BLOOD AND BODY FLUID PRECAUTIONS ACKNOWLEDGEMENT

In the interest of protecting all caregivers from potential exposure to infectious material, all employees providing patient care, - or those who have contact with blood, body fluids, or tissue – should adhere to the following guidelines. For the purpose of categorizing your risk, blood, body fluids and tissue on *all* patients will be considered infectious. The risk of exposure to blood or body fluids is broken down into three categories:

CATEGORY I:
Tasks involve probable exposure to infectious materials. For these tasks, protective equipment should be worn. The type of protective equipment is determined by the amount and type of exposure. For example: gloves should be worn for any procedure that involves contact to blood or body fluids, and the contact is limited to the hands. Mask and goggles should be worn if there is potential for spatter of acrosolization of blood or body fluids. A gown or apron should be worn if there is gross contamination.

CATEGORY II:
Tasks do not require contact with blood or body fluids but, in the course of the task, it may become necessary to move onto a Category I task. No protective equipment is necessary; however, it must be readily available in the event that a Category I task is called for.

CATEGORY III:
Tasks do not have any potential for exposure to blood and body fluids and do not require any protective equipment. Any waste, equipment, supplies or linen contaminated with blood or body fluids must also be considered infectious and handled accordingly.

EMPLOYMENT AGREEMENT

I have been advised of the Right to Know Law and have been instructed by my employer in the proper use and safest way to handle the chemical substances, which I use in my work. I understand it is my responsibility to take safety precautions when necessary.

Furthermore, I have received an in-service on Universal Blood and Body Fluid Precautions, from Continuum Nursing Services. I am capable of following said precautions as established by C. D. C.

I have also been informed of the H.R.S. Guidelines pertaining to blood and body fluids. I understand that I am:

CATEGORY I: □

CATEGORY II: □

CATEGORY III: □

______________________________________ ____________________
SIGNATURE OF EMPLOYEE DATE

______________________________________ ____________________
SIGNATURE OF NURSE MANAGER DATE

CONTINUUM PEDIATRIC NURSING SERVICES
EMPLOYMENT APPLICATION

We are an equal opportunity employer, dedicated to a policy of non-discrimination on any basis including, race, creed, color, age, sex, religion, or national origin.

Personal Information

Date: _______________

Full Legal Name: ____
(Last) (First) (Middle Initial)

Name you wish to be called: ____

Present Address: ____
____
(City) (State) (Zip Code)

Home Phone #: _____________________________ Mobile Phone #: ____________________________

Email Address: __________________________________ Best way to reach you: __________________

Referral Source: Newspaper/Internet: ___________ Individual _____________ Other________________
(Name) (Name) (Name)

Employment Desired

Position: Staff LPN Staff RN Other Date you can start: ______________

Full-time (32+ hours/week): ________________ Part-time ______________ PRN __________________

Geographical Preference: 1._________________ 2. ____________________ 3. ____________________

Areas of Clinical Nursing Experience: 1. ______________ 2. ________________ 3. ________________

Months/Years of Experience in Above Areas: 1. ____________ 2. _____________ 3. ________________

Have you had at least 1 year of experience which includes pediatric direct patient care within the last 3 years? YES NO

If yes, how much? ____

Shifts preference: Day Evening Night

Are you employed now? ____________ If so, may we inquire of your present employer? _____________

Have you ever applied to Continuum before? __________ If so, when? ___________________________

Professional License Number(s)/State/Expiration Date: ____

Have you ever been subjected to disciplinary action by the board of nursing? Circle one: **YES** **NO**

If yes, please explain:

____

____

____

____

Education

What **month** and **year** did you pass the nursing boards? ____

CPR Certified When _____________ Renewal Date __________________________________

Course Certifications i.e., ACLS, CCRN, etc.: ____

____

Name and Location of School **Last Year Completed** **Diplomas, Degrees Received**

____

Nursing School

____

College/Graduate School

____

Other

Employment Record List all employment beginning with your most recent employer.

