REQUIRED DOCUMENTATION CHECKLIST

(ALL COPIES MUST BE CLEAR)

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

Application Materials (forms provided in this document)

1. Job 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. Clinical Skills Checklist (Neonatal and OR in addition, if applicable).
3. Signed Job Description.
4. Two references and/or written references on letterhead or a performance evaluation with **one** other reference.
5. State Criminal Back Ground Check with in the last 6 months.

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

5. A current physical or physician's statement within previous 12 months.
6. Hepatitis B documentation (vaccination series of three, titer, booster, or signed declination).
7. A TB screen current within 12 months or chest X-ray current within two years.

Licenses, Professional Certifications, and Resuscitation Credentials

8. Clear copies of all current therapist licenses and professional certifications.
9. Clear copy of a current CPR card. If you have additional resuscitation credentials (ACLS, ENPC, NRP, PALS, TNCC).
13. Proof of eligibility to work within the United States (For example: a Social Security Card and a Driver's License, or Passport).

All the above items must be in your *completed* nurse file before your file is faxed to a facility for any assignment.

Please make sure that you include the highlighted items above with your application

Thank you for applying with One Call Rehab

3791 Dolan Way, Carmel IN 46074
Phone: 317-268-8525 | Fax: 1-317-268-8526
www.OneCallRehab.com

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

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 ____________

PT SKILLS/PROFICIENCY CHECKLIST

1=no experience 2=familiar with 3=experienced in 4=able to teach and supervise

WORK SETTINGS	1	2	3	4
Rehabilitation Hospital				
General Acute Care				
Rehabilitation Unit in Hospital				
Pediatric Rehab. Hospital/Clinic				
Sports Medicine Clinic				
Childrens Hospital				
School System				
Home Health Care				
Outpatient Clinic				
Nursing Home				
Private Practice				
Psychiatric Hospital				
Physician Office				
ORTHOPEDICS				
ROM				
Back School				
Back Syndromes				
Hip Fractures				
Total Hip/Total Knee				
Hand Injury				
TMJ Dysfunction				
Arthritis Programs				
Mobilization Techniques				
Gait Training				
Manipulation Techniques				
Post-surgical mgmt. tendon/muscle				
release				
NEUROLOGIC				
Stroke Rehab				
Coma Management				
Head Trauma				
Spinal Cord Injury				
Functional Splinting				
Adaptive Equipment				
Neuromuscular Rehabilitation				
PROSTHETICS/ ORTHOTICS				
AK Prosthetics				
BK Prosthetics				
UE Prosthetics				
Orthoplast				
Resting Splints				
AFO/PLS				
Static Splinting				
Dynamic Splinting				
Serial/Inhibitory Casting				
SPORTS MEDICINE				
Taping/Strapping				
Nautilus				
Bracing/Joint Immobilization				
ADAPTIVE EQUIPMENT				
Assessment				
Fabrication				
Wheelchair				
Seating				
Ordering				
WORK HARDENING				
Job Site Evaluation				
Functional Capacity Evaluation				
Work Capacity Evaluation				

MODALITIES	1	2	3	4
Acupuncture				
Hot Packs				
Neuromuscular Reeducation				
Myofascial Release Techn.				
Fluidotherapy				
Hydrotherapy				
Whirlpool				
Hubbard Tank				
Theraputic Pool				
Biofeedback				
TENS				
Muscle Stimulation				
Ultrasound				
Diathermy				
Cryotherapy				
Traction (Mechanical)				
Cervical				
Lumbar				
Cervical Traction (Manual)				
Massage				
Wound Dressing/Debridement				
Paraffin				
Vasopneumatic Devices				
Easy Street				
Continuous Passive Motion				
PEDIATRICS				
Learning Disabled				
Spina Bifida				
Balance Disorders				
Early Intervention				
NICU Treatment				
Neurodevelopmental Testing				
DDST				
Orthotics				
Equipment Assessment				
Adaptive				
ADL				
Mental Retardation				
Cerebral Palsy				
SPORTS MEDICINE				
Strength/Endurance Training				
Lido Back				
Kin Com				
Biodex				
Cybex				
Orthotron/Kinetron				
OTHER				
Symptom Magnification				
Assessment				
Cardic Rehabilitation				
Chest Physiotherapy				
Burn Management				
Inservice Education				
Geriatrics				
HHA supervision				
PTA supervision				

