E&S MEDICAL STAFFING

Thank you for your interest in E&S Medical Staffing !!! We are a full service staffing firm with opportunities for C.N.A.s, RNs, LPNs, and all allied health professional RIGHT IN YOUR LOCAL AREA. We work with some of the areas top medical institutions and are committed to making your experience with us a success. Please fill in all requested pages.

Please send your resume if you have one. Remember to make copies of the below requirements and send fax with application to us. If you have any questions what so ever please call me and I will walk you through the process. The sooner we receive your application the sooner we can get your stated in a facility in your area.

IN ADDITION TO THE APPLICATION PAGES WE NEED COPIES OF THE BELOW:

- Drivers License or State ID

- Social Security Card

- NY State Nursing License

- ACLS Certificate (if applicable)

- PALS Certificate (if applicable)

- Current CPR Card

- Physical within the last year

- TB or Chest X-Ray

- Titers

Please send or fax the copies with your application.

We hope to see you soon and look forward to working with you. Please feel free to call us at any time if you have any questions or concerns.

Thank You and Have a Nice Day!!!

299 North Plank Rd Suite 107
Newburgh, NY 12550
Phone: 845-565-8608 - Fax: 845-562-8863

Employment Application

Questions? Let us know!
Phone: 845-565-8608 Fax: 845-562-8863
Email: Eric@esmedicalstaffing.com
Web: www.esmedicalstaffing.com

Professional Summary

Today's Date

Nursing

Registered Nurse
- ☐ Licensed Practical Nurse
- ☐ Medical Assistant
- ☐ Certified Nurse Assistant
- ☐ Certified Registered Nurse Anesthetist

Allied – Therapy
- ☐ Physical Therapist
- ☐ Physical Therapist Assistant
- ☐ Certified Occupational Therapy Assistant
- ☐ Speech Language Pathologist
- ☐ Respiratory Therapist
- ☐ Occupational Therapist
- ☐ Speech Language Therapist Assistant

Allied – Imaging
- ☐ Radiography (X-Ray)
- ☐ Mammography
- ☐ MRI
- ☐ Nuclear Medicine
- ☐ Radiation Therapy
- ☐ Computed Tomography (CT Scan)
- ☐ Ultrasound
- ☐ Cardiovascular Interventional
- ☐ Vascular Technologist
- ☐ Echocardiography
- ☐ Special Procedures
- ☐ Other_____

Allied
- ☐ EEG Technician
- ☐ Medical Lab
- ☐ Polysomnographic Technician
- ☐ Sterile Processing Technician
- ☐ Surgical Technician
- ☐ Registered Polysomnographic Technician

Homecare
- ☐ Personal Care Aid
- ☐ Home Health Aid

Contact Information

Name _____
Last Middle First

Email Address _____

Citizenship ☐ US ☐ H1A ☐ H1B ☐ Trade NAFTA ☐ Work Authorization Card ☐ Resident Alien Card

Current Address _____
Street Address City State Zip

Home Phone ( ) - Work Phone ( ) - Cell Phone ( ) -

I will be at this address until: _____ The best time to reach me is: _____

Please reach me via: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Permanent Address _____
Street Address City State Zip

My Education

Education Level	Name, Location of School	Date Boards Passed	Diplomas/Degrees Received
College			
Graduate			
Professional or other			

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Web: www.esmedicalstaffing.com

Assignment Preferences

Date Available to Start: _____

Type of Employment Desired: ☐ Full Time ☐ Part Time ☐ Contract ☐ Travel ☐ Permanent

Location Preference 1. _____ 2. _____ 3. _____

	Specialty	Date Last Practiced	Years Experience
Primary			
Additional 1			
Additional 2			
Additional 3			

Have you Ever Applied/Interviewed with Vision? ☐ Yes ☐ No

Have you ever Been Employed By Vision? ☐ Yes ☐ No

Referral Source: ☐Newspaper Ad ☐Magazine ☐Email Survey ☐Referral
☐Word of Mouth ☐Internet Search Engine ☐Internet Job Board ☐Trade Show

Specifically: _____ If Referred By An Onward Employee, Please Identify: _____

Licensures and Certifications

LICENSURE –(Please include photocopies of all licenses held)

Original State of Licensure and number: _____

License # _____ Type _____ State _____ Exp. Date _____

License # _____ Type _____ State _____ Exp. Date _____

Have you ever held a license under a different name? If yes, please list name and location _____

Please identify current credentials/certifications:

Type: _____ Exp. Date _____ Type: _____ Exp. Date _____

Type: _____ Exp. Date _____ Type: _____ Exp. Date _____

Type: _____ Exp. Date _____ Type: _____ Exp. Date _____

Type: _____ Exp. Date _____ Type: _____ Exp. Date _____

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Disciplinary Actions

If you answer yes to any of the below questions, please attach a separate sheet with circumstances, dates, and final outcome:

Have you ever been convicted of a crime other than a minor traffic violation? _____

Has your license or certification ever been investigated or suspended? _____

Have you ever been named as a defendant in a malpractice claim? _____

Has your license been revoked, either temporarily or permanently by any state? _____

Have you ever been subject to disciplinary action by any state board? _____

Professional Liability Insurance

Present Carrier	Policy Number	Phone Number	
Address	City, State	Effective Date	Expiration Date
Previous Carrier	Policy Number	Phone Number	
Address	City, State	Effective Date	Expiration Date

If you answer yes to any of the below questions, please attach a separate sheet with circumstances, dates, and final outcome:

Have you ever been involved in a malpractice claim(s) (including dismissed actions)? ☐ Yes ☐ No

Has any monetary payment ever been made by you or on your behalf because of alleged medical malpractice? ☐ Yes ☐ No

Are there currently any pending medical malpractice claims or settlements involving yourself? ☐ Yes ☐ No

Has your professional liability insurance coverage ever been denied, limited, or canceled by any insurance company? ☐ Yes ☐ No

Has your current liability insurance carrier excluded any specific procedures from your insurance coverage? ☐ Yes ☐ No

Employment History

Please list your employment for the past 10 years beginning with your most recent experience. Document any periods of unemployment

Are you currently employed? ☐ Yes ☐ No

Facility/Agency _____ From _____ To _____

Address _____
Street Address City State Zip Code

Supervisor _____ ( ) -
Name Title Phone

Specialty _____ Position _____

Facility Type ☐ Pharmaceutical ☐ Biotechnology ☐ Medical Device ☐ CRO
☐ Physician's Office ☐ Clinical Setting ☐ Hospital ☐ University Medical Center
☐ Other _____

