Personal Profile

(Please complete even if attaching a resume)

Name (Last, First, Middle) ______ Specialty ______ Today's Date ______

Address ______ City ______ State ______ Zip ______

Home Phone # ______ Alternate Phone # ______ Cell Phone # ______ E-mail address (Print) ______

Date available: ______________________ Shift preferred: ☐ Day ☐ Night

Languages spoken other than English: ______________________

How were you referred to us? ☐ Advertising ☐ Website ☐ Associate/Friend ☐ Other ______________________

Can you submit verification of your legal right to work in the United States? ☐ Yes ☐ No

Are you able to perform the basic functions of the position for which you are applying with or without reasonable accommodations?
☐ Yes ☐ No

Have you ever been convicted of a crime that would prohibit you to function in a healthcare facility? ☐ Yes ☐ No

Are you willing to submit to a criminal background investigation? ☐ Yes ☐ No

Have you ever had disciplinary action taken against any of your licenses or are you currently the subject of a report or investigation? ☐ Yes ☐ No

You may be required to take and pass a drug and/or alcohol test as a pre-requisite

Emergency Contact

Primary contact: ______________________

Relationship: ______________________

Address: ______________________

____

Home phone: ______________________

Work phone: ______________________

Secondary contact: ______________________

Relationship: ______________________

Address: ______________________

____

Home phone: ______________________

Work phone: ______________________

For Office Use Only

Verified by: ______________________ Date: ______________

Approved by: ______________________ Date: ______________

Start date: ______________________

Professional Credentials & Personal References

Name: ____ Date: _________________

Education

1. College/University:________________________ Dates attended – From:_________ To:___________

   Location: ____________________________ Degree earned: ____________________________

2. College/University:________________________ Dates attended – From:_________ To:___________

   Location: ____________________________ Degree earned:____________________________

3. College/University:________________________ Dates attended – From:_________ To:___________

   Location:______________________________ Degree earned:___________________________

Licensure (Please include a copy of each)

State	Prof. License No.	Exp. Date	State	Prof. License No.	Exp. Date
_____	___________________	__________	_____	___________________	__________
_____	___________________	__________	_____	___________________	__________
_____	___________________	__________	_____	___________________	__________

Certifications (Please include a copy of each)

BCLS/CPR	Exp. date: ___________	**ACLS**	Exp. date: __________
NALS/NRP	Exp. date: ___________	**PALS**	Exp. date: __________
CEN	Exp. date: ___________	**CCRN**	Exp. date: __________
ENCP	Exp. date: ___________	**CNOR**	Exp. date: __________
CHEMO	Exp. date: ___________	**TNCC**	Exp. date: __________
Other	Exp. date: ___________	**Other**	Exp. date: __________

Personal References

Name ___________________________________Relationship ___________________ Phone No._______________

Address ____

Name __________________________________ Relationship ___________________ Phone No._______________

Address ____

Name __________________________________ Relationship ___________________ Phone No. ______________

Address ____

Job History (Please list in order, most recent first for the last seven (7) years)

Name: ______________________________ Date: ______________________

Date Employed: From ____________ to ______________ May we contact? □ Yes □ No
Hospital – Agency Name: ______________________ Position held: ______________________
Employer address: __________________________ Specialty/Unit: ______________________
__________________________________ Supervisor: ______________________
Duties and Responsibilities: ____
____

Date Employed: From ____________ to ______________ May we contact? □ Yes □ No
Hospital – Agency Name: ______________________ Position held: ______________________
Employer address: __________________________ Specialty/Unit: ______________________
__________________________________ Supervisor: ______________________
Duties and Responsibilities: ____
____

Date Employed: From ____________ to ______________ May we contact? □ Yes □ No
Hospital – Agency Name: ______________________ Position held: ______________________
Employer address: __________________________ Specialty/Unit: ______________________
__________________________________ Supervisor: ______________________
Duties and Responsibilities: ____
____

