REQUIRED DOCUMENTATION CHECKLIST

(All copies must be clear)

The Documentation Below Must Be In Your File Prior To Placement

☐ **Application Materials (forms provided in this document)**

1. Job Application must be completed in full, including the Primary Applicant Agreement/Professional Conduct Expectations. Job application is valid for one year. Please print or type neatly. You may include your resume, but it will not replace a complete job application.
2. Signed and completed I-9 Form.
3. **Two** written references on letterhead or a performance evaluation with **one** other reference. These are valid for one year.
4. Clinical Skills Checklist(s) and signed Job Description. These are valid for one year. Please be sure you fill out all of the skills checklists and job descriptions that apply to you:

All nursing applicants must complete the Essential/Practical Skills Checklist.

- Adult Pediatric Psychiatric Skills
- Cardiac Cath Lab Skills
- ER Unit Skills
- Endoscopy Skills
- *Essential/Practical Skills*
- Intensive Care Unit
- Interventional Radiology Skills
- Labor & Delivery Post Partum
- Medical/Surgical Skills
- NICU Skills
- Nursery Skills
- Operating Room Skills
- Operating Room Tech
- PICU Skills
- Pediatric Skills
- Post-Anesthesia Care Unit Skills
- Stepdown/PCU/Tele

You may access all skills checklists on the nurse portal at https://my.nursejob.com after you have obtained your login and password from the Applicant On Boarding Team at 800-736-8773, press option 2 to be connected with an AOB team member.

☐ **Medical Documentation (you may use the downloadable forms or provide clear, original copies with a Doctor's signature and an official stamp)**

5. A current physical or physician's statement within previous 12 months.
6. Hepatitis B documentation (vaccination series of three, titer, booster, or signed declination).
7. A TB screen current within 12 months or chest X-ray current within two years.
8. Proof of immunity to Rubeola, Rubella and Mumps (***positive titer or 1 official, physician signed MMR***).
9. Proof of immunity to Varicella-(positive titer or Varivax inoculation).
10. Tetanus within 10 years, or signed declination.

☐ **Licenses, Professional Certifications, and Resuscitation Credentials**

11. Clear copies of all current nursing licenses and professional certifications.
12. Clear copy of a current American Heart Association Healthcare Provider BLS card preferred. If you have additional resuscitation credentials (ACLS, ENPC, NRP, PALS, TNCC), please send copies of both front and back of credential.
13. Proof of eligibility to work within the United States (For example: a Social Security Card and a Driver's License, or Passport). A completed, notarized I-9 Form must accompany these documents.

All of the above items must be in your *completed* file before your file is faxed to a facility for any assignment.

Thank you for your attention to creating an admirable file.

FASTAFF ▪ 800-736-8773 ▪ Fax: 888-508-7854 ▪ www.fastaff.com
6501 S. Fiddler's Green Circle, Suite 200 ▪ Greenwood Village, CO 80111

JOB APPLICATION

Please Print Clearly and Use Black Ink Only

First Name_____Middle Name_____Last Name_____

Email Address _____

Mailing Address _____

City _____ State _____ Zip_____

Home Address (If Different) _____

City _____ State _____ Zip_____

Current Phone Number (____)_____Permanent Phone Number (____)_____

Other Phone Number (Cellular, Pager, Other) Type_____ (_____)_____

Social Security Number _____ Birth Date ____/____/____ (MM/DD/YY)

Required upon employment

Can you provide proof of eligibility to work in the United States? ☐ Yes ☐ No

Emergency Contact (not living with you) _____ Phone (_____)_____

Type of Profession: ☐ RN ☐ LPN/LVN ☐ Radiology Tech ☐ Physical Therapist ☐ Speech Therapist

☐ Occupational Therapist ☐ Certified Surgical Tech/OR Tech ☐ Other (please specify)_____

Referred By: (please select one of the following choices)

- ☐ **Direct Mail**- Ref# or Description_____
- ☐ **Website**- ___FASTAFF website ___U.S. Nursing website
- ☐ **Web Advertisement**- Please specify which site you saw the ad on: _____
- ☐ **Magazine/Journal**- ___RN Magazine ___ HT Magazine ___ AORN ___ Nurse Week
  Other (please specify) _____
- ☐ **Newspaper**- City, State of Newspaper_____
- ☐ **FASTAFF Road Recruitment**- City, State you visited FASTAFF_____
- ☐ **Personal Referral** - Name of Referrer_____
- ☐ **Trade Show**- Trade Show Name _____
- ☐ **Other** (please specify) _____

Have you spoken to a Placement Specialist? ☐ Yes Name _____ ☐No

EDUCATION

Name and Location of School(s)	Graduated (Date)	Type of Degree

LICENSURE

(Please list all including expired)

State	Professional License #	Expiration Date	State	Professional License #	Expiration Date	State	Professional License #	Expiration Date
AK			KY			NY		
AL			LA			OH		
AR			MA			OK		
AZ			MD			OR		
CA			ME			PA		
CO			MI			RI		
CT			MN			SC		
DC			MO			SD		
DE			MS			TN		
FL			MT			TX		
GA			NC			UT		
HI			ND			VA		
IA			NE			VT		
ID			NH			WA		
IL			NJ			WI		
IN			NM			WV		
KS			NV			WY		

Which of these licenses is your original state of licensure? _____

Has your license or certification ever been under investigation? ☐ Yes ☐ No

If YES, please explain _____

Has your license or certification ever been revoked or under suspension? ☐ Yes ☐ No

If YES, please explain _____

PROFESSIONAL CERTIFICATIONS

(Please list all certifications. Ex., CCRN, RNC-NICU, OCN, CRRN)

Type	Expiration Date

RESUSCITATION CREDENTIALS

Please indicate your resuscitation credential(s) by placing the expiration date next to the appropriate credential in the below table.

Resuscitation Credential	Expiration Date	Resuscitation Credential	Expiration Date
ACLS		NRP	
BLS		PALS	
ENPC		TNCC	

SPECIALTIES AND UNIT EXPERIENCE

Please list all primary and float experience within the last 5 years. ALL EXPERIENCE MUST BE AS A REGISTERED NURSE.