Salary _____ Staffing Assignment? Travel/ Contract/ None

Reason for Leaving _____

Employment Application

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Facility/Agency ______________________ From __________ To __________

Address ____
Street Address City State Zip Code

Supervisor ______________________________ ( ) -
Name Title Phone

Specialty ______________ Position ______________

Facility Type ☐ Pharmaceutical ☐ Biotechnology ☐ Medical Device ☐ CRO
☐ Physician's Office ☐ Clinical Setting ☐ Hospital ☐ University Medical Center
☐ Other ______________________________

Salary __________ Staffing Assignment? Travel/ Contract/ None

Reason for Leaving ______________________________

Facility/Agency ______________________ From __________ To __________

Address ____
Street Address City State Zip Code

Supervisor ______________________________ ( ) -
Name Title Phone

Specialty ______________ Position ______________

Facility Type ☐ Pharmaceutical ☐ Biotechnology ☐ Medical Device ☐ CRO
☐ Physician's Office ☐ Clinical Setting ☐ Hospital ☐ University Medical Center
☐ Other ______________________________

Salary __________ Staffing Assignment? Travel/ Contract/ None

Reason for Leaving ______________________________

Facility/Agency ______________________ From __________ To __________

Address ____
Street Address City State Zip Code

Supervisor ______________________________ ( ) -
Name Title Phone

Specialty ______________ Position ______________

Facility Type ☐ Pharmaceutical ☐ Biotechnology ☐ Medical Device ☐ CRO
☐ Physician's Office ☐ Clinical Setting ☐ Hospital ☐ University Medical Center
☐ Other ______________________________

Salary __________ Staffing Assignment? Travel/ Contract/ None

Reason for Leaving ______________________________

Facility/Agency ______________________ From __________ To __________

Address ____
Street Address City State Zip Code

Supervisor ______________________________ ( ) -
Name Title Phone

Specialty ______________ Position ______________

Employment Application

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Facility Type ☐ Pharmaceutical ☐ Biotechnology ☐ Medical Device ☐ CRO
☐ Physician's Office ☐ Clinical Setting ☐ Hospital ☐ University Medical Center
☐ Other _____

Salary _____ Staffing Assignment? Travel/ Contract/ None
Reason for Leaving _____

Please indicate any employers that you would prefer we not contact _____

In the event of an emergency, please contact:
Name _____ Phone ( ) -
Address _____
Street Address City State Zip

I understand and agree that any employment by E&S and myself is predicated upon the truthfulness of the statements made in this application and accompanying correspondence. I understand that any misrepresentations or omissions of facts called for is cause for immediate dismissal.
In connection with this application for employment, I authorize E&S, and/or its agents and/or its representatives, to make a complete, thorough and independent investigation of my background and to verify and make any and all inquiries deemed necessary concerning the information I have provided including the authorization to contact any persons, business entities, educational institutions, governmental agencies, law enforcement agencies, past or current employers and references for the purpose of reviewing my employment record, confirming any and all statements given to E&S or other information developed in connection with this application, determining my qualifications and abilities to E&S's satisfaction, or to comply with federal or state law; or to comply with the policies and procedures of E&S's clients. In furtherance of this application for employment, I authorize any and all persons business entities, educational institutions, governmental agencies, law enforcement agencies, past or current employers and references to provide E&S with any information concerning my character, current and/or prior employment performance, education, criminal background and professional licensure/certification standing without any liability whatsoever to them or E&S.
I hereby release E&S and/or its agents or representatives, without reservation or condition, including any person, business entities, educational institutions, governmental agencies, law enforcement agencies, past or current employers and references from any and all liability arising from, created by, or caused by the release of any such personal or business information, records and related documents to E&S, its agents and/or representatives. A copy of this release is acceptable in lieu of the original document.
I understand that if employed by E&S, I will be an employee 'at-will' and that I or E&S may terminate any employment at any time. I understand and agree that Vision retains the sole discretion to offer assignments to employee(s) that it believes, in its sole discretion, is most qualified for the assignment and would best represent the business interests of E&S

Signature: _____ Date: _____

Social Security Number _____

Applicant Reference Consent Form

Questions? Let us know!
Phone: 845-565-8608 Fax: 845-562-8863
Email: Eric@esmedicalstaffing.com
Web: www.esmedicalstaffing.com

Applicant Name _____
Print Name

Applicant: Please complete this reference request with three references to correspond with your employment on this application. Please sign and return this form. The facilities listed below have my consent to release any information to E&S Medical Staffing pertaining to my employment. I also authorize " to disclose my references to any of its clients, "E&S institutions, or affiliates.

Signature _____ Social Security Number _____ Date _____

Facility Name _____

Facility Address _____
City State Zip Code

Manager/Supervisor _____
Name Title

Reference Phone # _____ Best time to Contact _____

Facility Name _____

Facility Address _____
City State Zip Code

Manager/Supervisor _____
Name Title

Reference Phone # _____ Best time to Contact _____

Facility Name _____

Facility Address _____
City State Zip Code

Manager/Supervisor _____
Name Title

Reference Phone # _____ Best time to Contact _____

Questions? Let us know!
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Web: www.esmedicalstaffing.com

Background Investigation Consent Form

I, _____, hereby authorize E&S Medical Staffing to make and independent investigation of my background, references, character, past employment, education, credit, criminal or police records, driver's license records, including those maintained by both public and private organizations and all public records for the purpose of confirming the information contained on my application and/or obtaining other information which may be material to my qualifications.

I release E&S Medicaln Healthcare Staffing and any person or entity which provides information pursuant to this authorization, from any and all liabilities, claims or lawsuits in regards to the information obtained from any and all of the above referenced sources used.

According to the Fair Credit Reporting Act (FRCA), I am entitled to know if employment is denied because of information obtained by my prospective employer from a consumer reporting agency or the source which provided the information.

The following is my true and complete legal name, and all information is true and correct to the best of my knowledge:

_____
Full Name (Printed)

_____
Other Names Used

_____
Present Address

_____
City State Zip How Long?

_____ _____ _____ _____
DateBirth * Sex* Race* Social Security Number

_____ _____
Driver's License Number f State

_____ _____
Applicant's Signature Today's Date

Have you ever been CONVICTED of a crime or of violating any law?_____Yes _____No

Are you currently on probation, parole, or suspended sentence for any conviction?_____Yes _____No

***Note:** The above information is required to insure positive identification and is in no manner used in qualification. This information will NOT be part of your application file.

