- Professional Information
- Education
- Background Investigation
- Health Information
- Competency Test Scores
- Payroll

Blank for Comments:

Hospital **S**tafflink **N**etwork

A division of US Hospital Personnel, Inc.
24-Hour National Nursing Staff

Name _____ Classification_____ Date_____
Home Number_____ Cell Number_____ Other_____

Note Availability

☐ Hospital	☐ Day	☐ 8 Hours
☐ Nursing Home	☐ Evening	☐ 12 Hours
☐ Hospice	☐ Night	

Transportation	☐ By Car
	☐ By Public Transportation

Days Available:

☐ Mon ☐ Tue ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

Note Experience and places you have worked:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Comments: (Tell us what you want us to know about you)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Ask us about a monthly schedule

License Vocational Nurse

Name _____

Date _____

- Hospital (Acute Care)
- Nursing Home

LICENSE VOCATIONAL NURSE APPLICATION

DATE:_____ / _____/ _____ POSITION APPLIED FOR:_____

How did you hear about this position? _____

FULL TIME: _____ PART TIME: _____ PER DIEM: _____

PERSONAL INFORMATION

LAST NAME: _____FIRST NAME: _____ MIDDLE INITIAL:_____

SOCIAL SECURITY NUMBER: _____ - _____ - _____

MAILING ADDRESS: STREET:_____

CITY:_____ STATE:_____ ZIP CODE: _____

MOBILE NUMBER (____) _____ - _____ HOME (____) _____ - _____EMAIL:_____

Are you at least 18 years of age?

If hired can you furnish proof you are eligible to work in the U.S.? Yes_____ No_____

Have you ever been convicted of a crime other than minor traffic violations? Yes_____ No_____

If ever in military service, were you convicted by a general court martial? Yes_____ No_____

If your answer is yes to any of the last two questions, please explain below. A conviction does not automatically Disqualify you from employment consideration. What you were convicted of and how long ago are important. Give all facts so a fair decision can be made. _____

_____

_____

Have you ever worked here before? Yes_____ No_____

If yes, when: _____ Under what name? _____

PROFESSIONAL LICENSE/REGISTRATION/CERTIFICATION:

Type: _____ Number: _____ State: _____

Have you ever had a professional license suspended or revoked? Yes_____ No_____

EDUCATION

Circle highest grade completed: (Grade School:1 2 3 4 5 6 7 8) (High School: 1 2 3 4)

(College:1 2 3 4) (Graduate School: 1 2 3 4)

EDUCATION	NAME	ADDRESS CITY, STATE	MAJOR	DEGREE	DATES
NURSING SCHOOL (Note dates and address)					
HIGH SCHOOL					
OTHER					

SPECIAL SKILLS, APTITUDES AND OTHER QUALIFICATIONS

List details of all skills, aptitudes and other qualifications. The listing will be used only for the purpose of matching your application to available jobs.

Special qualifications and skills, license of certificates, and memberships in professional organizations of societies:

_____

List any computer application programs in which you are knowledgeable: _____

_____

PRESENT AND PRIOR EMPLOYMENT HISTORY

List below all present and past employment, beginning with your most recent job. All spaces must be completed. A resume may be used to supplement but not substitute for request information. Do not specify "see resume" in any space. Account for all periods of time including military service and any periods of employment. If self-employed, give firm name and supply business references.

May we contact your present/last employer? Yes_______ No_______ If not, when may we contact? __________

Name of Present or Last Employer	Street Address	Starting Salary $	Dates (Month/Year) From ______/______ To ______/______
Telephone ( ) -	City, State, Zip Code	Last Salary $	Job Title
Job Responsibilities:			Name of Last Supervisor
Reason for Leaving:			Name worked under if different

Name of Present or Last Employer	Street Address	Starting Salary $	Dates (Month/Year) From ______/______ To ______/______
Telephone ( ) -	City, State, Zip Code	Last Salary $	Job Title
Job Responsibilities:			Name of Last Supervisor
Reason for Leaving:			Name worked under if different

Name of Present or Last Employer	Street Address	Starting Salary $	Dates (Month/Year) From ______/______ To ______/______
Telephone ( ) -	City, State, Zip Code	Last Salary $	Job Title
Job Responsibilities:			Name of Last Supervisor
Reason for Leaving:			Name worked under if different

PLEASE READ CAREFULLY

CERTIFICATION- I understand and agree that any false or misleading information supplied by me will be cause for canceling the application process. If hired, it may cause my dismissal from HSN. I have answered all questions on this form completely and truthfully. I understand that this application must be fully completed, signed by me and dated for it to be given consideration

STATEMENT OF APPLICANT- I authorize any person, school, current employer (except as previously noted), past employers and organizations named in this application to furnish their records and any relevant information and options that may be useful in the making a hiring decision. I release such persons and organizations form any legal liability in providing information.

PHYSICAL FITNESS- I understand that if I am extended an offer of employement, it will be conditioned upon successfully passing a complete pre-employment physical examination. I consent to the release of any or all medical information as may be deemed necessary to judge my capability to do the essential functions of the positions for which I am applying. I also understand I may be required to successfully pass a drug-screening exam. Any illegal or controlled substances that cannot be substantiated with a doctor's prescription which shows in my test results will cause my immediate disqualification for employment with Hospital Stafflink Network. I hereby consent to a pre or post-employement drug screen.

EMPLOYMENT-AT-WILL- I understand that this application or subsequent employment does not create a contract of employment nor guarantee employment for any definite period of time. If employed, I understand that I have been hired at the will of Hospital Stafflink Network and that my employment may be termination at any time, with or without cause and with or without notice.

I certify that the facts set forth in the above employment application are true and complete to the best of my knowledge. I authorize you to make any investigation of my personal history.

Signature: ____ Date: _______ / _______ / ___________

A division of US Hospital Personnel, Inc.
24-Hour National Nursing Staff

Nursing Skills Competency Inventory

Please select the competency level that most accurately describes your knowledge or proficiency for each item. This inventory is presented by system; please review ALL SKILLS.

KEY: **(1)** Performs proficiently and independently **(2)** Some experience, may ask for assistance **(3)** Classroom training only **(4)** No training or experience

USE/ADMINISTRATION OF:	SKILL LEVEL	**PATIENT CARE:**	SKILL LEVEL	**MATERNAL CHILD NURSING:**	SKILL LEVEL	**PATIENT CARE:**	SKILL LEVEL
Atropine		Asthma		Childbirth Education		CHF	
Nipride		Bone Marrow Transplant		Managing Pre-eclampsia		COPD	
Dobutamine		Bronchopulmonary Dysplasia		Labor Suppressants		ARDS	
Anesthetic Reversal Agent		Cardiac Surgery		Labor Inducements		Pulmonary Edema	
Streptokinase/TPA		Failure to Thrive		Assist Vaginal Delivery		Pneumothorax	
Digoxin		Harrington Rod Insertion		Assist C-Section		Neuro Assessment	
Dopamine		RSV		Scrub C-Section		Head Injury Protocol	
Propranolol		RDS		Assist High Risk Delivery		Seizure Precautions	
Isuprel		Sickle Cell Disease		Labor Assessment		Lumbar Puncture (assist)	
Lidocaine		Spina Bifida		Connect Monitors		ICP Monitoring	
Nitroglycerin		PDA Ligation		Identify FHR Patterns		Halo Traction	
Pronestyl		Leukemia		Petoscope Doppler Use		Pin Site Care	
Inocor		**TYPES OF UNIT EXP.**		Assist Fetal Sc alp Blood Samples		Stryker Frame	
		Assaltive Behavior		**GENITOURINARY/RENAL**		Craniotomy	
PERINATAL CARE:		Adolescent Units		Foley Cath Insertion		Neuro Trauma	
Hypertension		Adult Units		Nephrostomy Tube		Spinal Cord Injury	
Multiple Gestation		Med/Psych Unit		Suprapubic Tube		CVA	
Placenta Previa		Geropsych Unit		Urine test Spec.Gravity/Glucose		Electrocution	
Placenta Abruptio		Voluntary Unit		Collect of Urine Specimen		Pre/post Neurosurgery	
Premature Labor		Involuntary Unit		Peritoneal Dialysis		AV Shunts	
Gestational Diabetes		Pediatric Units		Hemodialysis		**ORTHOPEDIC:**	
Diabetes Mellitus		**PEDIATRICS:**		**ORTHOPRDIC:**		Universal Precautions	
Rh Incompatibility		Calculation Pediatric Doses		Mechanical Traction		Fire & Safety	
Postpartum Assessment		Start Scalp Vein IV		Skin Traction		Blood borne Pathogens	
USE/ADMINSTRATION OF:		Apnea Monitor		CPM		Back Mechanics	
Insulin/Repair Cardiogenic Drips		Cardiac Monitor		Circulatory Assessment		OSHA Films/Orientation	
Dexamethasone		CPR-Infant Child		Cast Care		Ambulance Transfer	
Phenytoin		Preparation of ER Drugs		Spica Cast		Air Transfer	
Mannitol		Tracheostomy Care		Body Cast		Quality Assurance	
Phenobarbital Diazepam		Tracheostomy Suctioning		Pin Cast		Chart Review	
Quinidine		Assist Lumbar Puncture		Use of Transfer Belt		Computerized Charting	
ER Drug Preparation		Use of Croup Tent		Teach Crutch		Focus/Soup Charting	
		Use of Ventilators		Teach Walker Use		Team Nursing	

