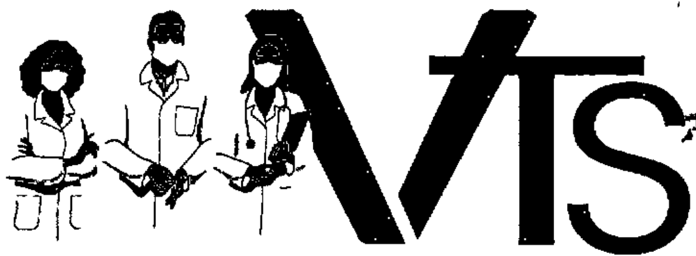


Employment Application Packet

Please complete this Application Packet and send back by e-mail at
info@virginiatelehealth&staffing.com

To ensure our compliance with the standards of both our clients and the Joint Commission, Virginia Telehealth & 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. CA 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 Titer, Rubeola Titer, Mumps Titer
   - Vaccine Zoster Titer, Immunity by History of Disease as Verified by MD and Vaccination
10. Hepatitis B Declination, Proof of Series, or Titer 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 staff? 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 ____

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 an emergency. Please provide that information below for our files and reference.

Primary Contact: ______________________________
Relationship: ______________________________
Address: ______________________________
____
____
____
____
Contact No.: ______________________________

Secondary Contact: ______________________________
Relationship: ______________________________
Address: ______________________________
____
____
____
____
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: ____________________

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: ________________________________

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 under the Penal code 1203.45b. Any conviction specified in Health and Safety code section 11361.5 which pertains to various marijuana offenses (a conviction will not necessarily disqualify you from consideration for employment).

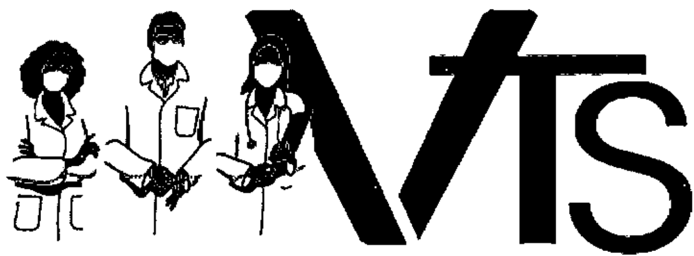
7. been arrested and are you out on bail on your own recognizance and still awaiting trial? ___________________

8. been released or discharged from employment or resigned to avoid such release or discharged?

   If yes, please provide dates and circumstances? ___________________

9. Has your driver's license been 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 Virginia Telehealth & Staffing in compliance with the Virginia Law. It also acknowledges that I am aware that it is my responsibility to review policy and procedure documents of each hospital/facility in which I work, prior to beginning my initial shift.

____

Applicant's Signature Date Position

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

____

Evaluator's

Employment Reference Check

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 **Current / Former Employer**

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

I hereby give permission to the above named employer to release information to Virginia Telehealth & Staffing regarding my performance while employed at the facility.

Applicant's Signature **Date**

Employment History

The person above is applying for employment with Virginia Telehealth & Staffing and has listed you as a 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: ________________________________

Employment Reference Check

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 **Current / Former Employer**

____

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

I hereby give permission to the above named employer to release information to Virginia Telehealth & Staffing regarding my performance while employed at the facility.

____

Applicant's Signature **Date**

Employment History

The person above is applying for employment with Virginia Telehealth & Staffing and has listed you as a 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: ______________________________

Name: ______________________________ **Date:** ______________

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 Reporting
Domestic Violence
Nursing Essentials

- End Of Life Care
- Emergency Codes
- Age specific Education
- EMTALA
- The HIPPA Privacy Rule
- Body Mechanics
- Advance Directives
- Understanding Cultural Diversity
- Discharge Planning
- Patient Rights and Responsibilities
- Utility Management
- Patient Education
- Medical Equipment Management
- Pain Management
- Radiation Safety
- Fall Prevention

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: ___________________

Employee Handbook Acknowledgement Form

I acknowledge that I have received a copy of Virginia Telehealth & Staffing Employee Handbook.