OFFICE USE ONLY

____Criminal ____Credit Report ____MVR _____Employment Check ____Drug Test ____Other(Specify)

Questions? Let us know!
Phone: 845-565-8608 Fax: 845-562-8863
Email: Eric@esmedicalstafing.com
Web: www.esmedicalstaffing.com

EMPLOYEE PRIVACY ACKNOWLEDGEMENT

I understand that while performing my official duties I may have access to protected personal and health information as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I also understand that:

- Protected health information is individually identifiable health information that is created, maintained or used within by E&S Medical Staffing.
- Protected health information is not available to the public.
- Special precautions are necessary to protect this type of information from unlawful or unauthorized access, use, modification, disclosure or destruction.

In order to help ensure the confidentiality and privacy of this information, I agree to:

- Access, use or modify protected health information only as needed for the purposes of performing my official duties.
- Never access or use protected health information out of curiosity, or for personal interest or advantage, or in the presence of any unauthorized third party.
- Never show, discuss, or disclose protected health information to or with anyone who does not have the legal authority.
- Never retaliate, coerce, threaten, intimidate or discriminate against or take other retaliatory actions against individuals or others who file complaints or participate in investigations or compliance reviews.
- Never remove protected health information from the work area without proper written authorization.
- Never share passwords with anyone or store passwords in a location accessible to unauthorized persons.
- Always store protected health information in a place physically secure from access by unauthorized persons and out of plain view.
- Dispose of protected health information by utilizing an approved method of destruction (i.e., shredding). I will not dispose of such information in wastebaskets or recycle bins.

I understand that penalties for violating one of the above limitations may include disciplinary action including possible termination, civil or criminal prosecution.

"I certify that I have read, understand and agree to the Privacy Acknowledgement Statement printed above."

Print Full Name (first, middle initial, last) _____	**Signature**: _____
E&S Representative: _____	**Date Signed**: _____

Questions? Let us know!
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Web: www.esmedicalstaffing.com

UNIVERSAL PRECAUTIONS POST-TEST

NAME:_____

DATE:_____ SCORE:_____

DIRECTIONS: Circle only ONE answer for each question.

1. **OSHA recommends that all workers who come into contact with blood be vaccinated to prevent HBV infections.**
a.)...TRUE b.)...FALSE

2. **HIV can cause flu-like illness with fever aches and swollen glands.**
a.)...TRUE b.)...FALSE

3. **OSHA has introduced a standard based on guidelines developed by the CDC that are designed to protect you from bloodborne disease.**
a.)...TRUE b.)...FALSE

4. **An HBV or HIV carrier may have no symptoms but can spread the disease to others**.
a.)...TRUE b.)...FALSE

5. **Which group faces the greatest risk of getting AIDS?**
a.) Healthcare Workers b.) Married Couples c.) Drug users who share needles d.) Blood donors

6. **Blood tests are used to determine if you have been infected with HIV or HBV**.
a.)...TRUE b.)...FALSE

7. **Blood is the most common source of HIV and HBV in the workplace.**
a.)...TRUE b.)...FALSE

8. **Universal Precautions should be observed when working with which group?**
a.) Male homosexuals b.) Only patients with AIDS c.) Drug users d.) All patients

9. **Blood on instruments or equipment cannot infect you**.
a.)...TRUE b.)...FALSE

10. **If recapping used needles is necessary, you should always use the one-handed scoop method or a recapping device to prevent needle stick injury.**
a.)...TRUE b.)...FALSE

11. **Which task requires wearing protective gloves?**
a.) Cleaning up blood b.) Assisting in minor surgery c.) Changing a dressing d.) All of the above

12. **Masks and protective eye ware are designed to protect you from_____**.
a.) Needle stick injury b.) Clothing contamination c) Mucous membrane contact d.) All of the above

13. **Clearly marked, puncture resistant containers should be available to dispose of used needles or other disposable sharps.**
a.)...TRUE b.)...FALSE

14. **Which activity can spread HIV or HBV from one person to another outside of work?**
a.) Using a toilet b.) Giving blood c.) Shaking hand d.) Having sex

15. **You can get HIV or HBV from puncture wounds, broken skin contact, and mucous membrane contact.**
a.)...TRUE b.)...FALSE

Questions? Let us know!
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Material Safety Data Sheet

OSHA Hazard Communication Standard, "Right To Know" Law ensures that the hazards of all chemicals produced or imported are examined by the manufacturers or importers and that information concerning their hazards are transmitted to employers and employees.

E&S acknowledges that every employee is entitled to work under the safest and most healthful conditions both in the office and in the home, if applicable.

A MSDS manual is available and kept in the E&S office for use by the field staff and internal personnel whenever they are working, seven days, twenty-four hours a day.

I have read and understand the MSDS manual and related policies and procedures outlined by E&S for safe handling and storage of chemicals. In addition, I know where they are located in the E&S office.

Employee Signature	ES Representative

REFERENCE FORM

Questions? Let us know!
Phone: 845-565-8608 Fax: 845-562-8863
Email: Eric@esmedicalstaffing.com
Web: www.esmedicalstaffing.com

Date:_____

REFERENCE NAME: _____

REFERENCE ADDRESS: _____

REFERENCE PHONE: _____

REFERENCE FORM

The person listed below has applied to E&S Medical Staffing for employment in the health care field and has submitted your name as a former employer for reference purposes. The serious nature of our responsibility to our patients and client institutions is such that any consideration of the individual by E&S Medical taffing is dependent upon receipt of satisfactory references. We would, therefore, appreciate your cooperation in replying to the questions listed below. Please be assured that your responses will be kept in the strictest confidence. Thank you in advance for this courtesy.

