employee Health Nurse or Emergency Department Physician.

Employee Signature: _____ Date: _____

RNS Inc. Signature: _____ Date: _____

TUBERCULOSIS SCREENING

The California Department of Health Services and Cal / OSHA require that all employees be screened for tuberculosis infection. The following questionnaire will assist RNS, Inc. with the screening process. Please answer the following questions to the best of your ability.

Name: _____

Circle the Appropriate Answer

1. Have you ever been diagnosed with active pulmonary tuberculosis disease (productive cough, fever, weight loss, and/or night sweats)?Y N Don't Know
2. If the answer to #1 is Yes, did you take medication to treat the infection?_Y N Don't Know
 If the answer to #2 is Yes, what medication did you take and how long did you take medication?

| | | |
|----------------------|--------------------|--------------------|
| Isoniazid | Date Started _____ | Date Stopped _____ |
| Ethambutol | Date Started _____ | Date Stopped _____ |
| Rifamfin | Date Started _____ | Date Stopped _____ |
| Pyrazinamide | Date Started _____ | Date Stopped _____ |
| Other (be specific): | _____ | |

3. Have you ever lived with another person who was diagnosed with active pulmonary tuberculosis disease?Y N Don't Know
4. Have you ever been exposed to a case of active pulmonary tuberculosis disease as a result of your occupation as a health-care worker?.....Y N Don't Know
5. Have you ever been tested for tuberculosis with the 4-pronged puncture technique (tine test) or with the 5 TU Protein Purified Derivative intra-dermal skin test (PPD)?Y N Don't Know

6. If the answer to #5 is Yes, please answer the following questions:

- a. Date of last TB test: _____
- b. Result of the TB test (check best answer):
- Positive – Greater than 10mm of induration (hard lump at the injection site)
 - Negative (0mm of induration)
 - Between 0 and 10mm of induration)
 - Don't know how may "mm" of induration was recorded
 - Redness only, no induration (hard lump at the injection site)

- c. Was the TB test "self-read"?Y N
 If the answer to "c" is No, who actually interpreted the results of the TB skin test?
- Doctor _____
 - Nurse _____
 - Other _____

7. Have you ever been vaccinated with BCG?Y N Don't Know
8. If the answer to #7 is Yes, approximately what year were you vaccinated and in what country?
 Year _____ Country _____

Employee Signature _____ Date _____

INFLUENZA VACCINE ATTESTATION

In compliance with regulatory requirements (formerly SB 739), hospitals must report influenza vaccination/declination data for all healthcare personnel to the California Department of Public Health. **Please complete this form and return a copy to RNS Incorporated via fax at 888.704.4402.**

If you wish to receive the 2010 flu vaccine, please contact our office for information on vaccination locations.

