Employment Application Packet

Please complete this Application Packet and send back by either Fax at (Fax Number) ore-mail at (email)

To ensure our compliance with the standards of both our clients and the State, Agency Staffing requires the following documentation in our system.

REQUIREMENTS:

☐ **RESUME**
- Explain **GAPS IN EMPLOYMENT**, if any to avoid delays in your Pre-Qualification process
- Please indicate the **CITY AND STATE** plus **MONTH AND YEAR** per work history
- Also if you speak any Language other than English.

☐ **APPLICATION FOR EMPLOYMENT**
- Application Form
- Employment History
- Emergency Contact
- Legal Questionnaire

☐ **EMPLOYMENT REFERENCE #1**

☐ **EMPLOYMENT REFERENCE #2**

☐ **CLINICAL SKILLS CHECKLIST – COMPLETED & SIGNED**

☐ **PROFESSIONAL CREDENTIALS – Please attach the following when submitting this Application:**

1. State Professional License – Front and Back copies with signature
2. Driver's License
3. BLS/CPR – Front and Back copies with signature. American Heart Association for healthcare provider
4. ACLS,PALS,MAB,EKG/ARRYTHMIA Certification as Applicable/Back should be signed, AHA provider
5. Diploma (Hospital requirement for education verification)
6. Physician Statement, taken within the last 12 months, *Physician Statement with Signature of M.D
7. Chest X-Ray or PPD Test
8. Drug Screen
9. Immunization Records (MMR and Varicella)
    - TB/PPD Test
    - Rubella Titre, Rubeola Titre, Mumps Titre
    - Vaccine Zoster Titre, Immunity by History of Disease as Verified by MD and Vaccination
    - Covid-19
10. Hepatitis B Declination, Proof of Series, or Titre Showing Immunity.

Application for Employment

(Please complete event if attaching a resume)

Name (Last, First and Middle Initial) Maiden/Other

Street Address City Select State Zip

E-mail Address Social Security Number

Date of Birth Driver's License Select State Expiration Date

Home Phone # Alternate Phone # Cell Phone # Preferred call time

Primary Emergency Contact Name and Phone # Secondary Emergency Contact Name and Phone #

Date Available: _____ Shift Preferred: ☐ Day ☐ Night

Type of position applying for (check all that applies): ☐ Per Diem ☐ 8 Weeks ☐ 13 Weeks+ ☐ Permanent

Do you speak any languages other than English? ☐ Yes ☐ No If yes, Please list _____

How were you referred to us? ☐ Advertising ☐ Internet site ☐ Friend / Associate _____

☐ Other _____

Were you recruited by a Staff Member? ☐ Yes ☐ No If yes, Recruiter's name _____

Have you done a Travel assignment before? ☐ Yes ☐ No If yes, with which company(s)? _____

Are you able to perform the basic functions of the position for which you are applying without any restrictions? ☐ Yes ☐ No

If no, Please explain _____

Position (Job Class) Applying for:

☐ RN ☐ PT ☐ LP/VN ☐ CNA ☐ OT ☐ PTA ☐ Clerical ☐ Other _____ Date Available: _____

Please use the space below to let us know your preferences in terms of Facility, Commute, Restrictions, Pay, etc.

_____

_____

Emergency Contact Information

We would like to have the names of two (2) contacts that we could call in the case of emergency. Please provide that information below for our files and reference.

Primary Contact: _____ Secondary Contact: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

_____ _____

_____ _____

Contact No.: _____ Contact No.: _____

Professional Credentials

Education: _____ From: _____ To: _____
College or University / Location

Degree Earned: _____

Education: _____ From: _____ To: _____
College or University / Location

Degree Earned: _____

Education: _____ From: _____ To: _____
College or University / Location

Degree Earned: _____

Specialty (Please list most current experience first)

1. _____ Years of Experience _____ as of (Indicate Date) _____

2. _____ Years of Experience _____ as of (Indicate Date) _____

Professional Licenses (Please attach a copy of each including front and back copies)

1. CA Medical License # _____ Expiry Date: _____

2. _____ Expiry Date: _____

3. _____ Expiry Date: _____

Certifications (Please attach a copy of each including front and back copies)

☐ BLS / CPR	Expiry Date: _____	☐ ACLS	Expiry Date: _____
☐ PALS	Expiry Date: _____	☐ NRP / NALS	Expiry Date: _____
☐ MAB	Expiry Date: _____	☐ CCRN	Expiry Date: _____
☐ CNOR	Expiry Date: _____	☐ TNCC	Expiry Date: _____
☐ EKG Cert	Expiry Date: _____	☐ CHEMO	Expiry Date: _____
☐ Other:	_____		Expiry Date: _____

Employment History (Please list in order, most recent first and explain gaps in employment if any)