Date Employed: From ____________ to ______________ May we contact? □ Yes □ No
Hospital – Agency Name: ______________________ Position held: ______________________
Employer address: __________________________ Specialty/Unit: ______________________
__________________________________ Supervisor: ______________________
Duties and Responsibilities: ____
____

Reference Check

Name: ____

Current/Former employer: _______________________________ Dates of employment: __________________________

Address: ____ Position held: ________________________________

____ Phone no.: ___________________________________

Supervisor's name: ___________________________________ Title: ____

I hereby give permission to the above name employer to release information to Urgent Nursing Resource, Inc. regarding my performance while employed at that facility.

Signature: ____ Date: ____

Employer

The person above is registered with Urgent Nursing Resource, Inc. and has listed you as a current or previous employer. We would appreciate your assistance in verifying employment and evaluating job performance. All information is confidential.

Is this employee eligible for rehire: □ Yes □ No

Personal Evaluation	Excellent	Above average	Satisfactory	Below average	Poor
Quality of work					
Quantity of work					
Attitude					
Adaptability to work situations					
Dependability					
Cooperation					
Ability to get along with others					
Attendance and punctuality					
Personal appearance					

Other comments: ____

____

Signature: ____ Date: _____________________________________

Reference Check

Name: ____

Current/Former employer: _____________________________ Dates of employment: ___________________________

Address: ____ Position held: _________________________________

____ Phone no.: ___________________________________

Supervisor's name: __________________________________ Title: ______________________________________

I hereby give permission to the above name employer to release information to Urgent Nursing Resource, Inc. regarding my performance while employed at that facility.

Signature: ____ Date: _______________________________________

Employer

The person above is registered with Urgent Nursing Resource, Inc. and has listed you as a current or previous employer. We would appreciate your assistance in verifying employment and evaluating job performance. All information is confidential.

Is this employee eligible for rehire: □ Yes □ No

Personal Evaluation	Excellent	Above average	Satisfactory	Below average	Poor
Quality of work					
Quantity of work					
Attitude					
Adaptability to work situations					
Dependability					
Cooperation					
Ability to get along with others					
Attendance and punctuality					
Personal appearance					

Other comments: ____

____

Signature: ____ Date: ____________________________________

License/Certification Verification

Authorization

I hereby release from all liability the company or person completing this form, and authorize them to release all information regarding my professional license/certification and status.

Signature:____ Date: _______________________

Please confirm the professional license/certificate of the following individual:

Name: ____

Address: ____

City/State/Zip: ____

License Number: ______________________ License Status: ___________________

Confirmation

The above-named individual does not have actions or complaints pending and is considered in

good standing with ____

Other comments: ____

____

Verified by: ____ Date: _________________________

Signature/Position: ____

Confidentiality Statement

I must hold confidential and private all information pertaining to patients, patient records, client facility policies, and procedures.

All protected patient information shall be kept safeguarded pursuant to the policies and procedures at each facility, respectively, and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the regulations issued hereunder, and any applicable state law to prevent impermissible disclosure, loss or misuse, and to ensure that only authorized persons have access to such protected information.

I will consult the facility Director of Nursing in the event I have any questions regarding the scope or application of the privacy policies described in this statement.

Private and confidential information will only be released to an outside party when legally required to do so and to the extent minimally necessary to respond to the request.

Failure to maintain confidentiality and privacy may lead to disciplinary action as well as any actions designated by the appropriate disciplinary and/or credentialing board.

I understand that any breach of confidentiality may be grounds for immediate termination of contract as well as any appropriate legal actions.

I understand and acknowledge the above Confidentiality Statements.

