REQUIRED DOCUMENTATION CHECKLIST

(ALL COPIES MUST BE CLEAR AND LEGIBLE)

The Documentation Below Must Be In Your File Prior To Any Assignment.

Application Materials (forms provided in this document)

1. (F) (S) Employment Application must be completed in full. Please print or type neatly. You may include your resume, but it will not replace a complete job application.
2. (F) Skills Checklist
3. (F) (S) Two References / Performance Evaluations – please ask former employer/ supervisor to accomplish
4. Employment Eligibility Form (F) (S) - I-9 Form
5. (F) (S) Direct Deposit Form with a copy of voided check
6. (F) (S) Tax Forms - W4
7. (M) (S)Tax Forms - State Tax Form
8. (M) Tax Forms - Permanent Tax Form
9. (M) (S) Signed Job Description
10. (S) Professional Conduct Expectation
11. (M) (S) HIPPA Quiz and Sign Off
12. (S) Latex Allergy
13. (S) Sexual Harassment
14. (F) OSHA Test, Blood Borne Pathogen (Post Test), HIV Confidentiality Test(no literature, please Google for answers)
15. (S) In-service for JCAHO and OSHA
16. (M) (S) Insurance Form (if waiving coverage, please complete sections #2 and #5)
17. (M) (S) 401 K application - please put 0% contribution if not choosing
18. (S) Employee to Release Info
19. (S) Disclosure & Authorization for Background Check & Release
20. (S) Confidentiality Agreement

LEGEND:

- **(F) – fillable forms using Adobe Acrobat**
- **(M) – to be filled-up manually**
- **(S) – must be signed after printing name**

Medical Documentation (you may use the forms attached or provide clear, original copies with a Doctor's signature and an official stamp)

21. **(**M) A current physical or Physician's Statement within previous 12 months.
22. Ten (10) panel non DOT Drug test- must requirement with all 10 panels listed on Report
23. Immunization Records (MMR, Varicella, Tetanus, if any available) Or Titers
24. (M) (S) Hepatitis B documentation (vaccination series of three, titer, booster, & signed declination).
25. (M) (S) 2 step TB screen current within 12 months or chest X-ray current within two years.

Licenses, Professional Certifications, and Company Policies

26. Clear copies of all current Professional licenses and certifications e.g. PT or OT or RN etc.
27. Clear copy of a current CPR-BLS & (BCLS, ACLS, PALS– as per requirement) (front and back)
28. Copy of SSN card (signed)
29. Copy of Driver's License (USA), International Driver's License – front & Back
30. Copy of EAD or Green Card – Front & Back
31. Copy of Passport
32. **Copy of Finger Printing Results (please coordinate with Marketing staff on this)**
33. (S) Signed Acknowledgement of Receipt of employee handbook (Page 5)
34. (S) Signed Orientation Checklist from employee handbook (Page 6)

All the above items must be in your *COMPLETED* file before you able to start any assignment.

Other Documents and Forms for Your Information and Use

1. Employee Handbook
2. Online Paystub Guide
3. Access Therapies Time Sheet
4. Vacation Request Form
5. Unpaid Leave of Absence Form
6. Employee Referral Form

Thank you for applying with One One Call RehabInc.

317-268-8525 Fax: 317-268-8526
www.onecallrehab.com

RN	_____	LPN	_____
SLP	_____	PT	_____
PTA	_____	OT	_____
COTA	_____	OTHER	_____

JOB APPLICATION

Personal Information

Name			Date
Social Security #		Date of Birth	
Present Address			
City	State		Zip
Home Phone ( )	Other Phone ( )		
Has your license or certification ever been under investigation?		Yes	No
CPR Expiration	Date of Last Physical Exam		Date of Last TB
Have you been convicted of a felony or a misdemeanor within the last 5 years?			Yes No
If yes, please describe			
Are you eligible to work in the United States?	Yes	No	
Drivers License #	State		
Name of person to be notified in case of an emergency			Phone ( )

Additional Information

Do you have any physical limitations that preclude you from performing any work for which you are being considered?
Yes No
If yes, what can be done to accommodate your limitation

Licensure and Certifications

PPD Test	Date Given	Date Read	Induration	Negative	Positive
Step 1					
Step 2					
Chest X-Ray	Date	Results (Results must be attached)			

Employment Desired

Position	Date available for work	Salary Desired
Are you currently employed?	If so, may we contact your present employer?	
By whom were you referred to us?		