Date Employed: From: _____ To: _____
Facility: _____
Position Held: _____
☐ **FT** ☐ **PT** ☐ Traveler-Agency _____
Address: _____
Immediate Supervisor: _____

Business Phone: _____
May We Contact? ☐ Yes ☐ No
Specialty Unit: _____
City and State: _____
Pay / HR: _____
Reason for leaving: _____

Employment History cont. (Please list in order, most recent first and explain gaps in employment if any)

Date Employed: From: ________________ To: ________________
Facility: ________________________________
Position Held: ________________________________
☐ **FT** ☐ **PT** ☐ Traveler-Agency ________________
Address: ________________________________
____
Immediate Supervisor: ________________________

Business Phone: ________________________
May We Contact? ☐ Yes ☐ No
Specialty Unit: ________________________
City and State: ________________________
Pay / HR: ________________________
Reason for leaving: ________________________

Date Employed: From: ________________ To: ________________
Facility: ________________________________
Position Held: ________________________________
☐ **FT** ☐ **PT** ☐ Traveler-Agency ________________
Address: ________________________________
____
Immediate Supervisor: ________________________

Business Phone: ________________________
May We Contact? ☐ Yes ☐ No
Specialty Unit: ________________________
City and State: ________________________
Pay / HR: ________________________
Reason for leaving: ________________________

Date Employed: From: ________________ To: ________________
Facility: ________________________________
Position Held: ________________________________
☐ **FT** ☐ **PT** ☐ Traveler-Agency ________________
Address: ________________________________
____
Immediate Supervisor: ________________________

Business Phone: ________________________
May We Contact? ☐ Yes ☐ No
Specialty Unit: ________________________
City and State: ________________________
Pay / HR: ________________________
Reason for leaving: ________________________

Date Employed: From: ________________ To: ________________
Facility: ________________________________
Position Held: ________________________________
☐ **FT** ☐ **PT** ☐ Traveler-Agency ________________
Address: ________________________________
____
Immediate Supervisor: ________________________

Business Phone: ________________________
May We Contact? ☐ Yes ☐ No
Specialty Unit: ________________________
City and State: ________________________
Pay / HR: ________________________
Reason for leaving: ________________________

Date Employed: From: ________________ To: ________________
Facility: ________________________________
Position Held: ________________________________
☐ **FT** ☐ **PT** ☐ Traveler-Agency ________________
Address: ________________________________
____
Immediate Supervisor: ________________________

Business Phone: ________________________
May We Contact? ☐ Yes ☐ No
Specialty Unit: ________________________
City and State: ________________________
Pay / HR: ________________________
Reason for leaving: ________________________

Name: _____ Date: _____

Position applied for: Other- _____

LEGAL QUESTIONNAIRE

Have you ever:

1. been named as a defendant in a malpractice action? _____ If yes, when? _____
   Who was your employer at that time? _____
2. had a license or certification in any jurisdiction limited, suspended, revoked or voluntarily relinquished? _____
   If yes, when? _____ In what state? _____
3. been licensed or practiced professionally under a different name? _____
   If yes, under what name? _____ and what state? _____
4. Are you eligible to work in the U.S.? ☐ Yes ☐ No Alien ID number _____ (if applicable)
5. been denied a license? _____ If yes, what state? _____ when? _____
   What reason? _____
6. been convicted by misdemeanor, felony including traffic violations? _____
   If yes, when? _____ in what state? _____
   What county? _____

(this includes any offense where you were found guilty, plead guilty or plead nolo contendere (no contest). You may omit: a conviction of misdemeanor while under the age of 18, if the records were sealed. Any conviction specified in Health and Safety code which pertains to various marijuana offenses (a conviction will not necessarily disqualify you from consideration for employment).

7. been arrested and are you out on bail on your own recognizance and still awaiting trial? _____
8. been released or discharged from employment or resigned to avoid such release or discharged? _____
   If yes, please provide dates and circumstances? _____

   _____

   _____
9. had your driver's licensee suspended or revoked? _____ If yes, when? _____
   Please explain why? _____

   _____

My signature certifies that all information contained within my application is correct and maybe verified by Agency Staffing in compliance with State Law. It also acknowledges that I am aware that it is my responsibility to review and policy and procedure documents of each hospital/facility in which I work, prior to beginning my initial shift.

Applicant's Signature _____ Date _____ Position Other- _____

I have reviewed the applicant's qualifications and skills that qualify for the position.