1. Employer: ____

Address: ____

Phone Number: ______________________________ Fax Number: ________________________________

Description of Duties, Equipment Used, Etc: ____

____

Employed from: ______________ to ______________ Most Recent Salary ________________________

Supervisor Name/Title: ____

Reason for Leaving: ____

2. Employer: ____

Address: ____

Phone Number: ______________________________ Fax Number: ________________________________

Description of Duties, Equipment Used, Etc: ____

____

Employed from: ______________ to ______________ Most Recent Salary ________________________

Supervisor Name/Title: ____

Reason for Leaving: ____

3. Employer: ____

Address: ____

Phone Number: ______________________________ Fax Number: ________________________________

Description of Duties, Equipment Used, Etc: ____

____

Employed from: ______________ to ______________ Most Recent Salary ________________________

Supervisor Name/Title: ____

Reason for Leaving: ____

4. Employer: ____

Address____

Phone Number: ______________________________ Fax Number: ________________________________

Description of Duties, Equipment Used, Etc: ____

____

Employed from: ______________ to ______________ Most Recent Salary ________________________

Supervisor Name/Title: ____

Reason for Leaving: ____

Personal References Below, Give the names of two persons not related to you, whom you have known at least one year and who know your qualifications.

Name	Address	Occupation	Years Known	Phone #

1.____

____

2. ____

____

In case of emergency notify: ____

(Name) (Relationship)

____

(Address) (Phone Number)

I certify that all of the above information is correct and that any misrepresentation or falsification of fact made as a part of this application may be considered sufficient cause for immediate dismissal from *CONTINUUM PEDIATRIC NURSING SERVICES*.

Signature: ____ Date: __________________________

EMPLOYMENT BACKGROUND INVESTIGATION AUTHORIZATON

I. I understand that an investigative report may be generated on me that may include information as to my character, work habits, performance and experience, along with reasons for termination of past employment, criminal/sex offender history records from any criminal justice agency in any or all federal, state, city and county jurisdictions, state Department of Motor Vehicle/Drivers' License Records. I understand a criminal history check searching the records of the FBI requiring my fingerprints may also be requested. I fully understand that Continuum Pediatric Nursing , may be requesting information from public and private sources about any of the information noted earlier in this paragraph now and as deemed necessary, and I freely give my consent for Continuum Pediatric Nursing to do so.

II. I agree that a photocopy or telephonic facsimile of this authorization shall be valid as the original. This release is valid for most federal, state and county agencies.

III. I hereby authorize, without reservation, any one contacted by Continuum Pediatric Nursing, to furnish the information described in Section 1.

IV. I hereby authorize, without reservation, Continuum Pediatric Nursing to contact my present employer for employment verification/references.

APPLICANT: COMPLETE THE FOLLOWING:

________________________________ _____________________
Signature **Today's Date**

____
Please print full name

The following information is required by law enforcement agencies and other positive identification purposes when checking public records. It is confidential and will not be used for any other purposes.

________________________________ _________________________
Please print other names you have used **Social Security Number -** Your Social Security Number will only be used in order to confirm your identity for purposes of completing an accurate background investigation.

____
Date of Birth - The Age Discrimination in Employment Act of 1967 and the Arizona Civil Rights Act prohibit discrimination on the basis of age with respect to individuals who are at least 40 years of age. Your date of birth is required on this form in order to confirm your identity for purposes of completing an accurate background investigation, and is not provided to the hiring official for any purpose in connection with consideration of your application for employment.

________________________________ ____
Home Address **City** **State** **Zip**

________________________________ ____
Driver's License Number and State **Name as it appears on License**

Have you ever been convicted of, plead guilty, or "no contest" to a crime that has or has not been expunged or removed from your record? ❑ No ❑ Yes **If yes, please explain:** (Make sure to include the city/state/county and the year the crime occurred for each conviction.)

____

____

FAIR CREDIT REPORTING ACT, DRIVER'S PRIVACY PROTECTION ACT, and ANY APPLICABLE STATE STATUE (S) NOTICE: In accordance with the Fair Credit Reporting Act, this information may only be used to verify a statement(s) made by an individual in conjunction with legitimate business needs. The depth of information available varies from state to state. The report that will be generated for employment purposes only and in compliance with the Fair Credit Reporting Act, the Driver's Protection Act, and any applicable state statue(s)
10/17/17

Health Care Worker Influenza Vaccination Tracking Form

I understand that receiving the influenza vaccine will help protect the patients I care for from serious complications of influenza.