Applicant Signature	
Applicant Name	
Date	

OT SKILLS/PROFICIENCY CHECKLIST

1=no experience 2=familiar with 3=experienced in 4=able to teach and supervise

WORK SETTINGS	1	2	3	4
Rehabilitation Hospital				
General Acute Care				
Rehabilitation Unit in Hospital				
Pediatric Rehab. Hospital/Clinic				
Sports Medicine Clinic				
Childrens Hospital				
School System				
Home Health Care				
Outpatient Clinic				
Nursing Home				
Private Practice				
Psychiatric Hospital				
Physician Office				
ASSESSMENT/EVALUATION				
Client initial assessment				
Client D/C assessment				
Functional evaluations				
ADLs				
Range of motion				
Muscle strength				
Sensation				
Cognition				
Perception				
Coordination				
Driving evaluation				
Swallowing				
Vocational Skills				
Leisure skills				
Mental status				
Neonatal/developmental assessment				
Functional capacity for work				
Oral motor skills				
Needs for adaptive/home equipment				
Evaluation for environmental control system				
PROCEDURE/INSTRUCTION				
Development of care plan				
Charting/documentation				
Upper extremity theraputic exercise				
Oral motor stimulation				
Neonatal infant stimulation				
Fabrication of splints				
Environmental adaptations				
ADL training				

	1	2	3	4
Neurodevelopmental therapy				
Myofascial therapy				
Joint mobilization				
Energy conservation/ work simplification				
Instruct in body mechanics				
Blood pressure monitoring				
Heart rate monitoring				
Purposeful activities- crafts/leisure				
Perceptual retraining				
Cognitive retraining/ compensatory activities				
Desensitization/resensitization				
W/C measurements/fitting				
W/C operations				
Behavior modification techniques				
Dysphagia treatment				
Universal Precautions				
SPECIALTY AREAS				
Spinal Cord Injury				
Procedures for post-CVA rehab				
Orthopedics				
Neurological disease				
Pediatric experience(0-3yr)				
Pediatric experience (3+yr)				
Head trauma				
HHA supervision				
COTA supervision				
Burn management				
Inservice education				
Geriatrics				
Total hip/ total knee				
Hand rehab				

Applicant Signature	
Applicant Name	
Date	

JOB DESCRIPTION: PHYSICAL THERAPIST

REQUIREMENTS: The Physical Therapist must meet recognized standards of professional education and qualifications. The Physical Therapist must:

1. Must be a graduate of an educational institution with a degree in Physical Therapy.
2. Must be licensed in the State (as applicable) to practice Physical Therapy.
    a. Temporary license may be accepted
3. Display evidence of interest in continued education within the profession and is encouraged to be a member of the American Physical Therapy Association.

ESSENTIAL FUNCTIONS:

1. The staff Physical Therapist reports to the Area Administrator of Physical Therapy.
2. He/She may be responsible for supervising/training other personnel such as; Physical Therapy Assistants and/or Physical Therapy Aides.
3. Following receipt of a doctor's referral, the therapist is responsible for evaluating the patient within 24 hours of written referral.
4. After evaluating the patient, the therapist is responsible for planning, administering and supervising the Physical Therapy Assistant in an appropriate treatment plan.
5. The Physical Therapist will communicate with the referring physician and members of the rehabilitation team regarding the patient's total treatment program.
6. The Physical Therapist will maintain an accurate daily record of treatments given to patients.
7. The Physical Therapist will maintain an accurate daily record of treatments administered to patients.
8. The Physical Therapist will provide in-service education to facilities, supportive staff, students and community.
9. The Physical Therapist will perform other duties as assigned by the Area Administrator.
10. The Physical Therapist will follow established policies and procedures of Therapist Express.

