Med-Link Nursing Services

Drugs in the Workplace

I, _____ understand that Med-Link Nursing Services and its affiliates have a Drug-Free Workplace Policy. I understand that I am required to pass a ten-panel drug screening prior to my employment. If drug use is suspected, I may be tested for drugs on the spot. I understand that Med-Link may require random drug screening to ensure compliance with the drug policy and failure to do so may result in termination of my employment.

_____
Employee Name (Print)

_____ Date _____
Employee Signature

Statements Required by
Section 11166.5 of California
Penal Code

Under California law certain employees are required to report any instances of know or reasonably suspected child abuse. Failure to comply is a misdemeanor. In addition, California law now requires that certain categories of employees hired after January 1, 1985 must sign a statement that he or she has knowledge of the reporting requirements and will comply with them. The law requires this signed statement as a prerequisite of employment. Specifically, Section 11166.5 of the Penal Code states:

"Any person who enters in to employment on or after January 1, 1985, as a child care custodian, medical practitioner, or non-medical practitioner, or with a child protective agency, prior to commencing his or her employment, and as a prerequisite to that employment, shall sign a statement on a form provided to him or her by his or her employer to effect that he or she has knowledge of the provision of Section 11166 and will comply with its provisions."

The Penal Code also provides that:

"The statement shall include the following provision:

Section 11166 of the Penal Code requires any child care custodian, medical practitioner, non-medical practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she know or reasonably suspects has been the victim of child abuse to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

'Child care custodian' includes: 'teachers, administrative officers, supervisors of child welfare and attendance, or certificated pupil personnel employees of any public or private school; administrators of a public or private day camp; licensed day car workers; administrators of community care facilities licensed to care for children; headstart teachers; licensing workers or licensing evaluators; public assistance workers; employees of a child care institution including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities; and social workers or probation officers.'

'Medical practitioner' includes: 'state or county public health employees who treat minors for venereal disease or any other condition; coroners; paramedics; marriage, family or child counselors; and religious practitioners who diagnose, examine, or treat children.'

The signed statements shall be retained by the employer. The cost of printing, distribution, and filing of these statements shall be borne by the employer.

Please read these provisions and note that signing these statements is a prerequisite to employment.

I have read and know the provisions of Section 11166 of the Penal Code and the Dependent Adult Abuse Reporting law and will comply with their provisions and obligations.

Employee Signature

Please print your name

Date

JCAHO/OSHA MANDATORY ANNUAL IN-SERVICES

Please fill in the date, initial each line, and sign at the bottom indicating that you have read and understand following information:

	Month:____ Year 20____		Month:____ Year 20____
1. Fire Safety in Health Care Facilities		33. Respiratory Protection	
2. Electrical Safety in Health Care Fac.		34. Personal Protective Equipment	
3. Lifting and Moving Patients Safety		35. Sexual Harassment	
4.About Universal Precautions		36. HIPPA	
5. Hazardous Materials & Waste			
6. Infection Control & JCAHO Standards			
7. About Bloodborne Pathogens			
8. Hepatitis B			
9. Continuous Quality Improvement			
10. Age Specific & Cultural Competency			
11. Earthquake Safety			
12. Preventing Elder and Child Abuse			
13. About Partner/Domestic Violence			
14. Emergency Preparedness			
15. Advance Medical Directives			
16. Understanding Patient Rights			
17. Patient Privacy & Confidentiality			
18. Capping (Unlawful Solicitation)			
19. Prop. 65/Employee Right to Know			
20. Preventing Medication Errors			
21. Using Restraints/Seclusion Properly			
22. Documenting Patient Care			
23. Learn About Diversity			
24. Precautions against Tuberculosis			
25. Caring for Patient w/Active TB			
26. AB508 Hospital Safety & Security			
27. About Latex Allergies			
28. Needle stick Prevention			
29. Understanding Pain Management			
30. Drug Free Workplace Act			
31. Preventing Workplace Violence			
32. Slips, Trips, & Falls			

Employee Signature:_____

Revised 09/06

MED-LINK NURSING SERVICES

ANNUAL OSHA AND JCAHO IN-SERVICE

I _____ acknowledge that I have Received Education, In-services, Review packages and a Quiz on Fire safety, Blood borne Pathogens, TB, Employee Right to know/ Hazardous Materials, Age Specific Competency. And HIPPA.