Evaluator's Signature _____ Date _____

Employment Reference Check #1

• Clinical references must provide dates of employment, give a rating of work history, state the position or specialty that the candidate worked. State the title of the person giving the references such as Charge RN, RN Supervisor, DON, Nurse Manager. The reference MUST be someone who the candidate reported to directly on the floor unit. •

Applicant's Name _____ **Position Held** _____

Dates of Employment (From month & year – To month & year) _____ **Current / Former Employer** _____

City _____ **State** _____ **Supervisor's Name** _____

☐ I hereby give permission to the above named employer to release information to Agency regarding my performance while employed at the facility.

Applicant's Signature _____ **Date** _____

Employment History

The person above is applying for an employment with Agency Staffing and has listed you as previous employer. We would appreciate your assistance in verifying employment and evaluating job performance. All information will be treated with utmost confidentiality.

Is this employee eligible for rehire? ☐ **YES** ☐ **NO**

Personal Evaluation	Above Average	Satisfactory	Did not meet expectations	Poor
Clinical Competency	☐	☐	☐	☐
Quality of Work	☐	☐	☐	☐
Quantity of Work	☐	☐	☐	☐
Attitude and Cooperation	☐	☐	☐	☐
Ability to get along with others	☐	☐	☐	☐
Adaptability to Work Situations	☐	☐	☐	☐
Dependability	☐	☐	☐	☐
Attendance and Punctuality	☐	☐	☐	☐
Personal Appearance	☐	☐	☐	☐

Comments:

Employment Reference Check #2

• Clinical references must provide dates of employment, give a rating of work history, state the position or specialty that the candidate worked. State the title of the person giving the references such as Charge RN, RN Supervisor, DON, and Nurse Manager. The reference MUST be someone who the candidate reported to directly on the floor unit. •

Applicant's Name _____ **Position Held** _____

Dates of Employment (From month & year – To month & year) _____ **Current / Former Employer** _____

City _____ **State** _____ **Supervisor's Name** _____

☐ I hereby give permission to the above named employer to release information to Agency regarding my performance while employed at the facility.

Applicant's Signature _____ **Date** _____

Employment History

The person above is applying for an employment with Agency Staffing and has listed you as previous employer. We would appreciate your assistance in verifying employment and evaluating job performance. All information will be treated with utmost confidentiality.

Is this employee eligible for rehire? ☐ **YES** ☐ **NO**

Personal Evaluation	Above Average	Satisfactory	Did not meet expectations	Poor
Clinical Competency	☐	☐	☐	☐
Quality of Work	☐	☐	☐	☐
Quantity of Work	☐	☐	☐	☐
Attitude and Cooperation	☐	☐	☐	☐
Ability to get along with others	☐	☐	☐	☐
Adaptability to Work Situations	☐	☐	☐	☐
Dependability	☐	☐	☐	☐
Attendance and Punctuality	☐	☐	☐	☐
Personal Appearance	☐	☐	☐	☐

Comments:

Employer's Signature _____ **Title** _____ **Date** _____

Note to Staffer – Please indicate this is verbal Verification: _____

Employee Handbook Acknowledgement Form

I acknowledge that I have received a copy of Agency Employee Handbook. I acknowledge that I have been informed that the complete Agency employee handbook.

I understand that in processing my application with Agency an investigation may be made in which information is obtained through personal interviews, and a review of information held by law enforcement or other government agencies. I authorize you to verify my past employment and education, criminal records, motor vehicle records, personal references, and other job related data provided on this application, or via the interview process. I authorize appropriate individuals, companies, institutions or agencies to release information, and I release them from any liability as a result of such inquires or disclosures. A consumer report may be generated summarizing this information. I further understand and waive my right of privacy in this investigation and release and hold harmless Agency from any liability. I agree that any decision to hire me is contingent upon the results of my report and certify that all statements and answers on my application, resume, or Interview are true and complete to the best of my knowledge. I understand that if any statements are false or that if information has been omitted, this will be cause for disqualification and immediate termination of my employment if employed. I further authorize Agency to check my credit and conviction records, as needed, on a continuous basis as it relates to my employment. I am granting Agency authorization to release confidential medical Information upon the request from Agency clients while I am actively workingat the client's facility and /or during the profiling and placement processes.

I understand that Agency's goal is to always provide me with a consistent level of service. If for any reason I am dissatisfied with Agency' service or the service providedby one of Agency Clients, I am encouraged to contact the local manager to discuss the issue. Agency has processes in place to resolve customer complaints in an effective and efficient manner. If the resolution does not meet my expectation, I am encouraged to call the Agency corporate office. A corporate representative will work with me to resolve my concern. I understand that any individual or organization that has a concerns about the quality and safety of patient care delivered by Agency healthcare professionals, which has not been addressed by Agency management, is encouraged to contact the State Regulatory. Agency demonstrates this commitment by taking no retaliatory or disciplinary action against employees when they do report safety or quality of care.

