

## 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

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Tel 800.704.4401 – Fax 888.704.4402  
rns@rnsonline.com



### 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.

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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? \_\_\_\_\_

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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? \_\_\_\_\_

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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? \_\_\_\_\_

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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? \_\_\_\_\_

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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? \_\_\_\_\_

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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? \_\_\_\_\_

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Explanation of any breaks:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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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.)

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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 #
<b>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.</b>		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)
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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)
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# 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.)

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

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

Form <b>W-4</b> Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ <b>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.</b></p>	OMB No. 1545-0074  <span style="font-size: 2em; font-weight: bold;">2011</span>
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. <b>Note.</b> 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)	6 Additional amount, if any, you want withheld from each paycheck	5 <u>      </u> 6 \$ <u>      </u>
7 I claim exemption from withholding for 2011, and I certify that I meet <b>both</b> of the following conditions for exemption. <ul style="list-style-type: none"> <li>• Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability <b>and</b></li> <li>• This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> tax liability.</li> </ul> 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:*

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**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.

<b>Name</b>
<b>Have you ever worn a respirator before?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    Manufacturer: _____    Type/Model #: _____ <span style="margin-left: 350px;">Size: _____</span>
<b>Type of Respirator To Be Used</b> <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?

<b>Isoniazid</b>	Date Started _____	Date Stopped _____
<b>Ethambutol</b>	Date Started _____	Date Stopped _____
<b>Rifamfin</b>	Date Started _____	Date Stopped _____
<b>Pyrazinamide</b>	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.

<b>NAME:</b> _____	<b>DATE:</b> _____																				
<b>ATTESTATION</b>																					
<b>***MUST ATTACH A COPY OF VACCINATION RECORD(S)***</b>																					
<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 _____																					
<b>DECLINATION</b>																					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30px; height: 20px;"></td> <td style="padding: 2px;">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><b>Reason(s) for declination:</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 30px; height: 20px;"></td><td style="padding: 2px;">Allergy to eggs, chicken feathers, and/or chicken dander</td></tr> <tr><td style="width: 30px; height: 20px;"></td><td style="padding: 2px;">History of Guillain Barre</td></tr> <tr><td style="width: 30px; height: 20px;"></td><td style="padding: 2px;">Past severe reaction to vaccine (describe):</td></tr> <tr><td style="width: 30px; height: 20px;"></td><td style="padding: 2px;">Immunocompromised status (current chemotherapy treatment, corticosteroid use, transplant patient, disease of or effecting the immune system)</td></tr> <tr><td style="width: 30px; height: 20px;"></td><td style="padding: 2px;">I am concerned about potential side effects</td></tr> <tr><td style="width: 30px; height: 20px;"></td><td style="padding: 2px;">I do not feel it is necessary</td></tr> <tr><td style="width: 30px; height: 20px;"></td><td style="padding: 2px;">Religious belief</td></tr> <tr><td style="width: 30px; height: 20px;"></td><td style="padding: 2px;">Fear of receiving vaccines</td></tr> <tr><td style="width: 30px; height: 20px;"></td><td style="padding: 2px;">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><b>0</b> – NO Experience. Theory only.</p> <p><b>1</b> – Limited competency / proficiency. Supervision required.</p>	<p><b>2</b> – Acceptable competency / proficiency</p> <p><b>3</b> – Competent / proficient. Performed frequently and independently during the past 2 years.</p>
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COMPLIANCE CRITERIA	0	1	2	3
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**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.				

<b>COMPLIANCE CRITERIA</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
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**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: \_\_\_\_\_

## MEDICAL SURGICAL SKILLS COMPETENCY CHECKLIST Registered Nurse (RN)

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

Total years of Medical Surgical nursing experience:

**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
<b>I. NURSING ROLES:</b>				
Charge Nurse				
Team Leader				
<b>II. PATIENT CARE DELIVERY:</b>				
Team Nursing				
Primary Nursing				
<b>III. NURSING PROCESS SKILLS:</b>				
Nursing History				
Physical Assessments				
Skin				
Cardiovascular				
Heart				
Peripheral Vascular System				
Respiratory				
Neurological				
Abdomen				
Bowel				
Bladder				
Musculoskeletal				
Psychosocial Status				
Fall Assessment				
Pain Assessment				
Elder / Domestic Abuse				
Patient Care Planning				
Nursing Intervention				
Patient Teaching				
Evaluation of Patient Care				
Discharge Instruction / Planning				
Documentation of Care Plan				
<b>IV. MEDICATION ADMINISTRATION:</b>				
Narcotic control				
Insulin Administration				
Skin Testing (Intradermal injection)				
Procedure				
Documentation				
Reading Results				
Heparin Administration / Lock				
Patient Controlled Analgesia				
Administration of Medications				
Oral / Sublingual				
I.M.				
Subcutaneous				
Topical / Medication Patches				
Eye				
Ear				

