Dear Healthcare Provider,

Thank you for your interest in working with HealthSource Global Staffing!

HealthSource is happy to provide you with high paying short term assignments that give you the opportunity to make money while having the flexibility and control over your work and life activities.

Please pay close attention to our file requirements. They will vary depending on your medical specialty. Your file needs to be complete prior to traveling with HealthSource. Our staff will work with you to facilitate this process. You are required to bring 3 complete files with you on all assignments.

Thank you for choosing to travel with Healthsource!

Sincerely,

HEALTHSOURCE GLOBAL STAFFING

What to Bring To Your Assignment

• **Complete File**
Hand-carry 3 copies of your complete file. Do not pack it in your luggage as it can become separated from you. All HealthSource Global documentation must reflect your legal name. Your file should include everything listed on the Standard File Requirements Checklist. Your recruiter will inform you of any additional requirements.

• **Cash and/or Credit Cards**
As with any trip that you might take, incidental expenses will occur. Please make sure you travel with enough cash, credit/debit cards or traveler's checks to cover meals, laundry, telephone calls, transportation for your leisure time and any incidental expenses.

• **Working Uniform or Scrubs**
Hospitals do not provide working uniforms or scrubs for most specialties. Your recruiter will inform you of the proper attire for your specialty.

HealthSource Global Staffing Standard File Requirements

Below are our standard file requirements. Certain facilities may request additional documentation. Your file must be complete and in compliance while on assignment. Please provide clear photocopies of all certifications, social security card, and your government issued photo ID.

Your complete file should include the following documents:

☐ Consent for Background Investigation & Drug Screening
☐ Physical within 1 year—Date of physical ___/___/___

☐ Negative PPD within 1 year—Date Read ___/___/___
OR if positive PPD:
☐ Chest x-Ray within 2 Years—Date Given ___/___/___
And:
☐ Annual TB Questionnaire—Date Completed___/___/___

IMMUNIZATION STATUS

☐ Hep B Vaccination Declination
OR
☐ Hep B Titer Immune ☐ Non Immune ☐
OR
☐ Hep B Series 1) ___/___/___ 2) ___/___/___ 3) ___/___/___

Proof of immunizations or positive titer results for Mumps. Rubeola (measles), Rubella and Varicella. Immunizations must include the date given and initials of the healthcare provider. The titer results can show the words "positive/immune," or a numerical value. If a number is given, a lab range indicating whether a number reflects a positive titer must be included. **All vaccine and titer requirements vary with each facility.**

☐ MMR Immunization(s)—Date ___/___/___ Date ___/___/___
OR
☐ Rubella Titer Immune ☐ Non Immune☐
☐ Rubeola Titer Immune☐ Non Immune☐
☐ Mumps Titer Immune ☐ Non Immune ☐

☐ Varivax Immunization—Date ___/___/___
OR
☐ Varicella Titer Immune ☐ Non Immune☐

PAYROLL DOCUMENTS

☐ Notarized I-9 form
☐ W-4 form

☐ Employment Application
☐ Professional Reference #1 (Current within 1 year)
☐ State License _____ Lic # _____ Expires ___/___/___
☐ Government Issued Photo ID—passport or driver's license
- Hand-carry original and include a clear photocopy

☐ Social Security Card—for payroll purposes
- Hand-carry original and include a clear photocopy

CERTIFICATIONS (clear photocopies of front and back)

☐ BLS Expires ___/___/___ (required for ALL units)

SIGNATURE DOCUMENTS

☐ Employee Confidentiality Agreement
☐ Health Insurance Portability & Accountability Act (HIPAA)
☐ OSHA Standards and Competency Assessment

All Standard File Requirements must remain current while on assignment.
Noncompliance will not be tolerated by the company or medical facility

Employment Application

Last Name _____ First Name _____ Middle _____
(Name as it appears on you SS card)

Street _____ County _____
(Current/Permanent Mailing Address)