I have read and understand the entire Agency policies and my requirements.
I understand that if I have any questions and/or need clarification for items addressed in the handbook, it is my responsibility to contact the Agency office to discuss.

_____	_____	_____
EMPLOYEE NAME	**EMPLOYEE SIGNATURE**	**DATE**

CONFIDENTIALITY AGREEMENT

It is the responsibility of all Healthcare workforce members, including employees, medical staff, and office staff to preserve and protect confidential patient, employee and business information.

The Federal Health Insurance Portability Accountability Act (the "Privacy Rule"), govern the release of patient identifiable information by home health agencies and other health care providers. These laws establish protections to preserve the confidentiality of various medical and personal information and specify that such information may not be disclosed except as authorized by law or the patient or individual.

Confidential Patient Care Information includes: Any individually identifiable information in possession or derived from a provider of health care regarding a patient's medical history, mental, or physical condition or treatment, as well as the patients and/or their family members records, test results, conversations, research records and financial information. (Note: this information is defined in the Privacy Rule as "protected health information.") Examples include, but are not limited to:

- Physical medical and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;
- Patient insurance and billing records;
- Computer and department based computerized patient data; and
- Visual observation of patients receiving medical care or accessing services; and
- Verbal information provided by or about a patient

Confidential Employee and Business Information includes, but is not limited to, the following:

- Employee home telephone number and address:
- Spouse or other relative names;
- Social Security number or income tax withholding records;
- Information related to evaluation of performance;
- Other such information obtained from the Agency records which if disclosed, would constitute unwarranted invasion of privacy; or
- Disclosure of Confidential business information that would cause harm to AGENCY.

I understand and acknowledge that:

1. I shall respect and maintain the confidentiality of all discussions, deliberations, patient care records and any other information generated in connection with individual patient care, risk management and/or peer review activities.

2. It is my legal and ethical responsibility to protect the privacy, confidentiality and security of all medical records, proprietary information and other confidential information relating to AGENCY and its affiliates, including business, employment and medical information relating to our patients, members, employees and health care providers.

3. I shall only access or disseminate patient care information in the performance of my assigned duties and where required by or permitted by law, and in a manner which is consistent with officially adopted policies of AGENCY,

or where no officially adopted policy exists, only with the express approval of my supervisor or designee. I shall make no voluntary disclosure of any discussion, deliberations, patient care records or any other patient care, peer review or risk management information, except to persons authorized to receive it in the conduct of AGENCY affairs.

4. AGENCY Administration performs audits and reviews patient records in order to identify inappropriate access.

5. My user ID is recorded when I access electronic records and that I am the only one authorized to use my user ID. I will only access the minimum necessary information to satisfy my job role or the need of the request.

6. I agree to discuss confidential information only in the work place and only for job related purposes and to not discuss such information outside of the work place or within hearing of other people who do not have a need to know about the information.

7. I understand that any and all references to HIV testing, such as any clinical test or laboratory test used to identify HIV, a component of HIV, or antibodies or antigens to HIV, are specifically protected under law and unauthorized release of confidential information may make me subject to legal and/or disciplinary action.

8. My obligation to safeguard patient confidentiality continues after my termination of employment with the AGENCY.

I hereby acknowledge that I have read and understand the foregoing information and that my signature below signifies my agreement to comply with the above terms. In the event of a breach or threatened breach of the Confidentiality Agreement, I acknowledge that the AGENCY may, as applicable and as it deems appropriate, pursue disciplinary action up to and including my termination from the AGENCY.

Dated: _____ Signature: _____

Print Name: _____

Department/Role: Other-_____

Acknowledgement of Annual Education and Confidentiality of Patient Healthcare Information

Administrative

Code Of Conduct

Standards of Conduct

- Dress Code / Fingernail Policy
- Substance Abuse : Drugs in the Workplace
- Sexual and Other Unlawful Harassment
- Customer service
- Physical Assault / Workplace Violence
- Child & Elder Abuse

Safety Management

- Life Safety (FIRE) Management
- Environmental Safety
- Emergency Preparedness / Disaster Safety
- Electrical Safety
- Chemical Safety / Hazardous Communications

Joint Commission Education

- National Patient Safety Goals
- Do-Not-Use Abbreviations
- Infection Control
- CDC Hand Hygiene Guidelines
- Isolation and Standard Precautions
- Bloodborne Pathogens
- Tuberculosis

Medication Safety and Documentation System (MSDS)

Suspected Abuse : Identification, Treatment and ReportingDomestic Violence

Nursing Essentials

- Restraints
- End Of Life Care
- Emergency Codes
- Age specific
- EducationEMTALA
- The HIPPA Privacy
- RuleBody Mechanics
- Advance Directives
- UnderstandingCultural Diversity
- Discharge Planning
- Patient Rights and Responsibilities
- UtilityManagement
- Patient Education
- Medical Equipment
- ManagementPain Management
- Radiation
- SafetyFall
- Prevention

Preventing Medication Errors

Compliant Resolution (Staff and Customer)Human Resources

Performance Improvement and Education ProgramReporting Any Issues

Clinical Incidents and Sentinel Events

I understand that the above mentioned materials provide guidelines and summary information about the company's policies and procedures. I also understand that it is my responsibility to read, understand, become familiar with, and comply with the standards that have been established.