A division of US Hospital Personnel, Inc.
24-Hour National Nursing Staff

KEY: **(1)** Performs proficiently and independently **(2)** Some experience, may ask for assistance **(3)** Classroom training only **(4)** No training or experience

CARDIAC:	SKILL LEVEL	**RESPIRATORY:**	SKILL LEVEL	**VASCULAR:**	SKILL LEVEL	**PSYCHOSOCIAL:**	SKILL LEVEL
ICU Experience		Assessment		Assessment of Peripheral Pulses		Recognizes Stages of Gnet	
CCU Experience		Establishing Airway		JVD		Crisis Intervention	
PACU Experience		Ambuing Technique		Ultrasonic Doppler		Leading Pt/Client Groups	
Telemetry Experience		Assist Placement of Chest Tubes		Maintain Heparin Lock		Knowledge of Neuro Meds	
12 Lead EKG		Chest Tube Care		Hyperalimentation/TPN		Use of Leather Restraints	
Interpretation of EKG		Suctioning		Read Normal Lab Values		Suicide Precautions	
Pacemaker-permanent		Tracheostomy Care		IV Starts		Eating Disorders	
Pacemaker-temporary		IPPB Treatments		IV Maintenance		Head Injuries	
ACLS Certified		Oxygen Administration		Venipuncture		Depression	
Cardioversion		ET Intubation/Extubation		Infusion Pump		Panic States	
A-Line		Monitoring of pts.Epidural Med		PCA Pump		Schizophrenia	
CVP Readings		Use of Portable Oxygen		Blood Transfusions		Manic States	
Swan Ganz		Ventilators		Hickman/Broviac Catheters		Obsessive Compulsive Disorder	
Interpretation of Hemo Dynamic Readings		Complications of PEEP		**CHEMICAL DEPENDENCY:**		**IMMEDIATE NEONATE CARE:**	
IV Push Medications		Complications of C-PAP		Inpatient		Assign APGAR Scores	
PICC Line Eclipse		Complications of IMV		Outpatient		Suction	
Cardiovascular Surgery		Weaning of Ventilator		Methadone Treatment		Prophylaxis Eyes	
Pre/Post Cardiac Cath		Drawing ABG Sample		12 Step Program		Heal Stick Capillary Sample	
Pre/Post Angioplasty		Oximetrty (0_2 Sats)		Overdose ETOH/Drugs		Connect Blood Cord Sample	
PACU		**PATIENT CARE:**		Detoxification		Newborn Assessment	
Fem-pop Bypass		GYN Surgery		Manager W/D From ETOH/Drugs		Well Baby Nursery	
Cardiac Tamponade		TURP		Seizure Precautions		NICU II or III (Circle)	
Carodiac Endarectomy		Nephrectomy		DTs		Neonatal Resuscitation	
Pre/Post Cardiothoracic Surgery		Renal Transplant		**ASSESSMENT OF**:		Teach Breast Feeding	
Heart Transplant		Acute Renal Failure		Caesarean Incision		**PATIENT CARE:**	
CHF Patient Care		**GASTOINTESTINAL:**		Lochia/Fundus (Circle)		Total Knee Replacement	
GASTROINTESTINAL:		NG Tube Placement		Bladder Distension		Total Hip Replacement	
Colostomy Care		Salem Pump/Gastric Lavage		Episiotomy		Arthroscopy/Arthrotomy	
Dehiscance		Tube Feeding		Bonding		Laminectomy	
Assist Endoscopy/ Colonscopy		Gastrostomy/ Jejunostomy Tube					

Please note any additional skills

A division of US Hospital Personnel, Inc.

24-Hour National Nursing Staff

_____ Hospital _____ Long Term Care

WORK EXPERIENCE (Skills Inventory)

Employee Name: _____ Date: _____ / _____ / _____

NURSING	FROM (MO / YR)	TO (MO / YR)		FROM (MO / YR)	TO (MO / YR)		FROM (MO / YR)	TO (MO / YR)
Air Flight			Intern. Nursery			Pediatrics ICU		
Ambulatory Care			Isolation			Post Partum		
Audit			IV Therapy					
Burns			Labor & Delivery			Psychiatric		
Call Center			Legal			Public Health		
Cat lab			Medical			Pulmonary ICU		
Chemotherapy			Newborn Nursery			QA/UR/Case Mgmt		
Corrections			Neurological			Reconstructive		
CCU			Neuro ICU			Recovery/PACU		
Dialysis			Nurse Education			Rehab		
Doctor's Office						Risk Management		
EENT			Nrsg. Home. Chrg.			Sports Medicine		
EKG			NICU			Surgical ICU		
Emergency Dept.			Occup./Indust.			Supervisor		
Geriatrics			Oncology			Teaching		
GI Lab			Open Heart			Team Leader		
Gynecological			OAR Circul. /Scrub			Telemetry		
Home Health			Outpatient Surg.			Transplant		
Hospice			Orthopedics			Trauma		
ICU			Pediatrics			Urology		
RESPIRATORY	FROM (MO / YR)	TO (MO / YR)		FROM (MO / YR)	TO (MO / YR)		FROM (MO / YR)	TO (MO / YR)
Treatments			Blood Banks			Cat Scan		
Pediatrics			Blood Gases			Mammography		
Trauma			Body Fluids			MRI		
ICU			Chemistry			Nuclear Med.		
NICU			Coagulation			Ultrasound OB		
Peds ICU			Cytology			Ultrasound Gen.		
Pul. Function			Hematology			X-ray Gen.		
Blood Gas			Microbiology					
Line Ins.			Phlebotomy			**Acute Care (Hosp)**		
Adult Intub.			Histology			**Private Duty**		
Infant Intub.						**Nursing Home**		
EKG								

As employees of Hospital Stafflink Network, we are
Committed to values as standards of behavior

To the best of my knowledge, I have given true and accurate information about my skills and previous experience herein the nursing skills competency inventory. I hereby authorize Hospital Stafflink Network to release this skills-competency inventory to client facilities when negotiating placement for the best match of my skills and my abilities with the client/facility needs and requirements. In no way does signing of this document promise or guarantee a permanent position or guarantee a 40-hour worksheets with Hospital Stafflink Network Falsification of any aspect of the nursing-skills competency inventory will lead to legal process and/or immediate termination of employment.

_____

Name (Printed)

_____

Signature **Date**

_____

Signature of HSN Representative **Date**

EDUCATION

A division of US Hospital Personnel, Inc.
24-Hour National Nursing Staff

Orientation
2018 Code of Conduct

NURSING, JOB DESCRIPTION and REQUIREMENTS

A. Application

(a) Initial application of employment

(b) Documentation of not less than three (3) reference checks at hire

(c) **Results of criminal background check in compliance with current State law or Hospital policy are performed at hire.** HSN shall be solely responsible for the costs of the criminal history background checks. The results of these checks may be provided to the Hospital upon request and the Hospital may require HSN to run or submit a new criminal background check at any time during the term of the agreement. If the results of the background check contains information that the Hospital considers not acceptable to give access to the Contractor's personnel to the recipients of the services of the Hospital, the Hospital may inform HSN that the individual not be permitted to render the services.

(d) EPLS, Sex Offender, SS Verification, OFAC, OIG Exclusions or documentation of results of research to verify that the individual has not been excluded or debarred from participation in government programs.

(e) W4 – Employee's Withholding Allowance Certificate

(f) I9 - Employment Eligibility Verification

(g) Documentation of attendance in service: fire safety, Annual OSHA, Bloodborne Pathogens, Employee Right to Know, Hazardous Materials, Age Specific Competency, Patient Rights, Body mechanics, Customer Relations, Pain Management and JCAHO **2015 Code of Conduct orientation.**

(h) Documentation of initial and on-going skill assessment acceptable to accrediting agencies to which Hospital subscribes

(i) Code of Conduct Orientation / Video

Section I – Mission Vision, Values & Goals Statement

Section II – Annual Safety Statement

Section III – Corporate Responsibility Program

Section IV - HIPAA

Section V – Team Building

Section VI – Patient Rights and Responsibilities

Section VII – Patient Safety

Section VIII – Abuse and Exploitation Reporting

Section IX – Medication Safety

Section X – Cultural Diversity and Sensitivity

Section XI – Impaired Physicians and Licensed Independent Practitioners (LIP)

Section XII – Body Mechanics

Section XIII – Workstation Ergonomics

Section XIV – Worker's Compensation

Section XV – Infection Control

Section XVI – Electrical Safety

Section XVII – Safe Medical Device Act

Section XVIII – Emergency Management

Section XIX – Fire Safety

Section XX – Hazardous Substances, Bio-Hazardous Materials, Medical and Pharmaceutical Waste

Section XXI – Radiation Safety

Section XXII – Portable Oxygen Safety

Section XXIII – Personal Safety/Assault Behavior

Section XXIV – Incident Reports

Section XXV – Ethical Issues

Section XXVI – Needs of Dying Patients and End of Life Care

Section XXVII – Organ and Tissue Procurement

Staff Requirements

(j) Copy of unrestricted license to practice in the State of California.

(k) Documentation of current license to practice in the State of California.

(l) Documentation of current certifications, as applicable, including, but not limited to a Medication Test acceptable to the Hospital, Advances Cardiac Life Support (ACLS), Cardio-Pulmonary Resuscitation (CPR), IV therapy, etc.

