Quick Response Staffing Inc.

Employment Application

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Date Available: _____ Social Security No.: _____ Desired Salary: **$** _____

Position Applied for: _____

Are you a citizen of the United States? YES ☐ NO ☐ If no, are you authorized to work in the U.S.? YES ☐ NO ☐

Have you ever worked for this company? YES ☐ NO ☐ If yes, when? _____

Have you ever been convicted of a felony? YES ☐ NO ☐

If yes, explain:

_____

Education

High School: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Diploma:: _____

College: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

Other: _____ Address: _____

From: _____ To: _____ Did you graduate? YES ☐ NO ☐ Degree: _____

Licenses/Certifications

RN/LPN/CNA License#: _____ *Expiration Date:* _____

BLS: _____ ACLS: _____ TNCC: _____ PALS: _____ NRP: _____ Other: _____

CCRN: _____ CEN: _____ Chemotherapy: _____ CNOR: _____

References

Full Name: ______________________ Relationship: ____________

Company: ______________________ Phone: ____________

Full Name: ______________________ Relationship: ____________

Company: ______________________ Phone: ____________

Previous Employment

Company: ______________________ Phone: ____________

Address: ______________________ Supervisor: ____________

Job Title: ____________ Starting Salary:$ ________ Ending Salary:$ ________

Responsibilities: ______________________

From: ________ To: ________ Reason for Leaving: ____________

May we contact your previous supervisor for a reference? YES ○ NO ○

Company: ______________________ Phone: ____________

Address: ______________________ Supervisor: ____________

Job Title: ____________ Starting Salary:$ ________ Ending Salary:$ ________

Responsibilities: ______________________

From: ________ To: ________ Reason for Leaving: ____________

May we contact your previous supervisor for a reference? YES ○ NO ○

Company: ______________________ Phone: ____________

Address: ______________________ Supervisor: ____________

Job Title: ____________ Starting Salary:$ ________ Ending Salary:$ ________

Responsibilities: ______________________

From: ________ To: ________ Reason for Leaving: ____________

May we contact your previous supervisor for a reference? YES ○ NO ○

Experience

Unit:	Experience Years/Months:	Used in Last Year? Yes/No
Acute Hospital Experience/Nursing		
Charge Nurse Experience		
Critical Care Experience/ CC Course		
Medical/Surgical		
Pediatrics		
Labor and Delivery/ Post Partum		
Proficiency in phlebotomy and IV Therapy		
Telemetry/EKG Course/Cardiac Rhythm Recognition		

Disclaimer and Signature

Have you ever had a license of certification investigated, revoked, or suspended? If yes, please attach a detailed explanation. □Yes □No Do you have at least one year of current experience on a hospital floor? □Yes □No Are you willing to submit to a criminal background check? □Yes □No Are you willing to submit to a drug screen? □Yes □No Can you perform the essential functions of the job for which you are applying? □Yes □No

Statement of Certification, Authorization, and Agreement

I certify that the information that I have provided in this application form, in my resume, and interview(s) is complete and accurate. I authorize all my former employers and personal references to answer inquiries made by the employer and I hereby release all such parties, including the employer, it's subsidiaries, employees, subscribers, and agents from liability as a result of doing so. I agree that if, in the exclusive opinion of the employer, I have made any misrepresentation, or the results of the investigation are not satisfactory, any offer of employment may be withdrawn or, if already hired and working, I may be terminated without liability, except for payment at the rate agreed upon for my services actually rendered. I understand this authorization to investigate my background is extended to, and covers, the entire period of my employment. A copy of this agreement and certification can serve as an original. I understand and agree that the employer is an "at will" employer and that this means my compensation can be changed by the company at any time or my employment can be terminated by me or the company at any time and for any reason, or for no reason at all, and that no one, except the employer's president, is authorized to enter into a contract or agreement of employment with me for any specific period of time or offer me any benefits different than those generally available to other similarly situated employees. Any such agreement must be in writing and signed by me and the employer's president. Any other such agreements, oral or written, by anyone else are considered null and void. I also understand that once I have entered into agreement upon signature, I will be unable to accept formal employment at any facility worked in as agency for a twelve month period, regardless of employment termination from either party, unless otherwise agreed upon by president with written permission signed by me and the employer's president. If I am hired, I understand I will be required to complete all forms and documentation the company requires for new hire processing. My failure to do so may result in withdrawal of any employment offer or termination if I have already started work. After employment, I understand that I will be required to complete all documentation the company requires upon demand including, but not limited to, tax withholding, personal information changes, benefit enrollment forms, performance appraisals, and warning notices and other corrective actions. My failure to do so may result in disciplinary action up to and including termination, as deemed appropriate by the company. I understand I must adhere to the policies and procedures of the company while I am an employee of the company.