City _____ Province/State _____ Zip Code _____

Email Address _____ Fax # _____

Social Security Number _____ Date of Birth _____

Emergency Contact Name _____ Phone # _____ Cell # _____

Type of Professional RN ☐ LVN/LPN ☐ TECH ☐ CNA ☐ Other please specify ☐ _____

Are you currently working in your profession? Yes ☐ No ☐ If no, why? _____

What language(s) do you speak fluently? _____ How did you hear about us? _____

Licensure: (*Include **clear** photocopies of all licenses held.)*

State: _____ License # _____ Exp. Date: _____ State: _____ License # _____ Exp. Date: _____

State: _____ License # _____ Exp. Date: _____ State: _____ License # _____ Exp. Date: _____

Current Certifications: (*Provide **clear** photocopies of all certification held)*

☐ BLS _____ Expires ☐ ACLS _____ Expires ☐ PALS _____ Expires ☐ NRP _____ Expires ☐ FHM _____ Expires ☐ TNCC _____ Expires ☐ CHEMO _____ Expires
☐ Other (s) _____

Education	City & State	Month/Year Graduated	Diplomas, Degrees received
College			
Graduate School			

Employment History (**DO NOT LIST AGENCY NAMES.)** Please start with your current or most recent job.
We will use your current resume for all other job history information

Hospital/Employer _____ Teaching Facility: Y / N Pay Rate: $_____/hr or yr

Street address _____ City _____ State _____ Zip _____

Dates of employed: From _____ To _____ Reason for leaving _____

Position held _____ Unit Specialty _____ Did you do charge? Y / N

Responsibilities _____

Immediate Supervisor _____ Phone _____

Hospital/Employer _____ Teaching Facility: Y / N Pay Rate: $_____/hr or yr

Street address _____ City _____ State _____ Zip _____

Dates of employed: From _____ To _____ Reason for leaving _____

Position held _____ Unit Specialty _____ Did you do charge? Y / N

Responsibilities _____

Immediate Supervisor _____ Phone _____

Hospital/Employer _____ Teaching Facility: Y / N Pay Rate: $_____/hr or yr

Street address _____ City _____ State _____ Zip _____

Dates of employed: From _____ To _____ Reason for leaving _____

Position held _____ Unit Specialty _____ Did you do charge? Y / N

Responsibilities _____

Immediate Supervisor _____ Phone _____

1. Yes☐ No☐ Is there any medical condition(s) which may limit your ability to perform any function required of a nurse?
2. Yes☐ No☐ Have you ever been convicted of a crime other than a minor traffic violation?
3. Yes☐ No☐ Has your professional license or certification ever been investigated or suspended?

If you answered Yes to any of the questions above, please explain below. Use additional paper if needed.

Can you submit verification of your legal right to work in the USA? Yes ☐ No ☐

I attest that the information provided in this application is complete and accurate, to the best of my knowledge. Providing incomplete or inaccurate information my result in disqualification from the program, and may be a violation of state law(s) that could result in civil penalties.

Print Name _____

Signature _____ **Date** _____

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Employment Reference

Applicant name: _____ SS#: _____

Name of Hospital/Facility: _____

Address, City, State: _____

Name of Supervisor: _____ _____
(Manager, Charge Nurse or higher) Please Print Title

I hereby authorize my past and present employers to provide information to HealthSource Global Staffing about my job performance while in their employment, permanent or temporary. I hereby release all such employers and their representatives from all liabilities for issuing this information to HealthSource. I also authorize HealthSource to disclose the client facilities for which I have expressed an employment interest.

_____
Applicant's Signature Date

	Above Average	Average	Below Average
Accurate and thorough documentation			
Adaptability to patient assignment			
Attendance and punctuality			
Enthusiasm toward job			
Communication skills			
Clinical skills			
Problem solving skills			
Professional appearance			
Productivity			
Professionalism			
Quality of work			
Cooperation			
Leadership ability			

Dates of Employment: From (MM/YY) _____ To (MM/YY) _____

Specialty / Unit worked _____

Reason for Leaving: ☐ Terminated ☐ Lay-Off ☐ Resigned ☐ Temporary Employee

Would you hire this healthcare professional again? ☐ Yes ☐ No

_____
Supervisor's Signature **Title** **Date**

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Revised 4/2008

Employee Confidentiality Agreement

As an employee of HealthSource Global Staffing, you have both a legal and ethical responsibility to protect the privacy of employees, client nurses and hospitals as well as all proprietary information of HealthSource Global Staffing. All information that you see or hear regarding nurses, staff, patients, directly or indirectly, is completely confidential and must not be discussed or released in any form, except when required in the performance of your duties. If you have access to employee information, you are expected to treat such information in the same confidential manner.