Name : _____

Signature : _____

Date : _____

Authorization to Disclose information on Employment file,Background check, Medical Records and Drug Screening

By affixing my signature hereunder, I authorize Agency to release any andall confidential employment background check and medical information contained in my employment file to any medical facility or entity with which Agency has staffing agreement, and to any other governmental or regulatory agency such agency's request. Forall other purposes, Agency Staffing, Inc, shall keep my employment confidential and shall advise any medical facility or other entity to which records have been provided to also keep such record confidential. I hereby hold Agency harmless for any result (s)that arises with regards to the release of this confidential information by Agency Medical records information is confidential and Agency will instruct client facilities and / or other entities to treat the provided information confidential as well.

I consent to a urine, blood or breath sample for the purpose of an alcohol drug, intoxicant or substance abuse screening test. Furthermore, I consent to the release of the results for purposes fordetermining the fitness of employment or continued employment.

I authorize Agency to contact past employers and references regarding myemployment history. I hereby release all previous employers and references from any liability for furnishing this information in this application, reference information and medical information to Agency and any facilities I might be sent on assignment.

My signature hereunder further indicated that I have read and understood the Employee authorization to release confidential information on employment file, background check, medicalrecords and drug screening.

I certify that the facts contained in this application are true and accurate. I authorize the employer to investigate any and all questions relating to this application. I release all parties from all liability, including but not limited to, the employer and any person, firm or corporation who provides information concerning my prior education, employment or character.

Agency does not discriminate in respect to hiring, termination, compensations and all other terms and conditions of privileges of employment on the basis of race,color, national origin, ancestry, sex, age, pregnancy or related medical conditions, marital status, religious creed or disability.

_____	_____	_____
Name (Print Name)	**Signature**	**Date**

PHYSICIAN'S STATEMENT

I hereby authorize Agency Staffing to use or disclose this information to its client facilities, which may be relevant in evaluating my qualifications for employment opportunities and relatedactivities.

_____ _____

Applicant Signature Date

I certify that _____ is in good physical and mental health, free of any communicable diseases, and is able to physically perform the job functions without restrictions.

_____ _____

Patient's Date of Birth Patient's Social Security Number

_____ _____

Physician's Signature Date of Medical Examination

_____ _____

Physician's License Number Physician's Name

CLINIC STAMP:

(Please make sure to have this stamped by the clinic)

TB QUESTIONNAIRE

Employment Name: _____ **Date:** _____

STEP I:
If you have had a positive PPD in the past, **go to STEP II.** If you received PPD's on an annual basis, complete **STEP I ONLY**.

DATE OF LAST PPD:_____/____/_____ **RESULTS OF LAST PPD IN MM:** _____

STEP II:
Since you have had a positive / sensitive PPD and are no longer required to have an annual chest x-ray, the following is to be completed annually and maintained in the personnel file. However, you must have the results of at least one XRAY on file.

DATE OF LAST XRAY:____/____/_____

Please read and put a checkmark in the correct YES / NO space if you are experiencing any of the following symptoms or if any of the following apply to you:

	YES	NO
1. Unplanned loss of weight (>10% of body weight)	☐	☐
2. Night sweats	☐	☐
3. Fever lasting several weeks	☐	☐
4. Frequent coughing in the absence of a cold or flu	☐	☐
5. Coughing blood-streaked sputum	☐	☐
6. Unusual tiredness or weakness lasting weeks	☐	☐
7. Pain in chest when taking a breath	☐	☐
8. Have you been recently diagnosed with diabetes, silicosis, HIV disease, renal disease or liver disease?	☐	☐
9. Have you been recently been exposed to a family member or other with active TB?	☐	☐

If you checked YES to any of the above questions, are you currently treating with a physician?

☐ **YES** ☐ **NO**

Please explain:

_____

_____

_____

IF YOU DEVELOP ANY OF THE SYMPTOMS LISTED ABOVE, PLEASE CONTACT YOUR PHYSICIAN AND AGENCY **IMMEDIATELY**. A CHEST X-RAY **MUST** BE PERFORMED PRIOR TO WORKING AGAIN.

