rns INCORPORATED

REQUIRED DOCUMENTATION CHECKLIST

(Please ensure that all copies submitted are legible)

Application Material (forms provided)

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

REQUIRED Medical Documentation

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

Licenses, Professional Certifications, Resuscitation Credentials & Miscellaneous

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

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

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

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

Revised Sept2010

rns INCORPORATED

EMPLOYMENT APPLICATION - HEALTHCARE PROFESSIONAL

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

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

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

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

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

Email Address: _____

Emergency Contact_____ Relationship _____Phone(____)_____

Date available to start work _____/_____/_____

Shift Preference: _____ AM / PM to _____AM / PM

Can you work rotating shifts? ☐ Yes ☐ No

CLINICAL EXPERIENCE*

Clinical Area	Years Experience	Clinical Area	Years Experience	Clinical Area	Years Experience

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

Clinical Area(s) preferred _____

LICENSE(S)

State	Number	Expires	State	Number	Expires

CERTIFICATION(S)

Name	Date Taken	Expires	Name	Date Taken	Expires

EDUCATION

SCHOOL	CITY/STATE	MO/YR GRADUATED	DEGREE

rns INCORPORATED

EMPLOYMENT HISTORY

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

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

Hospital Facility ______________________ Agency (if used)______________________________ ☐ Full-time ☐ Part-Time

Address _____________________________ City _________________________________ State ________ Zip __________

Immediate Supervisor _________________ Phone ___________________ May we contact this employer? ☐ Yes ☐ No

Specialty / Unit ______________________ Types of Patients ____

Number of Beds ___________ Charge Experience? ☐ Yes ☐ No Eligible for rehire? ☐ Yes ☐ No

Reason for leaving? ____

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

Hospital Facility ______________________ Agency (if used)______________________________ ☐ Full-time ☐ Part-Time

Address _____________________________ City ________________________________ State ________ Zip __________

Immediate Supervisor _________________ Phone ___________________ May we contact this employer? ☐ Yes ☐ No

Specialty / Unit ______________________ Types of Patients ____

Number of Beds ___________ Charge Experience? ☐ Yes ☐ No Eligible for rehire? ☐ Yes ☐ No

Reason for leaving? ____

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

Hospital Facility ______________________ Agency (if used)______________________________ ☐ Full-time ☐ Part-Time

Address _____________________________ City _________________________________ State ________ Zip __________

Immediate Supervisor _________________ Phone ___________________ May we contact this employer? ☐ Yes ☐ No

Specialty / Unit ______________________ Types of Patients ____

Number of Beds ___________ Charge Experience? ☐ Yes ☐ No Eligible for rehire? ☐ Yes ☐ No

Reason for leaving? ____

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

Hospital Facility ______________________ Agency (if used)______________________________ ☐ Full-time ☐ Part-Time

Address _____________________________ City _________________________________ State ________ Zip __________

Immediate Supervisor _________________ Phone ___________________ May we contact this employer? ☐ Yes ☐ No

Specialty / Unit ______________________ Types of Patients ____

Number of Beds ___________ Charge Experience? ☐ Yes ☐ No Eligible for rehire? ☐ Yes ☐ No

Reason for leaving? ____

---

rns INCORPORATED

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

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

Address _____ City _____ State _____ Zip _____

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

Specialty / Unit _____ Types of Patients _____

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

Reason for leaving? _____

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

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

Address _____ City _____ State _____ Zip _____

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

Specialty / Unit _____ Types of Patients _____

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

Reason for leaving? _____

Explanation of any breaks:

_____
_____
_____
_____

Have you ever been convicted of a crime other than a traffic violation? _____

If yes, please list conviction and explain:

_____
_____

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

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

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

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

Signature _____ Date _____

Printed Name _____

rns INCORPORATED

PROFESSIONAL REFERENCE

Please fax completed form to 888.704.4402

The individual named below has applied for a position with RNS Incorporated and has given your name as a professional reference. We would appreciate your assistance in verifying employment and evaluating the applicant's past performance. All information will be kept in strict confidence. Thank you for your assistance!