Signature ____ **Date _____________________**

UNRI Representative ______________________________ **Date _____________________**

Patient Bill of Rights

As a health care provider, personnel serve as an advocate for the patient. All personnel will adhere to the Patient Bill of Rights:

- The patient/patient's representative has a right to all information contained in the patient's medical record at the hospital and a right to examine the record upon request.
- The patient has the right to be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and care of personal needs.
- The patient has the right to be informed by the hospital of the address and telephone number of the complaint receiving unit of the State Department of Health and the right to file a complaint/grievance against any service or personnel with the agency, hospital or State Consumer Affairs without reprisal or disruption of services.
- The patient has the right to receive information from the staff to help the patient/family make informed decisions. The patient/family will be instructed in the patient's care and illness to aid the patient in becoming as independent as possible.
- The patient has the right to be assured that the personnel providing care are qualified through education, experience and licensing/certification to provide such services including the right to know the identity, professional status and role of hospital personnel.
- The patient has the right to prompt attention, especially in a medical emergency situation.
- The patient has the right to know what conduct and/or responsibilities are expected of them.
- The patient has the right to the same quality treatment given all patients and reasonable continuity of care regardless of race, color, national origin, sex, age, creed, and mental or physical handicap.
- The patient has the right to be fully informed prior to or at the time of admission of services available in the hospital and of related charges, including non-coverage or termination of his/her eligibility, examine an itemized and detailed bill for services rendered.
- The patient has the right to be fully informed by the physician of his/her medical condition, unless contraindicated, or any procedure (informed consent) and to be allowed the opportunity to participate in the planning of his/her medical treatment including the right to refuse to participate in experimental research.
- The patient has the right to participate in establishing their treatment plan and the right to refuse any personnel or discontinue services at any time with or without Physician approval.
- The patient has the right to be assured of confidential treatment of personal information and medical records including the right to approve or refuse their release to any individual outside the hospital except in the case of transfer to another facility or as required by law or third party payment contract. The patient/responsible party will sign a release of information form if a record is needed.

Personnel are expected to report the following events to a supervisor:

- Any action, order or treatment which in the professional judgment of the individual appears to be potentially harmful to the patient.
- Patient complaints regarding their care.

Signature: ____ Date: ______________________

Child Abuse Reporting

California law requires that employees hired as medical practitioners or non-medical practitioners after January 1, 1985 acknowledge that they understand the reporting requirements of section 11166 of the California Penal Code.

"Section 11166 of the Penal Code requires any child care custodian, medical practitioner, non-medical practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her employment whom he or she know or reasonably suspects has been the victim of a child abuse to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone or to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident".

Signature: ____ Date: ____________________________

Domestic Violence

Domestic violence is characterized as a pattern of coercive behaviors that may include repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation, and intimidation. These behaviors are perpetrated by someone who is or was involved in an intimate relationship with the victim.

The California Penal Code, part 4, Title 2, Article 2, Section 11160, stipulates, in part that any health practitioner employed in a health facility, clinic or physicians office who has knowledge of or observes in his/her professional capacity or within the scope of his/her employment, a patient whom he/she knows or reasonably suspects suffers from any wound or other injury inflicted by another, by means of a knife, firearm or other deadly weapon: and/or suffers from any wound or other physical injury inflicted upon the person which is the result of assault or abusive conduct, shall report same to a local law enforcement agency by telephone, immediately or as soon as practically possible, and via a written report prepared and sent to the agency within two working days of receiving the information or making the observation. "Assault or abusive conduct" includes but is not limited to:

- Assault with intent to commit mayhem, rape, sodomy, or oral copulation
- Battery, or sexual battery
- Rape or spousal rape
- Abuse of spouse or cohabitant; and
- Genital or anal penetration by foreign object.

Any person violating Article 2, Section 11160, is guilty of misdemeanor and may be subject to both civil liabilities and criminal sanctions.

The National Domestic Violence hotline, **(800) 333-SAFE**, is a 24-hour resource to help women find local shelters.

I acknowledge that I have read and understand the provisions of Section 11160 as related above and will comply with its provisions.