SPECIALTY	PRIMARY		FLOAT	
	START MM/YYYY	END MM/YYYY	START MM/YYYY	END MM/YYYY
CRITICAL CARE / EMERGENCY COMPETENCIES				
CRITICAL CARE				
Intensive Care Unit	___/_____	___/_____	___/_____	___/_____
EMERGENCY				
Emergency	___/_____	___/_____	___/_____	___/_____
Pediatrics Emergency	___/_____	___/_____	___/_____	___/_____
SPECIALTY DEPARTMENTS				
Interventional Radiology	___/_____	___/_____	___/_____	___/_____
Endoscopy	___/_____	___/_____	___/_____	___/_____
Cardiac Catheterization Lab	___/_____	___/_____	___/_____	___/_____
MEDICAL SURGICAL AND TELEMETRY COMPETENCIES				
MEDICAL SURGICAL				
Medical Surgical	___/_____	___/_____	___/_____	___/_____
Medical Surgical Telemetry (remote monitoring)	___/_____	___/_____	___/_____	___/_____
Home Health	___/_____	___/_____	___/_____	___/_____
PSYCHIATRIC				
Adult Psychiatric	___/_____	___/_____	___/_____	___/_____
Adolescent Psychiatric	___/_____	___/_____	___/_____	___/_____
IMC				
SDU/PCU/Telemetry	___/_____	___/_____	___/_____	___/_____
Hemodialysis	___/_____	___/_____	___/_____	___/_____
OPERATING ROOM COMPETENCIES				
OPERATING ROOM				
Operating Room	___/_____	___/_____	___/_____	___/_____
Cardiovascular Operating Room	___/_____	___/_____	___/_____	___/_____
Operating Room Tech	___/_____	___/_____	___/_____	___/_____
Post Anesthesia Care Unit	___/_____	___/_____	___/_____	___/_____
SDS/Ambulatory Care	___/_____	___/_____	___/_____	___/_____
WOMEN / CHILDREN COMPETENCIES				
WOMEN'S				
Labor & Delivery	___/_____	___/_____	___/_____	___/_____
Postpartum / Mother-Baby	___/_____	___/_____	___/_____	___/_____
CHILDREN'S				
Pediatrics	___/_____	___/_____	___/_____	___/_____
Nursery	___/_____	___/_____	___/_____	___/_____
NICU Level 2	___/_____	___/_____	___/_____	___/_____
NICU Level 3	___/_____	___/_____	___/_____	___/_____
PICU (includes CV, Burn, etc.)	___/_____	___/_____	___/_____	___/_____

ADDITIONAL INFORMATION

Have you been convicted of a felony that would prohibit your employment at a health care facility? ☐Yes ☐ No

Have you ever been convicted of any law violation? Include any plea of "guilty" or "no contest." (Exclude minor traffic violations) ☐Yes ☐No

If yes, give details _____

Are you currently employed? ☐Yes ☐No

If YES, may we contact your employer? ☐Yes ☐No

Do you have any physical or mental conditions that would inhibit or restrict your ability to perform the essential functions of your job? ☐Yes ☐No

If YES, would you be requesting any accommodations to aid you in fulfilling the essential duties of your job? ☐Yes ☐No

If YES, what are they?_____

Are you a graduate from a foreign Nursing School (including Canada)? ☐Yes ☐No

Nurses must have a minimum of 1-2 years experience based upon specialty. Do you have a minimum of 1 year of experience? ☐Yes ☐No

Do you carry your own medical malpractice insurance? ☐Yes ☐No

If yes, please list Carrier name and address and policy number. _____

Please check all that apply:

☐ I would like to be considered for positions with FASTAFF where I may need to travel to an assignment.

Date available for assignment _____

EMPLOYMENT EXPERIENCE

Fill out the following information for any job you have been employed at within the past 5 years.
A resume does not replace this form, however, it can be used in addition to completion of this employment experience form. Start with your present or last job. MAKE COPIES OF THIS PAGE AS NEEDED.

Employment Dates From ____/____/____ (MM/DD/YY) To ____/____/____ (MM/DD/YY)

Hospital/Facility Name _____ ☐ Full Time ☐ Part Time

Address_____ City_____ State _____Zip_____

Immediate Supervisor _____ May we contact this employer? ☐ Yes ☐ No

Specialty/Unit (Please check the Specialty/Unit that best describes your primary experience.)

☐ Intensive Care Unit ☐ Emergency ☐ Pediatric Emergency ☐ Interventional Radiology ☐ Endoscopy ☐ Cath Lab ☐ Medical Surgical ☐ Medical Surgical Telemetry (remote monitoring) ☐ Home Health ☐ Adult Psychiatric ☐ Adolescent Psychiatric ☐ SDU/PCU/Telemetry ☐ Hemodialysis ☐ Operating Room ☐ Cardiovascular Operating Room ☐ Operating Room Tech ☐ Post Anesthesia Care Unit ☐ SDS / Ambulatory Care ☐ Labor & Delivery ☐ Postpartum/Mother Baby ☐ Pediatrics ☐ Nursery ☐ NICU Level 2 ☐ NICU Level 3 ☐ PICU (includes CV, Burn, etc.)

Unit Type (ex. PACU, CVICU, Oncology, etc.) _____Number of Beds _____ Supervisory experience? ☐ Yes ☐ No

Was this a travel assignment? ☐ Yes ☐ No Agency (if used)_____

Position: ☐ RN ☐ LPN/LVN ☐ CNA ☐ Other _____

Reason for leaving _____

Employment Dates From ____/____/____ (MM/DD/YY) To ____/____/____ (MM/DD/YY)

Hospital/Facility Name _____ ☐ Full Time ☐ Part Time

Address_____ City_____ State _____Zip_____

Immediate Supervisor _____ May we contact this employer? ☐ Yes ☐ No

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Reason for leaving _____

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Hospital/Facility Name _____ ☐ Full Time ☐ Part Time

Address_____ City_____ State _____Zip_____

Immediate Supervisor _____ May we contact this employer? ☐ Yes ☐ No

Specialty/Unit

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Reason for leaving _____

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Hospital/Facility Name _____ ☐ Full Time ☐ Part Time

Address_____ City_____ State _____Zip_____

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Was this a travel assignment? ☐ Yes ☐ No Agency (if used)_____

Position: ☐ RN ☐ LPN/LVN ☐ CNA ☐ Other _____

Reason for leaving _____

PRIMARY APPLICANT AGREEMENT

The following agreement is for informational purposes. FASTAFF® Inc. has the right to decide whether to hire any applicant, and the applicant has the right to choose whether to be placed by FASTAFF. Both will agree to the following:

FASTAFF'S COMMITMENT

PLACEMENT. FASTAFF will attempt to secure placement of the Applicant at an assignment with a facility for the time period indicated on the Assignment Agreement Letter (AAL). This time period may be extended at the completion of the assignment as long as the facility, applicant, and FASTAFF agree on the terms at the time of the extension. The AAL will be sent to the applicant upon verification of placement and requires the Applicant's initials to represent agreement between all parties' expectations.