APPLICANT INFORMATION:

NAME: _____
LAST FIRST MI

EMPLOYER (Facility/Company): _____ CONTACT: _____

TITLE: _____

ADDRESS:_____ PHONE: _____

POSITION: RN LVN CNA OTHER: _____

UNIT: _____ # OF BEDS: _____

DATES EMPLOYED: _____ to _____

I hereby authorize any individual, facility, or company with whom I have been associated to furnish information to RNS concerning my employment and hereby release said individual, facility, company, and RNS from any liability incurred for the disclosure of such information.

_____ _____
Signature of Applicant *Date*

TO BE COMPLETED BY EMPLOYER:

1. Do the dates of employment listed above correspond to your records? ☐ YES ☐ NO
2. Would you re-employ this individual? ☐ YES ☐ NO If NO, Why? _____

PLEASE EVALUATE EACH OF THE FOLLOWING:

	EXCELLENT	*GOOD*	*AVERAGE*	*POOR*
Quality of Work	☐	☐	☐	☐
Problem Solving	☐	☐	☐	☐
Cooperation with Others	☐	☐	☐	☐
Written / Verbal Skills	☐	☐	☐	☐
Time Management	☐	☐	☐	☐
Attendance / Punctuality	☐	☐	☐	☐
Dependability / Flexibility	☐	☐	☐	☐
Attitude	☐	☐	☐	☐
Appearance	☐	☐	☐	☐

COMMENTS: _____
_____

_____ _____ _____
Employer Signature *Printed Name / Title* *Date*

RNS Verification: _____ Date: _____

rns INCORPORATED

PROFESSIONAL REFERENCE

Please fax completed form to 888.704.4402

The individual named below has applied for a position with RNS Incorporated and has given your name as a professional reference. We would appreciate your assistance in verifying employment and evaluating the applicant's past performance. All information will be kept in strict confidence. Thank you for your assistance!

APPLICANT INFORMATION:

NAME: _____
LAST FIRST MI

EMPLOYER (Facility/Company): _____ CONTACT: _____

TITLE: _____

ADDRESS:_____ PHONE: _____

POSITION: RN LVN CNA OTHER: _____

UNIT: _____ # OF BEDS: _____

DATES EMPLOYED: _____ to _____

I hereby authorize any individual, facility, or company with whom I have been associated to furnish information to RNS concerning my employment and hereby release said individual, facility, company, and RNS from any liability incurred for the disclosure of such information.

_____ _____
Signature of Applicant *Date*

TO BE COMPLETED BY EMPLOYER:

1. Do the dates of employment listed above correspond to your records? ☐ YES ☐ NO
2. Would you re-employ this individual? ☐ YES ☐ NO If NO, Why? _____

PLEASE EVALUATE EACH OF THE FOLLOWING:

	EXCELLENT	*GOOD*	*AVERAGE*	*POOR*
Quality of Work	☐	☐	☐	☐
Problem Solving	☐	☐	☐	☐
Cooperation with Others	☐	☐	☐	☐
Written / Verbal Skills	☐	☐	☐	☐
Time Management	☐	☐	☐	☐
Attendance / Punctuality	☐	☐	☐	☐
Dependability / Flexibility	☐	☐	☐	☐
Attitude	☐	☐	☐	☐
Appearance	☐	☐	☐	☐

COMMENTS: _____
_____

_____ _____ _____
Employer Signature *Printed Name / Title* *Date*

RNS Verification: _____ Date: _____

rns INCORPORATED

CONFIDENTIAL INFORMATION DISCLOSURE AND RELEASE

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

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

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

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

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

_____ _____

Employee Signature Date

_____ _____

Printed Name Last 4 Digits of SSN

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

1555 River Park Drive, Suite 206-I
Sacramento, CA 95815
Main 800.704.4401 Fax 888.704.4402
rns@rnsonline.com

Pre-Employment Inquiry Release

In connection with, and for the duration of my employment (including contract for services) with you, I understand that investigative background inquires are to be made on myself including consumer, criminal, driving, and other reports.

This information will, in whole or in part, be obtained from Acxiom Information Security Services (AISS), 6111 Oak Tree Blvd, 4th floor, Independence, OH 44131, telephone 800.853.3228. These reports will include information as to my general reputation, character, mode of living, work habits, performance and experience along with reasons for termination of past employment from previous employers. Further, I understand that you will be requesting information from various federal, state and other agencies which maintain public and non-public records concerning my past activities relating to my driving, credit, civil, education and other experiences.