Education

Name	Location	Graduated (Y/N)	Degree

Personal References

Name	Name
Address	Address
Phone ( )	Phone ( )

Employment Experience

Employer		Address		
Position	From	To		
Supervisor	Phone			
Reason for leaving?	May we contact your supervisor?		YES	NO

Employer		Address		
Position	From	To		
Supervisor	Phone			
Reason for leaving?	May we contact your supervisor?		YES	NO

Employer		Address		
Position	From	To		
Supervisor	Phone			
Reason for leaving?	May we contact your supervisor?		YES	NO

Experience

Area	Experience in last 3 years	Area	Experience in last 3 years	Area	Experience in last 3 years	Area	Experience in last 3 years
Alcohol Detox		Labor & delivery		Oncology		Psychiatric	
Burns		Medical Floor		Operating Room		Rehabilitation Care	
Cardiac Care		Medications		Orthopedics		Surgical Floor	
Doctor's Office		Neurological		OB/GYN		Urology	
Home Healthcare		Nursery		Pediatrics		Private Duty	
Intensive Care		Nursing Home					

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal. I authorize investigation of all statements contained herein and the references listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release all parties from all liability for any damage that may result from furnishing same to you. I understand and agree that, if hired, my employment is for no definite period and may, regardless of the date of payment of my wages and salary be terminated at any time without prior notice. I under stand that I am not to transport patients in my automobile, nor am I to drive patients in the patient's automobile without written consent from the One Call Rehab Office.

I agree, I will not seek or accept employment, either directly or indirectly in any capacity from any client of One Call Rehab to whom I have been assigned for at least 90 days after the last day of that assignment. I further understand that I cannot be paid until I present a time slip signed by both the client and me to the One Call Rehab Office.

Name of Applicant ______________________ Date ____________

Signature of Applicant ______________________ Date ____________

JOB DESCRIPTION: REGISTERED NURSE

Responsible to
Client Care Manager

Description
Provides and directs the provision of nursing care, based on agency policies and procedures, through the competent application of the nursing process.

JOB DUTIES/KNOWLEDGE (20%)

_____ Provides services requiring substantial and specialized nursing skill, in accordance with the plan of treatment signed by the physician and makes the initial evaluation visit to the client. Accepts only clients referred by the client care manager or designee. Demonstrates competency in all skills required for the agency, including, but not limited to, venipunctures, infusion therapy, infusion therapy device care, wound care and aseptic technique.

_____ Evaluates, and regularly reevaluates the nursing needs of the client; initiates, develops, implements and makes necessary revisions to the client's plan of care. Assesses the client's continual care needs. Addresses all problems in the plan of care or documents rationale for not doing so.

_____ Initiates diagnostic, preventive and rehabilitative nursing procedures as appropriate to the client's care and safety. Makes referrals to other disciplines as indicated by the client's needs or documents rationale for not doing so.

_____ Observes signs and symptoms and reports to the physician and/or other appropriate health professionals as often as needed, or upon changes in the client's condition.

_____ Teaches, supervises and counsels the client and family regarding nursing procedures and other care needs as appropriate to the client's condition. Utilizes agency educational material as appropriate.

_____ Coordinates the total plan of care and maintains continuity of client care by liaising with other health professionals assigned to the same clients. Attends client care conferences. Initiates client care conferences for complex and/or multidisciplinary clients whenever needed.

_____ Supervises and assesses the client's need for unskilled care and revises the plan of care as appropriate. Communicates the plan of care changes to the aide and scheduler as often as necessary.

_____ Develops, prepares and maintains individualized client care progress records with accuracy, timeliness and according to policies. Submits accurate documentation within 24 hours of visit.

