



Dear Allied Healthcare Professional,

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

Whether you are a Technician, Therapist, CNA or other medically skilled professional, we welcome you to the HealthSource team.

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

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

Thank you for choosing to travel with HealthSource!

Sincerely,

HEALTHSOURCE GLOBAL STAFFING

What to Bring To Your Assignment

- **Complete File**

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

- **Cash and/or Credit Cards**

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

- **Working Uniform or Scrubs**

Hospitals do not provide working uniforms or scrubs for most specialties. Please bring the appropriate attire for your nursing specialty or medical profession.

Healthsource Global Staffing Standard File Requirements

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

Your complete file should include the following documents:

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

- Negative PPD within 1 year—Date Read ___/___/___

Or if positive PPD:

- Chest x-Ray within 2 Years—Date Given ___/___/___

And:

- Annual TB Questionnaire—Date Completed ___/___/___

IMMUNIZATION STATUS

- Hep B Vaccination Declination

Or:

- Hep B Titer Immune Non Immune

Or:

- Hep B Series 1) ___/___/___ 2) ___/___/___ 3) ___/___/___

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

- MMR Immunization(s)—Date ___/___/___ Date ___/___/___

OR

- Rubella Titer Immune Non Immune
- Rubeola Titer Immune Non Immune
- Mumps Titer Immune Non Immune

- Varivax Immunization—Date ___/___/___

OR

- Varicella Titer Immune Non Immune

PAYROLL DOCUMENTS

- Notarized I-9 form
- W-4 form

- Employment Application
- Professional Reference #1 (Current within 1 year)
- State License _____ Lic # _____ Expires ___/___/___
- Government Issued Photo ID—passport or driver's license
 - Hand-carry original and include a clear photocopy
- Social Security Card—for payroll purposes
 - Hand-carry original and include a clear photocopy
- Clinical Skills Checklist—Specialty _____
- Clinical Skills Checklist—Specialty _____

CERTIFICATIONS (clear photocopies of front and back)

- BLS Expires ___/___/___ (required for ALL units)
- ACLS Expires ___/___/___ (ER, ICU, & PACU)
- PALS Expires ___/___/___ (ER, PEDS, & PICU)
- Other: _____ Expires ___/___/___
- Other: _____ Expires ___/___/___
- Other: _____ Expires ___/___/___

SIGNATURE DOCUMENTS

- Employee Confidentiality Agreement
- Employee Awareness Statement for California Penal Codes
- Health Insurance Portability & Accountability Act (HIPAA)
- Blood Borne Pathogens In-Service
- OSHA Standards and Competency Assessment
- 2008 National Patient Safety Goals

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



Employment Application

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

Street _____ County _____
 (Current/Permanent Mailing Address)

City _____ Province/State _____ Zip Code _____

Email Address _____ Fax # _____

Social Security Number _____ Date of Birth _____

Emergency Contact Name _____ Phone # _____ Cell # _____

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

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

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

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

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

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

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

BLS _____ Expires _____ ACLS _____ Expires _____ PALS _____ Expires _____ NRP _____ Expires _____ FHM _____ Expires _____ TNCC _____ Expires _____ CHEMO _____ Expires _____

Other (s) _____

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

Employment History (DO NOT LIST AGENCY NAMES.) Please start with your current or most recent job.

We will use your current resume for all other job history information

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

Street address _____ City _____ State _____ Zip _____

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

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

Responsibilities _____

Immediate Supervisor _____ Phone _____



Hospital/Employer _____ Teaching Facility: Y / N Pay Rate: \$ _____/hr or yr
Street address _____ City _____ State _____ Zip _____
Dates of employed: From _____ To _____ Reason for leaving _____
Position held _____ Unit Specialty _____ Did you do charge? Y / N
Responsibilities _____
Immediate Supervisor _____ Phone _____

Hospital/Employer _____ Teaching Facility: Y / N Pay Rate: \$ _____/hr or yr
Street address _____ City _____ State _____ Zip _____
Dates of employed: From _____ To _____ Reason for leaving _____
Position held _____ Unit Specialty _____ Did you do charge? Y / N
Responsibilities _____
Immediate Supervisor _____ Phone _____

1. Yes No Is there any medical condition(s) which may limit your ability to perform any function required of a nurse?
2. Yes No Have you ever been convicted of a crime other than a minor traffic violation?
3. Yes No Has your professional license or certification ever been investigated or suspended?
If you answered Yes to any of the questions above, please explain below. Use additional paper if needed.

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

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

Print Name _____

Signature _____ **Date** _____



Employment Reference

Applicant name: _____ SS#: _____

Name of Hospital/Facility: _____

Address, City, State: _____

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

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

Applicant's Signature _____ Date _____

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

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

Specialty / Unit worked _____

Reason for Leaving: Terminated Lay-Off Resigned Temporary Employee

Would you hire this healthcare professional again? Yes No

Supervisor's Signature _____ Title _____ Date _____



Employment Reference

Applicant name: _____ SS#: _____

Name of Hospital/Facility: _____

Address, City, State: _____

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Professionalism			
Quality of work			
Cooperation			
Leadership ability			

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

Specialty / Unit worked _____

Reason for Leaving: Terminated Lay-Off Resigned Temporary Employee

Would you hire this healthcare professional again? Yes No

Supervisor's Signature _____ Title _____ Date _____

Evaluations for Age Specific Performance Expectations

	Almost Never	Sometime	Almost Always	N/A
Neonate / Infant				
Involves the parent/guardian in care/teaching				
Provides a pacifier/distraction prn (as directed)				
Keeps parents in infant's line of vision, within safety specifications				
Offers familiar objects to infant				
Cuddles and hugs infant				
Ensures infant warmth during care/procedures				
Preschooler				
Involves the patient and parent/guardian in care/teaching				
Explains procedures using child's terminology				
Uses praise as a reward for desired behavior				
Plans care/procedures in advance to decrease child's waiting time.				
Allows child to have some control by allowing choices				
Explains unfamiliar objects				
Involves child in care whenever possible				
School Age/Adolescent				
Involves the patient in care/teaching				
Encourage questions during procedures				
Is aware of importance of relationship with peers (may need friends to visit)				
Allows child to have some control/choices when possible				
Explains unfamiliar objects				
Always provides for privacy for adolescent patients				
Allows for personal hygiene needs				
Adult				
Involves the patient in care/teaching				
Involves the patient in planning and providing of care				
Allows patient to maintain control and involves in decision making whenever possible				
Encourages verbalization of fears				
Geriatric				
Involves the patient in care/teaching				
Involves the patient in planning and providing of care				
Allows patient to maintain control and decision making in care when possible				
Recognizes potential for loss of hearing and/or sight				
Slows pace of care to allow for slower mobility of elderly				
Adjusts for transportation and mobilization needs				
Monitors for breakdown of skin and need for increased protection				
Assists with meals as needed				

Print Name

Signature

Date



Employee Confidentiality Agreement

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

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

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

Print Name

Signature

Date



Employee Awareness Statement for California Penal Codes

California Law requires all hospital employees to sign statements acknowledging that they are aware of their responsibilities with regard to section 11166 of the California Penal Code and Section 15630 of the California Welfare and Institutions Code, and to comply with the state obligations.

Section 11166 (Child Abuse) of the Penal Code requires any child care custodian, medical practitioner or employee of a child protective agency who has knowledge of or observes a child in his/her professional capacity or within the scope of his/her employment who he/she knows or reasonably suspects has been the victim of child abuse to report the 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.

Section 15630 (Elder Abuse) of the Welfare and Institutions Code requires any elder of dependent adult care custodian, health practitioner, or employee of a county adult protective services agency or a local law enforcement agency who in his/her professional capacity or within the scope of his/her employment, either has observed and incident that reasonably appears to be physical abuse, has observed a physical injury where the nature of the injury, it's location on the body or the repetition of the injury, clearly indicates that physical abuse had occurred, or is told by an elder or dependent adult that he/she has experienced behavior constituting physical abuse, shall report the known or suspected instance of physical abuse either to the long-term care ombudsman coordinator or to a local law enforcement agency when the physical abuse is alleged to have occurred in a long-term care facility, or to their county adult protective services agency or to a local law enforcement agency when the physical abuse is alleged to have occurred anywhere else, immediately or as soon as possible, by telephone and to prepare and send a written report thereof within 36 hours.

Section 11160-1163 (Suspected Violent Injuries/Suspected Domestic Violence Injuries) of the Penal Code requires reporting of any cases of patients with physical injuries caused by violent behavior to include domestic violence. Any health practitioner employed in a health facility, clinic, or physicians office who is in his/her professional capacity or within the scope of his/her employment, provides medical services for physical condition to a patient whom he/she knows or reasonably suspects is a person described as follows, shall immediately make a report of:

1. Any person suffering from any wound or other injury inflicted by his/her own act or inflicted by another where the injury is by means of a firearm.
2. Any person suffering from any wound or other physical injury inflicted upon the person where the injury is the result of assaultive or abusive conduct

This report shall be made to a local law enforcement agency as follow:

1. A report by telephone shall be made immediately or as soon as practically possible.
2. A written report shall be prepared and sent to a local law enforcement agency within two working days of receiving the information regarding the person.

I certify that I have read and understand this statement and will comply with my obligation under these laws. Furthermore, I understand that I may be fully prosecuted by the State under these Penal Codes for failure to comply with the law.