PAY RATE. FASTAFF agrees to pay the applicant according to the pay rate indicated on the AAL, and in accordance with applicable Federal, State, and Local laws. The pay rate may vary according to location of assignment and may change if there is an extension of the current assignment or relocation to a new assignment. Any pay rate changes will be addressed with a new AAL, which is sent to applicant for final approval.

BONUSES. FASTAFF is proud to be Health Care Staffing Services Certified by JCAHO. In order to ensure we are adhering to JCAHO standards, the company reserves the right to withhold all eligible bonus payments from any employee who fails to provide required file documentation including but not limited to renewed license and certifications, I-9 paperwork, physical, skills check list and any other documents required by the client or JACHO.

TRAVEL TO AND FROM TRAVEL ASSIGNMENT. If applicable, FASTAFF will coordinate travel of one round trip through Corporation's travel agency from Applicant's hometown or nearest approved airport to Facility and back home upon completion of travel assignment obligation. If the Applicant voluntarily departs or quits the assignment before the agreed upon completion date, Applicant will pay for the return costs home. Applicant also agrees that FASTAFF may deduct these costs from their paycheck. If the Applicant drives to the travel assignment, a mileage reimbursement policy will apply.

HOUSING. FASTAFF will use its best efforts in placing the Applicant in reasonable housing accommodations while on a travel assignment.

REIMBURSEMENTS. All requests for reimbursements are subject to FASTAFF approval and must be submitted to FASTAFF within 90 days of incurring expenditure. Reimbursement forms can be found on our website at www.fastaff.com.

BENEFITS. FASTAFF agrees to provide the Applicant with the benefits described in the FASTAFF benefit packet. Applicant is subject to terms and conditions of the benefit program. FASTAFF reserves the right to change the benefits at anytime with or without notification.

DEDUCTIONS FROM PAYCHECK. Applicant authorizes FASTAFF to deduct from Applicant's paycheck for any non authorized housing expenses.

DISCLAIMER. FASTAFF reserves the right, and the Applicant acknowledges FASTAFF may at anytime, with or without notice, modify this Primary Applicant Agreement (PAA). All modifications will be updated to the PAA so Applicants can remain informed as to the expectations of both the company and Applicants. Changes are effective immediately when made to the PAA, continued employment after any posted change is an acceptance by Applicant of the modification.

APPLICANT'S COMMITMENT

EDUCATION AND TRAINING. Applicant states that he/she has obtained education and training in the healthcare field and is duly licensed and authorized to practice nursing.

PLACEMENT ACCEPTANCE. Once Corporation secures placement for Applicant at an assignment, Applicant agrees that his or her acceptance will be binding. All details to specific assignments will be included in the AAL. Applicant is not obligated in any way to accept placement position secured by Corporation until the AAL is signed.

EMPLOYEE AT WILL. Applicant acknowledges FASTAFF employs Applicant "at will" and no employment promises have been made for any duration of time. Specifically, Applicant understands he/she may quit employment at any time with FASTAFF, with or without notice. Similarly, Applicant understands he/she may be discharged by FASTAFF at any time, without notice, for any lawful reason. Contracts of employment can only be made by a written agreement between Applicant and FASTAFF and require the approval and signature of the President and Chief Executive Officer of FASTAFF or authorized representative. Further, should Facility decide to end Applicant's assignment prior to completion date, FASTAFF may propose a new assignment as long as Applicant is in good standing with FASTAFF.

NONDISCLOSURE AND LIMITED NONCOMPETE. Applicant agrees not to disclose any FASTAFF trade secrets or any confidential or proprietary information of FASTAFF, FASTAFF employees, Facilities, or patients of Facilities. Applicant further agrees not to compete either as a direct competitor or with a competing company at the Facility assignment where Applicant has been placed by FASTAFF for a term of three months after Applicant's final day of work at Facility.

NONSOLICITATION OF CORPORATION EMPLOYEES. Applicant agrees not to solicit FASTAFF employees to work for any competing company while on assignment with a FASTAFF facility, and for a period of three months thereafter.

DRUG SCREENS. Prior to placement and throughout employment with FASTAFF, Applicant consents to a urine, blood or breath sample for the purposes of an alcohol, drug, intoxicant, or substance abuse screening test. Applicant also gives permission for the release of the test results for determining the fitness of employment or continued employment. Applicant will utilize clinics that are approved by FASTAFF.

BACKGROUND CHECKS. Before the Applicant is placed and throughout employment with FASTAFF, FASTAFF may, upon a facility's request, conduct background checks of any kind from any location for any purpose FASTAFF considers reasonable. Applicant also gives permission for release of the results for determining fitness of employment and/or continued employment.

EMPLOYMENT AND MEDICAL INFORMATION RELEASE. I authorize FASTAFF to release any and all confidential employment and medical information contained in my employment file to any medical facility or entity with whom FASTAFF has a staffing agreement, and to any other governmental or regulatory agency at such agency's request. For all other purposes, FASTAFF shall keep my employment and medical records confidential and shall advise any medical facility or other entity to whom records have been provided to also keep such records confidential. I hereby release and hold FASTAFF harmless for any result(s) that may arise with regard to the release of this confidential information by FASTAFF.

TRAVEL. Applicant agrees to follow all FASTAFF rules regarding travel. Any travel arrangements will be specified in the AAL.

HOUSING. Applicant accepts all FASTAFF rules regarding housing. If applicable, final housing arrangements will be encompassed in the AAL. Applicant may elect to share housing, or if available, choose a single supplement. If applicable and if applicant provides his or her own housing while on a travel assignment, FASTAFF will offer a reimbursement policy as indicated on the AAL.

REIMBURSEMENTS. Applicant agrees to adhere to all rules and policies regarding reimbursements, including but not limited to submitting expenses within 90 days of incurring expense. Further, Applicant acknowledges FASTAFF's rules and regulations regarding reimbursements may be modified at any time with or without notice for any reason.