Signature: ____ Date: _____________________________

Dependent Adult Abuse Reporting

California Law now requires that all Health Practitioners or employees of a health facility/clinic currently employed or employed after January 1, 1986, sign a statement to the effect that they have knowledge of and will comply with the new law requiring the reporting of dependent adult abuse.

The law required that this statement include the following:

"Section 15630 of the Welfare and Institute Code requires any custodian, health practitioner, or employee of an adult protective services agency or a local enforcement agency who has knowledge of or observes a dependent adult in his/her professional capacity or within the scope of his/her employment who he/she knows has been the victim of physical abuse, or who has injuries under circumstances which is consistent with abuse where the dependent adult's statements indicate, or in the case of a person with developmental disabilities where his/her statements or other corroborating evidence indicates that abuse has occurred, to report the unknown or suspected instance of physical abuse to an adult protective services or a local law enforcement agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident."
"Care custodian" means an administrator or an employee of any following public or private facilities: (1)Health facility, (2) Clinic, (3) Home Health Agency, (4) Educational Institution, (5) Sheltered Workshop, (6) Camp, (7) Respite Care Facility, (8) Residual Care Institution, (9) Community Care Facility, (10) Adult Day Care facility, including adult day care health care facilities, (11) Regional center for persons with developmental disabilities, (12) Licensing worker or evaluation, (13) Public assistance worker, (14) Adult Protective services agency, (15) Patient's Right Advocate, (16) Nursing Home, (17) Legal guardian or conservator, (18) Skilled Nursing Facility, (19) Intermediate Care Facility, (20) Local Law Enforcement Agency, (21) Any other person who provides good or services necessary to avoid physical harm or mental suffering and who performs duties.
"Health practitioner" means a Physician and Surgeon, Psychiatrists, Psychologists, Dentist, Resident Intern, Podiatrists, Chiropractor, Registered Nurse, Dental Hygienist, Marriage, Family, Child Counselor or any other person who is currently licensed under division 2 (commencing with Section 500) of the Business and Professions Code, any emergency Medical Technician I or II, Paramedic, a person certified pursuant to Section 2913 of the Business and Professions Code, or state or county public health employee who treats dependent adult for any condition, a coroner, or a religious practitioner who diagnoses, examines or treats dependents adults."

I acknowledge that I have knowledge of the provisions of Section 15630 as set forth and will comply with its provisions.

Signature: ____ Date: ________________________________

Acknowledgement to Keep Licenses and Health Certificates Current

1. I understand that in accordance with Urgent Nursing Resource, Inc. standards, state and Federal regulations JCAHO standards, it is my responsibility to provide Urgent Nursing Resource, Inc. with current license, CPR, Health Certificate, Safety Module, HIPAA, and other job related material as required.
2. I will assume responsibility and submit all required documents to Urgent Nursing Resource, Inc. within 10 business days from today.
3. I will assume responsibility to provide and update my health certificate, renewal of CPR certification, current licensure/renewal (if applicable), and re-certification annually for the Safety Module.

Signature: ____ Date: __________________

Acknowledgement of Substance Abuse and Drug Testing Policy

I have reviewed and understand the contents of the Substance Abuse and Drug Testing Policy.

I understand and agree to submit to urine, blood or hair specimen for testing under the circumstances and conditions outlined within this Policy. I understand and agree that if I am involved in an accident or other unusual occurrence, which requires medical treatment, the treating physician may order testing which includes a urine, blood or hair specimen.

I hereby hold harmless all parties concerned and involved in the process of administering such drug testing and will not use UNRI or the parties involved for any action taken as a result of said testing under this Policy that may prohibit me from securing a job with UNRI or prevent my continued contract with UNRI, or with any other company or party.

I understand that as a condition of placement, UNRI and/or the parties involved with the drug testing process may be required to provide documentation regarding drug testing to clients. I release UNRI to provide this information if required for placement.