SKILL	0	1	2	3
<b>IV. MEDICATION ADMINISTRATION (contd):</b>				
Nose				
Unit Dose Medication Administration				
Nebulizer/Aerosol Medication Treatments				
<b>V. INTRAVENOUS THERAPY:</b>				
Venipuncture Site Care				
Calculating & Monitoring Infusion Rate				
Infusion Pumps				
PCA Pumps				
Insulin Pumps				
IV Insertion				
Heparin Locks / Saline Locks				
Angio Caths				
Scalp Vein				
IV Push Medications				
IV Piggyback Medications				
IV Add-Mixture / Additives				
Blood / Blood Products Administration				
Monitoring Blood / Blood Products				
Lipids				
TPN / PPN				
Central Lines / Intravascular Access Ports				
PICC Lines				
<b>VI. CHEMOTHERAPY:</b>				
Administration of Chemo meds				
Precautions / Teaching				
Mixing / Preparation				
Disposal				
Chemotherapy Certified				
<b>VII. NURSING PROCEDURES:</b>				
Irrigations				
Eye				
Ear				
Foley				
Suprapubic				
Incision				
N/G Tube				
Ostomy				
Insertion of N/G Feeding Tube				
Hot Soaks				
Ice Packs				
Rectal Temperature				
Removal of Fecal Impaction				
Weighing Patients				
Vital Signs				

SKILL	0	1	2	3
<b>VII. NURSING PROCEDURES (contd):</b>				
Application of:				
Restraints				
Support Binders				
Ace Wraps				
Antimobolic Stocking				
Slings				
Soft Cervical Collar				
Rib Belts				
Clavicle Brace				
Back Supports				
Chairback				
Jewett				
LS Corsets				
Crutches				
Knee Immobilizers				
Monitoring CVP				
Care of Wound Drainage				
Hemovac Suction Device				
Jackson Pratt Suction Device				
Care of:				
G-Tube				
Penrose Drains				
NG Tubes / Feeding Tubes				
Chest Tubes / Drainage System				
Salem Tubes				
Catheterization				
Male Incontinence Device				
Foley Insertion				
Foley Catheter Care				
Foley Removal				
Straight Catheter				
Gastric Suction				
Electronic Thermometer				
Range of Motion: Active / Passive				
Seizure Precautions				
Peri-Care				
Cast Care				
Skin Care in Traction				
Incision Care				
AV Shunt Care				
Bladder Irrigations				
Infection Control Precautions				
Standard Universal Precautions				
Reverse Isolation				
TB / Airborne Precautions				
MRSA / VRE Precautions				
Urine, Sugar & Acetone				
Blood Glucose Monitoring				
Stool Hemocult				
Gastric Hemocult				
Urine Specific Gravity				
Oxygen Therapy Administration				
Ambu bag				
Bag & Mask				
BiPAP				
Face mask				
Nasal Cannula				
Tracheostomy care				

SKILL	0	1	2	3
<b>VII. NURSING PROCEDURES (contd):</b>				
IPPB Rx				
Chest PT / Breath sounds				
Postural Drainage				
Specimen Collection				
Blood				
Central Line				
Venous Stick				
Cultures				
Sputum				
Urine				
Clean Voided				
24-hour				
Sterile (Straight Catheter)				
Swab Culture				
Gastric Analysis				
Abdominal Fluid				
Anaerobic Cultures				
Aerobic Cultures				
Wound Cultures				
Stool Samples				
Suctioning				
Oral / Yankauer				
Oral-pharyngeal				
Nasal-pharyngeal				
Tracheostomy				
Wound / Ostomy Care				
Colostomy care / bag change				
Ileostomy care / bag change				
Irrigations				
Pressure Ulcers				
Staging				
Care				
Stasis Ulcers				
Sterile Dressing Changes				
Steristrip Application				
Surgical Wounds w/ or w/o Drains				
Neuro Skills:				
Neuro Assessment				
Glasgow Coma Scale				
Seizure Precautions				
Seizure Activity				
Mental Status / LOC				
Halo Traction				
<b>VIII. ASSIST WITH BASIC PROCEDURES:</b>				
Pelvic Exam				
Physical Exam				
Lumbar Puncture				
Thoracentesis / Paracentesis				
Dressing Change				
Staple / Suture Removal				
Insertion of Central / PA Catheter				
Insertion of Arterial Line				
Discontinue Arterial / Central Lines				
Insertion of Chest Tubes				
<b>IX. EQUIPMENT:</b>				
Hypothermia Blanket				
Pressure Mattress				
Restraints				

