

# Nurses Internet Staffing Services, Inc.

## Corporate Office

6055 E. Washington Blvd., Suite 409  
Commerce, CA 90040  
Tel (323) 720-9900  
Fax (323) 720-9903

## Bakersfield Office

26 Bernard Street, Suite 70  
Bakersfield, CA 93305  
Tel (661) 337-9900  
Fax (661) 337-9901



## Application For Employment

Classification \_\_\_\_\_ Specialty \_\_\_\_\_ Date of Application \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle Initial E-mail Address

Address \_\_\_\_\_  
Number Street City State ZIP

Home Telephone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Pager / Cell Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License Number \_\_\_\_\_ State \_\_\_\_\_

Average Days available for work: \_\_\_\_\_

Preferred Shift(s):

Su \_\_\_ M \_\_\_ Tu \_\_\_ W \_\_\_ Th \_\_\_ F \_\_\_ Sa \_\_\_

[ ] 7am-3pm [ ] 3pm-11pm [ ] 11pm-7am

[ ] 7am-7pm [ ] 7pm-7am

Do you have a car? Yes / No Are you employed now? Yes / No  
If no, can you provide your own transportation? Yes / No May we contact your present employer? Yes / No  
Are you prevented from lawfully becoming employed in this country because of Visa or immigration status? Yes / No  
Have you ever been injured on the job? Yes / No

If yes, give date \_\_\_\_\_ and explain \_\_\_\_\_

Were there any conditions that prevented you from working in acute facilities? Yes / No

If yes, give date \_\_\_\_\_ and explain \_\_\_\_\_

Have you ever been convicted of a felony? Yes / No

If yes, give date \_\_\_\_\_ and explain \_\_\_\_\_

If referred, name of the referring person \_\_\_\_\_

Applicants are considered for all positions without regard to race, color, religion, sex, national origin, age, marital or veteran status, and the presence of a non-job related medical condition or handicap.



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**PROFESSIONAL LICENSES**

Type of License	License #	Expiration Date	Issuing State

**EDUCATION AND TRAINING**

Education	Name and Location of School	# of Years	Year Graduated	Degree √
Basic Nursing				[ ] Associate
				[ ] BSN
Graduating Nursing Education				[ ] MSN
				[ ] Other List Below
Certificate Program/Other				
Special Training Skills				



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**PROFESSIONAL EXPERIENCE**

From	To	Class	Specialty
Hospital / Agency		Address	
		City / State	
Hospital Supervisor		Tel Number	
Agency Staffing Manager		Tel Number	
Duties			
Reason For Leaving		Comments	

From	To	Class	Specialty
Hospital / Agency		Address	
		City / State	
Hospital Supervisor		Tel Number	
Agency Staffing Manager		Tel Number	
Duties			
Reason For Leaving		Comments	

From	To	Class	Specialty
Hospital / Agency		Address	
		City / State	
Hospital Supervisor		Tel Number	
Agency Staffing Manager		Tel Number	
Duties			
Reason For Leaving		Comments	

Names of Other Hospitals and Agencies You Worked in Last Three (3) Years:
---------------------------------------------------------------------------

**How many years of acute experience do you have?** \_\_\_\_\_



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**PERSONAL REFERENCES**

Please give three references that are not related to you.

Name	Relationship	Tel. Number
Address		

Name	Relationship	Tel. Number
Address		

Name	Relationship	Tel. Number
Address		

**In case of an emergency, notify:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone Number \_\_\_\_\_ Other Telephone Number \_\_\_\_\_

Address: \_\_\_\_\_

Comment: \_\_\_\_\_



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## HEALTH QUESTIONNAIRE

NAME: (Last, First)	SSN:	DATE:
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*THIS SECTION TO BE COMPLETED BY APPLICANT*

Do you have or ever been told you have:	YES	NO	If YES, please explain:
Allergies, Asthma, Wheezing			
Chronic Cough, Colds			
Rheumatic Fever			
Heart Trouble			
High Blood Pressure			
Frequent Headaches			
Fainting or Dizziness			
Epilepsy or Convulsions			
Nervous Breakdown			
Difficult Hearing			
Need Hearing Aid			
Use Hearing Aid			
Difficulty Seeing			
Need Corrective Lenses			
Use Corrective Lenses			
Hernia			
Diabetes			
Varicose Veins			
Do you have any physical limitations?			
Do you take any prescription medications?			
Have you ever been treated for a drug or alcohol habit?			
Have you ever been treated for any back disorder?			
Are you under a physician's care?			