Signature: _____ Date: _____

The employer is an EQUAL OPPORTUNITY EMPLOYER. Qualified applicants receive consideration for employment without regard to race, religion, color, ancestry, age, sex, or disability. To be considered for employment, this application must be completed fully, including its addenda. Your responses to the questions in this application form must be accurate and complete and they will be judged in relation to the requirements of the job you are seeking. Applications may remain active for six months. Applicants selected for employment will be required to prove U.S. citizenship or a legal right to work in the U.S. as determined by the U.S. Citizenship and Immigration Services.

Consent for Drug/Alcohol Screen Testing

If you are offered and accepted employment with Quick Response Staffing Inc., in the interest of safety for all concerned, you will be required to take a urine test for drug and/or alcohol use. This test is mandatory and will be required yearly. I, _____, have been fully informed of the reason for this urine test for drug and/or alcohol, I understand what I am being tested for, the procedure involved, and do hereby freely give by consent. In addition, I understand that the results of this test will be forwarded to my potential contractor and become a part of my record. If this test is positive, and for this reason I am not hired, I understand that I will be given the opportunity to explain the results of this test.

I hereby authorize these test results to be released to Quick Response Staffing Inc.

_____

(Print Full Name)

_____Date:_____

(Signature)

Background Check Consent Form

I hereby authorize Quick Response Staffing Inc. to receive any criminal history on file pertinent to me from any federal, state, or local criminal justice agency.

_____

(Print Full Name)

_____

(Signature

_____

Street Address

_____

City State Zip

_____

*Sex *Ethnicity *DOB *Social Security Number

*The above information is necessary to retrieve criminal history information.

HIPAA Confidentiality Agreement

Nurses working as temporary staff at contracted facilities will have access to confidential information, both written and oral, in the course of their job responsibilities. It is imperative that this information is not disclosed to any unauthorized individuals to maintain the integrity of the patient or resident information. An unauthorized individual would be any person that is not currently directly related to the care of patients or residents of facilities. Any other disclosures may only occur at the direction of the privacy Office or by patient authorization.

I have read and understand the practice's policies with regards to privacy and security of personal health information. I agree to maintain confidentiality of all information obtained in the course of my contract including, personal and sensitive information regarding patients, employees, and vendors. I understand that inappropriate disclosure or release of patient information is grounds for termination.

_____ _____

Printed Name Date

_____

Signature

AUTHORIZATION TO RELEASE EMPLOYMENT INFORMATION

Date: _____

To: _____

The Undersigned authorizes the release of the below checked employment information to:

_____ Quick Response Staffing Inc.

_____ Any Third Party

Those terms for which information may be released include:

_____ Salary

_____ Position and Department

_____ Dates of Employment

_____ Part Time/Full Time or hours worked

_____ Reason for Separation

_____ Medical/Accidental/Illness Reports

_____ Other:

Thank You for Your Cooperation

_____ _____

Employee Signature Social Security Number

_____ _____

Address Position or Title

_____ _____

Date of Employment Department

Form W-4 (2016)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

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

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

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

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A	
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B	
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D	
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E	
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child	G	
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ▶	H	

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

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

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2016

1 Your first name and middle initial	Last name	2 **Your social security number**
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2016, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7

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

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

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1 Enter an estimate of your 2016 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over $311,300 and you are married filing jointly or are a qualifying widow(er); $285,350 if you are head of household; $259,400 if you are single and not head of household or a qualifying widow(er); or $155,650 if you are married filing separately. See Pub. 505 for details . . . 1 $

2 Enter: { $12,600 if married filing jointly or qualifying widow(er) / $9,300 if head of household / $6,300 if single or married filing separately } . . . . . 2 $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . 3 $

4 Enter an estimate of your 2016 adjustments to income and any additional standard deduction (see Pub. 505) 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2016 Form W-4* worksheet in Pub. 505.) . . . . . 5 $

