PERSONNEL CONNECTION

The Right Fit, Right Now.

101 N. Webster Ave
Green Bay, WI 54301
Phone: (920) 437-1874

CHECK LIST FOR C.N.A.'s, L.P.N.'s, and R.N.'s

The following are required documents & credentials for all C.N.A.'s:

- A current **TB/PPD** or **X-Ray** (within one year) (Exp. Date: _____)
- An original valid **Social Security Card** (signed)
- A current valid **Driver's License** (or photo ID)
- Complete Application (signed and dated on all pages)
- Drug Screen Date's done. (Hire,____) (1.____) (2.____) (3.____) (4._____)
  Interview time and date:_____

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Authorization for Criminal Background and Drug Testing

I, _____ hereby authorize **Personnel Connection**, to run a Urinary Drug Screen as deemed necessary. I further authorize the release of the drug screening results to be given to the client as deemed necessary for employment. I release all parties from liability for any damage that may result from furnishing the same to you.

I understand that any omission or misrepresentation of material fact in this application may result in refusal of or separation from employment.

In consideration of my employment, I agree to conform to the rules and regulation of the company and my employment and compensation can be terminated, with or without cause, and with or without notice, at any time, at the option of the company or myself.
I understand that no supervisor or other representative of the company other than the Personnel Connection has any authority to enter into an employment agreement for any specified period of time or to make any employment agreement contrary to the foregoing.

_____ _____

Signature of Applicant Date

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URINALYSIS

Employee Name: _____ Date: ___/___/___

Employee SS#:_____/___/_____

Reason for test: ( ) Pre-Employment ( ) Random ( ) Reasonable Suspicion/Cause ( ) Other ____

Daytime Phone #: (__) ____-____ Evening #: (__) ____-____

Date of Birth ____/___/____

Tested for: Cocaine (COC) Amphetamine (AMP) Marijuana (THC) Opiates (OPI) Phencyclidine (PCP)

Test Results ( )Negative Positive for: ( )COC ( )AMP ( )THC ( )MOR ( )BZO ( )MAMP

Prepared by: _____

Preparer Signature_____

Employer Name & Address

Personnel Connection
101 N. Webster Ave
Green Bay, WI 54301

_____ ____/____/____
Employee Signature Verifying Viewed Results Date

PC Staff Witness_____

If tested positive for any substance employee has 24 hours to go to Concentra Medical Center to get another test administered. Tests performed at Concentra will be paid by employee of Personnel Connection.

HIPAA CONFIDENTIALITY AND NONDISCLOUSRE AGREEMENT

The Intent of these laws and polices is to assure that confidentiality of information is maintained while used in the course of the business and clinical operations. In my job I may see or hear confidential information in any form (oral, written, disciplinary action)

I, _____, AGREE TO AND ACKNOWLEDGE THE FOLLOWING:

- I will protect the privacy of all business and medical information relating to our patients, members, employees and health care providers.
- I know that confidential information I lean on my job does belong to me and I have no right or ownership to it. Star One Staffing and/or facility may take away my access to confidential information at any time.
- I will not misuse confidential information and will only access information necessary to do my job. I will not disclose any confidential information unless required to do so in the official capacity of my relationship, employment or contract with Star One Staffing and/or facility.
- I will not share, charge or destroy any confidential information unless it is part of my job to do so. If any of these tasks are part of my job, I will follow the correct department procedure of the instructions of my supervisor and/or DON (such as shredding confidential paper). If a demand from an oversight agency, law enforcement or government agency is made upon written notice to my supervisor and/or DON.
- I will only print information from a facility and/or Star One Staffing information system when necessary for a legitimate work related purpose. I am accountable for this information until it is properly filed or disposed of.
- If I have access to electronic equipment and/or records, I will keep my computer password secret and I will not share it with any unauthorized individual. I am accountable for this information until it is properly filed or disposed of.
- I understand that I have an obligation to report to my DON and/or Clinical supervisor if I think someone misusing confidential information or is using my password. I further understand that Star One Staffing and/or facility will not tolerate any retaliation against me for making a report.
- On termination of my employment, I will return to Star One Staffing and/or facility all copies of documents containing Star One Staffing's and/or facility's confidential information or data in my possession or control. I will leave all facility materials and documents at the facility when I leave.
- I understand that the failure to comply with this agreement may result in corrective action up to, and including, termination of employment or other relationships with Star One Staffing and/or facility. I understand that I may also be subject to other remedies allowed by law. I understand that I must also comply with any laws, regulations and Star One Staffing and/or facility policies. This agreement shall survive the termination of my official relationship, employment or contract with Star One Staffing.