I understand that in processing my application with Virginia Telehealth & Staffing 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 inquiries 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 Virginia Telehealth & Staffing 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 Virginia Telehealth & Staffing to check my credit and conviction records, as needed, on a continuous basis as it relates to my employment. I am granting Virginia Telehealth & Staffing authorization to release confidential medical Information upon the request from Virginia Telehealth & Staffing clients while I am actively working at the client's facility and /or during the profiling and placement processes.

I understand that Virginia Telehealth & Staffing's goal is to always provide me with a consistent level of service. If for any reason I am dissatisfied with Virginia Telehealth & Staffing' service or the service provided by one of Virginia Telehealth & Staffing Clients, I am encouraged to contact the local manager to discuss the issue. Virginia Telehealth & Staffing 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 Virginia Telehealth & Staffing corporate office at (720) 288-3739. A corporate representative will work with me to resolve my concern. I understand that any individual or organization that has a concern about the quality and safety of patient care delivered by Virginia Telehealth & Staffing healthcare professionals, which has not been addressed by Virginia Telehealth & Staffing management, is encouraged to contact the Joint Commission at www.jointcommission.org or by calling the Office of Quality Monitoring at 630 792 5636. Virginia Telehealth & Staffing demonstrates this commitment by taking no retaliatory or disciplinary action against employees when they do report safety or quality of care concerns to the Joint Commission.

I have read and understand the entire Virginia Telehealth & Staffing policies and my requirements as a Virginia Telehealth & Staffing employee in particular the Section entitled "Do Not Send policy and Process".
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 Virginia Telehealth & Staffing office to discuss.

____________________	____________________	__________
EMPLOYEE NAME	**EMPLOYEE SIGNATURE**	**DATE**

Virginia Telehealth and Staffing

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

By affixing my signature hereunder, I authorize Virginia Telehealth & Staffing to release any and all confidential employment background check and medical information contained in my employment file to any medical facility or entity with which Virginia Telehealth & Staffing has staffing agreement, and to any other governmental or regulatory agency such agency's request. For all other purposes, Virginia Telehealth & Staffing, shall keep my employment confidential and shall advise any medical facility or other entity to which records have been provided to also keep such records confidential. I hereby hold Virginia Telehealth & Staffing harmless for any result (s) that arises with regards to the release of this confidential information by Virginia Telehealth & Staffing Medical records information is confidential and Virginia Telehealth & Staffing 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 for determining the fitness of employment or continued employment.

I authorize Virginia Telehealth & Staffing to contact past employers and references regarding my employment 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 Virginia Telehealth & Staffing 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, medical records 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.

Virginia Telehealth & Staffing 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 Virginia Telehealth & Staffing to use or disclose this information to its client facilities, which may be relevant in evaluating my qualifications for employment opportunities and related activities.

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 (printed)

CLINIC STAMP:

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

Virginia Telehealth and Staffing

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 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 in treatment with a physician?

______**YES** ______**NO**

VTS

Virginia Telehealth and Staffing

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% 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 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 any 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: ________________________________ 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: ________________________________ 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		
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

ANNUAL FLU VACCINE

I have been vaccinated for influenza this flu season. Date: ______________ (On file 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

LATEX ALLERGY QUESTIONNAIRE

EMPLOYEE NAME: ________________________________ POSITION: __________________________

1. Please check the appropriate answer:
   - Are you allergic to latex? YES____ NO____
     - o Do you wear latex gloves? YES____ NO____
   - Do you suffer from skin rashes on your hands? YES____ NO____
2. If you have ever worn latex gloves: YES____ NO____
   - Have you had a rash, itching, or cracking of your hands? YES____ NO____
   - Have these symptoms recently changed? YES____ NO____
   - Have you been using different types of rubber gloves? YES____ NO____
   - If you have tried non-latex gloves, did your problem persist? YES____ NO ____
3. When you are wearing or around others that wearing latex gloves, have you noted any:
   - Itchy red eyes, sneezing, runny or stuffy nose? YES____ NO____
   - Shortness of breath, wheezing, or chest tightness? YES____ NO____

4. If you have answered YES to any of the above questions, please explain:

____
____
____

EMPLOYEE SIGNATURE: ___________________________ DATE: __________

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: ________________________

Virginia Telehealth and Staffing

Welcome to Virginia Telehealth & Staffing. Your employment at Virginia Telehealth & Staffing 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 Virginia Telehealth & Staffing, 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 Virginia Telehealth & Staffing client. Failure to do so may result in termination of my employment with Virginia Telehealth & Staffing.