(m) Copy of Social Security Card

(n) Copy of California State Identification, Driver's License of Government issued Identification

B. Appearance

HSN requires that its employees maintain a presentable appearance at all times while on duty and shall wear clothing appropriate to their duties. Attention to good grooming and neatness is mandatory. The following dress is expected from the field staff:

- Any color nursing scrubs and any color closed toe shoe. If the Hospital requires a specific dress code (i.e. white scrubs and white shoes), then employees are expected to follow this code.
- HSN expects the dress code detailed above to be followed at all times. If the Hospital incorporates a "dress down" day. HSN employee will continue to follow standard scrub/closed toe shoe requirements. That is HSN do not honor dress-down days.

C. Health Screening

(a) Tuberculin (PPD) Screening – Questionnaire and Consent Form

(b) Results of drug testing 12 panel acceptable to Hospital, prior to placement

(c) Results of Hepatitis B antibody testing and, if not immune, proof of vaccination. If individual refuses vaccination, Contractor shall furnish documentation of refusal

(d) Evidence of tuberculosis test (including date) not more than twelve (12) months prior to placement

(e) Results of testing for measles, mumps, rubella and varicella, or documentation of having vaccination or the actual disease

(f) Health Certificates or written results of physical examination at hire

(g) Testing for Color Deficiency for quick and accurate assessment of colour vision deficiency of congenital origin.

(h) Latex Allegy Questionnaire

(i) Respiratory Protection Fit Test.

D. Annual Update

E. Exam and Orientation

Reporting for Duty

(i) Administrative

- Mission Statement
- Non-Discrimination
- Organizational Ethics / Code of Conduct
- Organizational Structure
- Staffing & Scheduling

(ii) Operational

- Smoke-Free Environment
- Drugs & Alcohol
- Worker's Compensation

(iii) Customer and External Relations

- Customer Satisfaction

(iv) Patients Rights and Information

- Patient's Bill of Rights
- Advanced Directives
- Age Specific

(v) Risk Management

- Fire Plan
- Infection Control
- Occurrence Reports
- OSHA / TB
- Age Specific
- Body Mechanics

(vi) General Policies

- Access to Personal File
- Employment Classifications
- Performance Appraisals

(vii) Recruitment and Employee Relations

- Annual Update
  - Testing on Specializations
  - Mission, Vision, Values and Goals Statement
  - Annual Safety Statement
  - Corporate Responsibility Program
  - HIPAA
  - Team Building
  - Patient Rights & Responsibilities
  - Patient Safety
  - Abuse and Exploitation Reporting
  - Medication Safety
  - Cultural Diversity and Sensitivity
  - Impaired Physicians and Licensed Independent Practitioners (LIP)
  - Body Mechanics
  - Workstation Ergonomics

- Worker's Compensation
- Infection Control
- Electrical Safety
- Safe Medical Device Act
- Emergency Management
- Fire Safety
- Hazardous Substances, Bio-Hazardous Materials, Medical and Pharmaceutical Waste
- Radiation Safety
- Portable Oxygen Safety
- Personal Safety / Assaultive Behavior
- Incident Reports
- Ethical Issues
- Needs of Dying Patients and End of Life Care
- Organ and Tissue Procurement
- National Patient Safety Goals

Orientation Program

- Overtime
- Pay Corrections / Pay Deductions / Pay Day
- On Call
- Productive Work Environment
- Security and Identification Badges
- Attendance and Punctuality
- Request for Time Off
- Holiday Compensation
- Work Breaks on Time Sheets
- Outside Employment
- Employee Behavior, Appearance and Dress

(viii) Employee Status, Leaves and Termination

- Appraisal Period
- Corrective Discipline
- Termination

(ix) Benefits

(x) Individual Hospital Orientation Packets

(xi) Job Description (see exhibits 1, 2 & 3)

(xii) Pain Management

(xiii) Patient Safety / Medication Errors

(xiv) Critical Thinking

(xv) Restraints

(xvi) Automated Medication Dispensing Systems Review (pyxis, Mckesson)

(xvii) Fit Test

G. Evaluation by Contractor of employee's work performance (see exhibit 4)

CONFIDENTIAL INFORMATION

Employees shall not reveal information of Hospital or HSN records to unauthorized persons. Employees shall not publish or broadcast material in which the Hospital, HSN or Employee is identified without first submitting such material to the appropriate Hospital officials for review and approval. The provisions shall supplement and not replace the California State Standard Terms and Conditions. Resident or Patient Information shall be Confidential Information as defined in Section of the State of California Standard Terms and Conditions. HSN and its employees, will abide with the laws and regulations concerning the confidentiality of healthcare information applicable to the Hospital, including but not limited to, the Health Insurance Portability and Accountability Act (HIPAA), Sections 262 and 264 of Public Law 104-91, 42 U.S.C. 1320d, and applicable Federal regulations, at 45 C.F.R. Parts 160, 162 and 164.

_____ _____ _____
HSN (Employee Name) Signature Date

_____
Classification

Hospital Stafflink Network

_____ _____ _____
Name and classification Signature Date

JOB DESCRIPTION

LICENSED VOCATIONAL NURSE

POSITION DESCRIPTION APPROVED BY BOARD OF DIRECTORS

REPORTS TO: Supervising Registered Nurse or Director of Professional Services.

POSITION SCOPE: To assume the responsibility for patient care in the absence of the physician within the scope of training and authority of the Registered Nurse and to provide necessary professional nursing care. To provide procedures that is essential to and helpful in the promotion, maintenance, and restoration of health and well being of patients under the direct supervision of a registered nurse. To ensure and coordinate quality and safe delivery of health care services within the scope of training of the registered professional nurses and in accordance with HSN operating policies, procedures and standards. To observe and report as necessary any significant patient symptoms of patient reactions, and to report the conditions and circumstances of patients promptly to physician in accordance with HSN operating policies and procedures. To ensure that all prescribed treatments and medications ordered by the physician are given. To provide health care in providing health care, instructions, and assistance to patients in required procedures for health care. To evaluate and monitor the patient's environment or the suitability of health care. To supervise and evaluate the health care being provided to patients on a continuing basis.

QUALIFICATIONS / CHARACTERISTICS:

- Graduate of an approved school of professional nursing.
- Valid, Current State practical nursing license.
- Minimum of (12) month's experience in an acute care hospital or long-term care setting preferred.
- Demonstrated knowledge of physical assessment duties.
- Evidence of team leader or case management skills.

RESPONSIBILITES / JOB DUTIES:

1. Performs health care services requiring substantial and specialized nursing skills.
2. Initiates appropriate preventative and rehabilitative nursing procedures fro patients.
3. Performs initial evaluation of patients, in an accurate and timely manner, insures that administrative forms are completed accurately and in a timely manner.
4. Evaluates the patient's environment for its suitability and promotion of the patient's care.
5. Initiates the plan of care and necessary revisions.
6. Prepares clinical records and progress notes in an accurate and timely manner.
7. Consults with and provides education for the patient and family regarding the disease process, self care techniques
8. Supervises and coordinates services for assigned patient's.
9. Communicates promptly and frequently with patient's physician and other supervising health care personnel Regarding the patient's condition.
10. Informs the physician and other personnel of changes in the patient's needs.
11. Participates in training programs as required by HSN management.
12. Serves on HSN committees as requested.
13. Participates is special projects and performs other duties as requested by HSN management.
14. Complies with HSN operational policies and procedures and personnel policies.

JOB CONDITIONS:

Must be able to communicate both verbally and in writing. Must be able to hear and speak in a manner understood by most people. Frequent writing and telephone communication may be required. Job may require ability to drive extensively within a specific geographical area. Hearing, eyesight and physical dexterity must be sufficient to perform and demonstrate patient care. Physical activities may include but are not limited to walking, sitting, stooping, lifting, and carrying.

EQUIPMENT OPERATION

Using standard nursing medical equipment including but not limited to blood pressure cuff, thermometer, Infection control items, penlight and one-way valve CPR mask.

COMPANY INFORMATION:

Access to all client medical records, which may be discussed with other HSN personnel in accordance with Confidentially guidelines.

Upon signing this document, I am clearly starting "I have read and fully understand my job duties and responsibilities. I have been given the opportunity to discuss or ask questions concerning my job responsibilities.

NAME_____ SIGNATURE_____LICENSE NO._____

DATE _____/_____/_____ Director of Professional Services for (HSN)_____

A division of Nurselink, Inc.
24-Hour National Nursing Staff

Employee Manual

An Equal Opportunity Employer

Name _____

Classification _____

Date _____

HOSPITAL STAFFLINK NETWORK, (The "Company") has established these General Rules of Conduct applicable to all Employees including field staff. The company from time to time concerning more specific issues and areas of operation may enact other more specific rules.

Clearly defined rules of conduct are necessary for the orderly operation of every company. Employees have a right to know what is expected of them. Each employee must familiarize himself of herself with all Company rules and regulations pertaining to their positions and duties.

HOSPITAL STAFFLINK NETWORK is considered a temporary staffing agency and under no circumstances will guarantee any assignments.

The Company requires that each employee faithfully abide these rules and regulations.

The following are rules of conduct of general application and are supplemental by local and departmental regulations that must also be observed. These rules may be modified at any time.

DRESS CODE

Employees shall maintain a presentable appearance at all times while on duty and shall wear clothing appropriate to their duties. Attention to good grooming and neatness is mandatory. The following dress is expected from the field staff:

A. Any color nursing scrubs and any color closed toe shoe. If a facility requires a specific dress code (i.e. white scrubs and white shoes), then employees are expected to follow this dress code.