I authorize, without reservation, any party or agency contacted by this employer to furnish the above mentioned information:

_____ _____/_____/_____ _____-_____-_____
Applicant Name Date of Birth* Social Security Number

_____
Alias/Maiden Name (s)

_____ _____ _____
Current Address City & State Zip Code

_____ _____ ___RNS Incorporated _____
Driver's License # State Prospective Employer

Applicant's Signature_____ Date _____

***Date of Birth is being requested in order to obtain accurate retrieval of records.**

_____ **California, Minnesota & Oklahoma Applicants Only:** Please check here to have a copy of your consumer report sent directly to you. Minnesota and Oklahoma applicants will receive a copy direct from AISS. California applicants may receive a copy from either the prospective employer or AISS.

Notice to California Applicants

Under Section 1786.22 of the California Civil Code, you have the right to request from AISS, upon proper identification, the nature and substance of all information in its files on you, including the sources of information, and the recipients of any reports on you which AISS has previously furnished within the two-year period preceding your request. You may view the file maintained on you by AISS during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services. Upon making a written request, you may receive a summary of your report via telephone.

U.S. Department of Justice
Immigration and Naturalization Service

OMB No. 1115-0136

Employment Eligibility Verification

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

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

Print Name: Last	First	Middle Initial	Maiden Name
Address *(Street Name and Number)*		Apt. #	Date of Birth *(month/day/year)*
City	State	Zip Code	Social Security #

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

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

- ☐ A citizen or national of the United States
- ☐ A Lawful Permanent Resident (Alien # A_____)
- ☐ An alien authorized to work until ___/___/___
  (Alien # or Admission #) _____

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

Preparer and/or Translator Certification.

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

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

Section 2. Employer Review and Verification.

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

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

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

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

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

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

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

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

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

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

Form W-4 (2011)

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

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

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

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

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

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

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

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

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

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

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

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
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 or more eligible children. • If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children	**G** _____
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 have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

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

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
2011

1	Type or print your first name and middle initial.	Last name	**2** **Your social security number**
	Home address (number and street or rural route)	**3** ☐ 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 2011, 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)

rns INCORPORATED

MEDICAL HISTORY QUESTIONNAIRE

Name _____ SSN _____

Date of Birth _____ Weight_____ Height _____

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

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

Date of Last Physical Exam _____ Name of Physician _____

Address _____

City _____ ST _____ Zip _____

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

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

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

rns INCORPORATED

19. Have you had any of the following?

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

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

Condition	*Details*	*Onset Mo/Yr*	*Duration*	*Result*

Additional Comments:

_____

_____

_____

_____

_____

PLEASE READ AND SIGN

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

I MAKE THESE REPRESENTATIONS FREELY AND VOLUNTARILY.

SIGNATURE _____ **DATE** _____

INFORMATION ABOUT HEPATITIS B VACCINE

THE DISEASE

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

THE VACCINE

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

POSSIBLE VACCINE SIDE EFFECTS

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

HEPATITS B (HBV) VACCINE INFORMED CONSENT

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

HEPATITIS B (HBV) VACCINE AUTHORIZATION & DOCUMENTATION

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

Employee Signature _____ Date _____

INITIAL DOSE: Date_____ Lot _____

Given By: _____

Comments: _____

1 MONTH DOSE: Date_____ Lot _____

Given By: _____

Comments: _____

6 MONTH DOSE: Date_____ Lot _____

Given By: _____

Comments: _____

PREVIOUS HEPATITIS B (HBV) VACCINE / TITER INFORMATION

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

Employee Signature _____ Date _____

HEPATITIS B (HBV) VACCINE DECLINATION

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

Employee Signature _____ Date _____

rns INCORPORATED

Respirator Medical Evaluation

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

Name
Have you ever worn a respirator before? □ Yes □ No Manufacturer: _____ Type/Model #: _____ Size: _____
Type of Respirator To Be Used □ N95 Particulate Respirator □ Powered Air Purifying Respirator □ Other : _____

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

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month…… Yes No

2. Have you ever had any of the following conditions?
   a. Seizures (fits):…….. Yes No
   b. Diabetes (sugar disease)…… Yes No
   c. Allergic reactions that interfere with your breathing:…… Yes No
   d. Claustrophobia (fear of closed-in places)…….. Yes No
   e. Trouble smelling odors (except when you had a cold)……. Yes No