Print Name

Signature Date

HealthSource Representative Date



Health Insurance Portability and Accountability Act (HIPAA)

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

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

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

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

Print Name

Signature

Date



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

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

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

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

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

Print Name

Signature

Date

HealthSource Representative

Date



Hepatitis B Vaccination Declination

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

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

I understand that I will be provided appropriate training at my assigned workplace and will adhere to the policies and procedures of the facility to which I am assigned. I understand that due to my occupational exposure to blood and/or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no cost to me, while on active assignment with HealthSource Global Staffing.

DECLINATION

I decline the Hepatitis B vaccine series. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other infectious material and want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to myself, while on assignment with HealthSource Global Staffing. I accept the responsibility to inform HealthSource Global Staffing of this decision at that time.

Date _____ Signature _____

COMPLETED SERIES

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

Date _____ Signature _____

VACCINATIONS IN PROCESS

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

Date _____ Signature _____

Annual TB Questionnaire

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

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

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

Tuberculosis Health Check Survey

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

- | | |
|--------------------------------|--|
| Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Streaked Sputum (phlegm) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Loss of Weight (unplanned) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Night Sweats | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia (loss of appetite) | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

Print Name

Signature

Date

Competency Test

The following questionnaire is generic in nature and is in addition to any specific orientation you will receive from any of the organizations for which you will be assigned. Individual organizational goals, policies or procedures will supersede this questionnaire and any generic information you receive regarding the covered topics. This is a requirement of Health Source Global and must be completed and returned to your file. Passing score is 80 percent.

1. Which of the following is the appropriate behavior to assure password security and confidentiality of information?
 - a. You may use your co-workers password to access the computer system
 - b. To quickly enter the system, all staff can use a generic password posted near the computer
 - c. You should exit out of the system before leaving the workstation.
 - d. You may look up your own and your family's medical information on the computer system.

2. Measures to help calm a potentially violent person include the following except.
 - a. Give full attention to the person.
 - b. Position yourself for a safe exit.
 - c. Keep very close to the person.
 - d. Speak in a calm voice and be aware of your body language.

3. When a disaster response is required, staff should.
 - a. Report to the parking garage.
 - b. Remove their ID's
 - c. Follow their department specific disaster response plan.
 - d. Use the telephones and elevators for non-emergency needs.

4. Which of the following is an example of an electrical hazard in the workplace?
 - a. Pulling on electrical cords to unplug the equipment.
 - b. A frayed cord with exposed wires.
 - c. The combination of a metal bed frame, wet bedding and faulty wiring.
 - d. A and B only.
 - e. All of the above

5. You need to plug in a piece of office equipment. What color receptacle/s should you use?
 - a. Red
 - b. White
 - c. Orange
 - d. Gray/Brown
 - e. The closest outlet – color doesn't matter.

6. Be sure that the medical equipment that you use:
 - a. Has a current inspection sticker placed by Clinical Engineering.
 - b. Is in proper working condition.
 - c. Is taken out of service if not working properly, labeled with the problem and send for repair.
 - d. You have been trained to use.
 - e. All of the above.

7. Medical equipment brought in by an inpatient should:
 - a. Be switched as soon as possible to hospital equipment that the staff is trained to use.
 - b. Be used throughout their hospital stay
 - c. Be stored in Human resources for safekeeping.
 - d. Be inspected by an outside vendor.

8. What should an employee who discovers a fire at work do second?
 - a. Rescue/remove anyone in immediate danger.
 - b. Alert others by activating the alarm.
 - c. Contain the fire.
 - d. Extinguish the fire.

9. What step is missing from the following procedure for the operation of a fire extinguisher?
Break the seal, Aim the hose at the base of the fire, squeeze the handle, Sweep.
 - a. Remove the cap
 - b. Insert the pin
 - c. Pull the pin
 - d. Shake the container

10. The following information can be found on the MSDS sheet.
 - a. How to clean up a chemical spill
 - b. First aid measures
 - c. Exposure controls and personal protection
 - d. All of the above

11. In most areas there is a process to keep regulated and non-regulated medical waste separated. How is this accomplished?
- Regulated medical waste is placed in clear bags and non-regulated medical waste is placed in red bags
 - Regulated medical waste is placed in red bags and non regulated medical waste is placed in clear bags
 - In some areas red bags are only kept in rooms where there is a large volume of bodily fluids or in general area such as a soiled utility room.
12. Products containing mercury should be:
- Placed in bags in the soiled utility room.
 - Tossed in the regular trash.
 - Placed in red bags with regulated medical waste.
 - Labeled and separated in your department for pick up.
13. A basic principle of Universal Precautions/Universal Body Substance Precautions is:
- To consider all body fluids potentially dangerous.
 - To wear gloves at all times.
 - To keep patient's room doors closed at all times.
 - To place all patients with infections in isolation.
14. The most important method to prevent the spread of infection is:
- Isolation procedures
 - Ultraviolet light
 - Adequate room ventilation
 - Hand washing
15. Unless no alternative is feasible, contaminated needles and sharps shall NOT be:
- Recapped or removed
 - Bent or broken
 - Sheared
 - All of the above
16. Given no feasible alternative, bending, recapping or needle removal must be accomplished through the use of a mechanical device or a one-handed technique.
17. Appropriate containers for contaminated, reusable sharps are:
- Puncture resistant
 - Labeled or color coded
 - Leak proof
 - All of the above