_____
E&S MedicalStaffing Representative

_____
Signature of Applicant

APPLICANT'S NAME: _____ SOC. SEC. NO: _____

POSITIONS HELD INYOURCOMPANY _____

EMPLOYMENT DATES: FROM_____TO_____

CHECK ONE: ☐ Applicant Resigned ☐ Applicant was a Temporary Employee ☐ Applicant was Terminated

WOULD YOU REHIRE? _____

PERSONAL EVALUATION	ABOVE AVERAGE	SATISFACTORY	NEEDS IMPROVEMENT	POOR
Quality of Work				
Quantity of Work				
Interest & Enthusiasm				
Ability to Relate to Patients				
Ability to Relate to Staff				
Adaptability to Change				
Ability to Handle Stress				
Willingness/Ability to Float				
Attendance				
Punctuality				
Personal Appearance				

Comments:_____

_____

_____

Signature: _____ Title: _____ Date: _____

Physical Form

Questions? Let us know!
Phone: 845-565-8608 Fax: 845-562-8863
Email: Eric@esmedicalstaffing.com
Web: www.esmedicalstaffing.com

MEDICAL EXAM:_____ **HEALTH ASSESMENT:**_____

Name_____ Social Security #_____

Address_____ Tel #_____

Please Complete the Following

Date of Physical Examination_____

	Positive	Negative	Date
PPD Skin Test results (req. 1 year)			
Chest X-Ray (req. 5 Years)			
Completed INH Prophylaxis			
BCG Value			

	Titer Value/Immune/Date	Vaccine/Date
Rubeola Titer (Measels)		
Rubeola Titer (German Measels)		
Varicella Titer (Chicken Pox)		
Tetnus Toxoid (req. 10 years)		

	Initial Date	Date (4 weeks)	Date (6 months)
Hepatitis B Vaccine (1 cc)			

I decline the Hepatitis B Vaccination at this time. I understand that declining this vaccine, I continue to be at risk of acquiring Hepatitis B (HBV), a serious disease. I understand that due to any occupational exposure to blood and other potentially infectious materials, I may be at a higher risk of acquiring HBV. However, if in the future I continue to have occupational exposure to blood or other potentially infectious materials and want to be vaccinated with the Hepatitis B Vaccine, I will receive the Vaccination series at that time.

_____ _____
Employee Date

II. Does the individual have any physical limitations?_____

III. Does the individual take any prescribed medications?_____

IV. Which of the following have you had since your last review?

Weight Gain/Loss_____lbs.	Y	N	Change in bowel habits	Y	N
Change in vision/hearing	Y	N	Black/bloody stool	Y	N
Frequent cough/night sweat/chills	Y	N	Persistent diarrhea	Y	N
Recurrent Fever	Y	N	Burning/blood in urine	Y	N
Generalized swollen Glands	Y	N	Problems urinating	Y	N
Indigestion/difficulty swallowing	Y	N	Muscle or joint pain	Y	N
Hoarseness	Y	N	Low back pain	Y	N
Difficulty breathing	Y	N	Breast lump/discharge	Y	N
Palpitation/irregular heartbeat	Y	N	Skin rash/sores, lumps	Y	N
Pain/pressure in chest	Y	N	Dizziness	Y	N

I have determined that the above is free from any physical and mental impairment which if of potential risk to patients or which might interfere with the performance of the person's duties, including but not limited to, the habituation of addiction to depressants, stimulants, narcotics, alcohol, or other drugs or "substances" which may alter the individual's behavior.

_____ _____ _____
Signature of Practitioner **Practitioner's Name (please print)** **Date**

_____
Address

Questions? Let us know!
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Email: Eric@esmedicalstaffing.com
Web: www.esmedicalstaffing.com

ACKNOWLEDGEMENT OF HEPATITIS B VACCINE POLICY

E&S Medical Staffing has provided information regarding the efficacy, safety and administration procedure for the Hepatitis B vaccination series and had offered to pay for the series. I certify that I have read and understand this policy and release E&S Medical Staffing from all liability for any adverse reactions that may result from this Hepatitis B vaccine series.

I accept the Hepatitis B vaccination series.

_____ _____

Employee Signature Date

RELEASE OF LIABILITY WAIVER AND VACCINE DECLINATION

If I decline the vaccination series, I release E&S Medical Staffing from all liability regarding the contraction of Hepatitis B in performance of my employment duties.

I am declining the Hepatitis B vaccination series from E&S because I have already received the vaccination within the last ten (10) years.

_____ _____

Employee Signature Date

Dates of Vaccine: 1st ____/____/_____ 2nd ____/____/___/ 3rd ____/____/_____

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____ _____

Employee Signature Date

_____ _____

E&S Representative Date

Questions? Let us know!
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Email: Eric@esmedicalstaffing.com
Web: www.esmedicalstaffing.com

Authorization Agreement for DIRECT DEPOSIT

E&S Medical Staffing Direct Deposit is a benefit we offer to our employees. The timing varies depending on your banks ACH (Automatic Clearing House) cycle. If your time card is turned in late, then Direct Deposit may be delayed until the following pay cycle.

In order for us to process your Direct Deposit request, you will need to include a **legible copy of a voided check** or a form from your financial institution (No deposit slips please).

Be sure and verify that funds are transferred to your account before you draw on those funds. E&S Medical will not be liable for the availability of your funds. It is E&S Medical Staffing's recommendation that you verify availability of funds on a weekly basis.

If there is a system shut down and transmission didn't take place the availability of your funds may be delayed. **Please make provision in the unlikely event that a problem may occur**.

Please be aware that if you change banks or accounts you will need to notify us two weeks before the change takes place.

Direct Deposit scheduling may be affected by a holiday and cause the deposit to be credited a day later to your account.

I (WE) HEREBY AUTHORIZE E&S MEDICAL STAFFING HEREIN AFTER CALLED "COMPANY", TO INITIATE CREDIT ENTRIES TO EMPLOYEES (NAMED BELOW) CHECKING ACCOUNT AT THE DEPOSITORY FINANCIAL INSTITUTION NAMED BELOW, HEREINAFTER CALLED DEPOSITORY, AND TO CREDIT THE SAME TO SUCH ACCOUNT.

EMPLOYEE INFORMATION & ACKNOWLEDGMENT		
Client Company		
Employee Name	**Employee Signature**	**Date**
Other Signer on Account Name (if any)	**Other Signer's Signature**	**Date**
BANK INFORMATION		
Name	**Address**	
Routing No./Account Number (Please include a copy of voided check) **( ) Checking ( ) Savings**		**Phone**

THIS AUTHORIZATION IS TO REMAIN IN FULL FORCE AND EFFECT UNTIL COMPANY HAS RECEIVED **WRITTEN** NOTIFICATION FROM ME (OR US) OF ITS TERMINATION IN SUCH TIME AND IN SUCH MANNER AS TO AFFORD COMPANY AND DEPOSITORY A REASONABLE OPPORTUNITY TO ACT ON IT (Two full weeks from the date of receipt). **NOTE:** ALL WRITTEN CREDIT AUTHORIZATIONS MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.