B. HOSPITAL STAFFLINK NETWORK expects the dress code detailed in A. above to be followed at All times. If a facility incorporates a "dress-down" day, HOSPITAL STAFFLINK NETWORK field Staff employee will continue to follow standard scrub/ closed toe shoe requirements. That is, we Do not honor dress-down days.

C. Examples for inappropriate dress in the work place are:
Jeans, sweaters, short skirts, shirts with slogans or messages, halter tops or strapless tops, form Fitting suggestive clothing, leggings or body wear, thongs or flip-flop sandals.

CONFIDENTIALITY

Employees shall not reveal information in Company records to unauthorized persons. Employees shall not publish or Broadcast material in which the Company is identified or the Employee's connection with the Company is expressed or Implied without first submitting such material to the appropriate Company officials for review and approval.

No employee shall knowingly submit inaccurate information for, or on, any Company record or document.

ABSENCE / TARDINESS

Employees must avoid tardiness, absences, and departure from work early without permission of their HOSPITAL STAFFINK NETWORK staffing office Employees must observe time Limitations on rest and meal periods. Every employee shall notify His or her supervisor or specified contact of an anticipated absence or lateness in accordance with Company and Departmental procedures. Sleeping or loafing on the job is prohibited.

A. Absence:
Employee shall call staffing office 24-hours prior to the shift if the employee is unable to complete an assignment.
B. Employee shall call the staffing office prior to shift, if employee is going to be tardy.
C. NO CALL-NO SHOW
Employee fails to call the staffing office and is considered a "NO CALL NO SHOW". ***1st offence is grounds for termination and report to the Board of Nursing.***

HOLIDAY PAY

HOSPITAL STAFFLINK NETWORK observes the following holidays:

New Year's Day	**Thanksgiving Day**
Memorial Day	**Independence Day**
Labor Day	**Christmas Day**

A. Employees that work on the above days will be compensated at time and ½.
B. If the employee does not work on the above days, the employee will not qualify to be paid any amount.

Initial_____
Date_____

AGENCY CANCELLATION
HOSPITAL STAFFLINK NETWORK shall compensate employee for 2 hours of pay at base rate is shift is canceled by the agency upon arrival at assignment.

SHIFT COMFIRMATION
It is the employee's responsibility to confirm any assignments with the staffing office at Hospital Stafflink Network. Employee shall not call the facility under any circumstances to confirm, cancel, or solicit any shifts.

PAYDAY

WEEKLY PAY

A. Payday is every Monday between the hours of 11:00 am to 5:00 pm. Applicable time slips are due every Wednesday by 5pm. All time slips turned in after 5pm on that Wednesday will be applied to the following Monday payday scheduled. One time slip per shift is required and appropriate information/ signatures are required before a check will be issued. No overtime shall be applied for a shift worked more than 8 hours in one day. Overtime is Acknowledged when hours are in excess of a 40-hour workweek that is worked at the same facility with the approval Of that particular Director of Nurses or appropriate responsible staff.

WEEKLY PAY
Pay day is every Monday

VACATION
Paid vacation is not available.
MEDICAL BENEFITS
Not Available

RULES OF CONDUCT
Employee shall not use Company equipment, materials, or office facilities for personal purposes.

No employee shall be on or about Company property soliciting funds or services, selling tickets, distributing petitions or literature for any purposes (except as provided by law) at any time without prior consent of a supervisor.

All duties shall be preformed in a professional and workmanlike manner both with regard to the specific conducts of work assignments and as such activities affect ones relationship with others. In the latter instance, harassment for reasons related to sex, color, race, religion, national origin, age, or handicap is strictly prohibited.

Every employee will comply with safety regulations and procedures.

Every employee has a duty to protect and safeguard Company property of customers and employees, and no employee shall occupy, use or operate Company property without prior authorization.

No employee shall be in authorized possession of any property of the Company, Its customers or employees or attempt to remove such property from Company premises.

Employees shall not bring their own or any other minor children to their place of work or elsewhere on Company premises during the employees working hours when such accompaniment might interfere with the discharge of the employee's duties and responsibilities.

No employees shall be in possession of firearms (licensed or unlicensed) or other weapons while on Company premises. The rule applies to all knives unless required for the performance of job duties.

Violations of any of these regulations may result in disciplinary action ranging from warning from discharge. The measure of discipline should correspond to the gravity of the offense as weighed by its potential effect on the Company as well as the seniority and work record of employee involved, among other factors.

Employee understands by signing HSN time slips they are agreeing that the indicated hours-worked are true and correct while working for HOSPITAL STAFFLINK NETWORK. Employee understands timecard forgery will be considered fraud and embezzlement.

HOSPITAL STAFFLINK NETWORK reserves the right to make inspections of employee lockers, desks, lunch boxes, vehicles, and other items of personal property located on company premises. In those instances where there is reason to believe that they contain evidence of violations of these regulations. Any refusal to cooperate fully in such inspections or searches will be considered a serious form of insubordination.

I acknowledge that I have read, understand and agree to the foregoing General Rules of Conduct and a copy of the rules has been provided for me.

_____	_____	_____	_____
Name	**Signature**	**License number**	**Date**

BACKGROUND INVESTIGATIONS

Hospital Stafflink Network

A division of us Hospital Personnel, Inc.
24-Hour National Nursing Staff

5000 W. Sunset Blvd, suite 630
Hollywood, CA 90027
323/462-7000
323/913-3300 fax

Date: _____/_____/_____

Complete this section when using form as a mailer

Attention: _____ Previous Employer: _____
Phone: _____ Fax: _____

The individual named below is applying for a position as **License Vocational Nurse** and has given you as a reference. As we place a great importance on the through screening of all our applicants, we would appreciate a prompt and Thoughtful response.

Thank you in advance. _____
(Name of HSN Representative)

Always Complete this section

Applicant Release

Applicant: _____
Last First MI Maiden

Position Held: _____

I hear by release from all liability the above referenced organization and authorize release of all information requested regarding my employment. I understand that this information may be released to clients of Hospital Stafflink Network and other requesting third parties on a need to know basis. I also release Hospital Stafflink network from all liability from disclosure of this information.

Applicant Signature: _____ Date: _____/_____/_____

APPLICANTS STOP HERE!

For Previous Employer

1. Please confirm the applicants employment: From: _____/_____ To_____/_____
9. Please confirm applicant's job title: _____
10. Please confirm applicant's pay rate: _____
11. Please comment on the applicant's attributes using the following scale:
    4 = Excellent 3 = Good 2 = Fair 1 = Poor N/A = Not Applicable
    Quality of work: _____ Knowledge and skills: _____
    Reliability and attendance: _____ Cooperation: _____
12. Please indicate specialty areas in which the applicant has had experience: _____
    _____
13. Please describe the major job responsibilities in the position:_____
    _____
14. Is applicant eligible for rehire? _____
    _____
15. Would applicant be a good match for this position_____
    _____

_____ _____ _____/_____/_____
Person filing out Form (Signature) Position/Title Date

(If mailed signature of person giving reference: If verbal, signature of HSN representative)

Hospital Stafflink Network

A division of us Hospital Personnel, Inc.
24-Hour National Nursing Staff

5000 W. Sunset Blvd, suite 630
Hollywood, CA 90027
323/462-7000
323/913-3300ax

Date: _____/_____/_____

Complete this section when using form as a mailer

Attention: _____ Previous Employer: _____
Phone: _____ Fax: _____

The individual named below is applying for a position as **Registered Nurse** and has given you as a reference.
As we place a great importance on the through screening of all our applicants, we would appreciate a prompt and Thoughtful response.

Thank you in advance. _____
(Name of HSN Representative)

Always Complete this section

Applicant Release

Applicant: _____
Last First MI Maiden

Position Held: _____
I hear by release from all liability the above referenced organization and authorize release of all information requested regarding my employment. I understand that this information may be released to clients of Hospital Stafflink Network and other requesting third parties on a need to know basis. I also release Hospital Stafflink network from all liability from disclosure of this information.
Applicant Signature: _____ Date: _____/_____/_____

APPLICANTS STOP HERE!

For Previous Employer
1. Please confirm the applicants employment: From: _____/_____ To_____/_____
2. Please confirm applicant's job title: _____
3. Please confirm applicant's pay rate: _____
4. Please comment on the applicant's attributes using the following scale:
   4 = Excellent 3 = Good 2 = Fair 1 = Poor N/A = Not Applicable
   Quality of work: _____ Knowledge and skills: _____
   Reliability and attendance: _____ Cooperation: _____
5. Please indicate specialty areas in which the applicant has had experience: _____
   _____
6. Please describe the major job responsibilities in the position:_____
   _____
7. Is applicant eligible for rehire? _____
   _____
8. Would applicant be a good match for this position_____
   _____

_____ _____ _____/_____/_____
Person filing out Form (Signature) Position/Title Date

(If mailed signature of person giving reference: If verbal, signature of HSN representative)

Hospital Stafflink Network

A division of US Hospital Personnel, Inc.
24-Hour National Nursing Staff

Confidential

Education Verification

Employee Name _____ **Social Security** _____

Dates attended from _____ **to** _____

Graduated YES NO (please circle one)
Nursing YES NO
OTHER _____

Verified By _____
Name of School _____

Comments:

_____

_____

Applicant _____
Last First MI Maiden

I hear by release from all liability the above referenced organization and authorize release of all information requested regarding my education. I understand that this information may be released to clients of Hospital Stafflink Network and other requesting third parties on a need to know basis. I also release Hospital Stafflink network from all liability from disclosure of this information.