I understand that any tests results reported to UNRI, that coincides with a confirmed use of a prescription drug that cannot be confirmed as a current prescription with my physician will result in contract termination with UNRI.

I hereby attest that I have read and understand the Substance Abuse and Drug Testing Policy and that I must be drug free and alcohol free in the performance of my job duties. I understand that adherence to this policy is a condition of placement and continued contract with UNRI as specified in the above policy.

Name ____ Date ___________________

Signature ____

Name of UNRI representative _________________________________ Date ___________________

Signature of UNRI representative ______________________________

Capping

Many healthcare workers have frequent contact with various organizations, union groups, welfare agencies, insurance representatives and others. Knowing of these outside agencies and how they can serve patients is important information for many Healthcare Workers involved with direct patient contact.

From time to time a patient may require the need for outside legal services and ask a Healthcare Worker for the name of an attorney or law firm. Under no circumstances may a Healthcare Worker refer any patient to a specific attorney or law firm for legal assistance. The County Bar Association has a lawyer's referral service to handle requests of this nature.

Capping is the practice of soliciting business for lawyers. It is a criminal offense and both the capper and the attorney are subject to prosecution for capping (a misdemeanor) and conspiracy (a felony). Action 6152 of the Business and Professions code is reproduced for our information.

6152 Prohibition of Solicitation
"It is unlawful for any person, in his individual capacity or in his capacity as a public or private employee, or for any firm, corporation, partnership, or association to act as a runner or capper for any such attorneys in and about the state prisons, county jails, city prisons, or other places of detection of persons, city receiving hospitals, city and county hospitals, justice courts, municipal courts, superior courts, or in any public institution or in any public place or upon any public street or highway or in and about private property of any character whatsoever".

Severe disciplinary action up to and including termination will be taken against any Healthcare Worker who refers a patient to a specific attorney or law firm.

Signature: ____ Date: ______________________

Age Specific Criteria Self-Assessment

Name: ____________________________________ Nursing License Number: ________________

You must be able to demonstrate the knowledge and skills necessary to provide care based on physical, psychosocial, educational, safety, cultural and related criteria appropriate to the age of the patients served in his/her assigned service area. The skill and knowledge needed to provide such care may be gained through education, training, or experience.

Please fill out the table with appropriate numbers listed below:

1. No knowledge/no experience
2. Knowledge only
3. Knowledge/extensive experience

	Infant/Child	Adolescent	Young Adult	Middle Adult	Geriatric
1. Knowledge of growth development					
2. Ability to assess Age Specific safety issues					
3. Ability to assess Age Specific Health Needs					
4. Ability to assess Age Specific Social Development					
5. Exhibits communication skill necessary to interpret the specific response.					
6. Ability to involve family/ significant other in decision making related to plan of care.					
7. Ability to obtain and interpret information in terms of the patient's needs and nursing related to physical development.					

I certify the above information is true and correct to the best of my knowledge.

Signature: ____ Date: ___________________

Tuberculosis Questionnaires

Name ____ Date of Birth: __________________________

Phone Number: ___________________________________ Sex _______

Read Carefully! All questions must be answered by all Healthcare Providers whether they have a (-) or (+) PPD.

(-) Negative PPD, fill out questionnaire and have PPD done
(+) Positive PPD, fill out questionnaire and please have a chest x-ray