3. Have you ever had any of the following pulmonary or lung problems?
   a. Asbestosis:…… Yes No
   b. Asthma:…… Yes No
   c. Chronic bronchitis:…….. Yes No
   d. Emphysema:…… Yes No
   e. Pneumonia:…….. Yes No
   f. Tuberculosis:…… Yes No
   g. Silicosis:…….. Yes No
   h. Pnemothorax (collapsed lung):……. Yes No
   i. Lung cancer:…… Yes No
   j. Broken ribs:…….. Yes No
   k. Any chest injuries or surgeries:…… Yes No
   l. Any other lung problems that you've been told about:…… Yes No

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of breath:…… Yes No
   b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:…… Yes No
   c. Shortness of breath when walking with other people at an ordinary pace on level ground:…….. Yes No
   d. Have to stop for breath when walking at your own pace on level ground:…… Yes No
   e. Shortness of breath when washing or dressing yourself:…… Yes No
   f. Shortness of breath that interferes with your job…… Yes No
   g. Coughing that produces phlegm (thick sputum)…… Yes No
   h. Coughing that wakes you early in the morning:……. Yes No
   i. Coughing that occurs when you are lying down:…… Yes No
   j. Coughing up blood in the last month:……... Yes No

k. Wheezing:……. Yes No
l. Wheezing that interferes with your job:…… Yes No
m. Chest pain when you breath deeply……. Yes No
n. Any other symptom that you think may be related to lung problems:……. Yes No

5. Have you ever had any of the following cardiovascular or heart problems?
   a. Heart attack:…….. Yes No
   b. Stroke:…….. Yes No
   c. Angina:…… Yes No
   d. Heart failure:…… Yea No
   e. Swelling in your legs or feet (not caused by walking)……. Yes No
   f. Heart arrhythmia (heart beating irregularly):…… Yes No
   g. High Blood Pressure:…… Yes No
   h. Any other heart problem that you've been told about:……. Yes No

6. Have you ever had any of the following cardiovascular or heart problems?
   a. Frequent pain or tightness in your chest:…… Yes No
   b. Pain or tightness in your chest during physical activity:……. Yes No
   c. Pain or tightness in your chest that interferes with your job:…….. Yes No
   d. In the past two years, have you noticed your heart skipping or missing a beat:……. Yes No
   e. Heartburn or indigestion that is not related to eating:…… Yes No
   f. Any other symptoms that you think may be related to heart or circulation problems:… Yes No

7. Do you currently take medication for any of the following problems?
   a. Breathing or lung problems:…… Yes No
   b. Heart trouble:…… Yes No
   c. Blood pressure:…….. Yes No
   d. Seizures (fits):…….. Yes No

8. Has your wearing a respirator caused any of the following problems? (If you have never used a respirator, check the following space:_____ and go to question 9)
   a. Eye irritation……. Yes No
   b. Skin allergies or rashes…… Yes No
   c. Anxiety that occurs only when you use the respirator…….. Yes No
   d. Unusual weakness or fatigue:…….. Yes No
   e. Any other problem that interferes with your use of a respirator…… Yes No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire:…… Yes No

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

Employee Signature: _____ Date: _____

RNS Inc. Signature: _____ Date: _____

rns INCORPORATED

TUBERCULOSIS SCREENING

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

Name: _____

Circle the Appropriate Answer

1. Have you ever been diagnosed with active pulmonary tuberculosis disease (productive cough, fever, weight loss, and/or night sweats)? .....Y N Don't Know

2. If the answer to #1 is Yes, did you take medication to treat the infection?_ .....Y N Don't Know
   If the answer to #2 is Yes, what medication did you take and how long did you take medication?