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|--|---------------------------|--|---|--|--|--|---|--|-------------------------------|--|------------------|--|----------------------------|--|-----------------------|
| NAME: _____ | DATE: _____ | | | | | | | | | | | | | | | | | | | | |
| ATTESTATION | | | | | | | | | | | | | | | | | | | | | |
| ***MUST ATTACH A COPY OF VACCINATION RECORD(S)*** | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> I received the influenza vaccine for the 2010-11 season on _____ <p style="text-align: center;">Setting where vaccine was administered:</p> <input type="checkbox"/> Hospital <input type="checkbox"/> Clinic <input type="checkbox"/> MD Office <input type="checkbox"/> Other _____ | | | | | | | | | | | | | | | | | | | | | |
| DECLINATION | | | | | | | | | | | | | | | | | | | | | |
| <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;"> </td> <td style="padding: 5px;">I have declined to receive the influenza vaccine for the 2010-11 flu season</td> </tr> </table> <p>I acknowledge that the influenza vaccine is recommended by the CDC for all healthcare workers and others with patient contact to prevent infection and transmission of the virus that causes influenza (the flu). I also understand that I may spread the virus to patients, co-workers, family, friends and other contacts prior to developing symptoms of this illness. I understand that by declining vaccination(s), I continue to be at an increased risk of acquiring the influenza virus and could be the vehicle by which this infection is passed on to others.</p> <p>Reason(s) for declination:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 5%; text-align: center;"> </td><td style="padding: 5px;">Allergy to eggs, chicken feathers, and/or chicken dander</td></tr> <tr><td style="width: 5%; text-align: center;"> </td><td style="padding: 5px;">History of Guillain Barre</td></tr> <tr><td style="width: 5%; text-align: center;"> </td><td style="padding: 5px;">Past severe reaction to vaccine (describe):</td></tr> <tr><td style="width: 5%; text-align: center;"> </td><td style="padding: 5px;">Immunocompromised status (current chemotherapy treatment, corticosteroid use, transplant patient, disease of or effecting the immune system)</td></tr> <tr><td style="width: 5%; text-align: center;"> </td><td style="padding: 5px;">I am concerned about potential side effects</td></tr> <tr><td style="width: 5%; text-align: center;"> </td><td style="padding: 5px;">I do not feel it is necessary</td></tr> <tr><td style="width: 5%; text-align: center;"> </td><td style="padding: 5px;">Religious belief</td></tr> <tr><td style="width: 5%; text-align: center;"> </td><td style="padding: 5px;">Fear of receiving vaccines</td></tr> <tr><td style="width: 5%; text-align: center;"> </td><td style="padding: 5px;">OTHER (Must specify):</td></tr> </table> | | | I have declined to receive the influenza vaccine for the 2010-11 flu season | | Allergy to eggs, chicken feathers, and/or chicken dander | | History of Guillain Barre | | Past severe reaction to vaccine (describe): | | Immunocompromised status (current chemotherapy treatment, corticosteroid use, transplant patient, disease of or effecting the immune system) | | I am concerned about potential side effects | | I do not feel it is necessary | | Religious belief | | Fear of receiving vaccines | | OTHER (Must specify): |
| | I have declined to receive the influenza vaccine for the 2010-11 flu season | | | | | | | | | | | | | | | | | | | | |
| | Allergy to eggs, chicken feathers, and/or chicken dander | | | | | | | | | | | | | | | | | | | | |
| | History of Guillain Barre | | | | | | | | | | | | | | | | | | | | |
| | Past severe reaction to vaccine (describe): | | | | | | | | | | | | | | | | | | | | |
| | Immunocompromised status (current chemotherapy treatment, corticosteroid use, transplant patient, disease of or effecting the immune system) | | | | | | | | | | | | | | | | | | | | |
| | I am concerned about potential side effects | | | | | | | | | | | | | | | | | | | | |
| | I do not feel it is necessary | | | | | | | | | | | | | | | | | | | | |
| | Religious belief | | | | | | | | | | | | | | | | | | | | |
| | Fear of receiving vaccines | | | | | | | | | | | | | | | | | | | | |
| | OTHER (Must specify): | | | | | | | | | | | | | | | | | | | | |

I authorize release of the above information to RNS Incorporated, their agents, and their client facilities for purposes of tracking and reporting influenza vaccination/declination data.

Signature: _____

Date: _____

AGE-RELATED COMPETENCY CHECKLIST

(To be completed by ALL Clinical Personnel)

Name: _____ Date: _____

Please rate your Skill Level:

| | |
|---|---|
| <p>0 – NO Experience. Theory only.</p> <p>1 – Limited competency / proficiency. Supervision required.</p> | <p>2 – Acceptable competency / proficiency</p> <p>3 – Competent / proficient. Performed frequently and independently during the past 2 years.</p> |
|---|---|

| COMPLIANCE CRITERIA | 0 | 1 | 2 | 3 |
|----------------------------|----------|----------|----------|----------|
|----------------------------|----------|----------|----------|----------|

NEONATE / INFANT (Newborn to 2 Years)

| | | | | |
|--|--|--|--|--|
| Maintains safe environment: warmth, crib rails in “up” position and locked, no toys with removable parts, limits visitors, no strangers allowed in room, identifies by leg/arm band. | | | | |
| Involves parents / caregivers in care; ensures return demonstration; encourages parental assistance in provision of care. | | | | |
| Provides information in immunizations. | | | | |
| Keeps parents / caregivers in field of vision. | | | | |
| Provides familiar objects (as possible and appropriate). | | | | |
| Uses distraction methods to calm (i.e., visually stimulating objects, bottle). | | | | |
| Approaches and provides care in calm, tender manner. | | | | |