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 Virginia Telehealth & Staffing. 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 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 Virginia Telehealth & Staffing.

4. I understand that I am to contact my Virginia Telehealth 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 Virginia Telehealth immediately if it is impossible for me to report to work. Virginia Telehealth staff are available 24/7, so you may call us any time of the day or night; however our normal office hours are 8:00 am to 5:00 pm, Monday to Friday. Please call us in enough time that we might schedule a replacement for your position. **I understand that if I do not report to my assignment and/or do not call Virginia Telehealth & Staffing, I have voluntarily terminated my employment with Virginia Telehealth & Staffing.** I understand that I must notify Virginia Telehealth & Staffing beforehand if I am late for work or take time off, **failing which I understand that I have voluntarily terminated my employment with Virginia Telehealth & Staffing.**

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

Virginia Telehealth & Staffing representative immediately. All fees and conditions are to be managed by Virginia Telehealth & Staffing. It is unlikely that one of Virginia Telehealth & Staffing's' Clients would ask me to work for them on my own rather than through Virginia Telehealth & Staffing. 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 Virginia Telehealth 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 Virginia Telehealth & Staffing 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 Virginia Telehealth & Staffing, I will notify Virginia Telehealth & Staffing 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 Virginia Telehealth & Staffing or its Client to any other entities or individuals.

10. Virginia Telehealth & Staffing issues paychecks every Friday for the hours worked in the preceding week. I understand I am required to present to Virginia Telehealth & Staffing, EVERY MONDAY, an actual timesheet signed by the Client to have my paycheck issued on Friday. If I fail to provide such a timecard 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 Virginia Telehealth & Staffing. 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 to the Virginia Telehealth & Staffing wages and rates are confidential and I will not discuss them with Clients, other employees of client or Virginia Telehealth & Staffing, 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 Virginia Telehealth & Staffing.

12. I understand that any monies due Virginia Telehealth & Staffing 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 Virginia Telehealth & Staffing 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 info@virginiatelehealth&staffing.com 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 Virginia Telehealth & Staffing and thereby voluntarily resigning from my employment with Virginia Telehealth & Staffing. 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 Virginia Telehealth & 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 Virginia Telehealth & Staffing will not be liable for any consequential damages, losses, expenses, inconveniences, or loss of alternative employment because of Client Facility's changes to the assignment. I understand Virginia Telehealth & 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 Virginia Telehealth, whose decision shall be final and binding on both parties.

As a condition of my employment with Virginia Telehealth & Staffing, I hereby acknowledge and agree to the above on this _____________day of _____, 20____. 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 NAMESIGNATURE

____ ________________________________

WITNESSED BY **DATE**

Registered Nurse Competency/ Skills Checklist

Please check the column that applies to your skill level:
0 = No experience,
1 = Need Direction (<6months experience)
2 = Minimal assistance needed (<1 year experience)
3 = Very Competent (>1 year experience)

Name: ______________________________

Date: _____/_____/_____

SKILLS	3	2	1	0	SKILLS	3	2	1	0
NURSING ROLES	--	--	–	–	**MEDICATION ADMINISTRATION**	–	–	–	--
Charge Nurse					Narcotic control				
Team Leader					Inulin Administration				
PATIENT CARE DELIVERY	--	--	–	–	Skin Testing (intradermal injection)				
Team Nursing					Procedure				
Primary Nursing					Documentation				
NURSING PROCESS SKILLS	–	–	–	–	Reading Results				
Nursing History					Heparin Administration/ Lock				
Physical Assessments					Patient Controlled Analgesia				
Skin					Administration of Medications				
Cardiovascular					Oral				
Heart					IM				
Peripheral Vascular System					Subcutaneous				
Respiratory					Topical/ Medication Patches				
Neurological					Eye				
Abdomen					Ear				
Bowel					Nose				
Bladder					Unit Dose Medication Administration				
Musculoskeletal					Nebulizer/ Aerosol Medication Therapy				
Psychosocial Status					**INTRAVENOUS THERAPY**	–	–	–	–
Fail Assessment					Venipuncture Site Care				
Pain Assessment					Calculating and Monitoring Infusion Rate				
Elder/ Domestic					Infusion Pumps				
Patient Care Planning					PCA pumps				
Nursing Intervention					Insulin pump				
Patient Teaching					IV insertion				
Evaluation of Patient Care					Heparin Locks/ Saline Locks				
Discharge Instruction/ Planning					Angio Caths				
Documentation of Care Plan					Scalp Vein				