I have read and understand this Confidential and Nondisclosure Agreement

Employee Signature: _____ Date: _____

AREAS OF EXPERIENCE- HOW MANY YEARS, DATES FROM-TO:

GENERAL HOSPITAL_____	**NEUROSURGICAL**_____
HOSPITAL CHARGE NURSE_____	**OPERATING ROOM**_____
MEDICATION NURSE_____	**S.O.A.P NOTES**_____
UNIT DOSE MED SYSTEM_____	**RECOVERY ROOM**_____
EMERGENCY ROOM_____	**PSYCHIATRIC**_____
ICU_____	**GERIATRIC**_____
CCU_____	**NURSING HOME STAFF**_____
MEDICAL STAFF NURSE_____	**KIDNEY DIALYSIS**_____
SURGICAL STAFF NURSE_____	**ISOLATION**_____
BURNS_____	**I.V.THERAPY**_____
PEDIATRICS_____	**INDUSTRIAL**_____
OBSTETRICS_____	**TEAM LEADER**_____
ORTHOPEDICS_____	**PRIVATE DUTY**_____
EENT_____	**TEACHING**_____
UROLOGY_____	**OTHER**_____

HAVE YOU ATTENDED CONTINUING EDUCATION/REFRESHER COURSES IN THE LAST YEAR? IF YES GIVE BRIEF DESCRIPTION AND WHO OFFERED THE CLASS:

_____

_____

DO YOU HAVE CERTIFICATION; DOCUMENTATION OF SPECIALIZE TRAINING THAT CAN BE COPIED AND PLACED IN YOUR PERSONNEL FILE? IF YES, LIST TYPE OF TAINING:

_____

IF LP/VN, ARE YOU CERTIFIED TO ADMINISTER MEDICATION?

_____

AIDE-ASSISTANT-ORDERLY

PLEASE CHECK AREAS IN WHICH YOU HAVE ACTUAL EXPERIENCE

_____T.P.R	_____IRRIGATE FOLEY CATCH.	_____ADMINISTER OXYGEN
_____ENEMA	_____SIMPLE DRESS CHANGES	_____PSYCH. PATIENTS
_____BED BATH	_____TUBE FEEDINGS	_____ALCOHOLIC PATIENTS
_____BLOOD PRESSURE	_____PREPARE MEALS	_____CHARTING

ALL APLICANTS

HOURS AVAILABLE: _____7A-3P _____7A-7P _____3P-11P _____11P-7A ____7P-7A ARE YOU AVAILABLE FOR (4) HOUR SHIFT?

CIRCLE DAYS AVAILABLE: SUNDAY MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY SATURDAY

IF YOYU ARE AVAILABLE FOR VARIOUS SHIFT DEPENDING ON THE DAY, PLEASE SPECIFY:

DO YOU HAVE MALPRACTIVE INSURANCE? NAME OF COMPANY:

POLICY NUMER: EXPIRATION DATE:

I HEREBY AUTHORIZE PERSONNEL CONNECTION AND ALSO AUTHORIZE AND REQUEST EACH FORMER EMPLOYER AND PERSON, FIRM OR CORPORATION GIVEN AS A REFERENCE, TO ANSWER ALL QUESTIONS THAT MAY BE ASKED, AND GIVE ALL INFORMATION THAT BE SOUGHT IN CONNECTION WITH THIS APPLICATION OR CONCERNING ME OR MY WORK HABITSM CHARACTER, SKILL OR MY ACTION IN ANY TRANSACTION.

I AGREE, IN CONSIDERATION OF YOU EMPLOYING ME THAT I WILL NOT SEEK OR ACCEPT EMPLOYMENT DIRECTLY OR INDIRECTLY FROM ANY HOSPITALS WHERE SERVICES ARE PROVIDED BY PERSONNEL CONNECTION FOR AT LEAST ONE (1) FULL YEAR AFTER THE LAST DATE OF THE ASSIGNEMENT GIVEN TO ME BY PERSONNEL CONNECTION. I FURTHER UNDERSTAND THAT I CANNOT BE PAID UNTIL I PRESENT A TIME SLIP FILLED OUT CORRECTLY AND SIGNED BY BOTH THE HOSPITAL AND MYSELF, AND TURNED INTO PERSONNEL CONNECTION.

SIGNATURE_____ **DATE**_____

1.-You walk into a patient's room, and witness another staff member striking the patient. What should you do?

1. Tell the abuser to stop immediately and then report the incident to management.
2. Leave the room immediately.
3. Tell the abuser to stop.
4. Report the incident to management.

2.-Your friend's Grandmother is one of the residents and visits with you, it is a VIOLATION of HIPPA to..

1. Tell your friend that you saw her Grandmother.
2. Talk with her grandmother
3. Tell your coworkers your relationship to the resident.
4. Visit her grandmother outside of work

3.-It is the end of workday and you need to discard your written work assignment that contains patient's names on it. Where should you discard it?

1. You should take it home and throw it out.
2. You should place it in a locked bin or directly into a paper shredder.
3. You should place it in wastepaper basket at the nurses' station.
4. You should place it in wastepaper basket in a patient's room.

4.-You are delivering tray to a diabetic patient. He asks you for a cup of coffee with sugar. What should you do?

1. Give him a coffee with sugar.
2. Give him tea with sugar.
3. Give him coffee and ask him whether a sugar substitute will suffice as he should not have sugar.
4. Ignore his request.

5.-You are told that your patient is to be NPO after midnight because of a procedure to be done the next day. What does that mean?

1. That you should allow patient to have small amounts of liquids,
2. That you should not give oral hygiene.
3. That you should only give the patient solid foods.
4. That the patient may have nothing by mouth.

6.-Which of the following are considered patient's rights according to HIPAA?

1. Confidentiality
2. Privacy and Respect
3. Personal choice
4. All of the above