PEDIATRICS (2 - 11 Years)

| | | | | |
|--|--|--|--|--|
| Maintain safe environment: bed rails in “up” position and locked, age appropriate toys and / or games. Aware of need for peer relationship (i.e., with visitors); however, questions any strangers attempting to enter room. Uses age appropriate equipment (i.e., potty chair); ensures safe nutrition (puts food into small bites to prevent choking). | | | | |
| Involves child in care and educates parents / caregivers at same time. Ensures return demonstration; allows child to have control by allowing choices, as appropriate to situation. | | | | |
| Discusses immunization status with parents. | | | | |
| Explains all procedures and test in language that child can understand. | | | | |
| Plans procedures and activities in relation to child’s impulse gratification needs and decreased attention span. | | | | |
| Approaches child in calm manner; uses direct approach with child; allows for privacy needs (ages 9-11); encourages personal hygiene and grooming as appropriate to condition. | | | | |
| Uses praise as a reward for positive attitudes and behavior. Uses touch as a form of comfort, as appropriate to child’s needs and reactions. | | | | |

ADOLESCENT (12 – 19 YEARS)

| | | | | |
|--|--|--|--|--|
| Maintains safe environment: bed rails in “up” position and locked; assesses for depression / suicidal ideation and keeps dangerous items out of patient’s ability to obtain. Assesses for “gang” relationships and considers appropriateness of visitors; assesses patient’s ability to manage “self-held” and/or “self-operated equipment.” | | | | |
| Involves patient in care, treatments and procedures. Allows time for and encourages questions, explaining issues to patient in language patient can understand. Allows patient to have choice and control over situations and environment, as appropriate to condition and situation. | | | | |
| Explains all treatments, tests and procedures thoroughly to patient before they are performed. | | | | |
| Allows for privacy needs. Encourages and allows for personal hygiene activities. | | | | |
| Maintains patient confidentiality with parental / caregiver involvement and education, as appropriate to age and consent of patient. | | | | |
| Encourages verbalization of fears. Discusses options and possible choices patient can make to increase control and foster patient confidence. | | | | |

| COMPLIANCE CRITERIA | 0 | 1 | 2 | 3 |
|----------------------------|----------|----------|----------|----------|
|----------------------------|----------|----------|----------|----------|

ADULT

| | | | | |
|---|--|--|--|--|
| Maintains safe environment related to equipment, bed rails, mental status. | | | | |
| Involves patient in care, treatments and procedures. Allows patient to maintain control; involves patient in decision-making and planning of care, as appropriate to condition and situation. | | | | |
| Explains rationale for all treatments, tests and procedures, explaining to patient prior to performance. | | | | |
| Encourages participation in care, provides education, as appropriate to disease entity and processes. | | | | |
| Encourages family visitation and support. | | | | |
| Encourages verbalization of fears and anxiety; maintains therapeutic communication with patient. | | | | |
| Maintains safe environment related to equipment, bed rails, mental status. | | | | |

GERIATRIC

| | | | | |
|--|--|--|--|--|
| Maintains safe environment related to equipment, bed rails, fall precautions, mobility needs, aspiration potential and mental status. | | | | |
| Involves patient in care, treatment and procedures. Allows patient to maintain control; involves patient decision-making and planning of care, as appropriate to condition and situation. | | | | |
| Explains all treatments, tests and procedures. Explaining to patient prior to performance. | | | | |
| Allows for possible hearing and / or vision loss, speaking in lower, louder tones as necessary; provides additional or brighter lighting, larger print, etc. | | | | |
| Provides all patient instructions slowly, speaking distinctly and assesses for patient understanding. Assesses and monitors potential for skin breakdown, decreased bowel function and / or medication absorption. | | | | |
| Considers mobility needs, provides appropriate transportation, maintains ROM. Prevents contracture formation. | | | | |
| Encourages family support, involving family in care, education and decision, as appropriate. | | | | |

Comments: _____

I hereby certify that all information I have provided to RNS Incorporated on this skills checklist is true and accurate. I understand and acknowledge that any misrepresentation or omission may result in disqualification from employment and/or immediate termination.

Nurse Signature: _____ Date: _____

RNS Inc. Reviewer Signature: _____ Date: _____

LVN / LPN SKILLS COMPETENCY CHECKLIST

Name: _____ Date: _____

Total years of LVN / LPN nursing experience: _____

IV Therapy Certification: YES NO

Please rate your Skill Level:

0 – No Experience. Theory Only.