Registered Nurse Skills Checklist p. 4	3	2	1	0		3	2	1	0
Trans Nerve Stimulator					Neuro Surgery				
Pyxis					Cranial Hemorrhage				
Portable Vital Signs Monitor					AV Shunt Placement				
Cardiac/ Tele Monitors					Multiple Sclerosis				
Lead Placement					Encephalitis (Viral/ Infectious)				
Arrhythmia Interpretation					**CARDIAC**	–	–	–	–
Blood Glucose Meters					Angina				
Pulse Oxymetry					Aneurysm				
Incentive Spirometer					Post MI				
Emergency/ Crash Cart					Hypertensive Crisis				
Ambu Bag (PPV) Mask/ Valve					Open Heart Surgery (Pre & Post Op Care)				
HEPA Filters					CHF				
PAIN MANAGEMENT	–	–	–	–	Cardiac Cath				
Pain assessment using pain scales					Fem/ Pop Bypass				
Epidural Analgesia					**RENAL/ GI**	–	–	–	–
IV Conscious Sedation					Chronic/ Acute Renal Failure				
Patient Controlled Analgesia (PCA)					Renal Calculi				
Narcotic Agents					Renal Trauma				
Non-narcotic agents					Nephrectomy				
Non-pharmacological Measures					TURP				
CARE OF PATIENTS					Radical Prostectomy				
RESPIRATORY	–	–	–	–	Hemodialysis				
COPD					Pentoneal Dialysis				
ARDS					**GI/ ABDOMINAL**	–	–	–	–
Thoracic Surgery					Appendicitis				
Asthma					GI Bleed				
Inhalation Injuries					Pancreatitis				
Pneumonia					Bowel Obstruction				
Pneumothorax					Paralytic Ileus				
Tuberculosis					Liver Failure				
Pulmonary Edema					Hepatitis				
Pulmonary Embolism					Laparoscopic Abdominal Procedures				
NEUROLOGY	–	–	–	–	Open Abdominal Procedures				
CVA/ TIA					Post endoscopic procedures				
Overdose					Pre & Post op patients				
Head injury/ Trauma					**ORTHOPEDIC**	–	–	–	–
Neuro Injury/ Trauma					Amputation				
Spinal Cord Injury					Arthroscopic Surgery				
Paraplegia					Total Joint Replacement (Hips & Knees)				
Quadriplegia					Cast Care				

Registered Nurse Skills Checklist p. 5	3	2	1	0					
Orthopedic Trauma									
Skeletal Traction									
Bucks Extension									
Pin site Care									
Laminectomy									
Passive ROM Exercises									
GYNECOLOGY	–	–	–	–					
Mastectomy									
Hysterectomy									
Tubal Ligation									
Ectopic pregnancy									
Abdominoplasty									
Reconstructive Breast Surgery									
Thyroidectomy									
Assist/ Preform GYN Exam/ PAP									
Removal of Cysts									
OTHER	–	–	–	–					
Sickle Cell Anemia									
Transfusion Reaction									
Anaphylaxis									
Septic Shock									
Cancer patients									
Infectious Diseases and Complications									
HIV/AIDS									
Shingles (Herpe)									
Chicken pox									
West Nile Virus									
Lyme Disease									
Terminally ill patients									
Death & Dying									
Suicide/ Homicide precautions									