_____ Responsible for following all policies and procedures of the agency regarding service delivery, documentation and care coordination. During supervisory visits, exhibits full compliance and verbalizes knowledge of agency policies including but not limited to client education, infection control, management of hazardous

wastes and age-specific behaviors for clients.

_____ Participates in the agency's quality improvement program.

JOB PERFORMANCE (15%)

Demonstrates initiative and skills in planning and organizing work

_____ Demonstrates a desire to set and meet objectives and to find increasingly efficient ways to perform tasks.

_____ Completes work, care and documentation with accuracy and within agency time frames.

_____ Requires minimal supervision and is self-directed.

MISSION/AGENCY STANDARDS (20%)

Demonstrates organizational awareness and commitment

_____ Understands and appropriately applies the chain of command in relation to job position and supervision.

_____ Knows and understands the agency mission in relation to own job position.

Observes confidentiality policy at all times

_____ Protects and honors customer and coworker confidentiality.

_____ Respects customers' and coworkers' right to privacy.

Observes attendance and attire policies

_____ Meets attendance and punctuality expectations.

_____ Demonstrates cooperation with scheduling requests to meet agency needs.

_____ Consistently adheres to agency dress code.

Complies with all other related policies, procedures and requests

_____ Recommends and/or supports changes to policies and procedures.

_____ Demonstrates knowledge of policies and procedures applicable to own job position.

_____ Adheres to policies and procedures. Honors requests of management for interim rules.

Conserves agency resources

_____ Maintains agency property, supplies and equipment in a manner that demonstrates ownership and accountability.

_____ Maintains the work area to reduce the likelihood of safety hazards and to enhance its general appearance.

COMMUNICATION SKILLS (25%)

Demonstrates interpersonal understanding and utilizes effective communication skills

_____ Considers effects of words and actions on others.
_____ Utilizes listening skills that indicate understanding and promotes accurate interpretation of others' concerns, motivations and feelings.
_____ Recognizes the influence of beliefs and cultures on behaviors and accepts strengths and limitations in others.
_____ Works toward resolution of interpersonal conflicts as they arise.
_____ Recognizes when others are in need of information, assistance or direction and consistently offers and provides help.
_____ Attends and participates positively in meetings.
_____ Regularly reads and appropriately applies information to practice.
_____ Uses words that express respect, patience and understanding in interactions with others.
_____ Acknowledges others verbally and nonverbally (eye contact, expression, tone of voice) promptly and courteously.
_____ Follows appropriate phone etiquette.

Exhibits behaviors of cooperation

_____ Develops cooperation and collaborative work efforts that generally benefit all involved parties.

_____ Demonstrates the initiative to meet the needs of the agency by assisting coworkers when work load permits.

PERSONAL/PROFESSIONAL DEVELOPMENT (10%)

Continuing education and personal/professional development responsibilities

_____ Maintains personal health status requirements in relation to job position.
_____ Maintains professional licensure/certification.
_____ Maintains current personnel file information and provides information to agency in timely manner.
_____ Sets own development challenges and volunteers to learn.
_____ Assists with orientation of new personnel.
_____ Adheres to agency infection control and safety policies, including education, reporting, and practice implementation specific to job position.
_____ Attends agency provided in-service programs to fulfill requirements of position and agency policies.

Exhibits adaptability, flexibility, self-control and maturity in work and behavior

_____ Maintains stable performance and emotions when faced with opposition, pressure and/or stressful conditions.

_____ Recognizes codependency issues in caregiving roles and exercises caution in relationships to maintain objectivity.
_____ Develops work relationships that honor and respect others' strengths and abilities.

PROBLEM SOLVING (10%)
Exhibits critical thinking abilities and applies them for continuous improvement of services and the agency

_____ Uses own knowledge and experience base and other resources as necessary to make logical decisions and solve problems.