SKILL	0	1	2	3
<b>IX. EQUIPMENT (contd):</b>				
Halo Apparatus				
Traction				
Balance Traction				
Footboard				
Foster / Stryker Frame				
Circ-O-Electric Bed				
Cradles				
Intermittent Suction				
Wall-Straight Suction				
Portable O2 Suction				
Straight Drainage				
Oxygen Wall Panel / Flowmeter				
Chest Tube Suction Device				
Hoyer Lift				
K-Pads				
Nelson Bed				
Pressure Relieving Beds				
Kangaroo Pumps				
Trans Nerve Stimulator				
Pyxis				
Portable Vital Signs Monitor				
Cardiac / Tele Monitors				
Lead Placement				
Arrhythmia Interpretation				
Blood Glucose Meters				
Pulse Oxymetry				
Incentive Spirometry				
Emergency / Crash Cart				
Ambu Bag (PPV) Mask / Valve				
HEPA Filters				

<b>X. PAIN MANAGEMENT:</b>				
Pain assessment using pain scales				
Epidural Analgesia				
IV Conscious Sedation				
Patient Controlled Analgesia (PCA)				
Narcotic Agents				
Non-narcotic agents				
Non-pharmacological Measures				

<b>XI. CARE OF PATIENTS:</b>				
<b>RESPIRATORY</b>				
COPD				
ARDS				
Thoracic Surgery				
Asthma				
Inhalation Injuries				
Pneumonia				
Pneumothorax				
Tuberculosis				
Pulmonary Edema				
Pulmonary Embolism				
<b>NEUROLOGY</b>				
CVA / TIA				
Overdose				
Head Injury / Trauma				
Neuro Injury / Trauma				
Spinal Cord Injury				

SKILL	0	1	2	3
<b>XI. CARE OF PATIENTS (contd):</b>				
<b>NEUROLOGY contd</b>				
Paraplegia				
Quadriplegia				
Neuro Surgery				
Cranial Hemorrhage				
AV Shunt Placement				
Multiple Sclerosis				
Encephalitis (Viral / Infectious)				
<b>CARDIAC</b>				
Angina				
Aneurysm				
Post MI				
Hypertensive Crisis				
Open Heart Surgery (Pre & Post Op Care)				
CHF				
Cardiac Cath				
Fem / Pop Bypass				
<b>RENAL / GU</b>				
Chronic / Acute Renal Failure				
Renal Calculi				
Renal Trauma				
Nephrectomy				
TURP				
Radical Prostatectomy				
Hemodialysis				
Peritoneal Dialysis				
<b>GI / ABDOMINAL</b>				
Appendicitis				
GI Bleed				
Pancreatitis				
Bowel Obstruction				
Paralytic Ileus				
Liver Failure				
Hepatitis				
Laparoscopic Abdominal Procedures				
Open Abdominal Procedures				
Post endoscopic procedures				
Pre & Post op patients				
<b>ORTHOPEDIC</b>				
Amputation				
Arthroscopic Surgery				
Total Joint Replacement (Hips & Knees)				
Cast Care				
Orthopedic Trauma				
Skeletal Traction				
Bucks Extension				
Pin Site Care				
Laminectomy				
Passive ROM Exercises				
<b>GYNECOLOGY</b>				
Mastectomy				
Hysterectomy				
Tubal Ligation				
Ectopic pregnancy				
Abdominoplasty				
Reconstructive Breast Surgery				

<b>SKILL</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>XI. CARE OF PATIENTS (contd):</b>				
<b>GYNECOLOGY contd</b>				
Thyroidectomy				
Assist / Perform GYN Exam/PAP				
Removal of Cysts				
<b>OTHER</b>				
Sickle Cell Anemia				
Transfusion Reaction				
Anaphylaxis				
Septic Shock				
Cancer patients				

<b>SKILL</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
<b>XI. CARE OF PATIENTS (contd):</b>				
<b>OTHER contd</b>				
Infectious Diseases & complications				
HIV / AIDS				
Shingles (Herpes)				
Chicken pox				
West Nile Virus				
Lyme Disease				
Terminally ill patients				
Death & Dying				

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: \_\_\_\_\_