6 Enter an estimate of your 2016 nonwage income (such as dividends or interest) . . . . . 6 $

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . . . 7 $

8 **Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction 8

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 9

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" 2

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet 4

5 Enter the number from line 1 of this worksheet 5

6 **Subtract** line 5 from line 4 6

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . 7 $

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . 8 $

9 Divide line 8 by the number of pay periods remaining in 2016. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2016. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $9,000	0
6,001 - 14,000	1	9,001 - 17,000	1
14,001 - 25,000	2	17,001 - 26,000	2
25,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 75,000	5
44,001 - 55,000	6	75,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
QUICK RESPONSE STAFFING INC	20-4688836
5. Employer address	**6. Employer phone number**
2606 FAIRWAY DRIVE	575-746-6117

7. City	8. State	9. ZIP code
ARTESIA	NM	88210

10. Who can we contact at this job?

11. Phone number (if different from above)	12. Email address

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

Acknowledgment of Receipt

I hereby acknowledge the receipt of the following documents from my employer:

1) New Health Insurance Marketplace Coverage Options and Your Health Coverage (form OMB No. 1210-0149).

_____

Employee Name (please print)

_____ _____

Employee Signature Date

Certified Nursing Assistant (CNA) Skills Competency Checklist

Name: _____ Date: _____

Total years of CNA clinical experience: _____

Please rate your SKILL level:

0 – No Experience. Theory Only

1 – Limited Competency/ Proficiency. Supervision Required.

2 – Acceptable Competency/ Proficiency.

3 – Competency/ Proficient. Performed frequently and independently during the past two years.

Skill	0	1	2	3	Skill	0	1	2	3
Assist with Admission of Patient					Observing Patients				
Assist with Ambulation					Oral Hygiene				
Assist with Bedpan/Urinal/Commode					Patient Safety Standards/ Precautions				
Backrub/ Back Care					Perineal Care				
Basic Medical Asepsis					Positioning Patients				
Bathing: Complete/Partial/ Sitz					Prosthetic Devices (Denture Care)				
Bed Cradles					Range of Motion Exercises				
Bed Making: Occupied/Unoccupied					Reporting Changes of Pt Condition				
Bed Rails: When/ How to use					Reporting/ Recording Pt Pain Level				
Cast Care					Restraints				
Charting/ Checklists/ Graphic Charts					Skin Care				
Compresses: Warm/Cold					Specimen Collection				
Coughing/ Deep Breathing					Routine Urine				
CPR					Clean Catch				
Crutch Walking: Assisting Patient					12 & 24 Hour Specimen				
Dangling Patient					Stool				
Dietary Restrictions					Culture				
Discharge of Patient					Sputum				
Documentation: Vital Signs, I&O					Collection from Foley Catheter				
Douches					Vital Signs				
Elastic Stockings (AE Hose)					Blood Pressure				
Elimination Check and Record					Pulse				
Enemas, Rectal Tubes, Harris Flush					Respirations				
Feed Patient					O2 Saturation				
Foley Catheter Care and Emptying					Temperature				
Footboard					Oral				
Hand Hygiene					Axillary				
Height: Measure and Record					Tympanic				
Intake & Output Measure and Record					Rectal				
Infection Control Precautions:					Age Appropriate Care				
Standard Universal Precautions					Newborn/Infant/Toddler				
Reverse Isolation					Preschooler/School Age				
TB/Airborne Precautions					Adolescent/Young Adult				
MRSA/VRE Precautions					Middle Adult				
Nourishment for Patients					Older Adult				

Checklist

_____ Application

_____ Resume

_____ Current License

_____ Current BLS, ACLS, PALS, and any other certifications

_____ 2 References

_____ Copy of Driver's License

_____ W4

_____ Hepatitis Verification

_____ TB Test

_____ Rubella Titer and Immunization Record

_____ Background Check

_____ Drug Screen

_____ Skills Checklist

_____ Flu/Pneumonia Vaccine Verification/Declination Form

*** All items on this checklist must be submitted before staffing placement can be made.

Direct Deposit Information

Name as it appears on account: _____

Name of Bank: _____

Type of Account: (Checking / Savings)

Routing Number: _____ Account Number: _____

Email Address: _____

Flu/Pneumonia Vaccine Verification Form

Date: _____

Name: _____

Date Flu Vaccine Received: _____

Date Pneumonia Vaccine Received: _____

Facility/Pharmacy/Clinic vaccine received at:_____

Signature:_____

Declination of Influenza Vaccination

My employer or affiliated health facility, _____, has recommended that I receive influenza vaccination to protect the patients I serve.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, even if my symptoms are mild or non-existent, I can spread it to others and they can become seriously ill.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including
  - all patients in this healthcare facility
  - my coworkers
  - my family
  - my community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons: _____

_____

_____

I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is still available.