_____ Continuously analyzes work processes and makes suggestions for improvement.

QUALIFICATIONS

- Bachelor's degree in nursing from a program accredited by the National League for Nursing.
- Licensed to practice professional nursing in the state.
- Minimum of one year of nursing experience required.
- Knowledge and Abilities:
    a) Demonstrated knowledge and skills necessary to provide care to and communicate with primarily the geriatric population, and to a lesser degree the pediatric and adult populations.
    b) Demonstrated knowledge of the principles of growth and development over the life span.
    c) Able to assess data reflecting the client's status and interpret the appropriate information needed identify each client's requirements relative to their age-specific needs.

DEGREE OF TRAVEL
Weekly office meetings. Must have reliable transportation and agency-required liability insurance.

DEGREE OF DISRUPTION TO ROUTINE, OVERTIME
Must be able to adapt to client status and needs, as directed. Schedule changes daily due to staffing, client condition, new clients, etc. Must be on-call.

SAFETY HAZARDS IN JOB
Possible infections from clients. Possible auto accident. Possible unsafe neighborhoods.

JOB TITLE: Registered Nurse

PHYSICAL DEMANDS	NEVER	OCCASIONALLY	FREQUENTLY	CONTINUALLY
Sit				X
Stand			X	
Walk			X	
Bend/Stoop			X	
Squat			X	
Crawl		X		
Climb		X		
Reach Above Shoulder Level		X		
Kneel		X		
Balance		X		
Lift, Carry, Push, Pull				
Maximum 10 Lbs.		X		
Maximum 20 Lbs.		X		
Maximum 50 Lbs.		X		
Maximum Over 50 Lbs.	X			
Must Be Able To				
See				X
Hear				X
Speak				X
Use One Hand				X
Use Both Hands				X

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JOB TITLE: Registered Nurse

Environmental Conditions	NEVER	OCCASIONALLY	FREQUENTLY	CONTINUALLY
Involves Being				
Inside				X
Outside		X		
Exposed to Temperatures of				
32°F and less		X		
100°F and more		X		
Wet & Humid Conditions		X		
Noise, Vibration		X		
Fumes, Dust		X		

Hazards, Exposure	NEVER	OCCASIONALLY	FREQUENTLY	CONTINUALLY
Infectious Wastes			X	
Toxic Chemicals			X	
Needles/Body Fluids			X	
Radiation	X			
Chemotherapeutics		X		

Occasionally = 1% to 33% of the time Frequently = 34% to 66% of the time
Continually = 67% to 100% of the time

Employee Printed Name: _____ Date: _____

Employee Signature: _____

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www.onecallrehab.com

One Call Rehab Inc.

3971 Dolan Way
Carmel, IN 46074
Tel: 317-268-8525

Reference Form

Clinician Name: _____ Date of Evaluation: _____

Facility Name: _____ Contact Person: _____

Address: _____ Title: _____

Phone #: _____ Signature: _____

Start Date: _____ End Date: _____ Specialty: _____

# of Beds: _____ Unit Description: _____

Eligible for Re-hire: _____ Avg. Patient Caseload: _____

EVALUATION:
Ratings: 4 = Outstanding 3 = Exceeds Expectation 2 = Meets job Requirement 1 = Not Met

Performance	Outstanding	Exceeded Expectation	Meets Job Requirements	Not Met
Job Knowledge				
Work Quality				
Initiative				
Dependability				
Creativity				
Accepts Directions				
Interpersonal Relationship				
Accurate Documentation				
Communicate Effectively				
Attendance				
Punctuality				

Signature of Employee: _____

Employee Name: _____ Date: _____

Reviewed By: _____ Date: _____

Title: _____

EMPLOYEE AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION ON EMPLOYMENT FILE, BACKGROUND CHECK, MEDICAL RECORDS, RANDOM DRUG SCREENING, AND PAYCHECK DEDUCTIONS:

By affixing my signature hereunder, I authorize ONE CALL REHAB INC. to release any and all confidential employment, background check and medical information contained in my employment file to any medical facility or entity with whom ONE CALL REHAB INC. has a staffing agreement, and to any other governmental or regulatory agency at such agency's request. For all other purposes, shall keep my employment records confidential and shall advise any medical facility or other entity to ONE CALL REHAB INC. whom records have been provided to also keep such records confidential. I hereby hold ONE CALL REHAB INC. harmless for any result(s) that arise with regards to the release of this confidential
Information by ONE CALL REHAB INC.
Medical records information is confidential and ONE CALL REHAB INC. will instruct client facilities and/or other entities to treat the provided information confidential as well. I consent to a urine, blood or breath sample for the purposes of an alcohol, drug, intoxicant, or substance abuse screening tests. Furthermore, I consent to the release of the test results for purposes of determining the fitness for employment or continued employment.
I authorize ONE CALL REHAB INC. to deduct from my paycheck for any of the following: unpaid single-supplement housing expenses being the cost incurred for rooming by oneself instead of sharing a room with a roommate, non-authorized housing expenses including but not limited to housing items taken from room(s) or other provided housing, telephone and fax charges to room left unpaid at time of departure, any other room service charges such as movie rentals or dry cleaning costs, any damage/destruction done to room or other housing, and any other expenses due and owing to ONE CALL REHAB INC.
My signature hereunder further indicates that I have read the EMPLOYEE AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION ON EMPLOYMENT FILE, BACKGROUND CHECK, MEDICAL RECORDS, RANDOM DRUG SCREENING AND DEDUCTION FROM PAYCHECK POLICY in its entirety and understand its contents.
I understand that my employment is "at will" and may be terminated by me or ONE CALL REHAB INC. at any time, with or without prior notice, for any lawful reason or no reason. I further understand no contract is intended by me or ONE CALL REHAB INC. and as such my employment is not governed by any contractual relationship with ONE CALL REHAB INC. I certify that the facts contained in this application are true and accurate. I understand that any misrepresentation or omission of facts is cause for dismissal. I authorize the employer to investigate any and all statements contained herein and request the persons, firms, and/or corporations named above to answer any and all questions relating to this application. I release all parties from all liability, including but not limited to, the employer and any person, firm or corporation who provides information concerning my prior education, employment or character.

_____	_____	_____
Employee Printed Name	Signature	Date

ONE CALL REHAB INC. *does not discriminate in respect to hiring, firing, compensation, and all other terms and conditions of privileges of employment on the basis of race, color, national origin, ancestry, sex, age, pregnancy or related medical conditions, marital status, religious creed, or disability.*

PREVENTING AND ADDRESSING SEXUAL HARASSMENT AND UNLAWFUL DISCRIMINATION

The Company is committed to working with Client healthcare facilities to provide a work environment that is free of harassment and discrimination. In keeping with this commitment, we do not tolerate any form of sexual harassment or any other form of unlawful discrimination.

Harassment based on race, sex, national origin, disability, sexual orientation; religion or other protected characteristic is a violation of state and federal laws. State and federal laws define sexual harassment to include unwelcome sexual advances, requests for sexual favors, and other verbal, visual, or physical conduct of a sexual nature. Any person who commits such a violation may be subject to personal liability as well as disciplinary actions, up to and including termination.

Sexual harassment of employees by supervisors, co-workers or clients/customers is strictly prohibited. Such conduct is unlawful when:

- Submission to the conduct is made a term or condition of employment;
- Submission to or rejection of the conduct is used as the basis for an employment decision affecting an employee; or
- The conduct has the purpose or effect of unreasonably interfering with an employee's work performance, or creating an intimidating, hostile, or offensive work environment.

Examples of sexual harassment include unwelcome sexual flirtations, advances or propositions; verbal abuse of a sexual nature; subtle pressure or requests for sexual favors; unnecessary touching of an individual; a display in the workplace of sexually suggestive objects or pictures; sexually explicit or offensive jokes; or a physical assault.

If at anytime on your assignment you believe that you are being subjected to discrimination or harassed in any way, please express your assessment of remarks made or actions taken as "harassment," or "discrimination" and the facts of the incident(s) to your direct supervisor, the house supervisor, or, if you prefer, the assignment facility's Human Resources department.

In many situations, individuals are insensitive to the offensiveness of their words or behaviors, but will cease the offensive behavior when its impact is brought to their attention. Try this approach, bearing in mind that what is acceptable in one environment may not be acceptable in another.