Registered Nurse Skills Checklist p. 2	3	2	1	0		3	2	1	0
IV Push Medications					Application of Crutches				
IV Piggyback Medications					Application of Knee Immobilizers				
IV Add-Mixture/ Additives					Monitoring CVP				
Blood/ Blood Products Administration					Care of Wound Drainage				
Monitoring Blood/ Blood Products					Hemovac Suction Device				
Lipids					Jackson Pratt Suction Device				
TPN/PPN					Care of G-tube				
Central Lines/ intravascular Access Ports					Care of Penrose Drains				
PICC Lines					Care of NG tubes/ Feeding tubes				
CHEMOTHERAPY	–	–	–	–	Care of Chest tubes/ Drainage system				
Administration of Chemo meds					Care of Salem tubes				
Precautions/ Teaching					Catheterization - male incontinence device				
Mixing/ Preparation					Catheterization- foley insertion				
Disposal					Catheterization- foley catheter care				
Chemotherapy Certified					Catheterization- foley removal				
NURSING PROCEDURES	–	–	–	–	Catheterization-straight catheter				
Irrigations					Gastric suction				
Eye					Electronic Thermometer				
Ear					Range of Motion: Active and Passive				
Foley					Seizure Precautions				
Suprapubic					Peri-Care				
Incision					Cast Care				
NG tube					Skin Care in Traction				
Ostomy					Incision Care				
Insertion of NG feeding tube					AV Shunt Care				
Hot Soaks					Bladder Irrigations				
Ice Packs					Infection Control Precautions				
Rectal Temperature					Standard Universal Precautions				
Removal of fecal impaction					Reverse Isolation				
Weighing patients					TB/ Airborne Precautions				
Vital Signs					MRSA/ VRE Precautions				
Application of Restraints					Urine, Sugar & Acetone				
Application of Support Binders					Blood Glucose Monitoring				
Application of Ace Wraps					Stool Hemocult				
Application of Antimobolic					Stocking Gastric Hemocult				
Application of Slings					Urine Specific Gravity				
Application of Soft Cervical Collar					Oxygen Therapy Administration				
Application of Rib Betts					Ambu bag				
Application of Clavicle Brace					Bag & Mask				
Application of Back Supports (Chairback. Jewett, Corsets)					BiPAP				

Registered Nurse Skills Checklist p. 3	3	2	1	0		3	2	1	0
Face Mask					Neuro Assessment				
Nasal Cannula					Glascow Coma Scale				
Tracheostomy Care					Seizure Precautions				
IPPB Rx					Seizure Activity				
Chest PT/ Breath Sounds					Mental Status/ LOC				
Postural Drainage					Halo Traction				
Specimen Collection					**ASSISTING WITH BASIC PROCEDURES**	–	–	–	–
Blood					Pelvic Exam				
Central Line					Physical Exam				
Venous Stick					Lumbar Puncture				
Cultures					Thoracenthesis/ Paracenthesis				
Sputum					Dressing Change				
Urine					Staple/ Suture Removal				
Clean Voided					Insertion of Central/ PA Catheter				
24-hour					Insertion of Arterial Line				
Sterile (Straight Cath)					Discontinue Arterial Line				
Swab Culture					Discontinue Central Lines				
Gastric Analysis					Insertion of Chest Tubes				
Abdominal Fluid					**EQUIPMENT**	–	–	–	–
Anaerobic Cultures					Hypothermia Blanket				
Aerobic Cultures					Pressure Mattress				
Wound Cultures					Restraints				
Stool Cultures					Halo Apparatus				
Suctioning					Traction				
Oral/ Yankeuer					Balance Traction				
Oral- pharyngeal					Footboard				
Nasal-pheryngeal					Foster/ Stryker Frame				
Tracheostomy					Cir-O-Electric Bed				
Wound/ Ostomy Care					Cradles				
Colostomy care/ bag change					Intermittent Suction				
Ileostomy care/ bag change					Wall Straight Suction				
Irrigations					Portable O2 Suction				
Pressure Ulcers					Straight Drainage				
Staging					Oxygen Wall Panel/ Flowmeter				
Care					Chest Tube Suction				
Statis Ulcers					Hoyer Lift				
Sterile Dressing Change					K-Pads				
Sterile Application					Nelson Bed				
Surgical Wounds with or without Drains					Pressure Relieving Beds				
Neuro Skills:					Kangaroo Pumps				