I have read and fully understand the information on this declination form.

Signature: _____ Date: _____

Name (print): _____

Department: _____

Reference: CDC. Prevention and Control of Influenza with Vaccines—Recommendations of ACIP at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html

Technical content reviewed by the Centers for Disease Control and Prevention

IMMUNIZATION ACTION COALITION Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4068.pdf • Item #P4068 (8/14)

Nursing (RN/LPN) Skills Competency Checklist

Name: _____ Date: _____

Total years of CNA clinical experience: _____

Please rate your SKILL level:

1 – No Experience. Theory Only/Not Applicable
2 – Some Experience (Some Assistance Required)
3 – Experienced/ Proficient.
4 – Performs Well. Performed frequently and independently (No Assistance Required)

Skill	1	2	3	4	Skill	1	2	3	4
Neurological System:					**CV/Circulatory Continued…**				
assess level of consciousness					use of cardiac monitor				
assess sensory motor function					use of doppler				
assess cranial nerves					care of patients with:				
assist with lumbar puncture					aneurysm				
halo traction					acute CHF				
pre/post op neuro surgical care					acute MI				
seizure precautions					blood lymph disease				
documentation of seizure					cardiac surgeries				
shunts (i/e/ ventriculoperitoneal)					CVA				
use of Glasgow Scale					bypass/vascular procedures				
use of anticonvulsants:					pacemakers				
Oral					transplant/cardiac				
IM					**Respiratory:**				
IV					Ambu techniques				
care of patients with:					apnea monitor usage				
acute head injury					assess lung sounds				
aphasia					chest tube care and maintenance				
autonomic dysreflexia					incentive spirometer				
cancer of the brain					IPPB machine				
craniotomy					nebulizers				
CVA					oxygen therapy:				
head trauma					nasal cannula				
impending DT's					face mask				
multiple sclerosis					precautions				
Parkinson's					use of portable oxygen tank				
quadriplegia					pulmonary hygiene:				
seizure disorders					oral suctioning				
spinal cord injury					tracheotomy suctioning				
CV/ Circulatory:					chest physiotherapy (CPT)				
ability to perform 1 person rescue:					determining proper catheter size				
(CPR) infant/child					nasotracheal suctioning				
adult					thoracentesis				
assess heart sounds (norm vs abnorm)					tracheostomy:				
basic EKG interpretation					cleaning of inner cannula				
initiation of arrest procedure					changing trach/tubing				
admin of meds during procedure					emergency management				
set up/run 12 lead EKG					skin care/ dressing changes				

Respiratory Continued…	**1**	**2**	**3**	**4**	**GI/Endocrine:**	**1**	**2**	**3**	**4**
ventilators:					bladder irrigations				
pressure pre-set					bladder training				
volume pre-set					care/maintenance/removal of:				
CPAP					3 way indwelling catheter				
PEEP					supra pubic indwelling catheter				
portables					catheter insertion male/female				
care of patients with:					diabetic care:				
AIDS					ADA diet				
asthma/wheezing					blood glucose testing				
cancer of lung					foot care				
COPD					infection prevention				
emphysema					insulin prep and administration				
pneumonia					insulin site rotation and education				
TB					skin care				
transplant/pulmonary					S & S hypo/hyper glycemia				
GI/Nutrition:					urine glucose testing				
abdominal drain care/ maintenance					use of blood test meters				
assess GI status					dialysis:				
bowel training					hemo				
enemas					peritoneal				
Gastrostomy tube care:					GYN exam/ PAP procedures				
G-Tube feedings					ileostomy care				
G-Tube change					intermittent catheterization				
Nasogastric tube insertion/reinsertion					S & S of UTI				
NG Tube feedings					urinary diversions (ileo-conduit)				
nasal intestinal tubes (ie. Miller-Abbot)					care of patients with:				
ostomy/stoma care					AV shunt/fistula				
ostomy irrigations					bladder disease				
ostomy education					cancer of kidney				
paracentesis					cancer of prostate				
parenteral feedings:					female reproductive organ cancer				
complications of					hysterectomy				
indications for					hypo/hyperthyroidism				
routes of administration					mastectomy				
verification of fluid/caloric					nephrectomy				
removal of fecal impaction					renal failure				
use of pumps for enteral feedings					transurethral resection				
care of patients with:					**Integumentary/Orthopedic**				
anorexia					amputations/stump care				
bowel disease					assist in use of prosthetic devices				
cancer of colon					cast care				
cancer of esophagus					cast/splint application and removal				
cancer of rectum					circo-electric bed				
GI bleeds					range of motion				
hepatic encephalopathy					Spika cast				
hepatitis					Stryker frame				
inflammatory bowel disease					TENS				
liver failure					traction: skin				
liver transplant					skeletal				