TYPICAL PHYSICAL DEMANDS:

Physical Therapist assigned must be able to perform the following physical job functions with or without reasonable accommodation:

1. Lift up to 50 pounds from floor to knuckle occasionally.
2. Lift up to 30 pounds from the knuckle to shoulder occasionally.
3. Lift up to 10 pounds overhead occasionally.
4. Pivot transfer up to 200 pounds continuously.
5. Carry up to 25 pounds, 200 feet frequently.
6. Push/pull 40 pounds, 300 feet frequently.
7. Squat and stoop up to 20 minutes occasionally.
8. Kneel and crawl up to 5 minutes continuously.
9. Fine hand manipulation, bilaterally frequently.
10. Heavy grasp, bilaterally, continuously.
11. Visually acuity corrected to 20/20.
12. Tactile discrimination continuously.
13. Drive up to 2 hours.
14. Comprehensible verbal communication skills continuously.

Employee Printed Name:_____ Date: _____

Employee Signature: _____

JOB DESCRIPTION: OCCUPATIONAL THERAPIST

Occupational Therapist Job Purpose: Facilitates development and rehabilitation of patients with mental, emotional, and physical disabilities by planning and administering medically prescribed occupational therapy.

Occupational Therapist Job Duties:

- Meets the patient's goals and needs and provides quality care by assessing and interpreting evaluations and test results; determining occupational therapy treatment plans in consultation with physicians or by prescription.
- Helps patient develop or regain physical or mental functioning or adjust to disabilities by implementing programs involving manual arts and crafts, practice in functional, prevocational, vocational, and homemaking skills, activities of daily living, and sensor motor, educational, recreational, and social activities; directing aides, technicians, and assistants.
- Promotes maximum independence by selecting and constructing therapies according to individual's physical capacity, intelligence level, and interest.
- Prepares patient for return to employment by consulting with employers; determining potential employee difficulties; retraining employees; helping employers understand necessary physical and job result accommodations.
- Evaluates results of occupational therapy by observing, noting, and evaluating patient's progress; recommending and implementing adjustments and modifications.
- Completes discharge planning by consulting with physicians, nurses, social workers, and other health care workers; contributing to patient care conferences.
- Assures continuation of therapeutic plan following discharge by designing and instructing patients, families, and caregivers in home exercise programs; recommending and/or providing assistive equipment; recommending outpatient or home health follow-up programs.
- Documents patient care services by charting in patient and department records.
- Maintains patient confidence and protects hospital operations by keeping information confidential.
- Maintains safe and clean working environment by complying with procedures, rules, and regulations.
- Protects patients and employees by adhering to infection-control policies and protocols.
- Ensures operation of equipment by completing preventive maintenance requirements; following manufacturer's instructions; troubleshooting malfunctions; calling for repairs.
- Maintains professional and technical knowledge by attending educational workshops; reviewing professional publications; establishing personal networks; participating in professional societies.
- Develops occupational therapy staff by providing information; developing and conducting in-service training programs.
- Complies with federal, state, and local legal and certification requirements by studying existing and new legislation; anticipating future legislation; enforcing adherence to requirements; advising management on needed actions.
- Contributes to team effort by accomplishing related results as needed.

Skills/Qualifications: Health Promotion and Maintenance, Creating a Safe, Effective Environment, Motivating Others, Legal Compliance, Bedside Manner, Medical Teamwork, Mental Health, Pain Management, Listening, Analyzing Information , Quality Focus

Employee Printed Name: _____ Date: _____

Employee Signature: _____

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 Name and 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.*

I hereby authorize the release of any information requested on this form. I also release the person / facility below from all liability in providing any type of reference information.

Applicant Signature _____

Social Security Number _____ Date _____

Do not write below this line

Dear _____ Phone _____

_____ has applied for employment with us. We would appreciate your cooperation in verifying or correcting the enclosed information and answering the following questions. Please return this self addressed letter to us as soon as possible. All information is confidential. Thank you for your assistance.

Employed from _____ to _____

Position(s) held _____

Applicant's reason for leaving _____

Subject to re-hire _____ If no, why not? _____

Facility/Company _____

Signature/Title _____ Date_____

☐ Telephone Reference

Comments: _____

_____

_____

_____ _____

Signature of person taking information Date

8/98

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

3791 Dolan Way, Carmel, IN 46074
Phone: 317-268-8525 | Fax: 1-317-268-8526

Reference Form

Clinician Name: _____ Date of Evaluation: _____

Company: _____ 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: _____

AGE SPECIFIC JOB REQUIREMENTS

JCAHO mandates that caregivers and other facility employees are competent to provide age appropriate care and services. As a result our Client facilities require that we document your competencies for all age groups for whom you provide care.