BE SURE TO INCLUDE A COPY OF A VOIDED CHECK.

U.S. Department of Justice
Immigration and Naturalization Service

OMB No. 1115-0136

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 of 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	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)*

Form W-4 (200

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2008 expires February 16, 2009. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds $900 and includes more than $300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/multiple job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

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

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2008. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . **A** _____

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

. . **B** _____

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . **C** _____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . **D** _____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . **E** _____

F Enter "1" if you have at least $1,500 of **child or dependent care expenses** for which you plan to claim a credit . . **F** _____
(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
- If your total income will be less than $58,000 ($86,000 if married), enter "2" for each eligible child.
- If your total income will be between $58,000 and $84,000 ($86,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have 4 or more eligible children. **G** _____

H Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶ **H** _____

For accuracy, complete all worksheets that apply.
- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($25,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074
200

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

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	**5**
6	Additional amount, if any, you want withheld from each paycheck	**6** $
7	I claim exemption from withholding for 2008, and I certify that I meet **both** of the following conditions for exemption. ● Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and** ● This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ▶	**7**

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

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

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

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions, claim certain credits, or claim adjustments to income on your 2008 tax return.

1 Enter an estimate of your 2008 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2008, you may have to reduce your itemized deductions if your income is over $159,950 ($79,975 if married filing separately). See *Worksheet 2* in Pub. 919 for details.) . . 1 $

2 Enter: { $10,900 if married filing jointly or qualifying widow(er) / $ 8,000 if head of household / $ 5,450 if single or married filing separately } . . . . . 2 $

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

4 Enter an estimate of your 2008 adjustments to income, including alimony, deductible IRA contributions, and student loan interest 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 8* in Pub. 919) . 5 $

6 Enter an estimate of your 2008 nonwage income (such as dividends or interest) . . . . . 6 $

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

8 **Divide** the amount on line 7 by $3,500 and enter the result here. Drop any fraction 8

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

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

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

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

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

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $50,000 or less, do not enter more than "3." 2

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

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

4 Enter the number from line 2 of this worksheet 4

5 Enter the number from line 1 of this worksheet 5

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

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

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

9 Divide line 8 by the number of pay periods remaining in 2008. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2007. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $4,500	0	$0 - $6,500	0
4,501 - 10,000	1	6,501 - 12,000	1
10,001 - 18,000	2	12,001 - 20,000	2
18,001 - 22,000	3	20,001 - 27,000	3
22,001 - 27,000	4	27,001 - 35,000	4
27,001 - 33,000	5	35,001 - 50,000	5
33,001 - 40,000	6	50,001 - 65,000	6
40,001 - 50,000	7	65,001 - 80,000	7
50,001 - 55,000	8	80,001 - 95,000	8
55,001 - 60,000	9	95,001 - 120,000	9
60,001 - 65,000	10	120,001 and over	10
65,001 - 75,000	11		
75,001 - 100,000	12		
100,001 - 110,000	13		
110,001 - 120,000	14		
120,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $65,000	$530	$0 - $35,000	$530
65,001 - 120,000	880	35,001 - 80,000	880
120,001 - 180,000	980	80,001 - 150,000	980
180,001 - 310,000	1,160	150,001 - 340,000	1,160
310,001 and over	1,230	340,001 and over	1,230

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

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

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

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

LPN/ Competency and Skills Checklist

Questions? Let us know!
Phone: 845-565-8608 Fax: 845-562-8863
Email: Eric@esmedicalstaffing.com
Web: www.esmedicalstaffing.com

Last Name _____ First Name _____ MI _____ Date _____

Please indicate years of experience in the following areas:

MED/SURG	___	CCU	___	PEDIATRICS	___
TELEMETRY	___	CATH LAB	___	L&D	___
ICU	___	ER	___	CLINICS	___
MICU/SICU	___	OR	___	HOME HEALTH	___
NICU	___	PACU	___	NSG HOMES	___
NEURO ICU	___	BURN UNIT	___	PSYCHIATRY	___

Instructions: Please check the appropriate column that best describes your experience level for each competency and skill. Please use the rating scale below to evaluate yourself based on experiences within the last two years.

Experience Rating Scale

1 = Limited/No Experience 2 = Infrequent / Minimal Experience 3 = Competent

General Skills	1	2	3	**Cardio-Vascular**	1	2	3
Computer Documentation	□	□	□	EKG/Arrythmia Interpretation	□	□	□
Med Administration – 5 RIGHTS	□	□	□	Pacemaker - Permanent	□	□	□
CODE Status	□	□	□	Pacemaker – Temp	□	□	□
BLS/CPR	□	□	□	Perform 12-lead EKG	□	□	□
ACLS/PALS	□	□	□	A-line Set-up/Draw Gases	□	□	□
IV Insertion	□	□	□	CVP Readings	□	□	□
Central Line Care	□	□	□	Swan-Ganz Readings	□	□	□
Infusion Pumps	□	□	□	IABP	□	□	□
IV Med Admin	□	□	□	Defib/cardioversion	□	□	□
Adult Dose Calculations	□	□	□	Chest Tubes	□	□	□
Peds Dose Calculations	□	□	□	Cardiac Drugs	□	□	□
Oxygen Administration	□	□	□	Dopamine/Dobutamine	□	□	□
Blood Draws	□	□	□	Brevibloc	□	□	□
Pain Assessment & Documentation	□	□	□	Lidocaine	□	□	□
Universal Precautions	□	□	□	Nipride	□	□	□
Blood Borne Precautions	□	□	□	Nitroglycerine	□	□	□
Droplet Precautions	□	□	□	Heparin	□	□	□
Reverse Isolation	□	□	□	Epi/Norepinephrine	□	□	□
PPE	□	□	□	Adenosine	□	□	□
Dressing Changes/Drains	□	□	□	Natrecor	□	□	□
Blood Product Admin	□	□	□	Bretyllium	□	□	□
Enteral Feedings	□	□	□	Verapamil	□	□	□

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Web: www.esmedicalstaffing.com

