



Employment Application Packet

Please complete this Application Packet and send back by e-mail at info@virginiatelehealthandstaffing.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/ARRHYTHMIA 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 even 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: _____
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City and State: _____
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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: _____



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Attendance and Punctuality				
Personal Appearance				

Comments:

Employer's Signature

Title

Date

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

Name: _____

Date: _____



Do Not Send Prevention: Quiz

1. Its 4:45 a.m. and La Tasha Davis has just been confirmed for the day shift at a Medical Center across town from her. La Tasha lives across town from and has never been to the Medical Center. Which of the sequences below will provide La Tasha with greatest chances of making a great first impression and having a successful shift?

- a) Wake up at 6:15am., take a shower, get dressed, hit the road at and head in general direction of the facility and call directions from the car.
- b) Get out of bed at 05:00am to obtain detailed directions and the nursing office phone number.
- c) Eat a small healthy breakfast, shower, dress neatly, gather nursing tools (ID Badge, Medication book, stethoscope etc.) and be on the road by 05:45am.
- d) Get out of bed at 05:00am to go to the gym, come home, shower, get dressed, walk the dog, be on the road at 07:05am, call the staffing firm and say she got lost.
- e) Refuse to go to the Medical Center located across town, call the staffing firm at 07:30am and ask if the hospital she usually works and has any late call needs.

2. Lynn Carson RN is alone at the Nursing station in a facility in which she has been working twice a week, For over a year, she has been faxing a new order to the Pharmacy. Before Lynn leaves the Nursing station the the phone rings, and several lines are blinking. Which of the following answers is the best example of excellent customer service?

- a) Lynn looks around and sees the unit secretary speaking to the charge nurse, the nurse manager, and two executives with hospital badges and wearing suits and yells out to the secretary that the "Phones are ringing!" and walks away from the Nursing Station.
- b) Lynn answers the phone lines and politely explains to every caller that she is not the unit secretary, and cannot help them before hanging up and walking away from the Nursing Station.
- c) Lynn finishes faxing her new medication order to the Pharmacy, doesn't acknowledge any of the phones ringing and walks away from the Nursing Station.
- d) Lynn sits down at the Nursing Station, answers all the lines and directs the calls courteously and professionally. Lynn then remains at the Nursing Station, Handling the phones for a few minutes until the unit secretary returns. Lynn then passes along all relevant information upon being relieved.



3. Kenny Slater, RN has an extremely heavy assignment working day shift in a very busy Telemetry unit for the first time. Kenny's patients tell him he has done a great job. However, the night shift Charge Nurse makes Kenny a Do Not Send, stating incomplete documentation as the reason. Which of the options below is the most reliable way to prevent this from happening in the future?

- a) Kenny could have communicated the condition of his patients, explained how busy he was, asked for help and requested the day shift Charge Nurse to audit his charts several hours before his shift ended.
- b) Kenny could have avoided fulfilling his pts requests, not followed up on MD orders, and missing medications and made completing his documentation his first priority.
- c) Kenny could have stated that his assignment was unfair and unsafe then complained to his patients and their families.
- d) Kenny could have done nothing more; it wasn't his fault. It was the hospital's fault for giving him such a hard assignment and not showing him all the details of the documentation process in the first place.

4. An MD on a pediatric floor order .1mg of M.S prn q 1○ and a Dig level QD. Please write in the correct versions of the abbreviations used above, which comply with Joint Commission National Patient Safety Goals.

a) _____

5. It's 09:30 and Ude Amin, RN. Who also works as a Real Estate agent, is working in the ICU. At the end of her morning break, Ude checks her voice mail. Ude checks her voice mail. Ude finds out an offer for a 2 million dollar property, from one of her clients, has been accepted! Which of the following actions would be appropriate?

- a) Ude tells the Charge RN she has a severe family emergency and leaves the facility immediately.
- b) Ude excitedly calls the seller's broker back from the Nursing Station, and asks him to fax the counter offer to the ICU, so she can fax it to her client right away.
- c) Ude waits until her lunch break to call the seller's broker back. She uses her mobile phone outside of the hospital.
- d) Ude uses the Nursing Station computer, logs on to the internet, and prints out pictures of the 2-million-dollar house she just sold. she then borrows another RN's calculator to estimate the commission she expects to earn from the sale.

NAME: _____

DATE: _____



TERMINATION SCALE ACKNOWLEDGEMENT

1Point

- Attitude / lack of professionalism / customer service

2 Points

- Clinical Incompetence – poor clinical performance
- Poor time management
- Medication Error
- Documentation Deficiencies Lack of Compassion

3 Points

- Danger to patients.
- No call, No Show.
- Departing facility before end of shift secondary to dissatisfaction with assignments.
- Do Not Send from any Travel Assignment regardless of origin.

5 Points

- Illegal Behavior (Includes false identity, falsified documentation, use of or distribution of controlled substances etc.)
- PT. abandonment. When nurse is under investigation for above behavior they will be considered terminated until exonerated from all accusations.
- Error resulting in Pt. Death or Permanent physical or mental damage.
- Self-terminating travel assignment without proper notice to facility or Staffing Agency.

A nurse who receives 5 points will be considered for termination.

Any nurse involved in illegal activity will be terminated immediately.

I have read and understand the Termination Scale Policy of Virginia Telehealth & Staffing in particular the Section entitled "Do Not Send policy and Process."

SIGNATURE: _____



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



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)



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**



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 liver 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: _____



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



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@virginiatelehealthandstaffing.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 _____, 2025____. 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