Unauthorized disclosure of medical information is also criminally punishable as a misdemeanor. The mere public acknowledgement of HIV disease, psychiatric disorders, drug abuse or alcohol abuse may expose the company to both substantial fines and liability to the person.

Any information provided to you by the nurses or hospitals is considered confidential and should not be shared with other except when required in the performance of your duties. I have read the above information and understand that any violation of this agreement is cause for immediate action.

_____

Print Name

_____

Signature Date

Health Insurance Portability and Accountability Act (HIPAA)

This notice describes how health information about you may be used and disclosed. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I authorize HealthSource Global Staffing the use and disclosure of my health information. I understand that this will be used by HealthSource Global Staffing and its clients to evaluate my qualifications for employment opportunities as it relates to the healthcare field. This information may also be used for workers compensation and similar programs, and/or when necessary to reduce or prevent a serious threat to your health and safety, or health and safety of others. We will only make disclosures to a person or organization able to help prevent the threat.

I further understand that if a person that receives this information is not a healthcare provider, the information disclosed may be re-disclosed and no longer protected by regulations. I understand that I may revoke this authorization at any time by sending a written request to HealthSource Global Staffing, except to the degree that action has been taken in reliance on upon this authorization.

This authorization will expire one year from the dated signature below.

_____

Print Name

_____

Signature Date

OSHA Standards and Competency Assessment

In compliance with JCAHO and OSHA requirements, I acknowledge that I have successfully completed the competency assessment as well as all of the following:

- Age Specific Job Requirements
- Back Safety
- Blood Borne Pathogens/Infectious Disease
- Disinfection and Sterilization
- Electrical Safety
- Ergonomics for Healthcare Workers
- Fire Safety
- Handling of Hazardous Materials
- Hand Washing
- HIPAA Privacy Compliance
- Personal Protective Equipment
- Patient Bill of Rights
- Patient Confidentiality
- Radiation Safety
- Tuberculosis
- Violence in the Workplace
- 2007 Patient Safety goals
- Cultural diversity and sensitivity training

_____

Print Name

_____

Signature Date

_____

HealthSource Representative Date

Employee Authorization to Release Employee Information and Consent for Background Investigation and Random Drug Screening

My signature below signifies my authorization for HealthSource Global Staffing to release any or all information contained within my employment file to any medical facility or entity with whom the company contacted to receive HealthSource Global Staffing and any regulatory or governmental agency upon that agency's request. My signature further allows HealthSource Global Staffing to request any additional necessary medical information from my care provider(s) to complete HealthSource Global Staffing medical history for my employee file.

I agree to submit to random alcohol and/or drug screens used for the purpose of determining my fitness for employment or continued employment, and I hereby authorize HealthSource Global Staffing to conduct background investigations of my activities, education and employment.

I agree that HealthSource may make the decision to release any and all information at its discretion providing such release is made to authorized representatives of appropriate entities as described. I understand that in all other cases, my employment records will remain confidential and will only be released with my written authorization.

My signature here indicates that I have read this **Employee Authorization to Release Employee Information and Consent for Background Investigation and Random Drug Screening** in its entirety and understand its contents.

_____

Print Name

_____

Signature Date

_____

HealthSource Representative Date

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Revised 4/2008

Physicians Statement

Applicant name: _____ SS#: _____

Tuberculosis Screening

	Date Given	Date Read	Results
PPD/ TB Skin Test			Induration _____ mm Negative Positive Circle One
Chest X-ray (if PPD +)*			

*Attach copy of the radiology report and a copy of the +PPD reading.