1 – Limited competency / proficiency.
Supervision Required.

2 – Acceptable competency / proficiency.

3 – Competent / proficient. Performed frequently and independently during the past 2 years.

| SKILL | 0 | 1 | 2 | 3 |
|---|---|---|---|---|
| Activities of Daily Living | | | | |
| Admission of Patient | | | | |
| Administration of Medication | | | | |
| Ambulation | | | | |
| Application of Heat and Cold | | | | |
| Aseptic Technique | | | | |
| Assist with Medical Examination | | | | |
| Bathing: Sitz, Tub, Bed & Shower | | | | |
| Bandaging | | | | |
| Binders | | | | |
| Body Alignment | | | | |
| Body Systems Review (Head to Toe Data Collection) | | | | |
| Cast Care | | | | |
| Catheterization / Foley Catheter Insertion | | | | |
| Charting | | | | |
| Colostomy Care & Irrigation | | | | |
| CPR | | | | |
| Crutch Walking | | | | |
| Decubitus Care | | | | |
| Diabetic Blood Glucose Testing | | | | |
| Diagnostic Tests & Preparation of Forms | | | | |
| Discharge Patients | | | | |
| Dosage Computation | | | | |
| Draping | | | | |
| Dressing (Sterile) | | | | |
| Ear Drops | | | | |
| Elimination Needs | | | | |
| Enemas, cleansing, retention, Harris Flush | | | | |
| Hand Hygiene | | | | |
| Infection Control Precautions | | | | |
| Standard Universal Precautions | | | | |
| Reverse Isolation | | | | |
| TB / Airborne Precautions | | | | |
| MRSA / VRE Precautions | | | | |
| Isolation procedure for specimen collection | | | | |
| IVs: Monitor Rate & Infusion Site | | | | |
| Medications: Oral, IM, Subcutaneous | | | | |
| Mouth Care | | | | |
| Nail Care | | | | |
| Neurological Check | | | | |
| Nutritional Needs | | | | |
| Observations: | | | | |
| Response to treatment/meds | | | | |
| Signs of significant body sys. chgs | | | | |
| Signs of shock | | | | |
| Signs of pain | | | | |
| Observes safety procedures | | | | |
| O2 Administration | | | | |
| Pain Assessment | | | | |
| Patient Care Plans (Revise & Update) | | | | |
| Patient Safety Standards / Precautions | | | | |
| Positioning Patient | | | | |
| Postural Drainage | | | | |
| Pre-Op & Post-Op Care | | | | |
| Provide Comfort, Safety & Privacy | | | | |
| Pulse Oxymetry | | | | |
| Range of Motion | | | | |
| Report Observations / Changes | | | | |

| SKILL | 0 | 1 | 2 | 3 |
|----------------------------------|----------|----------|----------|----------|
| Restraints | | | | |
| Skin Care | | | | |
| Specimen Collection: | | | | |
| Routine Urine | | | | |
| Clean Catch | | | | |
| 12 & 24-hour specimen | | | | |
| Stool | | | | |
| Culture | | | | |
| Sputum | | | | |
| From Foley Catheter | | | | |
| Suppositories (rectal & vaginal) | | | | |
| Suction – Oral | | | | |

| SKILL | 0 | 1 | 2 | 3 |
|---------------------------------|----------|----------|----------|----------|
| Surgical Preps | | | | |
| Trach Care / Suctioning | | | | |
| Telephone Manners | | | | |
| Topical Medication Application | | | | |
| Traction | | | | |
| Transfer / Transport Patients | | | | |
| Proper use of wheelchair | | | | |
| Proper use of gurney | | | | |
| Assist patient to chair | | | | |
| Urine tests for sugar / acetone | | | | |
| Vital Signs – TPR & BP | | | | |
| Weight: Bed & Standing scales | | | | |

Do you speak any other language(s) besides English? Yes / No If YES, please list other language(s): _____

Are you familiar with computer charting? Yes / No If YES, what system(s) have you used: _____

Comments:

I hereby certify that all information I have provided to RNS Incorporated on this skills checklist is true and accurate. I understand and acknowledge that any misrepresentation or omission may result in disqualification from employment and/or immediate termination.

Nurse Signature: _____ Date: _____

RNS, Inc. Reviewer Signature: _____ Date: _____