RECORDING OF TIME WORKED. Applicant agrees to abide by FASTAFF's procedures for reporting time worked, including hospital supervisor approval for shift time worked and missed lunch periods. The FASTAFF workweek begins at 7:00 AM on Sunday and concludes at 6:59 AM on the following Sunday. Applicant's time sheet must reach FASTAFF each Monday by 10 AM Mountain Standard Time in order to be paid in the current week. Any late submissions may be paid the following week.

LUNCH BREAK POLICY. Applicant will clock in and out for a minimum of thirty (30) minutes and up to a maximum of one (1) hour for meal periods, unless otherwise specified by facility policy. If the facility requests Applicant to work their lunch period due to patient care and safety, Applicant agrees to obtain two supervisor signatures of approval from Facility Healthcare Professional Managers for each applicable shift.

PERSONAL PROPERTY. U.S. Nursing and/or FASTAFF are not responsible for the theft, loss, destruction, or damage to the personal property of its employees.

TERMINATION. Applicant understands if he/she leaves his/her assignment early for any reason or is terminated by FASTAFF, Applicant must vacate company provided housing within 24 hours and will be responsible for return travel costs. Applicant authorizes FASTAFF to deduct any incurred costs from their paycheck.

GENERAL

CHOICE OF LAW. This Agreement will be construed in all respects according to the laws of the state of Colorado.

CONFIDENTIALITY OF AGREEMENT. FASTAFF and Applicant will maintain the confidentiality and exclusivity of this Agreement.

AGREEMENT REVIEW. FASTAFF and Applicant agree each party has fully read and reviewed this Agreement. Should any ambiguities arise, the interpretation of the ambiguity will not automatically be construed in favor of the Applicant.

EQUAL OPPORTUNITY EMPLOYER. FASTAFF is an equal opportunity employer incorporated in the State of Colorado and in good standing with the Colorado Secretary of State. FASTAFF does not discriminate in respect to hiring, firing, compensation, 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.

NOTICES. Any notices which are required or permitted will be in writing and will be deemed properly delivered to the other party when sent U.S. Mail, certified, postage prepaid and addressed to the following:

For Corporation:

FASTAFF®
Attn: Records Department
6501 S. Fiddlers Green Circle, Suite 200
Greenwood Village, CO 80111

For Applicant:

Applicant name: _____

Applicant address: _____

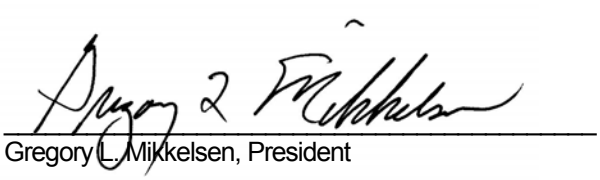
_____

HEALTHCARE PROFESSIONAL CONDUCT EXPECTATIONS

Your professional conduct and clinical performance on FASTAFF assignments is directly related to our ability to solicit new and interesting job opportunities for you. As such, FASTAFF expects you will adhere to the following Professional Conduct Expectations while on assignment. Failure to meet these expectations could lead to your termination from FASTAFF.

- I will not discuss any elements of my compensation with anyone employed at the host facility.
- I will not discuss any previous assignments worked for FASTAFF with anyone employed at the host facility.
- I will not recruit any Healthcare Professionals at the host facility, whether temporary or permanent employees.
- I will communicate with the management, staff and patients of the host facility in a respectful manner at all times.
- I will honor all terms of my agreement letter, including but not limited to beginning and ending assignment dates, housing arrangements if applicable, and travel arrangements if applicable.
- I will honor the policies and procedures of FASTAFF and the host facility.

I certify that I have read, understand and intend to comply with the Primary Applicant Agreement and Professional Conduct Expectations and the facts contained in this application are true and accurate. I understand any misrepresentation or omission of facts is cause for dismissal. I authorize the employer to investigate any and all statements contained herein and request the persons, firms, and/or corporations named above to answer 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.



Gregory L. Mikkelsen, President

_____

Name of Applicant

_____ _____

Signature of Applicant Date

REQUEST FOR REFERENCE

(Please have your reference fill out form completely before returning to FASTAFF)

I authorize, _____ from _____
(Name of Healthcare Professional's Manager) *(Facility Name and Address)*
to release information about me for the purpose of supplying a reference check.

_____ _____
Signature Date

How would you rate this former employee?

_____ has applied for a nursing position with FASTAFF Nursing and has
(Name of Healthcare Professional)
given us your name as a professional reference. We would appreciate it if you would evaluate the applicant's past performance and make any additional comments you feel might assist us in making our decision in hiring this Healthcare Professional. Your comments will be kept in strict confidence.

Name and Title of Reference:_____ Phone Number_____

Facility Name:_____ Address:_____ City, St Zip:_____

Dates Healthcare Professional was employed: From _____ To _____

Healthcare Professional's Title_____ Clinical Area Worked_____

	Exceeds Expectations	Meets Expectations	Meets Some Expectations	Does Not Meet Expectations
Quality of Work	☐	☐	☐	☐
Productivity	☐	☐	☐	☐
Professionalism	☐	☐	☐	☐
Emotional Stability	☐	☐	☐	☐
Flexibility	☐	☐	☐	☐
Dependability	☐	☐	☐	☐
Enthusiasm	☐	☐	☐	☐
Leadership Ability	☐	☐	☐	☐
Communication Skills	☐	☐	☐	☐
Attendance/Punctuality	☐	☐	☐	☐
Appearance	☐	☐	☐	☐
Customer Service Skills	☐	☐	☐	☐

Reason this Healthcare Professional left your facility: ☐ Terminated ☐ Lay-off ☐ Resigned ☐ Temporary

Comments (please continue on back, if necessary) _____

_____

_____

Would you hire this Healthcare Professional again? ☐ Yes ☐ No

Signature _____ Date_____

Please return this form to:
FASTAFF
6501 S. Fiddler's Green Circle, Suite 200
Greenwood Village, CO 80111