Applicant Signature: _____ **Date:** _____/_____/_____

A division of US Hospital Personnel, Inc.
24-Hour National Nursing Staff

BACKGROUND INVESTIGATION

At Hospital Stafflink Network, it is company policy to perform a routine Criminal Background Check, Not limited to; **OIG** Exclusions or documentation of results of research to verify that the individual has not been excluded or debarred from participation in government programs in addition, we do the following backgrounds; **EPLS, EDL, National sex offender, Social Security verification and E-verification.**

By signing this form. I authorize a National Criminal Background Check.

Signature:_____ Print Name: _____

Date: _____ / _____ / _____

BACKGROUND CHECK

In accordance with the Fair Credit Reporting Act 15 U.S.C. 1618 ET seq. We reserve the right to perform pre-employment searches on all applicants being considered for any position at Hospital Stafflink Network. All records stay within the Fair Credit Reporting Act guidelines and are kept strictly confidential, as specified in Section 613 Subsection 2 and Section 620 of the F.C.R.A. Searches may consist of, but not limited to, credit histories and any public record, state/or nationwide.

Complete the following information (please print):
Full Name: _____ (Maiden Name): _____
Current Address:_____ Date of Birth: _____ / _____ / _____
_____ Social Security #: _____-_____-_____
Driver's License #: _____ State: _____
Last Employer:_____ Address: _____
Phone: (_____) _____ - _____ _____
Personal References: 1) _____ Phone(_____) _____ - _____
2) _____ Phone(_____) _____ - _____
3) _____ Phone(_____) _____ - _____

I have read and understand the above paragraph and do hereby give my consent that the above information, provided by me, may be used to obtain a credit report or any public record deemed necessary.

Print Name: _____
Signature:_____ Date: _____ / _____ / _____
Verified by: _____ Date: _____ / _____ / _____
HSN Representative

Status: _____ Approved by: _____

An Equal Opportunity Employer

HEALTH INFORMATION

HOSPITAL STAFFLINK NETWORK
HEALTH CERTIFICATE

In order to protect the health and welfare of our employees and those with whom they have contact at work, HSN reserves the right to condition employment upon receipt of a satisfactory statement of a licensed physician. This statement must be on file within fourteen (14) days following the employment offer.

Whenever an employee suffers an illness, injury or disability, the employee may be asked to provide a physician's statement that verifies the nature of an illness, injury or disability, beginning and ending dates, the employees ability to work, and any associated health risk to the employee, co-workers or others. All medical data provided including this physician's verification is confidential and shall be accessed only when necessary to determine matters relevant to the placement and/or continued employment of the employee.

NAME_____ CLASSIFICATION_____

DATE OF EMPLOYMENT_____ OFFICE_____

A health certificate must be on file within fourteen (14)days following your date of hire, and at least every two (2) years thereafter, if required by state or federal regulation (unless local community standards dictate annual health examinations). Please facilitate the prompt return of this certificate.

CBC_____

PPD SKIN TEST: POSITIVE _____NEGATIVE_____

IF INDICATED CHEST X-RAY:_____

PHYSICAL EXAM:_____

VERIFICATION OF TITRE TEST PROVIDING IMMUNITY OR PROOF OF IMMUNIZATION

- Rubella Titer_____
- Rubeola Titer_____
- Mumps Titer_____
- Varicella Titer_____

OTHER LAB:_____

DESCRIBE ANY LIMITATIONS OR RESTRICTIONS:_____

THE PERSON LISTED ABOVE IS PHYSICALLY AND MEDICALLY QUALIFIED TO PERFORM THE DUTIES TO BE ASSIGNED AND HAS NO HEALTH CONDITION THAT WOULD CREATE A HAZARD TO PATIENTS.

_____ _____

MEDICAL DOCTOR
Print name and Signature

DATE OF EXAMINATION

_____ _____

ADDRESS

TELEPHONE NUMBER

PHYSICIAN STATEMENTS

PHYSICAL CLEARENCE

_____

Employee Name

Is able to work without restrictions and is free of communicable disease

_____

Physician signature

_____

Address

_____

Phone number

_____

Date

An Equal Opportunity Employer

HEALTH SCREEN / QUESTIONER

Employee Name: _____
Age:_____ Gender: M_____ F_____ Social Security #:_____-_____-_____
Primary Physician's Name: _____ Date of Last Visit: _____ / _____ / _____
Date of Last Physical Exam: _____ / _____ / _____ Do you smoke? Yes_____ No_____
Failure to be truthful, omission of information or failure to return this form may result in employee suspension and/or termination.

IF (*YES)* PLEASE COMMENT

	Yes	*No*	*Comments*
Have you ever been in a hospital, institution or clinic during the past year for an operation, treatment , observation or diagnosis ?	___	___	_____
Have you lost more than two (2) weeks of work due to illness or injury in the last year?	___	___	_____
Have you filed a compensation claim or received benefits as a result of an injury on the job in the past year?	___	___	_____
Have you experienced any wait loss or gain of more than 10 pounds during the last year?	___	___	_____
Have you had any shots, X-rays, blood tests, EKG, etc. during the last year?	___	___	_____
Do you have any health problems or limitations that may be risk to yourself?	___	___	_____
Do you have a habituation or addiction to antidepressants, stimulants, narcotics, alcohol, or any other substance that may alter your behavior; job performance, or the safety of yourself, clients, and/or co-workers ?	___	___	_____
Are you required to, or do you take medication on a daily basis? Please specify medical reason and list meds.	___	___	_____
Do you consume alcoholic beverages on a daily basis?	___	___	_____

Have you been told that you have, or have you been treated for any of the following conditions?

	Yes	*No*		*Yes*	*No*		*Yes*	*No*		*Yes*	*No*
Hepatitis	___	___	Frequent/Painful Urination	___	___	Change in Vision/Hearing	___	___	Unsteady Gait/Tremors	___	___
Staphylococcal Infection	___	___	Persistent Sores / Lumps	___	___	Frequent Cough	___	___	High Blood Pressure	___	___
Tuberculosis	___	___	Fainting/Severe Dizziness	___	___	Substance Abuse	___	___	Any contagious disease	___	___
Excessive Diarrhea	___	___	Fever Blisters/Cold Sores	___	___	Shortness of Breath	___	___	(Please specify)	_____	
Back Pain	___	___	Headache	___	___	Pain in Chest	___	___	_____		

Name of Emergency Contact: _____ Phone: (_____)_____ - _____

I verify that the information in this annual employee health reassessment is true and complete.

Employee Signature: _____ Date: _____ / _____ / _____

DATE_____/_____/_____

Release of liability:

STATEMENT OF PHYSICAL AND MENTAL CONDITION

Upon signing this document I _____
Employee

Confirm I am physical and medically qualified to perform all duties to be assigned to me, and have no heath condition that would adversely affect self or ability to carry out all clinical duties required.

I agree to adhere to policy and procedures of Hospital Stafflink Network regarding the safety and protection of my physical health, including but not limited to wearing back support while on the job when transferring, lifting, moving, turning or pushing any weight (lbs.) greater than what my physical condition allows me, without causing strain or trauma.

_____ _____
Employee Signature Required Date

_____ _____
Hospital Stafflink Representative Date

To Nursing Employees:
You are required to wear your gait belt while on the job, and that it is also a part of your nursing uniform. Our facilities have expressed that not everyone has met these requirements. To enforce this policy, we will be giving warnings for the first offense, a written warning for the second offense, and a suspension for 30 days for the third offense. Most facilities Will HSN you for not utilizing a gait belt. So, please remember to wear your gait belt and use it during all transfers.

Employee Name: _____ Date: _____ / _____ / _____

H.R. Recruiter: _____ Date: _____ / _____ / _____

A division of Nurselink, Inc.
24-Hour National Nursing Staff

Hepatitis **B V**accination **A**cknowledgement/**D**eclination

Name: _____ Classification:_____ Date:_____

Please carefully review your options below and select your preferred option.

- No- I have not received the Hepatitis Vaccine and continue to hold such status to date. I understand that by declining receipt of this vaccination. I continue to be at risk of contracting this disease. If in the future I continue to have occupational exposure to blood or any other potentially infectious materials and want to be vaccinated with the Hepatitis B Vaccine, I will consult with my Physician and obtain written approval before receiving the Hepatitis B Vaccine.

- Decline- I am currently receiving the Hepatitis B series elsewhere and will forward proof of administration upon completion thereof. Or I will provide written proof of (contraindications include: Pregnancy, active infection such as a cold or bronchitis, lactation, allergy to yeast or yeast products).

- Yes- I have received the Hepatitis B Vaccine and will be releasing liability from HSN.

I take full responsibly for myself if I co9ntract Hepatitis B while employed with HOSPITAL STAFFLINK NETWORK.

_____ _____/_____/_____
Signature: Date:

Drug Free Work Place

CONSENT FOR DRUG / ALCOHOL SCREEN TESTING

I _____, have been fully informed by my potential employer (HSN) of the reason for this Drug and alcohol test. I understand and agree of what I am being tested and the procedure involved. I hereby freely give my consent.