I realize that I must update my review of OSHA Blood borne Pathogens, Tuberculosis, Occupational safety, Fire safety, infection control, HIPPA, and update my health Information on a yearly basis in order to maintain my Eligibility for assignment by Med-Link Nursing Services.

Employee Signature _____
Date _____

MED-LINK NURSING SERVICES

HIPAA IN-SERVICE

I _____ have received in-service on HIPAA and promise to keep all patient information confident. I understand that HIPAA calls for severe civil and criminal penalties for non-compliance, including fines up to $250.000 and/or imprisonment up to 10 years for knowing misuse of individually identifiable health information. I understand non-compliant is a ground for termination.

Date: _____

Signature: _____

MED-LINK NURSING SERVICES
Excellence in Professional Healthcare

PHYSICAL EXAMINATION

Name: _____

Date: _____

Are you allergic to natural rubber Latex? YES/NO

Titers

Varicella: Date _____ Results: _____

Mumps: Date _____ Results: _____

Rubella: Date _____ Results: _____

Rubeola: Date _____ ResuLts: _____

Hepatitis B: Date _____ Results: _____

Immunizations

Varicella: Date _____ Results: _____

Mumps: Date _____ Results: _____

Rubella: Date _____ Results: _____

Rubeola: Date _____ Results: _____

Hepatitis B

Vaccine 1) Date _____ Results: _____

Vaccine 2) Date _____ Results: _____

Vaccine 3) Date _____ Results: _____

TB Screening
TB Skin Test Date given _____ Date read _____ Results _____
Or
If TB Skin Test Positive
Chest x-ray Date given _____ Results _____
TB Fit Test Mask Size _____

General Comments:

_____

_____

The above-named individual has been examined by me and is free from symptoms indicating the presence of an infectious disease and does not have any condition, which would interfere with the performance of his/her duties as a health care professional.

_____ _____ _____
Primary Care Provider's Name Primary Care Provider's Signature Date

revised 04/07

Med-Link Nursing Services

Unacceptable Abbreviations
Do Not Use List

I, _____ have received in-service and I have been informed about unacceptable abbreviations "Do Not Use" list. I promise to comply and refrain from using these unacceptable abbreviations at any clients' facilities.

By: _____ Date _____

Confidentiality Policy

THE AGENCY acknowledges patient rights, within the law, to ensure confidentiality and informational privacy.

THE AGENCY employees and representatives, including contracted providers, acknowledge the responsibility to safeguard information designated as personal, medical, or confidential with respect to both legal and ethical consideration.

Unauthorized, indiscriminate disclosure, use of review personal information, medical or otherwise, is expressly forbidden, individual who have access to patient/confidential information or management-designed proprietary/confidential information are expected to adhere to the **AGENCY'S CONFIDENTIALITY POLICY.**

_____ _____

Employee's Signature **Date**

_____ _____

Agency Representative **Date**

MED- LINK NURSING SERVICES

Latex Allergy Questionnaire

Employee Name: _____ Date:_____

- I DO HAVE A LATEX ALLERGY
- I DO NOT HAVE A LATEX ALLERGY

My signature below indicates that the above information is correct and I give permission for this information to be shared with Med- Link Client/Hospitals for the purpose of staffing placement at the facility.

Employee Signature_____ Date: _____

ASC American Screening Corporation

Substance Abuse Screening: Record and Chain of Custody

Company Name: RAPID CARE CLINIC

Applicant/ Employee Name: _____ Date: _____
(Print)

SS# / ID#: _____ Picture ID Verified: ☐ Yes ☐ No

Reason for Drug Test:
☐ Pre-employment ☐ Random ☐ Post Accident ☐ For Cause ☐ Other: _____

☐ **10 PANEL INTEGRATED CUP II**
TESTS FOR: MARIJUANA, COCAINE, OPIATES, AMPHETAMINES, METHAMPHETAMINES, PCP, BARBITURATES, BENZODIAZEPINES, ECSTACY, METHADONE)

☐ **OTHER:** _____

1: Test Valid: ☐ All Drugs ☐ No Test Valid Line _____

2: Drug Results: ☐ Negative: all drugs ☐ Positive Screen: Further Testing Needed (Record non-negative drugs) _____

Alcohol Results:

☐ Not Tested ☐ Negative ☐ Positive Screen: Employee taken to clinic.