While working as a Traveler you may find environments that are less tolerant of "kidding around" and "teasing" than you have been used to, or you may find yourself uncomfortable in an environment that is far more tolerant of "kidding around" or "teasing" than you have worked in before. In this situation, make your discomfort known through the appropriate chain of command at the healthcare facility.

If the situation is not resolved to your satisfaction, please report the facts of the incident(s) to the Clinical Liaison who will immediately investigate any complaint and work with the assignment facility to define and initiate appropriate preventive and/or corrective action(s).

No Traveler or corporate staff employee will be retaliated against for making a complaint or bringing inappropriate conduct to the Company's attention, for preventing unlawful practices, or for participating in an investigation, proceeding, or hearing conducted by any governmental agency.

TRAVELERS:

1. *Be aware that as a Traveler you will be viewed as a "newcomer," and may not ever become part of the facility's social "family." Be especially conscious of this status in your words and actions, taking care never to say or do anything that could be viewed as "in poor taste" or construed as harassing behavior. Always keep in mind that what is acceptable in one environment may not be acceptable in another, and that often one person's "kidding around" or "teasing" is another person's "harassment."*

2. *Show respect to everyone by refusing to participate in or tolerate inappropriate behavior.*

I have read, understood and intend to comply with these Professional Conduct Expectations.

_____ _____

Employee Signature Date

_____ _____

Please Print Name Date

PHYSICIANS STATEMENT

The section below is to be completed by employee.

Medical Release Authorization:

I _____ do hereby authorize _____ to release any information
(Applicant Name) (Physicians Name)
acquired during my medical examination to One Call Rehab Inc.. Furthermore I authorize One Call Rehab Inc. to release any information on this statement, relevant to employment, to any of its client facilities. I understand this must be completed before I can begin work with One Call Rehab Inc.

_____ _____
Employee Signature Date

The section below is to be completed by physician or staff.

Height:_____ **Weight**: _____ **Pupils**: Equal ____ Unequal ____

Blood Pressure: _____ **Heart Rate**: _____ **Pulse:** _____

MEDICAL:	NORMAL	ABNORMAL	COMMENTS
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL:			
Neck			
Back			
Shoulder/Arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			

I have examined this patient and determined that this person is in good physical health, free of communicable diseases and is able to function and perform all job duties without any physical limitations in his/her profession at full capacity.

_____ _____
Physician's Signature Physicians Medical ID Number

_____ _____
Physician Phone Address City State Zip

Date of exam: _____ Time of exam: _____

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HEPATITIS B VACCINATION FACT SHEET

The Vaccine:

Energix-B (Hepatitis B Vaccine-Recombinant) is a noninfectious, Recombinant DNA hepatitis B vaccine. Over several studies, at least 90% of the individuals immunized have been seroprotected. Duration of protection by the vaccine has not been fully defined and is still being studied; however, in one study 76% of the immunized individuals had titers high enough to be considered immune for 10 years after vaccination.

Persons with immune deficiency problems should obtain a written release from their physician prior to receiving the vaccine. Persons with known allergies to yeast may require a different form of the vaccine known as "Hepatitis B Virus Vaccine (Plasma-derived).

Benefits to Recipients:

The hepatitis B vaccine provides protection against acquiring the hepatitis B virus. It is especially recommended to those individuals who have occupational exposure to blood of other potentially infectious materials. Although most people who acquire hepatitis recover fully, about 10% become chronic carriers of the disease and 1-2% die of fulmative hepatitis. There also has been as association between hepatitis B virus and the development of liver cancer and/or cirrhosis of the liver. Thus the vaccine and the vaccination offer a method of protection, free of charge to the Jasneek Healthcare employee, from acquiring hepatitis B at work or elsewhere.

Possible Adverse Reactions:

Engerix-B (Hepatitis B Vaccine-Recombinant) is generally well tolerated. No substances of human origin are used in its manufacture. Adverse reactions, if any, to the vaccines are generally mild, infrequent, and transient. As with any vaccine, however, it is possible that expanded commercial use of the vaccine could reveal rare adverse reactions not observed in clinical studies.