The following highlights some of the most important caregiver actions related to the age of the patient. Identify the age groups of your patients.

Neonates

Provide protective environment.

- Cuddle and hug the baby.
- Use pacifier and bottle as distractions.
- Position babies in supine position for sleep.
- Ensure warmth.
- Involve parents in decision making process.
- Provide parents with information about support services available to aid them to meet the needs of their baby post-discharge.

Infants

- Keep parents in infant's line of vision within safety limits.
- Give infant a familiar object for comfort.
- Limit the number of strangers present.
- Remove equipment used and keep rail up after procedure.
- Position infant in supine position for sleep.
- Involve parents in decision-making processes.
- Do not allow infant to routinely use a bottle as a sleeping aid.
- Provide parents with information about support services available to help them to meet the needs of their child post-discharge.

Toddlers

- Explain what you'll do before beginning.
- Use firm, direct approach.
- Give one direction at a time.
- Prepare the child immediately before procedures.
- Allow choices when possible.
- Distract the toddler from focusing on pain or procedures.
- Use play as a means of preparation and explanation of procedures.
- Allow for religious/cultural beliefs as expressed by parents.
- Include parents in education of the toddler.
- Emphasize aspects of procedures that will require cooperation.

♦ Provide parents with information about support services available to help them meet the needs of their toddler post-discharge.

Pre-school and school-age patients

♦ Explain procedure and equipment using correct terminology.
♦ Plan for duration of education and play sessions appropriate to child's tolerance.
♦ Educate using games, rewards and praise.
♦ Allow child to have as much control over the environment as possible.
♦ Explain unfamiliar objects.
♦ Involve child whenever possible.
♦ Plan procedures in advance to reduce child's waiting time.
♦ Allow for expressions of religious/cultural beliefs as expressed by the parents.
♦ Include parents in the child's education.
♦ Provide parents with information about support services available to help them meet the needs of their child post-discharge.

Adolescents

♦ Include reasons in explanation of procedures.
♦ Encourage questions regarding the patient's fears.
♦ Provide privacy – especially for adolescents.
♦ Involve in decision making and planning.
♦ Expect resistance from the patient.
♦ Allow for religious/cultural beliefs.
♦ Include parents in the patient's education as appropriate to the family dynamic and medical condition of the patient.
♦ Provide parents and the adolescent with information about support services available to help them meet their needs after the patient's discharge.

Adults

♦ Include reasons in explanation of procedures.
♦ Encourage questions regarding the patient's fears.
♦ Provide privacy.
♦ Involve in decision making and planning.
♦ Allow for religious/cultural beliefs.
♦ Bring significant others into the patient's education.
♦ Provide for mobility of the patient.
♦ Provide information to patient and members of the patient's support network about available services to help meet the patient's and their needs post-discharge.

Geriatrics

♦ Include reasons in explanation of procedures.
♦ Encourage questions regarding patient's fears.
♦ Provide privacy.
♦ Speak distinctly.
♦ Focus light directly on objects.
♦ Slow the pace of explanations and presentations.

♦ Ensure warmth.
♦ Involve in decision making and planning.
♦ Provide for mobility of patient.
♦ Change patient positions slowly due to decreased circulatory force.
♦ Involve patient or designated individual in decisions involving treatment plan.
♦ Consider ability to chew, taste, see, hear, and think and remember in seeking patient's cooperation and in patient teaching.
♦ Provide information about support services to help caretakers and other family members meet the patient's and their needs post-discharge.

I have read, understood and intend to comply with these professional conduct expectations.

_____ _____

Nurse Associate Signature Date

_____ _____

Please Print Name Date

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.

_____ _____
Signature Date

_____
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

_____ _____
Signature Date

_____
Printed Name

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: _____

TB Skin Test Form

This section below is completed by employee

EMPLOYEE NAME:_____ **DATE:**_____ **DISCIPLINE:**_____

HAVE YOU EVER HAD A POSITIVE TB SKIN TEST(PPD) 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 Tests :

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 __