1. **Yes No** Have you had any new problem, which currently is infectious or would prevent you from performing your assigned duties at this time? If "yes" please describe____
____
2. **Yes No** Have you had an unexplained weight loss in the last year? If "yes", please describe
____
____
3. **Yes No** Do you have a persistent cough (lasting 3 weeks or more)?
4. **Yes No** Do you cough up blood?
5. **Yes No** Do you have persistent, unexplained fevers or night sweats?
6. **Yes No** Do you have a rash? If "yes", how long? ____
7. **Yes No** Have you seen a doctor for any of the above? If "yes", which numbered item? __________________
8. **Yes No** Do you have any reason to believe that your immune system may been altered or damaged due to any of the following conditions or medications, which could increase your risk for tuberculosis (i.e. cancer, sarcoidosis, HIV/AIDS, chemotherapy, chronic steroid therapy or medications to prevent transplant rejection)?
9. **Yes No** If you have a positive TB test, do you also have any one of the following conditions (you do not have to divulge your medical diagnosis); part of your stomach removed, underweight/malnourished, infection with the AIDS virus or a risk for it, diabetes, silicosis lung disease, leukemia or lymphoma, kidney failure, head/neck cancer?
10. **Yes No** Have you completed the hepatitis B vaccine series? How many shots have you had?
____
11. **Yes No** Do you handle IV cytotoxic (chemotherapy) drugs as part of your work assignment? **Example: Prepare, administer or handle at least once per week.**
12. **Yes No** Do you work with lasers? Type ____
13. **Yes No** Have you had any skin or other reaction after contact with latex gloves or other latex products?

Signature ____ **Date** ________________________________

Health Questionnaire

Name: (Last, First)	SSN:	Date:

This section to be completed by applicant

Do you have or ever been told you have:	**Yes**	**No**	**If yes, explain:**
Allergies, Asthma, Wheezing			
Chronic cough, Colds			
Rheumatic Fever			
Heart Trouble			
High Blood Pressure			
Frequent Headaches			
Fainting or Dizziness			
Epilepsy or Convulsions			
Nervous Breakdown			
Difficulty Hearing			
Need Hearing Aid			
Use Hearing Aid			
Difficulty Seeing			
Need Corrective Lenses			
Use Corrective Lenses			
Hernia			
Diabetes			
Varicose Veins			
Do you have any physical limitations?			
Do you take any prescription medications?			
Have you ever been treated for a drug or alcohol habit?			
Have you ever been treated for any back disorder?			
Are you in good health to the best of your knowledge?			
Are you under a physician care?			

Name of Physician ______________________________________Phone No. ____________________________

Address ____

I hereby authorize the above information to be released to Urgent Nursing Resource, Inc.

Signature ____ Date ____________________________

Chicken Pox Questionnaire

Have you ever had Chicken Pox? ( ) Yes ( ) No

If yes, how old were you? ________Years Old

What were your symptoms? ____

____

For those with unknown history of Chicken Pox, a Varicella titer is necessary. Healthcare providers with negative titers who were exposed to patients with Chicken Pox will be restricted from care of patients from day 10 through day 21.

Hepatitis B Vaccination Waiver

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection.

However, I decline Hepatitis B Vaccination at this time. I understand that by declining this option, I continue to be at risk of acquiring Hepatitis B, a serious disease.

I decline this option:

_________ I have been vaccinated against the Hepatitis B virus.

I was vaccinated at _____________________________________ Date ____________________
(Test results will need to be submitted)

_________ I do not want to be vaccinated.

I understand I may rescind this waiver at any time at my discretion.

Signature ____ Date ____________________

Acknowledgement

I certify that the information in this application is accurate, current and complete. I understand that misstatements or omissions may result in disqualification from further consideration or termination. I acknowledge that I have read, understand and received a copy of UNRI handbook.

I authorize Urgent Nursing Resource, Inc to investigate my job history, credentials and to obtain any relevant information (including a criminal background check). I authorize UNRI to disclose this Personal Information about me obtained through reference checks or during the course of the interview process for state, federal, contractual or accreditation audit purposes. I also authorize UNRI to disclose any of my performance evaluations, disciplinary records or skills tests. I release UNRI and any individual or entity providing information to UNRI all liability for any damages from the disclosure of this information.