The most frequently reported adverse reactions include: injection site soreness, fatigue, weakness, induration, erythema, swelling, fever, headache, and dizziness. Adverse reactions of a more serious nature have been reported, but with a frequency of less than 1% of the immunized population. If there are any further questions regarding adverse reactions of the vaccine, ask your supervisor.

Contraindications:

Not to be used in persons with a known allergy/hypersensitivity to yeast and/or other components of the vaccine. The vaccine should be administered with caution to any person known to have thrombocytopenia or bleeding disorder. These persons should have the vaccination administered via the subcutaneous versus the intramuscular route.

Dosing Schedules:

Three doses of the hepatitis B vaccine are required to confer immunization against infection. "Engerix-B" is administered on a selected date, then again at one-month and at six-months from the date of the first injection.

Pregnancy, Fertility and Lactation:

Since animal reproduction studies have not been carried out on "Engerix-B", the vaccine should be given to pregnant women only when clearly indicated. It is also not known whether the vaccine can cause any harm to the fetus when administered to a pregnant woman. It is not known if the vaccine affects fertility. Finally, it is not known if the vaccine is excreted in human breast milk. Because many drugs are excreted in human breast milk, caution should be used when considering administering the vaccine to a nursing mother.

Source: American Hospital Formulary Service Drug Information

American Society of Hospital Pharmacists, publishers.

Bethesda, MD 1991, pp. 2025-2032

HEPATITIS B VIRUS VACCINE CONSENT/DECLINATION

Please sign and date EITHER the verification OR declination.
DO NOT SIGN BOTH.

BLOODBORNE PATHOGENS

I HAVE BEEN INFORMED OF THE SYMPTOMS AND MODES OF TRANSMISSION OF BLOODBORNE PATHOGENS INCLUDING HEPATITIS B VIRUS (HBV). I KNOW ABOUT THE AGENCY'S INFECTION CONTROL PROGRAM AND UNDERSTAND THE PROCEDURE TO FOLLOW IF AN EXPOSURE INCIDENT OCCURS.

HEPATITIS B VACCINE VERIFICATION

I fully understand that my occupation may lead to exposure of blood or other potentially infectious materials. I may be at risk of acquiring Hepatitis B infection. I was vaccinated for Hepatitis B (HBV) in the past (ALL 3 vaccines) and the date of my last vaccination was _____. I will provide all records of previous of Hepatitis B vaccinations.

_____ _____
Employee Signature Date

_____
Employee Printed Name

HEPATITIS B VACCINE DECLINATION

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. 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 choose to be vaccinated for Hepatitis B, I will pursue the vaccination series

_____ _____
Employee Signature Date

_____
Employee Printed Name

TUBERCULOSIS SCREENING QUESTIONNAIRE & TB (PPD) SKIN TEST

This section below is completed by employee

EMPLOYEE NAME:_____ DATE:_____ DISCIPLINE:_____

HAVE YOU EVER HAD A POSITIVE TB (PPD) SKIN TEST RESULT: YES___ NO____

IF YES; DATE OF CHEST X-RAY:_____

Screening Questionnaire: **Please indicate if you have had any of the following problems for three weeks or longer:**

	Yes	No	Comments
Chronic Cough (greater than 3 weeks):			
Production of Sputum:			
Blood Streaked Sputum:			
Unexplained Weight Loss:			
Fever:			
Fatigue/Tiredness:			
Night Sweats:			
Shortness of Breath:			

_____ _____

Employee Signature Date

This Section Below is completed by persons authorized to administer and read Monteux Skin Test:

Testing Location: _____ Date Placed: _____

Site: Right _____ Left: _____ Lot #: _____ Exp Date: _____

Signature (administered by): _____ RN ___ MD ___ Other __

Date Read (within 48-72 hours of date placed): _____ Induration: _____mm

PPD (Mantoux) Result: Negative_____ Positive _____

Signature (administered by): _____ RN ___ MD ___ Other __

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