SIGNATURE: _____

Hepatitis B Vaccine informed consent / waiver

HEPATITIS B

Is a viral infection caused by Hepatitis B virus (HBV) which causes death in 1-2% of patients. Most people with hepatitis B recover completely but approximately 5-10% becomes 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 live cancer.** Thus, immunization against hepatitis can prevent acute hepatitis and also reduce sickness and death from chronic active hepatitis, cirrhosis and liver cancer.

VACCINE

The Hepatitis B vaccine is produced from the plasma of chronic HBV carriers. The vaccine consists of highly purified formalin-inactivated hepatitis B antigen (viral coating material). It has been extensively tested for safety in chimpanzees and three doses of vaccine achieve high levels of surface antibody.
(anti-HBS) and protection against Hepatitis B. Persons with immune system abnormalities such as dialysis patients have less response to the vaccines but, over half of those receiving it do develop antibodies. Full immunization requires 3 doses of vaccine over 6 month's period although; some persons may not develop immunity after 3 doses. There is no evidence that the vaccine has ever caused hepatitis B or AIDS. 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, but is probably long term.

POSSIBLE SIDE EFFECTS

The incidence of side effects is very low. No serious side effects have been reported with the vaccine. A few persons experienced tenderness and redness at the site injection. Low grade fever may occur. Rash, nausea, joint pain and mild fatigue have also been reported. The possibilities exist that more serious side effects may be identified in the future.

☐ *Declination*

I understand that due to my occupational exposure to blood and other potentially infectious materials. I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been informed and have the opportunity to ask questions and understand the benefits and risks of Hepatitis B vaccine. I understand that I must have three (3) doses of vaccine to confer immunity. However, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience an adverse side effects from the vaccine. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B which is a serious disease.

Name:_____ Position: Other-_____ Date: _____

☐ *Attestation*

I have already been vaccinated for Hepatitis B. I will be able to provide the proper documentation or record of my vaccination.

*Name:*_____ *Position:* Other-_____ *Date:*_____

Respiratory Fit Test

Participant's Name (Please print): _____

Classification:_____Sensitivity # (Number of squeezes needed to detect taste): _

Breathing normally	**Pass**	**Fail**
Breathing deeply	**Pass**	**Fail**
Turning head from side to side	**Pass**	**Fail**
Nodding head up and down	**Pass**	**Fail**
Resuming normal breathing	**Pass**	**Fail**
Bending Over	**Pass**	**Fail**
Grimace (15 seconds)	**Pass**	**Fail**
Speaking	**Pass**	**Fail**

Based on standard criteria used in respiratory fit-testing procedures, the above participant has the following designation after being tested:

Alpha Protech N95 **3M N95**

The above participant has been determined to be fitted for the following size respirator:

SMALL **MEDIUM** **LARGE**

Tested By (Print Name):_____

Tester's Signature:_____Date: _____

Safe use of respiratory equipment is the responsibility of the user. Re-testing shall be performed in the event of a weight change of 20 pounds or more, significant facial scarring, major dental changes, cosmetic surgery or any other change which may affect respirator sealing. It is the responsibility of the wearer to inform their supervisor of the OSHA-regulated facility of any changes necessary for re-testing.

Participant's Signature:_____Date: _____

Vaccination Attestation Form

COVID-19 VACCINE

☐ I have been vaccinated for Covid-19. Date _____(On file agency)

☐ I have a contraindication to receiving the Covid-19 vaccine.

☐ I decline the Covid-19 vaccine, and I understand that because I work in a healthcare environment I may place patients or co-workers at risk of illness or death if I work while infected with Covid-19 virus. I am required to wear a mask at all times while in any clinical area. My agency and manager, including division and department leadership will be notified that I declined.

ANNUAL FLU VACCINE

☐ I have been vaccinated for influenza this flu season. Date_____ (On file with agency)

☐ I have a contraindication to receiving the influenza vaccine.

☐ I decline the influenza vaccine, and I understand that due to my occupational exposure, I may be at risk of acquiring influenza infection. In addition, I may spread influenza to my patients and other healthcare workers, and my family, even if I have no symptoms. This can result in serious infection, particularly in persons at high risk for influenza complications. Accordingly, I understand that for infection control purposes I will be required to wear a surgical mask (except in the main lobby or cafeteria) throughout the flu season.

H1N1 VACCINE

☐ I have been vaccinated for H1N1 flu season. Date _____(On file agency)

☐ I have a contraindication to receiving the H1N1 flu vaccine.

☐ I decline the H1N1 vaccine, and I understand that because I work in a healthcare environment I may place patients or co-workers at risk of illness or death if I work while infected with H1N1 (flu) virus. I am required to wear a mask at all times while in any clinical area during the influenza season. My agency and manager, including division and department leadership will be notified that I declined.