I also understand and agree that

- Passing a medical examination and/or participating in a medical screening may be required. If medical restrictions cannot be reasonably accommodated, there may not be a contract, or if with a contract, contract may be terminated.
- Subject to applicable state laws, UNRI reserves the right to conduct drug screening and testing for reasonable suspicion at any time during the contract period and as a pre requirement for a contract .Any violation of this policy shall result in the declination of the application process.

I understand and agree that nothing contained in this application or in granting of an interview creates a contract between UNRI and me. No promises regarding approved application have been made to me. If an agreement is established, I understand that my contract will be terminated "at will", that I will have the right to terminate my contract at any time, and that UNRI will retain a similar right to terminate my contract at any time.

I understand that should I be registered with UNRI, I will decide my schedules and/or work locations and are subject to change at my discretion.

Signature ____ Date __________________

Authorization to Release Information

I authorize Urgent Nursing Resource, Inc. to release all relevant information obtained from this application to healthcare facilities for job purposes, state, federal, contractual or accreditation purposes.

____ ______________________

Name Date

____

Signature

DISCLOSURE & AUTHORIZATION FORM

Urgent Nursing Resource, Inc. will procure a consumer report and/or investigate consumer report on you in connection with your application.

The report will contain information bearing your character, general reputation, personal characteristics, mode of living and credit standing. The types of information that may be obtained include but are not limited to: credit reports, social security number verification, criminal records checks, public court records checks, driving records checks, educational records checks, verification of employment positions held, personal and professional references checks, licensing and certification checks, etc. The information contained in the report will be obtained from private and/or public record sources, including sources identified by you or through interviews or correspondence with your past or present coworkers, neighbors, friends, associates, or current or former employers, educational institutions or other acquaintances.

AUTHORIZATION

I have carefully read and understand this Disclosure and Authorization form. By my signature below, I consent to the release of consumer reports and investigative consumer reports prepared by a consumer reporting agency. I understand that if Urgent Nursing Resource, Inc. hires me, my consent will apply throughout my contract unless I revoke or cancel it. I understand that, to the extent allowed by law, information contained in my job application or otherwise disclosed by me before, during or after my contract, if any, may be utilized for the purpose of obtaining consumer reports or investigate consumer reports.

By my signature below, I also authorize Urgent Nursing Resource, Inc. to disclose and release all relevant information obtained from this application to healthcare facilities and government agencies for contractual or accreditation audit purposes. I release Urgent Nursing Resource, Inc., all healthcare facilities and agencies providing and receiving these information all liability for any damages from the disclosure of these information.

Print Name: ____ Date: __________________

Signature: ____

Td Vaccination Waiver

Vaccination is the best way to protect against Tetanus and Diphtheria which are serious diseases. Due to my occupational exposure to germs causing these diseases, I may be at risk of being infected. However, I decline Td Vaccination at this time. I understand that by declining this option, I continue to be at risk of acquiring Tetanus or Diphtheria.

I understand I may rescind this waiver at any time.

Signature ____ Date __________________

Witness: ____ Date: _________________

National Patient Safety Goals Acknowledgement

This is to acknowledge that I have read and understand the _____ National Patient Safety Goals. A copy was provided to me as a reference material.

____ Date ______________________
Signature

____
Print Name

REPORT OF COMPLAINTS ABOUT HEALTHCARE ORGANIZATIONS

If you have a safety or quality of care concern, please discuss it with your immediate supervisor or other appropriate person. As an accredited organization, staff may report such concerns to the Joint Commission on Accreditation of Healthcare Organization (JCAHO). No disciplinary action will be taken against a Healthcare worker who makes a valid report.

You may contact JCAHO at:

Phone: 800-994-6610

Fax: Office of Quality Monitoring, (630) 792-5636

E-mail: complaint@jcaho.org

Mail: Office of Quality Monitoring
Joint Commission on Accreditation of Healthcare Organizations
One Renaissance Boulevard
Oakbrook Terrace, IL 60181

Acknowledged by:

____________________________________ __________________

Name of Healthcare Worker Date