PROFESSIONAL INFORMATION

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

NURSING CREDENTIALS: Please note all your nursing credentials

Name of Credential	Professional License Number	Original Date Received	Active (Yes or No)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Note Experience and places you have worked:

_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____

Ask us about a monthly schedule

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

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

Registered Nurse

Name _____

Date _____

- Hospital (Acute Care)
- Nursing Home

Hospital Stafflink Network

A division of US Hospital Personnel, Inc.

24-Hour National Nursing Staff

REGISTERED 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: _____

● **H**ospital **S**tafflink **N**etwork

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24-Hour National Nursing Staff

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

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: _______ / _______ / ___________

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24-Hour National Nursing Staff

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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 ______/______
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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: _______ / _______ / ___________

● Hospital Stafflink Network

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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 equirements. In no way does signing of this document promise or guarantee a permanent position or guarantee a 40-hour orksheet 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**

SHIFT CONFORMATION POLICY

Hospital Stafflink Network's new shift conformation policy is as follows:

If you have not received a conformation call two hours prior to your assigned shift, you must call Hospital Stafflink Network no later than 15 minutes after conformation time. The phone number is (303) 757-0303.

Failure to do so may result in a no call no show, and it will be documented.

I _____ have read the above and will make sure that if I do not receive a phone call two hours before my shift, I will call Hospital Stafflink Network within fifteen minutes after the two hour time frame.

_____ _____

Applicant Signature Date

_____ _____

HSN Representative Date

Employee Agreement
Non solicitation

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

Employee further agrees and understands that Hospital Stafflink Network is a recruiting medical staffing company and temp to hire firm and Employee further agrees not to solicit or accept employment with HSN/Company clients.

Employee further agrees for a period of one (1) year commencing on that date upon which Employee's employment relationship with the Company shall terminate for any reason whatsoever shall not solicit or accept employment with HSN clients.

Employee acknowledges that, as a result of his/her acceptance of employment with HSN client in consideration for this service, that if employed directly by Hospital Stafflink Network client, Employee agrees to pay Hospital Stafflink Network a settlement finders fee equivalent to the permanent placement fee of (3,000.00) three thousand dollars and payable to Hospital Stafflink Network upon acceptance of HSN client employment.

No changes or modification hereof shall be valid or binding unless the same is in writing and signed by the parties hereto.

I acknowledge that I have read and understand to the foregoing Non Solicitation agreement and a copy has been provided for me.

_____ _____ _____ _____ _____
HSN Employee Classification Date

_____ _____ _____
Branch Manager Date

_____ _____ _____
Witness Date

EDUCATION

Registered Nurse

HIPPA/OSHA
INITIAL COMPETENCY

Name _____

Date _____

Score _____

Section 1: HIPPA

Section 2: OSHA / Infection Control/Back Safety/General Safety/Patient Safety/ TB/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

● **H**ospital **S**tafflink **N**etwork

A division of US Hospital Personnel, Inc.

24-Hour National Nursing Staff

JOB DESCRIPTION

REGISTERED 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)_____

● **H**ospital **S**tafflink **N**etwork

A division of US Hospital Personnel, 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_____

Hospital Stafflink Network

A division of US Hospital Personnel, Inc.

24-Hour National Nursing Staff

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.

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

Registered Nurse

Restraints Competency
Orientation

Name _____

Date _____

Score _____

Remidiated

YES OR NO

Remidiated to _____

HSN representative

_____

_____
Date

BACKGROUND VERIFICATIONS INVESTIGATION

● **H**ospital **S**tafflink **N**etwork

A division of US Hospital Personnel, Inc.
24-Hour National Nursing Staff
4704 Harlan St. Suite 695
Denver, CO 80212
303/757-0303 303/458-3938 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 **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

HSN USE ONLY

Verification date: _____
Verified by: _____
Approved by: _____

Confidential

Education Verification

Employee Name _____ **Social Security** _____

Dates attended from _____ **to** _____

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

Name of School _____
Address _____
Phone Number _____
Fax Number _____

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:** _____/_____/_____

Please Fax back to 303-500-5072
Thank you

Hospital Stafflink Network

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

HSN USE ONLY

Verification date: _____
Verified by: _____
Approved by: _____

Confidential

Education Verification

Employee Name _____ **Social Security** _____

For Institution Use ONLY

Dates attended from _____ to _____

Graduated YES NO (please circle one) **Program** _____

Verified by: _____

Comments: _____

Name of School _____
Address _____
Phone Number _____
Fax Number _____

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:** _____/_____/_____

Please Fax back to (303) 458-3938
Thank you

"An Equal Opportunity Employer"

Hospital Stafflink Network

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: _____

HEALTH INFORMATION

PHYSICIAN STATEMENTS

PHYSICAL CLEARENCE

_____

Employee Name

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

_____

Physician signature

_____

Address

_____

Phone number

_____

Date

Hospital Stafflink Network

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

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: _____ / _____ / _____

Hospital Stafflink Network

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

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: _____ / _____ / _____

Hospital Stafflink Network

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

Hepatitis B Vaccination Acknowledgement/Declination

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:

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

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

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: _____ / _____ / _____

Hospital Stafflink Network

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

Respiratory Protection Acknowledgement/Declination

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:

Color Deficit

Date: _____

Name: _____ Classification: _____

Testing Results: (Check appropriate line)

_____ Sufficient

_____ Deficit

_____ _____
HSN Representative Conducting test Date

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

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: _____

OMB No. 1615-0047; Expires 08/31/12

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

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

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

Print Name: Last	First	Middle Initial	Maiden Name

Address *(Street Name and Number)*	Apt. #	Date of Birth *(month/day/year)*

City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) _____
- ☐ An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - *month/day/year*) _____

Employee's Signature — Date *(month/day/year)*

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

Preparer's/Translator's Signature	Print Name

Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

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

	List A	OR	List B	AND	List C
Document title:					
Issuing authority:					
Document #:					
Expiration Date *(if any)*:					
Document #:					
Expiration Date *(if any)*:					

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

Signature of Employer or Authorized Representative	Print Name	Title

Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

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

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

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

Document Title: _____ Document #: _____ Expiration Date *(if any)*: _____

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	Date *(month/day/year)*

Form W-4 (2012)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2012 expires February 18, 2013. See Pub. 505, Tax Withholding and Estimated Tax.

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

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

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

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

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2012. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. The IRS has created a page on IRS.gov for information about Form W-4, at *www.irs.gov/w4*. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted on that page.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E** _____
F	Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to seven eligible children or **less** "2" if you have eight or more eligible children. • If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child	**G** _____
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

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

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2012

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, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	**4** **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	
5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)		**5**
6	Additional amount, if any, you want withheld from each paycheck		**6** $
7	I claim exemption from withholding for 2012, 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 lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)