Or fax to: 888-508-7854
Or email to:updates@fastaff.com

CLINICAL EVALUATION

RN Information

Name: _____ Assignment Dates: _____

Would this RN be welcome to work in your facility again? ☐ Yes ☐ No

Facility Information

Facility Name: _____ Location: _____

Unit Name: _____ Unit Specialty: _____ # Unit Beds: _____

Facility Type: ☐ Teaching ☐ Non-Teaching

Clinical Performance/Attributes	Exceeds Standards	Meets Standards	Does Not Meet Standards*
Assesses patients in a timely, thorough and individualized manner according to patient need	☐	☐	☐
Works collaboratively with other members of the team to develop an individualized plan of patient care	☐	☐	☐
Performs interventions in a timely, accurate and safe manner	☐	☐	☐
Documents the patient care process accurately	☐	☐	☐
Demonstrates competency appropriate for assigned patient population including adaptations for age specific care	☐	☐	☐
Communicates respectfully & effectively with patients, families, visitors & all facility staff and physicians	☐	☐	☐
Maintains confidentiality in all aspects of patient care	☐	☐	☐
Adheres to facility policies and procedures	☐	☐	☐
Reports to work on time and as scheduled. Notifies immediate supervisor if unable to work	☐	☐	☐
Exhibits a high level of professionalism	☐	☐	☐
Exhibits flexibility and adaptability	☐	☐	☐

* = Please specify deficiencies in comment section below.

Comments: _____

_____

_____

Print: Name/Title _____

Signature _____ **Date** _____

Please fax back to 888-873-7812

CLINICAL EVALUATION

RN Information

Name: _____ Assignment Dates: _____

Would this RN be welcome to work in your facility again? ☐ Yes ☐ No

Facility Information

Facility Name: _____ Location: _____

Unit Name: _____ Unit Specialty: _____ # Unit Beds: _____

Facility Type: ☐ Teaching ☐ Non-Teaching

Clinical Performance/Attributes	Exceeds Standards	Meets Standards	Does Not Meet Standards*
Assesses patients in a timely, thorough and individualized manner according to patient need	☐	☐	☐
Works collaboratively with other members of the team to develop an individualized plan of patient care	☐	☐	☐
Performs interventions in a timely, accurate and safe manner	☐	☐	☐
Documents the patient care process accurately	☐	☐	☐
Demonstrates competency appropriate for assigned patient population including adaptations for age specific care	☐	☐	☐
Communicates respectfully & effectively with patients, families, visitors & all facility staff and physicians	☐	☐	☐
Maintains confidentiality in all aspects of patient care	☐	☐	☐
Adheres to facility policies and procedures	☐	☐	☐
Reports to work on time and as scheduled. Notifies immediate supervisor if unable to work	☐	☐	☐
Exhibits a high level of professionalism	☐	☐	☐
Exhibits flexibility and adaptability	☐	☐	☐

* = Please specify deficiencies in comment section below.

Comments: _____

_____

_____

Print: Name/Title _____

Signature _____ **Date** _____

Please fax back to 888-873-7812

PHYSICIAN'S STATEMENT

(Please print clearly)

Full Name:_____
Please Print

Note: It is the responsibility of the applicant to have their physician fill out the appropriate section of this form.

PHYSICIAN TO COMPLETE THIS SECTION:

TB Skin Test	Date Completed_____	Results _____
Chest X-ray (If TB test positive)	Date Completed_____	Results _____
Rubella Titer ☐ MMR ☐	Date Completed_____	Results _____
Rubeola Titer ☐ MMR ☐	Date Completed_____	Results _____
Mumps Titer ☐ MMR ☐	Date Completed_____	Results _____
Varicella Titer ☐ Varivax ☐	Date Completed_____	Results _____
Hepatitis B Titer ☐ Booster ☐	Date Completed_____	Results _____
Hepatitis B Series ☐	1st Date Completed _____ 2nd Date_____ 3rd Date _____	
Tetanus ☐	Date Completed _____	

Please submit supporting documentation of immunization records and lab results.

I have examined the individual named above, and to the best of my knowledge, he/she is in good physical and mental health, free of any communicable diseases, and is able to function in his/her profession at full capacity. By signing below I certify that the above information is valid.

Physician Signature _____ Date _____

Printed Physician's Name _____

DECLINATION OF VACCINATION

FASTAFF applicant to complete the following:

HEPATITIS B VACCINATION

I, _____, RN, understand that I understand the OSHA guidelines and have been requested to supply proof of Hepatitus B Vaccination or agree to the vaccination prior to placement with FASTAFF, Inc. However, I decline the Hepatitus B Vaccination. Further, I understand that my refusal may limit my placement options in that I understand I cannot be placed at a FASTAFF client (hereinafter "Facility") that requires the Hepatitus B Vaccination.

Therefore, in consideration of my employment with FASTAFF and placement at a Facility, I agree to hold harmless both Facility and FASTAFF, their owners, directors, employees, staff, and agents, from any and all liability arising out of my refusal of the Hepatitus B Vaccination.

Signature _____ Date _____

TETANUS VACCINATION DECLINATION

I, _____, RN, understand that I have been requested to supply proof of Tetanus Vaccination or agree to the vaccination prior to placement with FASTAFF, Inc. However, I decline the Tetanus Vaccination. Further, I understand that my refusal may limit my placement options in that I understand I cannot be placed at a FASTAFF client (hereinafter "Facility") that requires the Tetanus vaccination.

Therefore, in consideration of my employment with FASTAFF and placement at a Facility, I agree to hold harmless both Facility and FASTAFF, their owners, directors, employees, staff, and agents, from any and all liability arising out of my refusal of the Tetanus Vaccination.

Signature _____ Date _____

Job Search Agent & Nurse Portal

Have it all.

Would you like to be the first to hear about new travel nursing opportunities with FASTAFF? With FASTAFF's new job search agent you will be the first to know when positions meeting your specialty and desired locations are posted to our web site. Our new job search agent allows you to set up your own criteria and have new opportunities delivered to your email box daily. Visit www.fastaff.com/Nurses-Section/jobs/SAMain.aspxto set up your job search agent today!

Exclusively for you.

FASTAFF's nurse portal provides you with the ability to access your information securely from any location and at any time you wish. Now you can:

- Update your licenses, specialties and work history
- View your references and certifications
- Update your mailing address, phone and email
- Review your paycheck
- Enter and track your referrals
- Enroll for benefits programs
- Review and apply to your recruiter for open orders
- Receive instant auto notification on new jobs matching your licenses and skills
- Complete skills checklists including the mandatory Essential & Practical Skills

Take advantage of this exclusive tool at https://my.nursejob.com by contacting your recruiter for your personal login.

FASTAFF TRAVEL NURSING

Easy Steps To Enroll Benefits Program

Easy steps to enroll.

Eligible employees must complete Step 1 and Step 2 to enroll in Benefits and return them to USNC Human Resources Department by the Monday following their assignment start date. Log into the nurse portal to complete the necessary forms at https://my.nursejob.com.

Step 1

USNC Field Benefit Enrollment Form– All the elections you choose should be marked on this form including Medical, Dental, Vision, Life, 529 College Plan and Cancer

American Fidelity Assurance - For voluntary Cancer Indemnity Assurance Program (100% paid by the employee) Contact Human Resources for an enrollment form. Cancer Coverage is not available if your home residence is in one of these states: Connecticutt, District of Columbia, Florida, Iowa, Maine, Maryland, Massachusetts New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia

Step 2

Return the completed forms to:
6501 S. Fiddler's Green Circle Suite 200, Greenwood Village, CO 80111
hrdept@usnursing.com | Fax - 866-427-3479 or 720-921-3804
To ensure timely processing and coverage, your benefits paperwork is due in the corporate HR office by the Monday following your assignment start date. Paperwork can be sent via fax, scanned and emailed, or standard mail. If proper enrollment and payroll deduction forms are not provided to Human Resources by the Monday following your start date or benefit election change date, all benefit elections will default as "waived" for your assignment.

www.myuhc.com - United Healthcare offers on-line services where members can:

- View eligibility and claims status
- Find a physician
- Request a replacement ID Card
- Access a world of health and well-being information
- Participate in live on-line health discussions
- Download coupons for discounts on related health and well-being products & services offered through United Healthcare

IMPORTANT NUMBERS & WEBSITES:

United Healthcare (Medical / RX/Dental)
Group # 702937

Customer Service - Medical:	**1-866-317-6368**
Customer Service - Dental:	**1-877-816-3596**
Pharmacy Management (mail order)	**1-877-842-6048**
Website:	**www.myuhc.com or www.uhc.com**

Spectera Vision Plan

Customer Service	**1-800-638-3120**
Website	**www.spectera.com**

ING

Customer Service:	**1-888-238-4840**
Website:	**www.ingemployeebenefits-us.com**

U.S. Nursing Corporation Human Resources

Fax Number:	**1-866-427-3479**
Website:	**hrdept@faststaff.com**

Note: Election forms and information can be found on the Nurse Portal, under "Field Benefits and Instructions"

***Please make sure your Recruiter has your correct address. This information is very important when it comes to obtaining your insurance cards.**

You are ineligible to participate in USNC Options if :

- You waive benefits for the calendar year
- You fail to maintain active placement of 80 hours per month
- You have greater than a 30 calendar day lapse between assignments
- If lapse of assignments is greater than 30 calendar days, you may be eligible to continue applicable benefits (at full cost paid by you) under the guidelines of COBRA
- If you fail to pay/have USNC payroll deductions for applicable Employee portion of benefits

What happens to my coverage if I'm NOT WORKING?
If you do not work regularly to cover the employee monthly portion of the benefit premium (to be taken via USNC payroll deduction), you are *required to forward a personal check monthly to USNC to cover your portion of the premium cost*. Failure to do this will result in cancellation of the benefit(s) in accordance with the Plan Document eligibility criteria. USNC will not notify you of premiums due! This is your responsibility to track. If benefits are cancelled due to non-eligibility or lack of payment, you will be eligible to continue benefits via the guidelines of COBRA and any other portability plan regulations associated with the benefits options offered by USNC.

Send monthly payments to:
Human Resources
U.S. Nursing Corporation
6501 S. Fiddler's Green Circle, Suite 200
Greenwood Village, CO 80111

THIS BROCHURE IS ONLY A BRIEF SUMMARY OF YOUR BENEFITS AND DOES NOT CONSTITUTE A POLICY. YOUR PLAN DOCUMENT WILL CONTAIN THE ACTUAL DETAILED PROVISIONS OF YOUR BENEFITS. IF DISCREPANCIES EXIST BETWEEN THIS BROCHURE AND THE PLAN DOCUMENT, THE INFORMATION IN THE PLAN DOCUMENT WILL PREVAIL.

EMPLOYEE BENEFITS PROGRAM

U.S. Nursing Corporation℠
Expect more from us.

Field Employees
2009 Benefits Plan Year
January 1, 2009—December 31, 2009

BENEFITS PROVIDED

Eligibility

You are eligible to participate in USNC Options℠ if you are:

- Field Staff working for U.S. Nursing Corporation (USNC), FASTAFF, or any other affiliated organization which falls under the corporate umbrella of USNC and meets the covered participant job classification criteria
- First day worked and maintain active placement of 80 hours per month
- Your completed enrollment paperwork must be confirmed with Human Resources by the Monday following your assignment start date for coverage
- **If proper enrollment and payroll deduction forms are not provided to Human Resources by the Monday following your start date, all benefit elections will default as "waived" for your assignment**

You are not eligible to participate in USNC Options℠ if:

- You waive benefits for the calendar year
- You fail to maintain active placement of 80 hours per month
- You have a greater than 30 calendar day lapse between assignments
- Benefits end on the last day of your assignment, you would be eligible to continue applicable benefits (at full cost paid by you) under the guidelines of COBRA

MEDICAL - UNITED HEALTHCARE

The PPO plans allow flexibility in choosing coverage that meets your needs. To receive network benefits, you will use a network physician and pay applicable co-pays, deductibles and coinsurance.

United Healthcare	Field Plan	
	In-Network	Out-of-Network
Pre-Existing Condition Clause	Twelve (12) Months	
Lifetime Maximum	$2,000,000	
Deductible Individual / Family	$2,000 / $5,000	$5,000 / $8,000
Out-of-Pocket Maximum Individual / Family	$25,000 / $50,000	$25,000 / $50,000
Inpatient Hospital Expenses	Deductible, 50%	Deductible, 50%
Emergency Room	100% to $300 then Deductible, 50%	Same as in-network
Outpatient Surgery	Deductible, 50%	Deductible, 50%
Outpatient Physician Office Visit	$50 per visit	Deductible, 50%
X-Ray and Lab Tests	Deductible, 50%	Deductible, 50%
Prescription Drugs (30-Day Supply) Generic Preferred Non-Preferred	***Mandatory Generic Rule Applies*** $15 Copay $50 Copay $100 Copay	Not Covered
Mail Order Drugs (90-Day Supply)	***Mandatory Generic Rule Applies*** 2x retail copay	Not Covered
Preventive Services Routine Physicals Routine OB-GYN Exam Immunizations Routine Pap Smear Routine Prostate Screening	100% 100% 100% 100% 100%	Deductible, 50% Deductible, 50% Deductible, 50% Deductible, 50% Deductible, 50%
	Maximum Benefit $500 Per Year on Preventive	
Mental Nervous Treatment Inpatient (21 day max) Outpatient (21 visit max)	Deductible, 50% $20 Copay	Deductible, 50% Deductible, 50%
Substance Abuse Inpatient Outpatient (21 visit max)	Not Covered $20 Copay	Not Covered Deductible, 50%

Please refer to www.myuhc.com for a listing of network providers

DENTAL - UNITED HEALTHCARE

You receive discounted rates on services by using a United Healthcare provider. Using a non-network provider may result in higher out-of-pocket costs to you.

United Healthcare	DPO	
	In-Network	*Non-Network*
Deductible	$50 Single $150 Family	
Preventive Basic Major	100% Ded., 80% Ded., 50%	100% Ded., 80% Ded., 50%
Annual Maximum	$1,500	

VISION - SPECTERA

Summary of Benefits	In-Network	Out-of-Network
Eye Exam (every 12 months)	$10 Copay	Up to $40 allowance
Lenses (every 12 months) Single Bifocal Trifocal	 100% 100% 100%	 Up to $40 allowance Up to $60 allowance Up to $80 allowance
Frames (every 24 months)	$10 copay, then 100%	Up to $45 allowance
Contact Lenses In-lieu of glasses	$105 allowance	Up to $105 allowance

EMPLOYEE CONTRIBUTIONS – Monthly Contributions

Employee Medical/Rx, Dental and Vision - Monthly Contributions			
	UHC Field Plan - Medical	UHC - Dental	Spectera - Vision
Employee Only	$220.00	$35.00	$8.76
Employee + 1	$420.00	$68.00	$14.74
Employee + Family	$595.00	$90.00	$22.31

LIFE & AD&D INSURANCE - ING

Your Benefit: $25,000, 100% provided by U.S. Nursing

VOLUNTARY CANCER INDEMNITY COVERAGE PROGRAM

You may purchase the following insurance coverage on a voluntary basis:

- Cancer Indemnity Coverage - First Occurrence Cash Plan (Cancer coverage is not available in the following states: Connecticut, Washington D.C., Florida, Iowa, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Virginia, and West Virginia)

401(k) RETIREMENT SAVINGS PLAN

You are eligible to participate in the 401(k) plan after you have completed 90 days of service with U.S. Nursing Corporation and are 21 years of age. Once you've met these requirements, you may join the plan on the first day of any month. Visit www.qwrs.com for more information. Please contact Human Resources at 1-800-726-8773 ext. 1904 for details. Group Plan Number: 936641-01

SECTION 529

The Section 529 Plan is designed to help you save for future college expenses on behalf of a designated beneficiary. Please contact Human Resources at 1-800-726-8773 ext. 1904 for details.

I-9 COMPLETION INSTRUCTIONS

If you have received an offer and are going to accept an assignment with Fastaff Travel Nursing or US Nursing, you must complete a Department of Homeland Security Form I-9, Employment Eligibility Verification for our file.

Following is a 2-page letter which should be given to the Notary Public who will be acting as an Authorized Representative for FASTAFF and an instruction sheet printed by the DHS. These contain an explanation for Section 1 to be completed by the employee, and for Section 2 to be completed by the Notary Public.

Print the instruction sheets, the I-9 form, the List of Acceptable Documents and the Notary Public I-9 Information Verification Certificate. Take this to a Notary and in front of the notary complete Section 1, sign it, date it, and DON'T FORGET to check the appropriate box indicating your citizenship status. The Notary should then complete either Section 2 of the I-9 Form, or the Notary Public I-9 Information Verification Certificate. Both do not need to be completed by the Notary.

Present the Notary with your **original** document(s) (copies are not acceptable) indicating your eligibility to work in the US. The Notary should enter the appropriate document info on the appropriate lines: i.e. if you are using a passport, this is a document from List A (no additional documents are needed). Document title should be "USA Passport", Issuing Authority should be whichever governmental department or agency issued the passport such as New Orleans Passport Agency, or Department of State. This information is generally found near the bottom right of the passport. The document number will be the passport 9-digit number in the upper right portion of the passport, and the expiration date needs to be listed as well. If you are not using a passport or another document from List A, you must have a document from List B **AND** a document from List C. Refer to the Lists of Acceptable Documents which follows the I-9 form.

If the Notary does not want to enter the document information on the I-9 form, the I-9 Information Verification Certificate can be used, as long as there is document information from a List A document entered on the first line OR document information from a List B document on the first line and from a List C document on the second line.

Immediately upon completion send the Original I-9 form with copies of the documents used for verification to our office. The address is at the bottom of the Notary Public memo.

FASTAFF has earned the Joint Commission's Gold Seal of Approval

TO: NOTARY PUBLIC

RE: I-9 FORM COMPLETION AND SUPPORTING DOCUMENTATION

FASTAFF is an organization that provides health care workers to client facilities throughout the United States. Our business requires the company to hire remote workers. The Immigration Reform and Control Act (IRCA) requires all U.S. employers to verify the employment eligibility and identity of all employees hired to work in the United States after November 6, 1986. To implement the law, employers are required to complete Employment Eligibility Verification forms (Form I-9) for all employees, including U.S. citizens. A blank copy of the I-9 form is enclosed with this letter.

NOTARY AS EMPLOYER'S AGENT. The person presenting the I-9 form to you is a prospective employee for our company. Because it is not physically possible for this person to come to our offices in Denver, Colorado to complete the I9 paperwork, the United States Customs and Immigration Service (USCIS) allows employers to designate agents, such as you, to carry out their I-9 responsibilities. The law does not allow the employer to carry out I-9 responsibilities by means of documents faxed by an employee.

EMPLOYEE MUST COMPLETE SECTION 1 OF FORM. Our employee must complete Section 1 of the Form I-9. The employee's signature holds him/her responsible for the accuracy of the information provided. No documentation is required to substantiate Section 1 information provided by the employee.

NOTARY MUST COMPLETE SECTION 2 OF FORM. The employer, or the designated agent, must review original documents and complete Section 2 of the Form I-9. We are asking you to act as our agent and review the documents for us to satisfy this requirement.

FASTAFF is responsible to ensure proper completion of the entire form. Proper documentation establishes both that the employee is authorized to work in the U.S. and that the employee who presents the employment authorization document is the person to whom it was issued.

The official list of acceptable documents for establishing identity and work eligibility is enclosed with this letter being presented by our prospective employee.

1. You may accept **any List A document**, which establishes both identity and work eligibility.

2. **OR,** you may accept **one document from List B** (establishing identity) **and one document from List C** (establishing work eligibility).

You should examine the document(s) and accept them if they reasonably appear to be genuine and if they reasonably appear to relate to the person standing before you. Requesting more or different documentation than the minimum necessary to meet this requirement may constitute an unfair immigration-related employment practice. If the documentation presented by an employee does not reasonably appear to be genuine or relate to the employee who presents them, then you must refuse to accept them, and you must ask for other documentation from the list of acceptable documents.

GENUINENESS OF DOCUMENTS. You are not required to be a document expert. In reviewing the genuineness of the documents presented by an employee, employers are held to reasonableness standards.

PHOTOCOPIES OF DOCUMENTS NOT ACCEPTABLE. You cannot accept photocopies of identity or employment eligibility documents to fulfill I-9 requirements. Only the original documents, meaning the actual document issued by the issuing authority, are satisfactory with the single exception of a certified photocopy of a birth certificate. Please make copies of the documents presented by the employee to be sent with the completed I-9 form, as we would like to retain photocopies with the completed I-9 form.

ENCLOSURES. Thank you for accepting this commission. Enclosed please find the original Form I-9, the list of acceptable documentation, and Instructions for Completion of the form.

Sincerely,

FASTAFF Travel Nursing
Records Department
6501 South Fiddlers Green Circle, Suite 200
Greenwood Village, Colorado 80111

OMB No. 1615-0047; Expires 06/30/09

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

Form I-9, Employment Eligibility Verification

Instructions

Please read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination.

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and non-citizen) hired after November 6, 1986 is authorized to work in the United States.

When Should the Form I-9 Be Used?

All employees, citizens and noncitizens, hired after November 6, 1986 and working in the United States must complete a Form I-9.

Filling Out the Form I-9

Section 1, Employee: This part of the form must be completed at the time of hire, which is the actual beginning of employment. Providing the Social Security number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Preparer/Translator Certification. The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his/her own. However, the employee must still sign **Section 1** personally.

Section 2, Employer: For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors.

Employers must complete **Section 2** by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, **Section 2** must be completed at the time employment begins. **Employers must record:**

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the Form I-9. **However, employers are still responsible for completing and retaining the Form I-9.**

Section 3, Updating and Reverification: Employers must complete **Section 3** when updating and/or reverifying the Form I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in **Section 1**. Employers **CANNOT** specify which document(s) they will accept from an employee.

A. If an employee's name has changed at the time this form is being updated/reverified, complete Block A.

B. If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.

C. If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B and:

1. Examine any document that reflects that the employee is authorized to work in the U.S. (see List A **or** C);
2. Record the document title, document number and expiration date (if any) in Block C, and
3. Complete the signature block.

OMB No. 1615-0047; Expires 06/30/09

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

Form I-9, Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address *(Street Name and Number)*		Apt. #	Date of Birth *(month/day/year)*
City	State	Zip Code	Social Security #

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

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

- ☐ A citizen or national of the United States
- ☐ A lawful permanent resident (Alien #) A _____
- ☐ An alien authorized to work until _____

(Alien # or Admission #) _____

Employee's Signature	Date *(month/day/year)*

Preparer and/or Translator Certification. *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name
Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

	List A	OR	List B	AND	List C
Document title:					
Issuing authority:					
Document #:					
Expiration Date *(if any)*:					
Document #:					
Expiration Date *(if any)*:					

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* _____ **and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)*		Date *(month/day/year)*

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title: _____ Document #: _____ Expiration Date (if any): _____

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

Signature of Employer or Authorized Representative	Date *(month/day/year)*

LISTS OF ACCEPTABLE DOCUMENTS

LIST A **Documents that Establish Both Identity and Employment Eligibility**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Eligibility**
1. U.S. Passport (unexpired or expired)		**1.** Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address		**1.** U.S. Social Security card issued by the Social Security Administration *(other than a card stating it is not valid for employment)*
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address		**2.** Certification of Birth Abroad issued by the Department of State *(Form FS-545 or Form DS-1350)*
3. An unexpired foreign passport with a temporary I-551 stamp		**3.** School ID card with a photograph		**3.** Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal
4. An unexpired Employment Authorization Document that contains a photograph (Form I-766, I-688, I-688A, I-688B)		**4.** Voter's registration card		**4.** Native American tribal document
		5. U.S. Military card or draft record		**5.** U.S. Citizen ID Card *(Form I-197)*
5. An unexpired foreign passport with an unexpired Arrival-Departure Record, Form I-94, bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, if that status authorizes the alien to work for the employer		**6.** Military dependent's ID card		**6.** ID Card for use of Resident Citizen in the United States *(Form I-179)*
		7. U.S. Coast Guard Merchant Mariner Card		
		8. Native American tribal document		**7.** Unexpired employment authorization document issued by DHS *(other than those listed under List A)*
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor or hospital record		
		12. Day-care or nursery school record		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

NOTARY PUBLIC
I-9 Information Verification Certificate

On _____, in the State of _____
(date)

County of _____, _____
Name of employee/traveling RN

Personally submitted to me, _____
Name of Notary Public

I attest, under the penalty of perjury, that I have examined the documents(s) listed. (See "Lists of Acceptable Documents" located on reverse of Department of Homeland Security – Employment Eligibility Verification Form I-9).

_____

Document Title /Issuing Authority /Document # /Exp. Date if any

AND/OR

_____

Document Title /Issuing Authority /Document # /Exp. Date if any

These documents were presented by the above-named person and appear to be genuine and relate to this person.

Witness my hand and seal.

_____

Notary Public Signature Date

This form must accompany the I-9 with the upper portion filled in by the applicant and signed.