LPN COMPETENCY AND SKILLS CHECKLIST

Cardio-Vascular	1	2	3
Care of Patients with:	□	□	□
Angina/MI	□	□	□
CHF	□	□	□
Post CABG	□	□	□
Pro/Post Cardiac Cath	□	□	□
Cardio/Hypovolemic Shock	□	□	□
Aneurysm	□	□	□
Heart Transplant	□	□	□
Pre/Post Open Heart Surgery	□	□	□
Fem-Pop Bypass	□	□	□
Hypertensive Crisis	□	□	□

Pulmonary			
Differentiate Breath Sounds	□	□	□
Arterial Puncture	□	□	□
ABG Interpretation	□	□	□
Oral-Pharyngcal-ET Suctioning	□	□	□
Ventilator Management	□	□	□
ET Intubation/Extubation	□	□	□
Incentive Spirometer	□	□	□
Chest Tubes/Pleuravac	□	□	□
Care of Patients with:			
COPD	□	□	□
ARDS	□	□	□
Pneumonia	□	□	□
Pulm. Embolism	□	□	□
Thoracic Surgery (Pre/Post)	□	□	□
Pneumo/Hemothorax	□	□	□
Tuberculosis	□	□	□
Inhalation Injuries	□	□	□

Neuro			
Neuro Assessment	□	□	□
Glasgow Coma Scale	□	□	□
Seizure Precautions	□	□	□
ICP Monitoring	□	□	□
Assist with Lumbar Puncture	□	□	□
TENS unit	□	□	□
Halo Traction/Stryker Frame	□	□	□
Care of Patients with:			
CVA	□	□	□
Seizure Disorder	□	□	□
Craniotomy	□	□	□
Head/Spinal Cord Injury	□	□	□
Neurosurgery (Pre/Post)	□	□	□
DT's	□	□	□
Administration of the following:			
Dilantin	□	□	□
Phenobarbital	□	□	□
Neuro-muscular Blocking Agents	□	□	□
Steroids	□	□	□

Genito-Urinary/Renal	1	2	3
Foley/Straight Catheter Insertion	□	□	□
Suprapubic/Nephrostomy Tube	□	□	□
Bladder Irrigation	□	□	□
Urine Dipsticks	□	□	□
Bladder Scanner Use	□	□	□
Electrolyte Imbalance/Replacement	□	□	□
Care of Patients with:			
Renal Failure	□	□	□
Renal Transplant	□	□	□
Hemodialysis	□	□	□
Nephrectomy	□	□	□
TURP	□	□	□
Radical Prostatectomy	□	□	□
Peritoncal Dialysis	□	□	□
Renal Calculi	□	□	□
Shunts and Fistulas	□	□	□

Gastro-Intestinal			
NG Tube Insertion	□	□	□
Gastrostomy/Jcjunostomy Tube	□	□	□
Colostomy/Ileostomy Care	□	□	□
Feeding Pumps	□	□	□
Bowel Preps/Enemas	□	□	□
Care of Patients with:			
G.I. Bleed	□	□	□
Pancreatitis	□	□	□
Hepatitis	□	□	□
Liver Cirrhosis	□	□	□
Bowel Surgery (Pre/Post)	□	□	□
Bowel Obstructoin	□	□	□
Paralitic Ileus	□	□	□
Whipple Procedure	□	□	□
Liver Transplant	□	□	□
E.R.C.P.	□	□	□

Orthopedic			
ROM Excercises	□	□	□
Circulation Assessment	□	□	□
Cervical Collars	□	□	□
Skeletal Tractions	□	□	□
CMP	□	□	□
Polar Ice	□	□	□
Care of Patients wth:			
Arthroscopic Surgery (Pre/Post)	□	□	□
Total Joint Replacement (Pre/Post)	□	□	□
Laminectomy	□	□	□
Spika Cast	□	□	□
	□	□	□
	□	□	□
	□	□	□
	□	□	□

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LPN COMPETENCY AND SKILLS CHECKLIST

Gynecologic	1	2	3
Self Breast Exam	□	□	□
Assist/Perform GYN Exam/PAP	□	□	□
Patients with:			
Mastectomy	□	□	□
Hysterectomy	□	□	□
Tubal Ligation	□	□	□
Ectopic Pregnancy	□	□	□
Abruptio Placenta	□	□	□
Pro-Eclampsia	□	□	□
Episiotomy	□	□	□
Assist with Vag. Delivery	□	□	□
Assist/Circulate in C-Section	□	□	□
Oxytocin Induction	□	□	□
Mag Sulfate Rx	□	□	□

Neonatal /Pediatric			
Calc. Of Neonatal Dosages	□	□	□
APGAR Scores	□	□	□
Collect Cord Blood	□	□	□
Eye Prophylaxis	□	□	□
Suction Therapy	□	□	□
Phototherapy	□	□	□
Croup Tent	□	□	□
Apnea monitor	□	□	□
CPR Infant/Child	□	□	□
Care of Patients with:			
Schizophrenia	□	□	□
Bipolar	□	□	□
Substance Abuse	□	□	□
Suicidal Precautions	□	□	□
Neurosurgery	□	□	□
DT's	□	□	□

Endocrine			1	2	3
Diabetic Management			□	□	□
Diabetic Teaching			□	□	□
Diabetic Foot, Nail and Skin Care			□	□	□
Insulin Administration			□	□	□
Accucheck/Glucometer			□	□	□
Operating Room					
(Indicate with S=Scrub,C=Circulate)			□	□	□
Cardio-Vascular	S	C	□	□	□
Open-Heart	S	C	□	□	□
Orthopedic	S	C	□	□	□
Neuro	S	C	□	□	□
GI	S	C	□	□	□
GU and Renal	S	C	□	□	□
OB-GYNE	S	C	□	□	□
ENT	S	C	□	□	□
Harvesting/Transplants	S	C	□	□	□
Laser	S	C	□	□	□
Endoscopy	S	C	□	□	□
Out-patient Surgery	S	C	□	□	□
Home Health					
Medicare Documentation			□	□	□
Case Management			□	□	□
Med Set-up			□	□	□
Ventilators			□	□	□
Other Skills					
Chemotherapy			□	□	□
Burn Patients			□	□	□
Pain Management			□	□	□
Epidural Pumps			□	□	□
PCA Pumps			□	□	□
Stryker Pumps			□	□	□

Questions? Let us know!
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Email: Eric@esmedicalstaffing.com
Web: www.esmedicalstaffing.com

Additional Information

Please list any other areas in which you feel you have extensive experience which were not included in the skills survey:

_____

_____

_____

_____

_____

_____

_____

_____

LICENSES:

State: _____

Number: _____

Expiration Date: _____

State: _____

Number: _____

Expiration Date: _____

CERTIFICATIONS:

Name: _____ Date: _____

Name: _____ Date: _____

Name: _____ Date: _____

The information I have given is true and accurate to the best of my knowledge. In addition, I hereby authorize E&S Medical to release this Skills Checklist to client institutions in relation to my assignment with that institution.