In addition, I understand that the results of this test will be part of my record with Hospital Stafflink Network. I authorize Hospital Stafflink Network to release any information to any associated clients of Hospital Stafflink Network.

If this test result is positive, and for this reason I am not hired, I understand that I will be given the opportunity to explain the results of this test.

I hereby authorize these tests to be released to: Hospital Stafflink Network and Clients of Hospital Stafflink Network not limited to any other Hospital Stafflink Network locations.

Signature: _____ Date: _____ / _____ / _____

Witness: _____ Date: _____ / _____ / _____

Initial Drug Screen Result Form

Collection Test Date: Collector: Lot:

Donor's Name _____

ID# or SSN _____

I hereby certify that the specimen provided is my own and has not been substituted or adulterated. I further agree and grant permission for the testing of my specimen for drug metabolites and/or alcohol.

***Donor's Signature*_____ *Date*_____**

I hereby certify that I collected the specimen provided by the aforementioned Donor and that it was not substituted or adulterated to the best of my knowledge. The specimen temperature and color were acceptable.

***Collector's Signature*_____ *Date*_____**

Drug Name	Device Code	Negative	Confirm	Not Tested
Cocaine	COC			
Marijuana	THC			
Opiates/Morphine	OPI/MOR			
Amphetamines	AMP			
Methamphetamine	mAMP			
Phencyclidine	PCP			
Benzodiazepine	BZO			
Barbiturates	BAR			
Methadone	MTD			
Tricyclic	TCA			
Oxycodone	OXY			
Propoxphene	PPX			
Methylenedioxymethamphetamine	MDMA			

ALCOHOL SCREEN ALC _____ Level _____

A division of Nurselink, Inc.
24-Hour National Nursing Staff

Respiratory **P**rotection **A**cknowledgement/**D**eclination

Name: _____ Classification:_____ Date:_____

Please carefully review your options below and select your preferred option.

I understand that due to my occupational exposure. I may be at risk of acquiring Mycobacterium Tuberculosis (TB). For this reason I have selected the following responses to acknowledgement of this particular exposure.

- No- I have not been tested for (TB) and continue to hold such status to date. I understand that by declining receipt of this vaccination I continue to be at risk of contracting this disease. If in the future I continue to have occupational exposure to blood or any other potentially infectious materials and want to be tested for (TB), I will consult with my physician and obtain written approval before receiving the test. I also understand that workers compensation will be limited or denied if I become infected with (TB).

- CONTRAINDICATION- I have a medical conditional where (TB) testing and use of a respirator mask is contraindicated. (Contraindications include: Pregnancy, active infections such as a cold or bronchitis, lactation, allergy to yeast or yeast products.) And continuously test positive for (TB) thus needing an annual chest x-ray for proof of results.

- COMPLETED- I am aware of the mandatory usage of a respirator mask when it is necessary and will follow medical procedures for protecting myself, available for my use when working with Hospital Stafflink Network.

_____ _____/_____/_____
Signature: Date:

A division of US Hospital Personnel, Inc.
24-Hour National Nursing Staff

Color Deficit

Date: _____

Name: _____ Classification: _____

Testing Results: (Check appropriate line)

_____ Sufficient

_____ Deficit

_____ _____
HSN Representative Conducting test Date

A division of US Hospital Personnel ,Inc.
24-Hour National Nursing Staff

Latex **A**llergy **Q**uestionnaire

Name: _____ Classification:_____ Date:_____

Please carefully review your options below and select your preferred option.

- I do have a latex allergy
- I do not have a latex allergy
- I have sensitivity to powder and require powder free gloves

My signature below indicates that the above information is correct and I give permission for this information to be shared with Hospital Stafflink Network and facilities for the purpose of staffing placement at the facility.

_____ _____/_____/_____
Signature: Date:

Chicken pox (VARICELLA) WAIVER

I agree to waive any liability to Hospital Stafflink Network or any of it's affiliate Hospitals of contracting chicken pox (VARICELLA)

_____
Employee Signature

_____
Date

COMPETENCY TEST SCORES

Licensed Vocational Nurses Test

Name _____

Date _____

Score _____

Remidiated

YES OR NO

Remidiated to _____

HSN representative

_____

_____
Date

HOSPITAL STAFFLINK NETWORK

A division of Nurselink, Inc

24 Hour National Nursing Staff

Licensed Vocational Nurse Test

Name:_____ Date:_____

MATCH WITH THE CORRECT DEFINITIONS

1.	Neupogen	_____	A.	Oral Antidiabetic/Hypoglycemic
2.	Compazine	_____	B.	Decreases Stomach Acid
3.	Demerol	_____	C.	Bedtime
4.	Prednisone	_____	D.	Narcotic Analgesic
5.	qod	_____	E.	Bronchodilator
6.	Lanoxin	_____	F.	Diuretic
7.	Vancomycin	_____	G.	Antibiotic
8.	Benadryl	_____	H.	Antiemetic
9.	Stat	_____	I.	Antihistamine
10.	Heparin	_____	J.	Steroid
11.	Theo-dur	_____	K.	Strengthens Heartbeat
12.	Lasix	_____	L.	Calcium Channel Blocker
13.	Tagamet	_____	M.	Anti-Coagulant
14.	Verapamil	_____	N.	Immediately
15.	Micronase	_____	O.	Twice a Day
16.	ac	_____	P.	Everyday
17.	hs	_____	Q.	Before meals
18.	mcg	_____	R.	Stimulate white blood cell production
19.	gtt	_____	S.	Without
20.	tid	_____	T.	Microgram
21.	qd	_____	U.	Drop
22.	q8h	_____	V.	Every 8 hours
23.	b.i.d.	_____	W.	Three times a day
24.	p.c.	_____	X.	After Meals
25.	s.	_____	Y.	Every other day

MULTIPLE CHOICE

Mr. Smith is 71 years old has a history of two heart attacks over the past twelve years. He also has hypertension and was recently diagnosed as having congestive heart failure. His medications include aldomet 250 mg q.i.d., Lasix 20 mg daily in a.m., and Digoxin 0.25 mg daily in a.m.

26. The nurse is to administer Digoxin to Mr. Smith. What actions should be taken prior to administering Digoxin?

A. Assess his blood pressure and withhold the medication if the systolic is below 100.
B. Assess his radial pulse and withhold the medication if the pulse rate is below 60.
C. Assess his weight and withhold the medication if his weight loss is greater than 3 pounds.
D. Assess his apical pulse and withhold his medication if the pulse rate is below 60.

27. When observing Mr. Smith for digitalis toxicity, the nurse should be alert for which of the following symptoms?
A. Nausea, vomiting, and irregular heartbeat
B. Flushed face, puritus, and hives
C. Dry skin, excessive thirst, and elevated temperature
D. Twitching, muscle tremor, and seizure activity

28. Mr. Smith asks the nurse to sign as a witness to a change he wishes to make in his will. Which of the following actions would be appropriate for the nurse to take?
A. Sign the will but maintain Mr. Smith's privacy by not reading the document
B. Sign the will only after reading the document
C. Refuse to sign the will, and offer to call close friends to serve as a witness
D. Refuse to sign the will, stating that it is illegal to do so

29. As the nurse arrives for duty, Mr. Smith says that he took one of three pills that morning but, since he spilled one of the containers he is not sure which ones he took. His pulse rate is 48 and his blood pressure is 180/100 mmHg. He has voided but does not recall it being an abnormally large or small amount. Which of the following actions should the nurse take?

A. Continue to monitor Mr. Smith's blood pressure and pulse and notify the nursing supervisor if further changes occur.
B. Notify the nursing supervisor immediately and continue to monitor Mr. Smith's blood pressure and pulse rate.
C. Administer the Aldomet on schedule and withold the Lasix and Digoxin.
D. Take Mr. Smith to the emergency room.

Mr. Jones, a 45 year-old was hospitalized for six weeks during which time he underwent multiple surgeries and therapies for terminal cancer. At his family's request, he was discharged "to live his final days in peace at home". Mr. Jones receives tube feedings via a nasogastric tube. The home health care nurse was called after Mr. Jones pulled the nasogastric tube out during a period of restlessness.

30. When the nasogastric tube has been inserted which of the following methods should the nurse employ to check its position?

A. Instill 5cc of tube feeding formula and observe for any backflow
B. Instill 10cc of water and observe for bubbling in the tube
C. Instill 5 to 10cc of air while auscultating Mr. Jones' stomach
D. Instill 5 to 10cc of water while auscultating Mr. Jones stomach

31. One morning Mr. Jones complains of abdominal fullness. The nurse should use which of these methods to assess his condition?

A. Irrigating the nasogastric tube with tap water
B. Instilling 10cc of air into the nasogastric tube
C. Aspirating the nasogastric tube and measuring the amount aspirated
D. Allowing the nasogastric tube to drain the emesis basin

32. When administering Mr. Jone's tube feeding which of the following actions should the nurse take?

A. Make certain the temperature of the formula is similar to warm soup.
B. Check for retention of the previous feeding by aspirating the stomach contents
C. Administer the tube feeding over a 30 minute period to prevent bacterial growth in the formula.
D. Flush the tubing after the feeding with saline solution that is 95-100 degrees F.

Mrs. Jamison is 55 years-old and has multiple sclerosis. She has little movement in her legs and has progressively lost control of her bladder. Her skin is beginning to break down, and she is to have an indwelling catheter inserted to allow healing of the skin.