Integumentary/Orthopedic Cont…	1	2	3	4	IV Therapy Continued…	1	2	3	4
transfers:					dressing changes				
documentation of wounds					S & S complications				
preventative skin care					record keeping				
sterile dressing changes					pump operations				
use of Braden scale					hanging IV piggybacks				
wound enzyme debriders					S & S infection				
wound irrigations					S & S infiltration				
care of patients with:					Insertion of peripheral lines				
amputation					TPN (Total Parenteral Nutrition)				
arthritic disease					**IV Therapy Continued…**				
burns					intralipids				
decubitus ulcers					heparin lock				
gun shot					Hickman catheter				
hip replacement					porta-Cath				
incisions					triple lumen catheter				
knee replacement					**Additional Nursing Responsibilities:**				
laminectomy					admission procedure				
skin cancer					initial assessment				
stab wounds					discharge planning				
Oncology:					injections				
bone marrow transplant					universal precautions				
counseling for:					knowledge of unit doses				
altered image					lab value interpretation				
grieving process					pre/post op teaching				
imagery					problem oriented medical records				
relaxation techniques					SOAP charting				
assessing analgesic effectiveness					specimen collection:				
morphine pumps					arterial blood gas draw				
narcotics via continuous infusion					capillary draw				
side effects of chemotherapy					heel stick				
radiation therapy					venipuncture				
radium plants					sputum				
IV Therapy:					stool				
administration of chemotherapy					clean catch urine				
administration/mixing IV meds					24 hour urine				
blood/blood product administration					urine via indwelling catheter				
calculate dosages					wound culture				
care of central lines:					use of restraints				
infusion procedures					charge nurse responsibilities				
care of insertion site					primary nurse responsibilities				
					team leading				

Responsibilities

As you consider working with Quick Response Staffing Inc., here are a few things you should know…

QRS Inc. is NURSE owned and operated. Our goal is to work for and with you so that you are in control of your own career. We make every effort to keep you as busy as you want to be and are here for you when you need us, 24 hours a day, 7 days a week.

We at QRS are proud of the relationships that we have with the facilities we contract with and know that this is only possible because of the professionalism of the nurses we have working in those facilities.

This is how you can help us to help you:

1. As an independent contractor, you are strongly encouraged to carry your own liability insurance. This is for your protection.

2. The work week begins on Sunday and ends on Saturday. Always use the QRS time sheets that we have provided. Remember to make copies!! Make sure that your documented time matches the time clock. Your timesheet must be signed by a charge or approved staff member. Fax, email, or bring in time sheets BEFORE 10:00am on each Monday. Payday is weekly, on Fridays.

3. Every shift is booked in 8 or 12 hour increments according to the facility work day.

4. If you clock in earlier than 15 minutes prior to your shift beginning or later than 15 minutes after your shift ends, make sure that the approved staff member is aware before signing your timesheet.

5. Make sure that, if required by the facility, you clock in and out. This helps us to make your case if there is any questions in regards to the hours you worked.

6. If you agree to work, and we confirm your shift with a facility, you cannot cancel. If you do cancel, QRS will be automatically fined your rate times 12 hours. If the facility cancels you with less than 2 hours' notice, the facility is fined their rate times 2 hours. Either debit or credit received will be passed on to you.

7. Once you have worked at a facility, you will be unable to obtain formal employment at that facility for a twelve month period, unless otherwise agreed upon by company president with signed consent. If approached by a facility for employment, it is your responsibility to report to QRS Inc., as solicitation is strictly prohibited.

QRS Inc. works for you, and we are here to help you in any way we can. If you have any questions please feel free to call, text, and email or message us at any time. All contact numbers can be found on the contact sheet provided below.

Thank You-

Quick Response Staffing Inc.

By signing below you are stating that you have read and agree to the list of **Responsibilities**.

_____

Applicant Signature Date

Stephanie Jones

575-361-0509

Email: Stephanie@qrsnurse.com

Renee Pinson

575-308-8002

Email: renee@qrsnurse.com

Misti Jackson (Staffing)

575-749-9794

QRS Phone answered 24 hours

575-746-6117

Fax: 575-746-6997