_____ _____

Signature Date

Questions? Let us know!
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LPN/ SCREENING EXAM

INSTRUCTIONS: Please complete each question by selecting **ONE BEST** answer. **DO NOT write on the test**; use the answer sheet provided.

Beth Lee is a 24-year-old Insulin dependent diabetic who is compliant and usually maintains good control. She was brought into the E.R. for a hypoglycemic episode, which rendered her unconscious. She is awake, alert, and oriented X3 now, and is being admitted overnight for observation and re-evaluation. Beth works as a clerk to help support her young daughter and husband, who is disabled. Beth is currently on NPH Insulin 22 units, and Regular Insulin, 5 units every morning at 7 o'clock.

1. Since Mrs. Lee is taking NPH Insulin, the nurse reinforces her knowledge of a proper diet by testing her understanding of the importance of snacks at which time of the day?

a. Mid-Morning
b. Mid-Afternoon
c. Bedtime
d. Late
e. Evening

2. Mrs. Lee tells you that she administers her insulin in one injection, because it allows her to use each site less frequently. Which of the following should be reinforced with Mrs. Lee?

a. The nurse should enforce to Mrs. Lee that insulin should never be mixed.
b. The nurse should' enforce that Mrs. Lee draws up the Regular Insulin before the NPH Insulin.
c. The nurse should ensure that Mrs. Lee draws up the NPH before the Regular Insulin.
d. None of the above.

3. When you check Mrs. Lees' fingerstick at 5pm, her glucose level reads 58. Mrs. Lee is awake, alert, oriented X3 and has" no complaints. Her skin is slightly clammy to the touch. What should your first action be?

a. Administer her 8 pm dose of regular insulin early.
b. Nothing, Mrs. Lee is having no serious symptoms, therefore her body is able to tolerate this sugar level.
c. Give Mrs. Lee a cool rag to wipe her skin with.
d. Give Mrs. Lee some orange juice with sugar and notify the MD.

Mr. Adams, a 56-year-old male, is transferred from CCU to your unit. He was admitted one week ago to CCU with an anterior wall myocardial infarction.

4. A diagnosis of Myocardial Infarction indicates which of the following has happened?

a. A temporary spasm of all of the arteries that supply the heart with blood, leaving no permanent damage.
b. An accumulation of fluid around the heart.
c. A temporary, ischemic episode within the heart.
d. Necrosis of some portion of the heart has occurred after that area was deprived of oxvoenated blood.

Questions? Let us know!
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CLINICAL SCREENING- LPN

5. When administering SQ Heparin, you should always keep in mind which of the following?

a. Always rub the site vigorously before giving the Heparin.
b. Remember to aspirate before giving the Heparin.
c. Never give Heparin in the stomach or lower abdomen region.
d. None of the above.

6. The antidote for Heparin is:

a. Protam Sulfate
b. Vi tamin K
c. Vitamin B12 given deep IM
d. Coumadin.

7. Mr Adams complains of chest pain. Which of the following would you do. first?

a. Give 3 SL NTG all at once, immediately.
b. Administer oxygen, give SL NTG q5 minutes X3 (If the chest pain is not relieved).
c. Get an EKG, stat.
d. Draw blood for a CPK level and call the doctor.

8. Mrs. Smith has just returned from a left radical mastectomy. Its a good idea to write a sign and place it over the patient's bed indicating that no blood pressures or needle sticks are to be done on.the left arm.

a. True
b. False

9. When assessing a renal dialysis shunt, it is important to assess for, and document which of the following?

a. The location of the shunt.
b. Absence or presence of a bruit.
c. Color, warmth and sensation of extremity below the shunt placement.
d. All of the above.

10. Because of Mrs. Frank's COPD, an appropriate oxygen order for Mrs. Frank would be:

a. 6- L/MIN 7
b. 1- L MI 2 N
c 10- . L/MI 12 N
d. Face mask at 100% oxygen.

11. Mrs. Cox has just returned from a total hip replacement. Which of the following is not a correct principle?

a. Roll the patient toward the affected hip.
b. Keep the hip abducted.
c. Log roll the patient with an abductor pillow in place.
d. Encourage coughing and deep breathing.

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12. Kathy Lee has an order for dressing changes q day and pm. When you change the dressing, what should be documented?

a: The color of the drainage.
b. The amount of the drainage.
c. The odor of the drainage.
d. All of the above.

13. When you are going to hang blood, you know to hang it with which of the following IV solutions?
a. D5W
b. NS
c. D5W 1/2 NS
d. D10W

14. A recently hired nurse is administering medications to residents in a long-term care facility where identification wristband are not used. The nurse does not know any of the residents. Which of these actions would most safely ensure that they receive the correct medications?

a. Ask the resident their names prior to drug administration.
b. Call out the full name of each resident.
c. Have a staff member who knows the residents identify them by name.

15. When a patient is receiving Heparin, which laboratory test is usually ordered daily?
a. Platelet
b. Serum
Iron

d. PTT (Partial Thromboplastin Time)

16. Mr. Coop has been depressed and threatened to commit suicide, he now states he feels much better. The nurse should:

a. Encourage him to evaluate the reason for the improvement.
b. Observe the patient closely as he may have settled on method for suicide-
c. Begin plans-for follow-up care after he is discharged.
d. Both a and b.

17. When caring for a patient in skeletal traction, the nurse should know that:

a. The ropes and pulleys should be in straight alignment.
b. The weights should be removed for 5 minutes every two hours.
c. The body of the patient should be perpendicular to the ropes providing traction.
d. Both b and c.

18. Nursing care following a total hip replacement usually includes all of the following except:

a. Encourage the patient to ambulate on affected extremity ad lib.
b. Keep the affected leg abducted. •
c. Ensure that the patient avoids acute flexion of the hip.
d. Assess frequently for signs of pulmonary edema. .

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CLINICAL SCREENING- LPN

19. Which of the following is often a very early sign of increasing intracranial pressure?

a. Increasingly severe headache.
b. Decrease in responsiveness.
c. Seizures
d. Drop in blood pressure.