33. The nurse inserts the catheter into Mrs. Jamison's bladder. The urine flowing from the catheter is odorous and cloudy in appearance. Which of the actions would be most important?

A. Measure the amount of urine output
B. Tell Mrs. Jamison that she must increase her fluid intake
C. Report the character of the urine to the nursing supervisor
D. Suggest that Mrs. Jamison drink 6-ounces of cranberry juice

34. The nurse returns the next day and finds that Mrs. Jamison is complaining of pain in her lower abdomen. Which of the following actions would be most important?

A. Check to see if urine is draining from the catheter
B. Listen for bowel sounds
C. Palpate the bladder for fullness
D. Check for temperature elevation

Mr. Jennings, a 55 year-old, has a history of tuberculosis and repeated pneumothorax. He was recently hospitalized for a thoractomy. His discharge instructions included low-flow oxygen, terbutaline sulfate for 30 minutes b.i.d., and terbutaline sulfate (Brethine)2.5 mg t.i.d.

35. Which of the following would be best for the nurse to administer Mr. Jennings postural drainage treatment?
    A. Early morning
    B. After breakfast
    C. After bathing
    D. Before medication administration

36. One morning, the nurse finds Mr. Jennings sleepy and lethargic. His face is flushed, his oxygen flow rate is 5 liters per minute, and his respiratory rate is 10. The first nursing action should be?
    A. Turn the oxygen to 8 liters per minute and call the nursing supervisor
    B. Take his blood pressure
    C. Turn the oxygen to 2 liters per minute and call the nursing supervisor
    D. Perform postural drainage

Mrs. Schwartz, a 77 year-old, has had chronic lymphocytic leukemia for six years. She is presently in remission. She has a keep open IV to facilitate steroid and antibiotic therapy. Because of bone pain and problems with mobility, and indwelling urethral catheter is in place. The nurse responsibilities include changing the IV solution, giving catheter care per schedule, and preparing meals.

37. The nurse could best assess the severity of circulatory fluid overload by?
    A. Auscultation of the lungs
    B. Auscultation of the heart
    C. Palpation of pedal pulses
    D. Palpation of the abdomen

38. Which of the following nurses actions would help decrease the incidence of urinary tract infection due to Mrs. Schwartz's indwelling urethral catheter?
    A. Changing the catheter every two weeks
    B. Manually irrigating the bladder with antiseptic solution b.i.d.
    C. Cleaning the perineum with soap and water b.i.d.
    D. Changing the sterile collection system unit daily

39. The chief complaint that may develop as a result of heparin sodium overdose is?
    A. Increased blood pressure
    B. Hemorrhage
    C. Headache
    D. Respiratory distress

40. Mrs. Wong, age 67, has right hemiplegia of sudden onset. A CAT scan shows a thrombus causing an infarction in the left cerebral hemisphere. She is left-handed. Diagnosis CVA. What can a nurse expect to find upon observation of Mrs. Wong?
    A. Right hemi-paresis, aphasia, loss of sensation on the right side.
    B. Left hemi-paresis, loss of sensation on the left side.
    C. Exaggerated reflexes, one side
    D. Absence of reflexes, right side

41. The negligent conduct of professional persons is known as:
    A. Felony
    B. A misdemeanor
    C. Malpractice
    D. A tort

42. Which of the following legal offenses would have been committed if a nurse performed a venupuncture against the wishes of a competent patient?
    A. Assault and Battery
    B. False imprisonment
    C. Negligence
    D. Slander and libel

Licensed Vocational Nurse

HIPPA/OSHA
INITIAL COMPETENCY

Name _____

Date _____

Score _____

Section 1: HIPPA

Section 2: OSHA / Infection Control/Back Safety/General Safety/Patient Safety/Personal Safety/Assaultive Behavior/radiation Safety/Medication Safety/Medication Safety/Emergency Preparedness

Section 3: Age Specific/Assault/Abuse Reporting/Glucose Monitoring/Organization Effectiveness/Impaired Physician & LIPs/Patient Rights/Restraints/Customer Relations/Pain Management/Cultural Diversity/Pt Fall Prevention/Safe Medical Device Act/Teamwork/End of Life.

Remidiated

YES OR NO

Remidiated to _____

HSN representative

_____

_____
Date

HIPPA/OSHA
INITIAL COMPETENCY TEST

Section 1: HIPPA

1. **Criminal and Civil are the two kinds of sanctions under HIPPA.**
   a. **True**
   b. **False**

2. **Authorization is required to release psychotherapy notes for any reason including treatment.**
   a. **True**
   b. **False**

3. **Confidentiality protections cover not just a patient's health-related information, such as his or her diagnosis, but also other identifying information such as Social Security number and telephone number.**
   a. **True**
   b. **False**

4. **Computer equipment that has been used to store patient health information must undergo special processing to removal all traces of information before it can be disposed of.**
   a. **True**
   b. **False**

5. **The minimum necessary rule applies to all uses and discloser including those for treatment.**
   a. **True**
   b. **False**

Section 2: OSHA / Infection Control/Back Safety/General Safety/Patient Safety/Personal Safety/Assaultive Behavior/radiation Safety/Medication Safety/Medication Safety/Emergency Preparedness

6. **The MSDS gives detailed information about a material's hazards and how to control them.**
   a. **True**
   b. **False**

7. **All MSDS forms contain the same information in the same order.**
   a. **True**
   b. **False**

8. **You can assume the contents of an unlabeled container are harmless if there is no chemical odor.**
   a. **True**
   b. **False**

9. **The Hazard Communication Standard gives you a right to know about hazardous chemicals in your workplace.**
   a. **True**
   b. **False**

12. You cannot continue to work if you have a TB infection.

a. True
b. False

10. **Patients suspected of having active TB should be isolated quickly.**

a. True
b. False

11. **Patients suspected of having active TB should be isolated quickly.**

a. True
b. False

12. **Hand washing is not required after gloves or personal protective equipment is removed.**

a. True
b. False

13. **Airborne Isolation Precautions must be initiated when a patient is diagnosed with or suspected of an airborne communicable disease.**

a. True
b. False

14. **You can prevent injury to your back by using good body mechanics.**

a. True
b. False

15. **Working too high of a surface adds to the demands on the arms and shoulders.**

a. True
b. False

16. **The most commonly identified areas of healthcare violence are in pediatric units.**

a. True
b. False

17. **To help prevent a violent outburst from a patient, you should be friendly and listen intently.**

a. True
b. False

18. A trigger event usually happens after an attack occurs.

a. True
b. False

19. Threats of violence from co-workers are an obvious clue that violence may occur.

a. **True**
b. **False**

20. If you receive an electrical shock your muscles may automatically contract and it may be difficult and dangerous for someone to pull you free unless that person is insulated from the electrical hazard. The electrical hazard is the source of the shock. Insulated means that the person rescuing the victim is not grounded, and therefore, safe from being shocked.

a. True
b. False

Licensed Vocational Nurse

Restraints Competency
Orientation

Name _____

Date _____

Score _____

Remidiated

YES OR NO

Remidiated to _____

HSN representative

_____

_____
Date

Name_____ Date _____

RESTRAINT POLICY/PROCEDURE QUIZ

1. **Restraints must be clinically justified and used as a last resort when all other less restrictive measures have been exhausted.** **T or F**

2. **Assessment and evaluation of patients in behavioral restraints is every 15 minutes and every 2 hours if a patient is in Medical / Surgical restraints.** **T or F**

3. **Assuring the patient is appropriately covered, and calling patient by his/her name are examples of maintaining the patient's dignity.** **T or F**

4. **A physician must see the patient within _____ hour of behavioral restraint application to complete a face to face assessment and to evaluate the need for restraint if applied in an emergent dangerous situation.**

5. **A member of nursing administration/management must review the need for restraints with the RN who has determined that the least restrictive measures were ineffective and the patient requires restraints.** **T or F**

6. **The physician will be notified immediately but no more than _____ minutes of initiation, if a restraint has been applied in an emergent dangerous situation.**

7. **If a restraint is discontinued prior to the expiration of original order and re-initiation of restraint is indicated, a new order must be obtained and a face to face assessment completed by the ordering physician.** **T or F**

8. **The RN must notify the family when behavioral restraints are initiated.** **T or F**

9. **Position change, respiratory check, food/fluid offered, toileting provided, ADL provided and dignity maintained are included on the every 15 minute monitor tool.** **T or F**

10. **Complications of restraints include: poor circulation, pressure sores, increased agitation, inability to sleep.** **T or F**

RESTRAINT CHECKLIST

1. _____ Describe alternative interventions. Psychosocial, Environmental and Physiological and Sitters.

2. _____ Describe signs of physical distress in patients who are restrained or secluded.

3. _____ Describe documentation practices as recommended for the medical record.

4. _____ When is a 2nd tier / management review required for restraint application?

5. _____ Describe the RN's role in patient/family education.

6. _____ Demonstrate the initiation, safe application and removal of restraints to include monitoring and reassessment.

7. _____ Demonstrate quick release tie.