Immunization Status

Document date of vaccine/titre and results. Attach all Titre laboratory reports.

Vaccination	Vaccination Date	Results
Tetanus		
MMR Vaccine 1		
MMR Vaccine 2		
Hepatitis B Vaccine 1		
Hepatitis B Vaccine 2		
Hepatitis B Vaccine 3		
Varivax Vaccine		
Titres		
Titre	**Titre Date**	**Results**
Rubella Titre		___ Immune ___ Non-Immune
Rubeola Titre		___ Immune ___ Non-Immune
Mumps Titre		___ Immune ___ Non-Immune
Varicella Titre		___ Immune ___ Non-Immune
Hepatitis B Titre		___ Immune ___ Non-Immune

The above named patient has been examined by me and found to be in good physical and mental health, free of communicable disease, and able to function without physical limitations as a healthcare professional.

Physician's Signature **License Number** **Date of Exam**

Physician's Name **City/State** **Telephone**

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Hepatitis B Vaccination Declination

OSHA requires all health care workers to have the opportunity to have the Hepatitis B Vaccination offered to them, by their employer.

1. If you decline to have the Hepatitis B Vaccine, please indicate this by signing and dating under Declination.
2. If you have completed the vaccination series, please indicate this by signing and dating under Completed Series. You must provide documentation of the vaccinations if you sign that you have completed the series.
3. If you are in the process of receiving the series, please indicate this by signing and dating Vaccinations in Progress. Please indicate if you require a dose of the vaccine.

I understand that I will be provided appropriate training at my assigned workplace and will adhere to the policies and procedures of the facility to which I am assigned. I understand that due to my occupational exposure to blood and/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 the Hepatitis B vaccine, at no cost to me, while on active assignment with HealthSource Global Staffing.

DECLINATION

I decline the Hepatitis B vaccine series. 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 infectious material and want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to myself, while on assignment with HealthSource Global Staffing. I accept the responsibility to inform HealthSource Global Staffing of this decision at that time.

Date _____ Signature _____

COMPLETED SERIES

I understand the OSHA guidelines and decline because I have completed the Hepatitis B Vaccination. I will provide documentation of the series to HealthSource Global Staffing.

Date _____ Signature _____

VACCINATIONS IN PROCESS

I understand the OSHA guidelines and need #_____ or booster in the series. I will make arrangements to complete the series or booster, or if on assignment, I will make arrangements with HealthSource Global Staffing to receive this dose of the vaccine series. I will provide documentation of the series/booster to HealthSource Global Staffing and provide appropriate updates.

Date _____ Signature _____

Annual TB Questionnaire

The Annual Tuberculosis Questionnaire is used to evaluate your current TB status. We cannot utilize the tuberculin skin test (PPD or Mantoux), because you have a positive reaction to the test. A position skin test means that sometime during your life you came into contact with tuberculosis or have had a vaccination to prevent you from contracting tuberculosis. It does not mean that you have TB now.

In the past yearly chest x-rays were performed; however, recent studies show that they are unnecessary. Instead, this health survey will assist Employee Health to monitor possible TB Symptoms. Chest x-rays are required every two years.

TB symptoms can progress slowly and/or mimic other diseases. You can develop symptoms of TB a few weeks after contracting the bacteria – or not until years after the initial infection. This questionnaire targets some of the most common symptoms. Please familiarize yourself with them. You are the first to know when you are not feeling well and may have TB symptoms.

Tuberculosis Health Check Survey

Have you ever experienced any of the following symptoms **NOT** associated with a specific illness (i.e. flu or cold) and lasting 3 weeks or longer?

Cough	☐ Yes ☐ No
Blood Streaked Sputum (phlegm)	☐ Yes ☐ No
Loss of Weight (unplanned)	☐ Yes ☐ No
Night Sweats	☐ Yes ☐ No
Fever	☐ Yes ☐ No
Anorexia (loss of appetite)	☐ Yes ☐ No

This authorization will expire one year from the dated signature below.

_____

Print Name

_____

Signature Date

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