20. Which of the following nursing measures would you include when suctioning a patient with a tracheostomy?

a. Apply suction when inserting and removing the catheter.
b. Suction for at least 30 seconds. ,
c. Orally suction before suctioning through the tracheostomy.
d. Use a clean suction set-up each time -and be sure that the suction catheter doesn't exceed half the diameter of the tracheostomy.

21. Before beginning tube feedings on a patient, which of th£ following procedures should be included when checking placement?

a. Inserting air into the tube while listening with a stethoscope to hear the air enter the stomach.
b. Draw back on the NGT contents with a syringe to assure that there are gastric contents in the tube.
c. Dip the end of the NGT in water and observe for bubbling caused by air.
d. All of the above.

22. Mr. Jones is comatose and receiving ISOCAL.1/2 strength at 30cc per hour. Which positioning of Mr. Jones is correct and will help prevent aspiration?

a. On their back, or side, with the HOB at 40 degrees.
b. On their side or back, with the HOB flat.
c. In trendelenburg.
d. The patient may be placed in any position.

23. When you check Mr. Jones; gastric residuals, you get 200cc's back in the syringe. Which of the following actions is appropriate? .

a. Turn off the tube feedings and notify the MD._
b. Continue the feedings as ordered.
c. Ask the MD to increase the feedings.
d. None of the above.

24. In the immediate post-op period following a cataract extraction, the one action that is contraindicated for Mrs. Clark compared with patients after most other operations is which of the following?

a. Coughing.
b. Turning on the inoperative side.
c. Measures to control nausea.
d. Eating after nausea passes.

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CLINICAL SCREENING- LPN

25. Who should be aware of a patient's DNR status?

a. nurse
b. physician
c. in homea careregivers
d. all of the above

26. The side effect most frequently associated with Zidovudine Retrovir therapy:

a. anemia
b. cardiomyopathy
c. spontaneous pneumo thorax
re calcul dni

27. You arrive at Mr. Jones home and Mrs. Jones informs you that Mr. Jones fell last night while trying to transfer between the bed and bedside commode. You would:

a. assess Mr. Jones for injury, instruct Mrs. Jones on safety measures when transferring, contact physician to provide a patient update and complete a incident report.
b. instruct wife to use bedpan and urinal'from now on
c. instruct wife to use sliding board for transfers
d. instruct Mrs. Jones that the patient should use diapers and be incontinent for the first two weeks at home while strength returns.

28. Nancy Nurse draws a blood sample on Mr. Smith. The correct procedure for transport of the specimen to the lab from Mr. Smith's home is:

a. place specimen on ice
b. leave in your nursing bag while you make the rest of your visits
c. place specimen in puncture proof container and transport to lab
d. place in plastic baggie and. put in lunch tote and transport to lab

29. Your homecare patient is receiving Gancyclovir via a hickman catheter. After completion of the infusion what pertinent safety issues must be addressed?

a. assess tubing for kinks
b. throw empty IV tubing in trash
c. leave IV tubing and bag hanging for PM dose
d. dispose of tubing an IVPB into red bag or red container after each use

30. You arrive at Mrs. Adams house on Monday morning and as you are providing wound care, you notice many suspicious bruises. When you ask Mrs. Adams about the bruises, she says "I don't want to talk about it." You should:

a. respect Mrs Adams wishes and do nothing
b. call your supervisor and report the bruises
c. call her son at work and ask him if he hit her
d. ignore the problem

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CLINICAL SCREENING- LPN

31. The nurse is reviewing the medication profile form in the home. The dose on the medicine bottle does not match what is written on the medication profile. You would:

a. call the doctor to verify the correct dosage of medication
b. change the medication profile to match the medication bottle
c. tell the patient to check with the physician
d: call the pharmacy listed on the bottle and verify the dosage written

32. Extrapyramidal symptoms are likely to be most severe with which of these antipsychotic drugs?

a. Chlorpromazine hydrochloride (Thorazine)
b. Haloperido (Haldo l)
c. Thiridaxzine hydrochloride (Mellaril)
d. Cardizem

33. The patient is at greatest risk for which of the following when medications such as phenytoin (Dilantin) is abruptly stopped.

a. a severe hypoglycemic reaction a
b. cerebral vascular occlusion
c. sttus epilept icus

34. Care plan development includes:

a. specifying interventions and expected outcomes within a set time frame for given diagnosis
b. differentiate between short and long term goals
c. define a priority list of patient care needs
d. all of the above

35. Mrs. Dow is a 62 year old female with a long standing history of diabetes controlled by oral agents. Yesterday her physician told her she would have to start on insulin injections twice a day. She is concerned about her care due to her limited vision and hearing^ problems. In planning her care you would:

a. order her insulin and syringes
b. teach her to use a magnifier
c. have large size type educational materials
d. all of the above

36. You arrive at your patient's home to find your patient's IV leaking around the transparent dressing site. The IV remains secure and patent. You would:

a. discontinue the IV
b. reinforce the dressing with tape
c. do site care and apply a new dressing
d. tell the patient you are behind schedule and will change the dressing tomorrow.

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CLINICAL SCREENING- LPN

37. Mr Johnson has just returned from his physicians office. He received a PPD during his appointment 4 hours ago. The area is red and warm to touch. Mr Johnson asks if this means he has TB. You would:

a. tell him to call his physician
b. measure the area and call the physician
c. tell him you must now wear a mask
d. explain that it is normal for the area to be warm and reddened after the skin test

38. You enter your patient's home and find him lying on the floor face down. Your first action would be:

a. open the airway
b. establish unresponsiveness
c. check a radial pulse
d. examine the victim for bleeding

39. Ms. Smith is receiving Lasix 40mg po daily. What lab value is most important to monitor with Lasix?

a. Na + , Lasix can cause hypernatremia
b. K + , Lasix can cause hypokalemia
c. K + , Lasix can cause hyperkalemia
d. there is no particular lab value to monitor

40. Juanita Sanchez, age-78, has been living with her daughter since her husband's death 5 years ago. She has be\come increasingly forgetful and unable to care for herself. The family has decided to place Mrs. Sanchez in a nursing home.
Based on the diagnosis of Alzheimers Disease, the nursing assessment would most likely reveal which of the following intellectual changes?

a. decreased ability to handle anxiety
b. disorientation to time and place
c. emotional Liablilty
d. paranoo nideät