Are you in <b>good health</b> to the best of your knowledge?			
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Name of Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

I hereby authorize the following requested information to be released to the agency.

Applicant Signature \_\_\_\_\_ Date: \_\_\_\_\_



### HEPATITIS B VACCINATION

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 already been vaccinated against the Hepatitis B virus.

\_\_\_\_\_ I was vaccinated at \_\_\_\_\_ Date \_\_\_\_\_  
(TEST RESULTS WILL NEED TO BE SUBMITTED)

\_\_\_\_\_ I do not wish to be vaccinated.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### CHICKEN POX

1. Have you ever had Chicken Pox? [ ] Yes [ ] No

If yes, how old were you? \_\_\_\_\_ Years Old

What were your symptoms? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. For those with unknown history of chicken pox, a varicella titer is necessary. Persons with negative titers will be restricted from care of patients from day 10 through day 21 after exposure.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**HEALTH ASSESSMENT**

**Name of Applicant:** \_\_\_\_\_

*THIS SECTION TO BE COMPLETED AND SIGNED BY A PHYSICIAN*

	Positive	Negative	Clinical Results	Date
PPD and/or CXR				
Hepatitis B Core Antibody Titer (pre)				
Hepatitis B Surface Antibody Titer (post)				
Rubella Titer				
Measles Titer				
Mumps Titer				
Varicella Titer				
CBC				
Urinalysis				
Other				

Blood Pressure	Temperature	Pulse	Respiration	Height	Weight
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**REVIEW OF SYSTEMS**

Head / Neck	
EENT	
Respiratory	
Cardiovascular	
Abdomen / GI	
Musculoskeletal	
Neurological	
Endocrine	
Integumentary	
Other	

Physician's initial \_\_\_\_\_



**HEALTH ASSESSMENT (Continued)**

**Name of Applicant:** \_\_\_\_\_

I have interviewed the above named individual concerning the times addressed above and have responded according to the information provided.

I have documented any significant findings on the Systems Review.

I have examined the above named individual and verify that (s)he is free from signs or symptoms of infectious disease. This person is physically and mentally free from health conditions which would interfere with the individual's ability to perform assigned duties.

\_\_\_\_ There are no limitations that would keep this individual from performing his/her job responsibilities.

\_\_\_\_ Limitations:

\_\_\_\_\_

Physician Name: \_\_\_\_\_ License # \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date of Exam: \_\_\_\_\_



## **PATIENT BILL OF RIGHTS**

As a health care provider, personnel serve as an advocate for the patient. All personnel will adhere to the Patient Bill of Rights:

- The patient/patient's representative has a right to all information contained in the patient's medical record at the hospital and a right to examine the record upon request.
- The patient has the right to be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and care of personal needs.
- The patient has the right to be informed by the hospital of the address and telephone number of the complaint receiving unit of the State Department of Health and the right to file a complaint/grievance against any service or personnel with the agency, hospital or State Consumer Affairs without reprisal or disruption of services.
- The patient has the right to receive information from the staff to help the patient/family make informed decisions. The patient/family will be instructed in the patient's care and illness to aid the patient in becoming as independent as possible.
- The patient has the right to be assured that the personnel providing care are qualified through education, experience and licensing/certification to provide such services including the right to know the identity, professional status and role of hospital personnel.
- The patient has the right to prompt attention, especially in a medical emergency situation.
- The patient has the right to know what conduct and/or responsibilities are expected of them.
- The patient has the right to the same quality treatment given all patients and reasonable continuity of care regardless of race, color, national origin, sex, age, creed, and mental or physical handicap.
- The patient has the right to be fully informed prior to or at the time of admission of services available in the hospital and of related charges, including non-coverage or termination of his/her eligibility, examine an itemized and detailed bill for services rendered.
- The patient has the right to be fully informed by the physician of his/her medical condition, unless contraindicated, or any procedure (informed consent) and to be allowed the opportunity to participate in the planning of his/her medical treatment including the right to refuse to participate in experimental research.
- The patient has the right to informed participation in establishing their treatment plan and the right to refuse any personnel or discontinue services at any time with or without physician approval.
- The patient has the right to be assured of confidential treatment of personal information and medical records including the right to approve or refuse their release to any individual outside the hospital except in the case of transfer to another facility or as required by law or third party payment contract. The patient/responsible party will sign a release of information form if a record is needed. Case discussion will be limited to persons involved in care and treatment except as otherwise dictated by law or third party payment contract.

Personnel are expected to report the following events to a supervisor:

- Any action, order or treatment which in the professional judgment of the individual appears to be potentially harmful to the patient.
- Patient complaints regarding their care.

Applicant Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## **CONFIDENTIALITY OF PATIENT INFORMATION**

Nurses Internet Staffing Services, Inc. acknowledges both a legal and ethical responsibility to protect the privacy of patients and employees. Consequently, the indiscriminate or unauthorized review, use, or disclosure of personal information, medical or otherwise, regarding any patient or employee is expressly prohibited.

Except when required in the regular course of business, the discussion, use, transmission, or narration in any form of any patient information which was obtained in the regular course of your employment is STRICTLY forbidden.

Those individuals who also have access to employee information are expected respect and treat the confidentiality of such information in the same manner as that of patient information.

Any violation of this policy shall constitute grounds for severe disciplinary action including possible termination of the offending employee.

*I have read and understand the significance of this policy.*

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## EMPLOYMENT AGREEMENT

**Nurses Internet Staffing Services, Inc.** is a temporary staffing agency. The number of hours worked by our employees is based on a combination of the needs at our client hospitals and the availability/flexibility of our nursing staff who has the matching qualifications required by our client hospitals. **Nurses Internet Staffing Services, Inc.** cannot guarantee you any number of hours in any given week. Even if you have worked a full week, you must not expect the same in the following weeks or months.

This employment agreement is non-exclusive. You are free to seek employment at other temporary staffing agencies as well as at other medical facilities while working as a temporary employee of **Nurses Internet Staffing Services, Inc.** Although we will do everything possible to meet your scheduling needs, we are not responsible for your transportation problems. If you do not have a car, we cannot guarantee work close to your home, nor within walking distance, or near a bus line.

Any controversy or claim arising out of or related to this agreement or the breach of it shall be settled by arbitration in accordance with applicable laws.

As a registry nurse you are expected to be flexible and to float from one unit to another. You must accept transfer of assignment only when you have the capacity and experience. If in case you don't, explain clearly the reason of your refusal. Make sure that you put patient safety and quality of care above else.

***My signature certifies that I have read and understand the above statement. It is also an indication that all information contained within my application is correct and may be verified by Nurses Internet Staffing Services, Inc. in compliance with the California Labor Law.***

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## FLOAT POLICY

Nurses assigned to work in the hospital may be subject to reassignment (floating) to the unit other than initial assignment. Such reassignment may be to any duty that is reasonably consistent with the Nurse's professional qualifications and experience. However, if the nurse will be reassigned in the area in which they do not feel competent, the nurse should inform the registry.

As stated in the hospital contracts, in the event that the Nurse refused to accept the transfer, the hospital may dismiss the Nurse during the shift and at the sole discretion of the hospital may instruct the Nurse not to return to the hospital for future scheduled shifts. The nurse will be compensated to the number of hours actually worked.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## CAPPING

Many employees have frequent contact with various organizations, union groups, welfare agencies, insurance representatives and others. Knowing of these outside agencies and how they can serve patients is important information for many employees involved with direct patient contact.