18. If you experience a needle stick or other exposure to blood or body fluids, which of the following should be done?
- Immediately cleanse the affected area.
 - Report the exposure to the hospital's employee health service and complete the appropriate form.
 - Notify your supervisor/manager.
 - Follow the procedure for blood/body fluid exposure
 - Notify Health Source Global of the incident
 - All of the above
19. Which hospital employees are required to protect the confidentiality of HIV/AIDS related information?
- Physicians, nurse, nurse practitioners, and physicians assistants
 - Billing department employees
 - Secretaries
 - Outreach workers
 - All of the above
20. What can you do to protect patient confidentiality?
- Talk about patients only to those who "need to know" in order to deliver effective care
 - Talk about patients only at home or with friends.
 - Leave the medical record available to the patient's family and friends.
 - Leave patient information on the computer screen.
21. Which of the following are patient rights?
- The right to know the name, function, and position of any hospital employee.
 - The right to receive emergency care if needed.
 - The right to receive considerate and respectful care in a clean and safe environment, free from unnecessary restraints.
 - The right to refuse treatment.
 - All of the above
22. Which statement is true regarding a health care proxy?
- It allows a person to appoint someone they trust to decide about medical care and treatment if they lose the ability to decide for themselves.
 - It allows another designated person to make medical decisions for you even at times when you are able to make your own decisions.
 - Once written, it cannot be revoked
 - It only lists the person's wishes for health care options when they lose the ability to make such decisions.

23. Which statement is true in most acute care organizations about DNR orders?
- They must be reviewed at certain periodic intervals.
 - The patient or health care proxy can revoke them at any time.
 - They are discussed in the organization's policy manual in detail.
 - All of the above
24. Each employee is responsible for:
- Complying with applicable laws, regulations and contractual agreements.
 - Reporting any acts of non-compliance
 - Ethical conduct
 - All of the above
25. Which of the following statements regarding the reporting of a child abuse incident is true?
- Report to Child Protective Services (or Agency) by telephone immediately
 - Submit a written report to same within 36 hours of incident
 - All of the above
26. Which of the following statements regarding the reporting of an elder abuse incident is true?
- For long term care facilities, report incident to LTC Ombudsman or local law enforcement agency immediately.
 - All elder abuse must be reported to a local law enforcement agency or to the county APS (Adult Protective Services) office
 - All of the above
27. Which of the following statements regarding the reporting of a domestic violence or violent injury is NOT true?
- Report incident immediately, or as soon as practically possible, by telephone to local law enforcement agency.
 - Within two working days, a written report must be submitted to local law enforcement agency.
 - Talk to your supervisor the next day.
28. What is considered professional misconduct?
- Having a valid license
 - Practicing while impaired by alcohol, drugs, physical or mental disability
 - Utilizing appropriate infection control techniques.
 - Only delegating activities within the scope of the unlicensed staff member's job description.
 - All of the above

29. If any employee does not wish to participate in the care or treatment of a patient based on ethical, religious or cultural beliefs, the employee:
- Needs to request to be excused from providing care or treatment
 - Should ensure that patient care is not compromised.
 - Follow the procedures of the institution regarding reporting of the situation.
 - All of the above
30. An adverse drug reaction is defined as a response to a medication that is undesired, unintended or unexpected in doses recognized in accepted medical practice that result in the following except:
- Shorter hospital stay
 - Change in drug therapy
 - Discontinuation of the drug
 - Emergency room visit
31. Providing an environment free of sexual harassment is the responsibility of:
- All staff
 - Faculty
 - Supervisors/administrators
 - All of the above
32. TRUE /FALSE Age specific guidelines means that patients are treated based upon their chronological age only.
33. TRUE /FALSE When caring for the geriatric patients, you should take into consideration that they may have short-term memory loss and loss of visual acuity.
34. TRUE /FALSE Tuberculosis is an airborne disease that must be inhaled and is not easily transmitted.
35. TRUE /FALSE When lifting heavy objects, you should bend at the waist and raise the object up as you are standing up. This places weight on the muscles that are strongest for lifting.
36. TRUE /FALSE Quality assurance and performance improvement are only the responsibilities of the regular hospital personnel and not that of the traveler or agency nurse.

I attest I am the person completing the Competency Test.

Signature

Date