_____

Signature

_____

Print Name

_____

Date of Attestation

_____

Agency Representative Signature

TDAP Immunization Declination Form

I understand that my occupational exposure to patients, blood or other potentially infectious materials at healthcare facilities with the following vaccine preventable diseases puts me at risk of acquiring the disease. I have had the opportunity to be vaccinated, however, I choose to decline the vaccination(s) checked below at this time. I understand that by declining vaccine protection I continue to be at risk of acquiring the disease.

☐ I have received the TDAP vaccine on_____(date)

☐ I have received TD vaccine on_____(date)

☐ I refuse vaccination at this time

I understand that in the event of exposure, I may be requested to not visit healthcare facilities for at least the incubation period of the disease to which I have been exposed.

I acknowledge that each healthcare facility determines vaccination requirements, and that a vaccination declination may not satisfy these requirements.

Printed Name: _____

Signature: _____

Date: _____

Welcome to our Agency. Your employment at Agency is at will and either party may terminate employment with or without cause. This agreement is not designed to be a contract or to alter the at-will nature of the employment relationship. If you accept employment with Agency, you agree to abide by the Company's rules and policies set forth in this agreement and in the employee manual.

1. I understand that I will be required to provide, in a timely manner, all necessary documentation, including but not limited to, my resume, licenses, certificates, physical report, drug screens, background checks etc. in order for me to be approved for any travel/per-diem assignment with a Agency client. Failure to do so may result in termination of my employment with Agency.

2. I understand that as part of the above approval process, an investigation may be made in which information is obtained through personal interviews, and a review of information held by law enforcement or other government agencies. I hereby authorize you to verify my past employment and education, criminal records, motor vehicle records, personal references, and other job related data provided on this application, or via the interview process. I authorize appropriate individuals, companies, institutions or agencies to release information, and I release them from any liability as a result of such inquiries or disclosure.

3. I understand that I am not in any obligation to accept an assignment offered by Agency. But once I accept a travel/per-diem assignment, I pledge the following:

    a. To cooperate with the Client's reasonable instructions and accept the direction, supervision, and control of any and all responsible person(s) in the Client facility
    b. To observe any relevant rules and regulations of the Client facility to which my attention has either been drawn or which I might reasonably be expected to ascertain
    c. To not engage in any conduct detrimental to the interests of the Client
    d. To honor my commitment to complete any assignment/shift that I have accepted. If I fail to complete any assignment/shift, I understand that I have voluntarily terminated my employment with Agency.

4. I understand that I am to contact my Agency representative immediately if I am experiencing any difficulty on my assignment/shift or if there are any changes in job description, location, or working hours by the Client.

5. I am to contact Agency immediately if it is impossible for me to report to work. Agency staffers are available 24/7, so you may call us any time of the day or night. Please call us in enough time that we might schedule a replacement f or your position. **I understand that if I do not report to my assignment and/or do not call Agency, I have voluntarily terminated my employment with Agency.** I understand that I must notify Agency beforehand if I am late for work or take time off, **failing which I understand that I have voluntarily terminated my employment with Agency.**

6. If I am confirmed for a shift and I cancel my availability for that shift later than 2 hours before the start of that shift, then I may be required to pay a late cancellation fee equivalent to 4 hours times the Client bill rate. The late cancellation penalty will be applied to my payroll by deducting the full amount from the next payroll cycle.

7. While on a temporary assignment, if the Client offers me a permanent position or if one is discussed, I will contact my Agency representative immediately. All fees and conditions are to be handled by Agency. It is unlikely that one of Agencys' Clients would ask me to work for them on my own rather than through Agency. I understand that if I go work directly for a Client within one year of my temporary assignment, I will be responsible for paying all employment fees or charges incurred.

8. I understand that Agency is committed to maintaining a safe working environment for all employees. If I am ever asked to do anything unsafe, observe unsafe working conditions, or am injured at work, I will contact Agency immediately. Furthermore, I agree to perform all work in as safe a manner as possible. If I experience an accident or injury while working for Agency, I will notify Agency within 48 hours of the incident.

9. I understand that all client and patient information supplied to me shall be held in strictest confidence, and all product and materials, including, but not limited to, patent records, client records, documentation, reports, charts, manuals, letters, programs and any and all other sources of information given to me or obtained by me from the client or at the work location will be returned to the Client at the completion of my shift/assignment. I also agree not to disclose any company trade secrets or confidential information of Agency or its Client to any other entities or individuals.

10. Agency issues paychecks every Week for the hours worked in the preceding week. I understand I am required to present to Agency, EVERY MONDAY, an actual timesheet signed by the Client in order to have my paycheck issued on Friday. If I fail to provide such time card in a prompt manner, I understand that it will result in my pay being carried over to the next pay period.