   Isoniazid Date Started_____ Date Stopped _____
   Ethambutol Date Started_____ Date Stopped _____
   Rifamfin Date Started_____ Date Stopped _____
   Pyrazinamide Date Started_____ Date Stopped _____
   Other (be specific): _____

3. Have you ever lived with another person who was diagnosed with active pulmonary tuberculosis disease? .....Y N Don't Know

4. Have you ever been exposed to a case of active pulmonary tuberculosis disease as a result of your occupation as a health-care worker?.....Y N Don't Know

5. Have you ever been tested for tuberculosis with the 4-pronged puncture technique (tine test) or with the 5 TU Protein Purified Derivative intra-dermal skin test (PPD)? .....Y N Don't Know

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

   a. Date of last TB test:_____
   b. Result of the TB test (check best answer):

      Positive – Greater than 10mm of induration (hard lump at the injection site)

      Negative (0mm of induration)

      Between 0 and 10mm of induration)

      Don't know how may "mm" of induration was recorded

      Redness only, no induration (hard lump at the injection site)
   c. Was the TB test "self-read"?.....Y N
      If the answer to "c" is No, who actually interpreted the results of the TB skin test?

      Doctor

      Nurse

      Other _____

7. Have you ever been vaccinated with BCG?.....Y N Don't Know

8. If the answer to #7 is Yes, approximately what year were you vaccinated and in what country?
   Year _____ Country _____

Employee Signature _____ Date_____

REV 06/04

rns INCORPORATED

INFLUENZA VACCINE ATTESTATION

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

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

NAME:	**DATE:**

ATTESTATION
*****MUST ATTACH A COPY OF VACCINATION RECORD(S)*****

☐ I received the influenza vaccine for the 2010-11 season on _____

Setting where vaccine was administered:

☐ Hospital ☐ Clinic ☐ MD Office ☐ Other_____

DECLINATION

	I have declined to receive the influenza vaccine for the 2010-11 flu season

I acknowledge that the influenza vaccine is recommended by the CDC for all healthcare workers and others with patient contact to prevent infection and transmission of the virus that causes influenza (the flu). I also understand that I may spread the virus to patients, co-workers, family, friends and other contacts prior to developing symptoms of this illness. I understand that by declining vaccination(s), I continue to be at an increased risk of acquiring the influenza virus and could be the vehicle by which this infection is passed on to others.

Reason(s) for declination:

	Allergy to eggs, chicken feathers, and/or chicken dander
	History of Guillain Barre
	Past severe reaction to vaccine (describe):
	Immunocompromised status (current chemotherapy treatment, corticosteroid use, transplant patient, disease of or effecting the immune system)
	I am concerned about potential side effects
	I do not feel it is necessary
	Religious belief
	Fear of receiving vaccines
	OTHER (Must specify):

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

Signature: _____ Date: _____

rns INCORPORATED

AGE-RELATED COMPETENCY CHECKLIST

(To be completed by ALL Clinical Personnel)

Name: _____ Date: _____

Please rate your Skill Level:

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

COMPLIANCE CRITERIA	0	1	2	3
NEONATE / INFANT (Newborn to 2 Years)				
Maintains safe environment: warmth, crib rails in "up" position and locked, no toys with removable parts, limits visitors, no strangers allowed in room, identifies by leg/arm band.				
Involves parents / caregivers in care; ensures return demonstration; encourages parental assistance in provision of care.				
Provides information in immunizations.				
Keeps parents / caregivers in field of vision.				
Provides familiar objects (as possible and appropriate).				
Uses distraction methods to calm (i.e., visually stimulating objects, bottle).				
Approaches and provides care in calm, tender manner.				
PEDIATRICS (2 - 11 Years)				
Maintain safe environment: bed rails in "up" position and locked, age appropriate toys and / or games. Aware of need for peer relationship (i.e., with visitors); however, questions any strangers attempting to enter room. Uses age appropriate equipment (i.e., potty chair); ensures safe nutrition (puts food unto small bites to prevent choking).				
Involves child in care and educates parents / caregivers at same time. Ensures return demonstration; allows child to have control by allowing choices, as appropriate to situation.				
Discusses immunization status with parents.				
Explains all procedures and test in language that child can understand.				
Plans procedures and activities in relation to child's impulse gratification needs and decreased attention span.				
Approaches child in calm manner; uses direct approach with child; allows for privacy needs (ages 9-11); encourages personal hygiene and grooming as appropriate to condition.				
Uses praise as a reward for positive attitudes and behavior. Uses touch as a form of comfort, as appropriate to child's needs and reactions.				
ADOLESCENT (12 – 19 YEARS)				
Maintains safe environment: bed rails in "up" position and locked; assesses for depression / suicidal ideation and keeps dangerous items out of patient's ability to obtain. Assesses for "gang" relationships and considers appropriateness of visitors; assesses patient's ability to manage "self-held" and/or "self-operated equipment."				
Involves patient in care, treatments and procedures. Allows time for and encourages questions, explaining issues to patient in language patient can understand. Allows patient to have choice and control over situations and environment, as appropriate to condition and situation.				
Explains all treatments, tests and procedures thoroughly to patient before they are performed.				
Allows for privacy needs. Encourages and allows for personal hygiene activities.				
Maintains patient confidentiality with parental / caregiver involvement and education, as appropriate to age and consent of patient.				
Encourages verbalization of fears. Discusses options and possible choices patient can make to increase control and foster patient confidence.				