HSN Representative:_____

Date: _____

Behavior Assessment Tool		
Patient Safety	**Expectations**	**Variations**
1. CMS (Circulation, Movement & Sensation	Fingers should be pink, warm, and non-swollen. Pt. should be able to move fingers freely and feel touch to hand. Skin under restraint is free from pressure areas.	If any variation, remove restraint and reapply and notify charge nurse. A space of two fingers between restraint and skin.
2. Security	Check restraint from limb to knot for security. Assure quick release knot. Assure bed rails are up if necessary. Assure bed is in low position. If bed alarms are in place ensure they are on and audible.	Retie knot or re-secure restraint device.
Patient Dignity		
1. Privacy	Assure patient is appropriately clothed/covered at all times. If a sitter is present, the curtains should be pulled around patient to provide privacy from hallways and view of other patients.	No variance
2. Always refer to patient by name	A form of identification, recognition and respect, i.e, Mr. or Mrs., or "Betty" instead of Elizabeth.	No variance
3. Maintenance of a quiet environment	Reduce stimuli, ie: noise reduction, bright lights, thereby reducing agitation and confusion to patient.	May need to move patient to quieter room.
Patient Rights		
1. Reminding patient of behaviors exhibited for restraint use and behaviors expected for release of restraints.	Patient must meet expectations for release as ordered by physician on restraint orders.	R. N. to reassess every 2 hours
2. Does patient have any nutritional, positional, elimination, warmth or cold needs.	All physical needs must be met to assure reduction in agitation, ability to sleep and increased comfort.	No Variance
3. Notify family of restraint need	Families must be notified of behavioral restraints being required for the patient's /others safety	No variance.

Alternative Interventions

To be Attempted Prior to Restraint Utilization

- **Psychosocial Alternatives**

Diversion	Family interaction	Orientation
Pastoral visit	Reassurance	Reading
Relaxation techniques	Interpreter services	Setting Limits
Quiet area	One-on-one discussion	Decreased stimulation
Change in environment	Re-establishing communication	Personal Possessions available

- **Environmental Alternatives**

Commode at bedside	Decreased noise	Music/TV
Night light	Room close to nursing station	Call light within reach
Bed alarm in use	Specialty low bed	Decreased stimulation
Providing a quiet area	Physical activity	Orientation
Sensory aides available	(glasses, hearing aide)	

- **Physiological Alternatives**

Toileting	Fluids/nutrition/snack	Positional devices
Pain intervention	Assisted ambulation	Re-positioning
Rest/sleep	Providing assistance	Additional warmth
Decreased temperature	Check lab values	Pharmacy consult

- **Sitters**

Sitters may be used for those patients whose behavior is out of control (i.e., increased motor activity, impulsive with lack of judgment, inability to tolerate environmental stimuli, faulty sense of reality, all other alternatives have proven ineffective and the next step would be to restrain the patient).

PAYROLL

WELCOME TO Hospital Stafflink Network!

How did you hear about us? _____

Have you ever worked through an agency? Yes _____ No _____

What days of the week are you available? M T W TH F S S

Day _____ Evening _____ Night _____ Any _____

Note facilities you have worked through Agency: _____

_____

_____

_____

PAY RATE AGREEMENT (For Office Use Only)

Last Name: _____ First Name: _____

Rate of Pay: _____ Effective Date: _____

Increase
Rate of Pay: _____ Effective Date: _____

I understand my rate of pay can fluctuate depending on assignment. I also understand Hospital Stafflink Network is a Temporary Staffing Agency and under no circumstances will guarantee any Hours.

If I do not show up to a committed assignment, any unpaid hours I am owed will be paid by Hospital Stafflink Network at minimum wage.

Employee Signature: _____Date: _____ / _____ / _____

HSN Representative: _____ Date: _____ / _____ / _____

ARBITRATION AGREEMENT

In the event of any dispute between Hospital Stafflink Network (the "Company") and Employee that involves wages or an alleged violation of any of those categories identified in the Company's employment manual under "Standards of Conduct Harassment" that can not be informally resolved through the Company's internal complaint procedures, Employee agrees that, in lieu of filing a complaint in any state or federal court, Employee shall be required to arbitrate the claim.

Employee agrees that the arbitration decision shall be final and binding, and that the claims and decision re-addressed in any court of law. Arbitration will be conducted and arbitrators selected in the accordance with the rule rules of the American Arbitration Association. The Company and Employee shall evenly divide the costs of arbitration, except that the Company and Employee shall be responsible for their own attorney's fees and costs, if any.

Employee further agrees that any claim subject to this Arbitration Agreement not acted on by Employee within six (6) months of its occurrence shall be waived. However, to the extent that any statute prohibits private circumscription of the period for acting on a claim, in no event shall the right to make a claim extend beyond the limitations imposed by the statute.

This Arbitration Agreement dose not in any way change, alter, or nullify the at-will employment status of the employee.

EMPLOYEE VERIFICATION

I have read the foregoing Arbitration Agreement. The Arbitration Agreement has been explained to me and I have had the opportunity to have any questions answered. I understand that I am subject to the Arbitration Agreement.

Employee Name (Print Name): _____ Date: _____ / _____ / _____
Employee Signature: _____

Form W-4 (2018)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

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. You may claim exemption from withholding for 2018 if **both** of the following apply.

- For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2018 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

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 might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. *Head of household please note:* Generally, you can claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse, during the year.

Line F. Credit for other dependents. When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

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Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you're 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.**

OMB No. 1545-0074

2018

1 Your first name and middle initial	Last name	**2** Your social security number
Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married filing separately, check "Married, but withhold at higher Single rate."	
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 800-772-1213 for a replacement card. ▶ ☐	

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages) . . .	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2018, and I certify that I meet **both** of the following conditions for exemption. • 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**	

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 boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	**9** First date of employment	**10** Employer identification number (EIN)

your wages and other income, including income earned by a spouse, during the year.

Line G. Other credits. You might be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as the earned income tax credit and tax credits for education and child care expenses. If you do so, your paycheck will be larger but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account.

Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at *www.irs.gov/W4App*. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn $60,000 per year and your spouse earns $20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("-0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at *www.irs.gov/W4App* to make your withholding more accurate.

Tip: If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

New hire reporting. Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to ***www.acf.hhs.gov/programs/css/employers***.

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

Box 8. Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

Box 9. If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

Box 10. Enter the employer's employer identification number (EIN).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself	A	
B	Enter "1" if you will file as married filing jointly	B	
C	Enter "1" if you will file as head of household	C	
D	Enter "1" if: • You're single, or married filing separately, and have only one job; or • You're married filing jointly, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	D	
E	**Child tax credit.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "4" for each eligible child. • If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "2" for each eligible child. • If your total income will be from $175,551 to $200,000 ($339,001 to $400,000 if married filing jointly), enter "1" for each eligible child. • If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter "-0-"	E	
F	**Credit for other dependents.** • If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "1" for each eligible dependent. • If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents). • If your total income will be higher than $175,550 ($339,000 if married filing jointly), enter "-0-"	F	
G	**Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here	G	
H	Add lines A through G and enter the total here ▶	H	

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work**, and the combined earnings from all jobs exceed $52,000 ($24,000 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 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 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income.

1	Enter an estimate of your 2018 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income. See Pub. 505 for details	1	$
2	Enter: $24,000 if you're married filing jointly or qualifying widow(er); $18,000 if you're head of household; $12,000 if you're single or married filing separately	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2018 adjustments to income and any additional standard deduction for age or blindness (see Pub. 505 for information about these items)	4	$
5	**Add** lines 3 and 4 and enter the total	5	$
6	Enter an estimate of your 2018 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses	7	$
8	**Divide** the amount on line 7 by $4,150 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H above	9	
10	**Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/ Multiple Jobs Worksheet,** also enter this total on line 1, page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet

Note: Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

1 Enter the number from the **Personal Allowances Worksheet,** line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) . . . . . 1 _____

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don't enter more than "3" . . . . . 2 _____

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . . 3 _____

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet . . . . . 4 _____

5 Enter the number from line 1 of this worksheet . . . . . 5 _____

6 **Subtract** line 5 from line 4 . . . . . 6 _____

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . . 7 $ _____

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . 8 $ _____

9 **Divide** line 8 by the number of pay periods remaining in 2018. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2018. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $7,000	0
5,001 - 9,500	1	7,001 - 12,500	1
9,501 - 19,000	2	12,501 - 24,500	2
19,001 - 26,500	3	24,501 - 31,500	3
26,501 - 37,000	4	31,501 - 39,000	4
37,001 - 43,500	5	39,001 - 55,000	5
43,501 - 55,000	6	55,001 - 70,000	6
55,001 - 60,000	7	70,001 - 85,000	7
60,001 - 70,000	8	85,001 - 90,000	8
70,001 - 75,000	9	90,001 - 100,000	9
75,001 - 85,000	10	100,001 - 105,000	10
85,001 - 95,000	11	105,001 - 115,000	11
95,001 - 130,000	12	115,001 - 120,000	12
130,001 - 150,000	13	120,001 - 130,000	13
150,001 - 160,000	14	130,001 - 145,000	14
160,001 - 170,000	15	145,001 - 155,000	15
170,001 - 180,000	16	155,001 - 185,000	16
180,001 - 190,000	17	185,001 and over	17
190,001 - 200,000	18		
200,001 and over	19		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $24,375	$420	$0 - $7,000	$420
24,376 - 82,725	500	7,001 - 36,175	500
82,726 - 170,325	910	36,176 - 79,975	910
170,326 - 320,325	1,000	79,976 - 154,975	1,000
320,326 - 405,325	1,330	154,976 - 197,475	1,330
405,326 - 605,325	1,450	197,476 - 497,475	1,450
605,326 and over	1,540	497,476 and over	1,540

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You aren't required to provide the information requested on a form that's subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

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 boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized 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	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative