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. 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.

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

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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**- ___U.S. NURSING 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____

☐ **U.S. NURSING Road Recruitment**- City, State you visited U.S. NURSING____________________
_____

☐ **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
AK		
AL		
AR		
AZ		
CA		
CO		
CT		
DC		
DE		
FL		
GA		
HI		
IA		
ID		
IL		
IN		
KS		

State	Professional License #	Expiration Date
KY		
LA		
MA		
MD		
ME		
MI		
MN		
MO		
MS		
MT		
NC		
ND		
NE		
NH		
NJ		
NM		
NV		

State	Professional License #	Expiration Date
NY		
OH		
OK		
OR		
PA		
RI		
SC		
SD		
TN		
TX		
UT		
VA		
VT		
WA		
WI		
WV		
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	

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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 U.S. NURSING 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.

First Name ______________________________ MI __________ Last Name ____________________________________

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)

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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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Address ____ City_______________ State ________Zip___________

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

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Hospital/Facility Name _____________________________ ☐ Full Time ☐ Part Time

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

Reason for leaving ____

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PRIMARY APPLICANT AGREEMENT

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

U.S. NURSING'S COMMITMENT

PLACEMENT. U.S. NURSING 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 U.S. NURSING 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. U.S. NURSING 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. U.S. NURSING 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, U.S. NURSING 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 U.S. NURSING may deduct these costs from their paycheck. If the Applicant drives to the travel assignment, a mileage reimbursement policy will apply.

HOUSING. U.S. NURSING 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 U.S. NURSING approval and must be submitted to U.S. NURSING within 90 days of incurring expenditure. Reimbursement forms can be found on our website at www.U.S. Nursing.com.

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

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

DISCLAIMER. U.S. NURSING reserves the right, and the Applicant acknowledges U.S. NURSING 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 U.S. NURSING 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 U.S. NURSING, with or without notice. Similarly, Applicant understands he/she may be discharged by U.S. NURSING at any time, without notice, for any lawful reason. Contracts of employment can only be made by a written agreement between Applicant and U.S. NURSING and require the approval and signature of the President and Chief Executive Officer of U.S. NURSING or authorized representative. Further, should Facility decide to end Applicant's assignment prior to completion date, U.S. NURSING may propose a new assignment as long as Applicant is in good standing with U.S. NURSING.

NONDISCLOSURE AND LIMITED NONCOMPETE. Applicant agrees not to disclose any U.S. NURSING trade secrets or any confidential or proprietary information of U.S. NURSING, U.S. NURSING 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 U.S. NURSING for a term of three months after Applicant's final day of work at Facility.

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

DRUG SCREENS. Prior to placement and throughout employment with U.S. NURSING, 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 U.S. NURSING.

BACKGROUND CHECKS. Before the Applicant is placed and throughout employment with U.S. NURSING, U.S. NURSING may, upon a facility's request, conduct background checks of any kind from any location for any purpose U.S. NURSING 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 U.S. NURSING to release any and all confidential employment and medical information contained in my employment file to any medical facility or entity with whom U.S. NURSING has a staffing agreement, and to any other governmental or regulatory agency at such agency's request. For all other purposes, U.S. NURSING 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 U.S. NURSING harmless for any result(s) that may arise with regard to the release of this confidential information by U.S. NURSING.

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

HOUSING. Applicant accepts all U.S. NURSING 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, U.S. NURSING 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 U.S. NURSING's rules and regulations regarding reimbursements may be modified at any time with or without notice for any reason.

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RECORDING OF TIME WORKED. Applicant agrees to abide by U.S. NURSING's procedures for reporting time worked, including hospital supervisor approval for shift time worked and missed lunch periods. The U.S. NURSING workweek begins at 7:00 AM on Sunday and concludes at 6:59 AM on the following Sunday. Applicant's time sheet must reach U.S. NURSING 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 U.S. NURSING 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 U.S. NURSING, Applicant must vacate company provided housing within 24 hours and will be responsible for return travel costs. Applicant authorizes U.S. NURSING 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. U.S. NURSING and Applicant will maintain the confidentiality and exclusivity of this Agreement.

AGREEMENT REVIEW. U.S. NURSING 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. U.S. NURSING is an equal opportunity employer incorporated in the State of Colorado and in good standing with the Colorado Secretary of State. U.S. NURSING 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:

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

For Applicant:

Applicant name: ________________________________

Applicant address:________________________________

____

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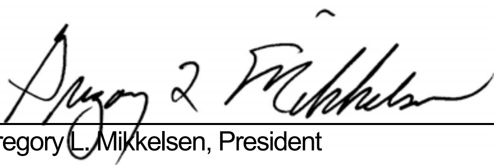
HEALTHCARE PROFESSIONAL CONDUCT EXPECTATIONS

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

- 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 U.S. NURSING 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 U.S. NURSING 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

______________________________________ Date ____________

Signature of Applicant

REQUEST FOR REFERENCE

(Please have your reference fill out form completely before returning to U.S. NURSING)

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 U.S. NURSING 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:
U.S. NURSING
6501 S. Fiddler's Green Circle, Suite 200
Nursing.com
Greenwood Village, CO 80111

Or fax to: 888-508-7854
Or email to:updates@U.S.

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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

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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

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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 ____

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DECLINATION OF VACCINATION

U.S. NURSING 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 U.S. NURSING, 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 U.S. NURSING client (hereinafter "Facility") that requires the Hepatitus B Vaccination.

Therefore, in consideration of my employment with U.S. NURSING and placement at a Facility, I agree to hold harmless both Facility and U.S. NURSING, 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 U.S. NURSING, 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 U.S. NURSING client (hereinafter "Facility") that requires the Tetanus vaccination.

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

Signature ____ Date ___________________

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