COMPLIANCE CRITERIA	0	1	2	3

ADULT

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

GERIATRIC

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

Comments: _____
_____
_____
_____

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

Nurse Signature: _____ Date: _____

RNS Inc. Reviewer Signature: _____ Date: _____

rns INCORPORATED

MEDICAL SURGICAL SKILLS COMPETENCY CHECKLIST
Registered Nurse (RN)

Name: _____ Date: _____

Total years of Medical Surgical nursing experience: [ ]

Please rate your Skill Level:

0 – No Experience. Theory Only.
1 – Limited competency / proficiency. Supervision Required.
2 – Acceptable competency / proficiency.
3 – Competent / proficient. Performed frequently and independently during the past 2 years.

SKILL	0	1	2	3
I. NURSING ROLES:				
Charge Nurse				
Team Leader				
II. PATIENT CARE DELIVERY:				
Team Nursing				
Primary Nursing				
III. NURSING PROCESS SKILLS:				
Nursing History				
Physical Assessments				
Skin				
Cardiovascular				
Heart				
Peripheral Vascular System				
Respiratory				
Neurological				
Abdomen				
Bowel				
Bladder				
Musculoskeletal				
Psychosocial Status				
Fall Assessment				
Pain Assessment				
Elder / Domestic Abuse				
Patient Care Planning				
Nursing Intervention				
Patient Teaching				
Evaluation of Patient Care				
Discharge Instruction / Planning				
Documentation of Care Plan				
IV. MEDICATION ADMINISTRATION:				
Narcotic control				
Insulin Administration				
Skin Testing (Intradermal injection)				
Procedure				
Documentation				
Reading Results				
Heparin Administration / Lock				
Patient Controlled Analgesia				
Administration of Medications				
Oral / Sublingual				
I.M.				
Subcutaneous				
Topical / Medication Patches				
Eye				
Ear				

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

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

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

SKILL	0	1	2	3
IX. EQUIPMENT (contd):				
Halo Apparatus				
Traction				
Balance Traction				
Footboard				
Foster / Stryker Frame				
Circ-O-Electric Bed				
Cradles				
Intermittent Suction				
Wall-Straight Suction				
Portable O2 Suction				
Straight Drainage				
Oxygen Wall Panel / Flowmeter				
Chest Tube Suction Device				
Hoyer Lift				
K-Pads				
Nelson Bed				
Pressure Relieving Beds				
Kangaroo Pumps				
Trans Nerve Stimulator				
Pyxis				
Portable Vital Signs Monitor				
Cardiac / Tele Monitors				
Lead Placement				
Arrhythmia Interpretation				
Blood Glucose Meters				
Pulse Oxymetry				
Incentive Spirometry				
Emergency / Crash Cart				
Ambu Bag (PPV) Mask / Valve				
HEPA Filters				
X. PAIN MANAGEMENT:				
Pain assessment using pain scales				
Epidural Analgesia				
IV Conscious Sedation				
Patient Controlled Analgesia (PCA)				
Narcotic Agents				
Non-narcotic agents				
Non-pharmacological Measures				
XI. CARE OF PATIENTS:				
RESPIRATORY				
COPD				
ARDS				
Thoracic Surgery				
Asthma				
Inhalation Injuries				
Pneumonia				
Pneumothorax				
Tuberculosis				
Pulmonary Edema				
Pulmonary Embolism				
NEUROLOGY				
CVA / TIA				
Overdose				
Head Injury / Trauma				
Neuro Injury / Trauma				
Spinal Cord Injury				

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

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

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

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

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

Comments:
_____
_____
_____

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

Nurse Signature: _____ Date: _____

RNS, Inc. Reviewer Signature: _____ Date: _____