From time to time a patient may require the need for outside legal services and ask an employee for the name of an attorney or law firm. Under no circumstances may any employee refer any patient to a specific attorney or law firm for legal assistance. The County Bar Association has a lawyer's referral service to handle requests of this nature.

Capping is the practice of soliciting business for lawyers. It is a criminal offense and both the capper and the attorney are subject to prosecution for capping (a misdemeanor) and conspiracy (a felony). Action 6152 of the Business and Professions code is reproduced for our information.

### **6152 Prohibition of Solicitation**

"It is unlawful for any person, in his individual capacity or in his capacity as a public or private employee, or for any firm, corporation, partnership, or association to act as a runner or capper for any such attorneys in and about the state prisons, county jails, city prisons, or other places of detention of persons, city receiving hospitals, city and county receiving hospitals, county hospitals, justice courts, municipal courts, superior courts, or in any public institution or in any public place or upon any public street or highway or in and about private hospital, sanitariums or in and about any private institution or upon private property of any character whatsoever."

Severe disciplinary action up to and including termination will be taken against any employee who refers a patient to a specific attorney or law firm.

Applicant Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**AUTHORIZATION TO BACKGROUND CHECK**

I certify that answers given herein are true and complete to the best of my knowledge. I authorize investigations of all statements contained in this Application for Employment. I understand that this Application for Employment is not intended to be a Contract of Employment. In the event of employment, I understand that false or misleading information given in my interview may result in discharge. I understand that I am required to abide by all rules and regulations of the Nurses Internet Staffing Services, Inc. I authorize Nurses Internet Staffing Services to check the references and to verify criminal background check.

Information on my background check results will be kept separate from other employee information and will be maintained confidentially. Access to this information will be limited to my employer and its client hospitals. I hereby authorize my employer and its client hospitals to have access on my background check results.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**INFORMATION RELEASE FORM**

Access to my medical, health and all information on this application package will be limited to my employer and all its client hospitals.

I hereby authorize my employer and its client hospitals to have access to these files.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**EMPLOYEE'S CONSENT FOR DRUG SCREENING**

I hereby understand that it is a policy of Nurses Internet Staffing Services, Inc. for its employees to perform drug-screening test; therefore, I consent to the collection of a urine/blood sample and its forensic analysis for drugs of abuse. I further authorize the laboratory to release the results of this test to my employer, prospective employer, my employer's authorized personnel or medical review officer.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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## REFERENCE CHECK

Name of Applicant: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Address: \_\_\_\_\_

Hospital: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Contact: \_\_\_\_\_ Date Employed: From \_\_\_\_\_ To \_\_\_\_\_

Position Held: \_\_\_\_\_ Reason For Leaving: \_\_\_\_\_

### Employee Authorization

I, \_\_\_\_\_, the undersigned, have applied for employment with Nurses Internet Staffing Services, Inc. and I authorize them to collect any information concerning my qualifications and past performance. Further, I hereby release the company or person completing this form from any and all liability in providing the requested information.

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

### TO BE COMPLETED BY THE EMPLOYER

Would You Rehire?     Yes     No                      If no, why not? \_\_\_\_\_

PLEASE CHECK THE APPROPRIATE RATING:

PERFORMANCE	Above Average	Average	Below Average
QUALITY OF WORK			
DEPENDABILITY			
COOPERATION			

Additional Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

_____	_____	_____	_____
<b>Print Name</b>	<b>Signature</b>	<b>Date</b>	<b>Position</b>



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Address: \_\_\_\_\_

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Position Held: \_\_\_\_\_ Reason For Leaving: \_\_\_\_\_

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Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

**TO BE COMPLETED BY THE EMPLOYER**

Would You Rehire?     Yes     No                      If no, why not? \_\_\_\_\_

PLEASE CHECK THE APPROPRIATE RATING:

PERFORMANCE	Above Average	Average	Below Average
QUALITY OF WORK			
DEPENDABILITY			
COOPERATION			

Additional Comments:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

_____	_____	_____	_____
<b>Print Name</b>	<b>Signature</b>	<b>Date</b>	<b>Position</b>