11. I understand that ALL overtime hours must be pre-authorized by Agency. If I work overtime that is not pre- authorized, I accept and understand that I will not be paid for those hours. I further understand that all matters relating t o the Agency wages and rates are confidential and I will not discuss them with Clients, other employees of client or Agency, or any co-worker at the work location, and in doing so, could result in my immediate dismissal from the assignment and possible termination from Agency.

12. I understand that any monies due Agency resulting from loans, advances, damaged property, lost property including badges, or unauthorized use of property, including, but not limited to late shift cancellation penalties, the unauthorized or improper use of telephone, postage meters, computer equipment, software etc. at Agency or the Client, may be deducted from my paycheck(s).

13. **When assigned to a contract or per-diem assignment, I understand that within 24 hours from the last day of my assignment, I am required to confirm my availability for a new assignment. I understand that it must be in WRITING ONLY, by either email to OR fax. I accept and understand that when I do not email or fax my availability within the specified time period, I am refusing further work with Agency and thereby voluntarily resigning from my employment with Agency. I understand that my unemployment benefits may be denied when I voluntarily resign my employment with any company.**

14. I understand that the assignment is based on the agreement between Agency Staffing and the Client Facility. Client Facility has the right and privilege to cancel or modify the terms of the assignment with or without notice. I understand and accept that Agency will not be liable for any consequential damages, losses, expenses, inconveniences, or loss of alternative employment as a result of Client Facility's changes to the assignment. I understand Agency Staffing will be obligated to pay only for the approved hours worked as indicated on a client-approved timesheet.

15. I understand and agree that in case of dispute or controversy arising from or relating to this Employment Agreement, the matter shall be referred for resolution to Agency, whose decision shall be final and binding on both parties.

As a condition of my employment with Agency, I hereby acknowledge and agree to the above on this day of _____ . I acknowledge that before I signed the document, I was provided a copy for my review and was advised to seek legal counsel before signing this document.

PRINT NAME	**SIGNATURE**
WITNESSED BY	**DATE**

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

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

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

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

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

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

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

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

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

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

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

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

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

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

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)
Capital Area Health Consortium 270 Farmington Ave, Ste 352 Farmington, CT 06032		51-0173264

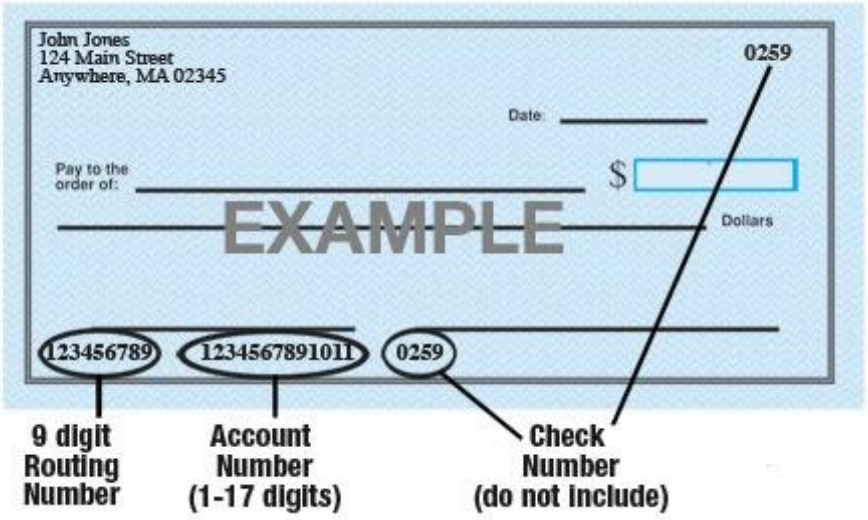
Direct Deposit Authorization Form

Please print and complete ALL the information below.

Name: _____

Address: _____

City, State, Zip: _____



Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Amount: ☐ $ _____ ☐ _____% or ☐ Entire Paycheck

Type of Account: ☐ Checking ☐ Savings (Circle One)

Please attach a voided check for each bank account to which funds should be deposited.

Agency is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee Signature: _____

Date: _____

ACH AUTHORIZATION AGREEMENT

Company Name:		Company ID#	

I hereby authorize **Agency** to initiate credit entries and to initiate, ifnecessary, debit entries and adjustments for any error to my *(select one)* checking or savings account at the depository financial institution named below.

I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

Depository Financial Institution Name:					
Branch:					
City:		State:		Zip:	
Routing #:					
Account #:					

IMPORTANT: Attach a VOIDED check for the above referenced account to this form.

This authorization is to remain in full force and effect until **the Agency** hasreceived written notification from me of its termination in such time and in such manner as to afford the Payroll Specialist and DEPOSITORY a reasonable opportunity to act on it.

Name:	
	(Please Print.)
Signature:	
Date:	