Further Testing Needed: Any positive screen or abnormal test results.
☐ Sample Sent to Lab for GC/MS Confirmation Testing. *Name of Lab:* _____

☐ Applicant/ Employee Directed to Lab / Clinic: *Name of Clinic/Lab:* _____

☐ Applicant/ Employee Refused Further Testing: *Signature of Donor:* _____

Chain of Custody:
I certify that the above specimen was collected on (date) _____. I verify that the above information is true and correct, that the specimen is my own, hasn't been tampered with . I release my specimen to the individual listed below.

Donor:
Employee/Applicant Signature: _____ Date: _____

Received/ Tested by: _____ Date: _____ Time: _____

Tester's Signature: _____ Date: _____

Witness: _____ Date: _____

Additional Notes: _____

6658 Youree Dr. Ste 180 PMB 404
Shreveport, LA 71105
Toll Free: 1-866-526-2873
Phone number- (318)227-4994 * Fax number-(318) 227-4996
www.americanscreeningcorp.com

HEPATITIS B VACCINATION
DECLINATION FORM

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: _____

(Printed) Name: _____

Date Signed: _____

hepform

PROCEDURE

Handwashing

1. Turn on water to comfortable temperature and wet hands and lower arms liberally with water.

2. Apply soap and work up lather using friction getting between all fingers and around nail beds. Scrub well with good friction for a minimum of 15 seconds. The principle to good handwashing technique is primarily that of mechanical removal of dirt and microorganisms by lathering, using friction, and rinsing well with running water.

3. Rinse thoroughly under running water allowing water to flow downward toward the fingertips.

4. Dry arms and hands thoroughly with paper towels.

5. Turn off the faucet with a paper towel and discard. (All faucets are considered contaminated).

Waterless Hand Cleanser

The waterless hand cleanser (located in all patient rooms and workstations) may be substituted for handwashing when hands need to be decontaminated and are not visibly soiled. Apply 1 to 2 pumps of cleanser to either palm. Work cleanser into hands, paying special attention to nail beds and wrists. Rub into hands for a minimum of 15 seconds, or until hands feel dry.

I have read and understand this, the "Statement of Acknowledgement - Hand Hygiene". Further, I will comply with the procedures contained herein as set forth by the Infection Control Policies and Procedures.

_____ _____

Print your name Department

_____

Sign your name

_____

Date

Developed 2/2005
Revised: 10/12/05

OMB No. 1615-0047; Expires 03/31/07

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

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)*

NOTE: This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

Form W-4 (2007)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

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 2007 expires February 16, 2008. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds $850 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.

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/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.

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 2007. 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 $1,000 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 (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F ____
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 $57,000 ($85,000 if married), enter "2" for each eligible child. • If your total income will be between $57,000 and $84,000 ($85,000 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

2007

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 2007, 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)

Authorization for Direct Deposit

I authorize _____to deposit my pay automatically to the account(s) indicated below and, if necessary, to adjust or reverse a deposit for any payroll entry made to my account in error. This authorization will remain in effect until I cancel it in writing and in such time as to afford _____ a reasonable opportunity to act on it.

Name on bank account: _____

Bank account number: _____Checking ___ Savings ___

Bank routing number: _____

Amount: $ _____ or entire paycheck: ___

***Balance of pay to:**

_____ Manual (paper check)

_____ Account described below

***Note**: Split payments are not available for contractors.

Name on bank account: _____

Bank account number: _____Checking ___ Savings ___

Bank routing number: _____

Important: Please attach a voided check for each bank account to which funds should be deposited.

Employee/Contractor signature: _____

Date: _____

Payers: Do not send this form with your Direct Deposit enrollment. Keep for your records.