I have/will received this year's influenza vaccine: **YES** **NO** **Date received flu vaccine**: _______________

I will be vaccinated at this time: **YES** **NO** **N/A**

Please initial next to the reason(s) for declining vaccination acknowledging that you have reviewed and understood the educational materials provided.

Initial	Reason	Consideration
	I have a fear of needles.	The nasal spray – LAIV (live attenuated intranasal vaccine) or Flumist may be a good option if you are under the age of 50. Ask your health care provider for more information.
	I am concerned about the safety of the vaccine.	Influenza vaccine has undergone rigorous safety testing, has been determined safe by the FDA, and has a very long standing record. Serious adverse reactions are very rare.
	I am not in a high-risk group.	The CDC has made a universal recommendation for flu vaccine, including those individuals who are not at high risk for complications of influenza. Even healthy adults may become seriously ill with influenza. In addition, even if you aren't in high risk group most of your patients are at high-risk for complications of influenza and you could easily spread influenza to them if you are not vaccinated.
	I got sick the last time I got a flu shot and I am concerned that I will get the flu from the flu shot.	Some people do get mild-like symptoms for a short time after being vaccinated, but this is a sign that your body is responding to the vaccine and giving you protection. It is not the flu. Also, because cold viruses are constantly circulating, it is possible that a person could become ill with a cold at the same time they receive the flu vaccine.
	I never get sick.	Healthy adults may have mild symptoms when they get influenza. But it is possible to spread the influenza virus to patients even if you don't feel ill or only feel mildly ill.
	I am pregnant or breastfeeding.	Pregnancy increases the risk of serious medical complications of influenza. Pregnant women are among the CDC's top priority groups for influenza vaccination. Inactivated vaccines, like the flu shot, have not been known to pose a risk to the unborn fetus. Also, recent studies suggest that newborns benefit from the vaccination of their mother. Flu vaccine is safe and recommended for breastfeeding women as well. Breastfeeding women could easily spread influenza to their infant who is at high risk for complications of influenza.
	I have a religious or philosophical opposition to the vaccination.	We understand that some individuals oppose vaccination including influenza. Please understand that it is our mission to provide a safe environment – both for the patients and for employees. Influenza vaccination is a primary prevention activity that we use to accomplish this mission. Please be aware that employees that choose not to be vaccinated may be asked to stay home when they have influenza-like illness (ILI) symptoms. They also may have to wear PPE whenever caring for patients with ILI.
	I have another reason	Please explain:

Print name: ____ **Date:**________________

Signature:____

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 the hepatitis B virus (HBV) infection. I have been given the opportunity to be reimbursed the cost of a hepatitis B vaccine at a medical office of my choice. However, I decline to receive a hepatitis B vaccination at his time. I understand that by declining this vaccine, I continue to have occupational exposure to blood or other potentially infectious materials and that at any time during my employment with *Continuum Pediatric Nursing Services*, I can be reimbursed the cost to receive a hepatitis B vaccine.

____

Employee Signature   Date

CONSENT TO RECEIVE RECOMBINANT HEPATITIS B VACCINE

I have read and have been explained to my satisfaction the administration of Recombinant Hepatitis B Vaccine, including the risks and benefits and possible adverse reactions or complications associated with the vaccines. I hereby consent to receive a reimbursement of cost for a hepatitis B vaccine at a medical office of my choice. I understand that I must provide a receipt to receive the reimbursement.

I acknowledge and agree that if my employment is terminated for any reason prior to the completion of the three injection series of the vaccine, that I will be responsible for the cost. I acknowledge that no guarantee or assurance has been made to me concerning the vaccine. *Continuum Pediatric Nursing Services* specifically disclaims any warranty of merchantability or fitness for a particular purpose concerning the vaccine.

____

Employee Signature   Date

HEPATITIS B IMMUNIZATION PROGRAM EMPLOYEE INFORMATION

WHAT IS HEPATITIS B?

Hepatitis B is a systemic viral infectious disease affecting the liver. An estimated 300,000 persons in the United States are affected each year. Most of these individuals have no symptoms, but can continue to transmit infection to others as carriers. The incubation period for Hepatitis B is relatively long; six weeks to six months may elapse between exposure and the onset of symptoms. Transmission of the disease occurs primarily through contact with blood and body fluids. The average length of disability from acute infection is 7 weeks. Individuals who are frequently or intensely exposed to blood or body fluids are at substantial risk of acquiring Hepatitis B infection.

RISK OF ACQUIRING HEPATITIS B:

Health care personnel who are at risk of acquiring Hepatitis B virus infection are those individuals who have frequent contact with blood and body fluids. Frequent routes of exposure to blood and body fluids include accidental puncture wounds or cuts, and splashes to the eye or mouth.

ENGERIX – B:

Energix – B is a non-infectious Hepatitis virus vaccine that is derived from recombinant yeast cultures, and it is free of all human blood or blood products. Full immunization requires a three-stage process, consisting of an intramuscular dose of vaccine initially, then a second and third dose given one and six months later. All three injections are required for protection. The Vaccine may not confer immunity upon any individual who was exposed to Hepatitis B prior to the time of administered soon after an acute exposure to Hepatitis B. The duration of immunity from Energix – B vaccine is unknown at this time and a booster dose of the vaccine might be necessary at some time in the future. An employee should consult with his or her own physician regarding this issue and produce written permission for the vaccine to be given. The vaccine will be provided free of charge to the employee. Clinical studies have shown that 90-96 percent of vaccinated individuals show evidence of immunity. Testing for immunity one-month post vaccination will be performed upon request. If immunity has not developed, a booster will also be provided free of charge by the facility at which you work.

POSSIBLE SIDE EFFECTS:

The incidence of side effects is low, but includes soreness and redness at the injection site, low-grade fever, headache, nausea, fatigue, vertigo, rash and joint pain. As with any vaccine or medical treatment, more serious side effects including death are a possibility, but have not been reported and are not expected.

VACCINE CONTRA-INDICATIONS:

This vaccine should not be administered to:

1. Persons with bleeding disorders
2. Persons with severe heart or lung disease
3. Persons with active infection or febrile illness
4. Persons receiving immunosuppressive therapy
5. Pregnant or nursing women (unless approved in writing with personal physician)
6. Persons with hypersensitivity to yeast or any vaccine component.

____

Employee Signature Date

I, __________________________, hereby affirm that I am not bound or constrained by any prior contracts or agreements of any kind between myself and any former employer relating to my future employment that would limit my ability to work on any case for which I accept assignment by Continuum Pediatric Nursing or affiliated companies (Continuum), either as a nurse or in any other capacity.

I understand and acknowledge that if I am employed by Continuum, and the foregoing is found not to be true and accurate, that that is grounds for immediate termination of my employment with Continuum; and furthermore, that I will pay, on behalf of Continuum, all costs, including attorney's fees, incurred by Continuum as a result of said misrepresentation.

______________________________	______________________________
Printed Name of New Employee	Signature of New Employee

____
Date

______________________________	______________________________
Printed Name & Title of Witness	Signature of Witness

____
Date

Pre-Orientation Guidelines

Nurse Name: ____ Date: ___________________

Your Orientation Shift is a continuation of the interview process with Continuum Pediatric Nursing. Your employment is contingent on successful completion of all orientation activities including the in-home orientation for which you are scheduled. Your performance on this shift will be considered by the patient's family/caregivers as well as Continuum. The results will not only determine your suitability for the particular case you are orienting on, but will impact your eligibility to work on other cases with Continuum in the future. To help you achieve success in this important step in your career with Continuum, please review the following basic Orientation Shift guidelines:

GUIDELINE	INITIAL
1. **Arrive on-time or early for your shift!** Leave your home with plenty of extra time to account for possible traffic or road-work. If you are running late for any reason, or if you are lost, you MUST call our office IMMEDIATELY. If you call before our switchboard is open, follow the instructions to reach our on-call coordinator who will contact the family on your behalf or provide directions. Of course, please practice safe mobile phone use and pull over to make the call.	____________
2. **Dress Professionally.** We recommend scrubs for your orientation shift, during which you may ask the family's preferences if you are offered the position. Regardless, no jeans or sweats please – your appearance is an important first impression and an indication of your professionalism.	____________
3. **Communicate Professionally.** Your conversation should be professional and emphasize learning more about the patient and the home. DO NOT discuss other cases, other nurses, your pay-rate or personal matters. While you are in a home setting, you should conduct yourself as if you were working on a hospital unit or skilled nursing facility floor – particularly on an orientation shift.	____________
4. **No Cell Phone use.** While you may keep your cell phone with you in the event of an emergency *incoming* call, you may not text or make any outgoing calls during your orientation shift. While house-rules will guide cell phone use if you are offered the position, on an orientation shift there is to be absolutely no personal use of phones or other communication devices.	____________
5. **DO NOT FALL ASLEEP!** We shouldn't have to state this, but we understand that in shift-oriented careers the possibility of nodding-off is a (preventable) risk. Please get adequate sleep prior to your shift; remaining fully alert is the number one requirement of home care nursing. If you do sleep on your shift you will be subject to immediate termination. Needless to say, sleeping on an orientation shift will disqualify you for employment with Continuum.	____________

I Understand that I represent Continuum and my profession when working in a patient's home and my actions there will determine my current and future employment prospects. I agree to follow these basic Orientation Guidelines as part of my commitment to succeed in my career in homecare.

Nurse Signature: ____

RN/LPN SKILLS SELF ASSESSMENT

Key: Level of experience / Proficiency:

1	**Never preformed**
2	**Familiar with, but minimal; need review and practice**
3	**Proficient**
4	**Proficient and can act as a resource**
A/P	**Adult or Pediatric**

Vital Signs

Skill	A	P
Apical Pulse	A____	P____
Respiratory Rate	A____	P____
Axillary Temperature	A____	P____
Rectal Temperature	A____	P____

Tracheostomy Care

Skill	A	P
Skin Care	A____	P____
String Change	A____	P____
Velcro Tube Holders	A____	P____
Metal Tube Holders	A____	P____
Trach Change	A____	P____
Trach Cleaning	A____	P____
Humidivent/Passymuir Use	A____	P____

Gastrostomy Care

Skill	A	P
Skin Care	A____	P____
Use of Button	A____	P____
Replacing G-Tube	A____	P____
Flushing	A____	P____

Nasogastric Tube Care

Skill	A	P
Insertion	A____	P____
Measuring	A____	P____
Checking Placement	A____	P____
Taping	A____	P____

Central Venous Line

Skill	A	P
Dressing Change	A____	P____
Flushing	A____	P____
Drawing Blood	A____	P____
Troubleshooting	A____	P____

Colostomy Care

Skill	A	P
Stoma Care	A____	P____
Change Bag	A____	P____

Equipment

Equipment	A	P	Equipment	A	P
Apnea Monitor	A____	P____	Nebulizer	A____	P____
Pulse Oximeter	A____	P____	CADD Pump	A____	P____
Kangaroo Pump	A____	P____	Infusion Pump	A____	P____
Enterolite Pump	A____	P____	BIPAP/CPAP Machines	A____	P____
Suction Machine	A____	P____	Cystic Fibrosis Vest	A____	P____
O2 Tank/Concentrator	A____	P____	IPPB Machine	A____	P____
Ambu Bag	A____	P____	Ventilator	A____	P____
Coughilator	A____	P____			

Key: Level of experience / Proficiency:

1	**Never preformed**
2	**Familiar with, but minimal; need review and practice**
3	**Proficient**
4	**Proficient and can act as a resource**
A/P	**Adult or Pediatric**

Procedures

Chest PT	A____	P____
Postural Drainage	A____	P____
SQ/IM Injections	A____	P____
Foley Catheter Insertion	A____	P____
Starting IVs	A____	P____
Obtaining Venous Blood	A____	P____
Administration of Blood and Blood Products	A____	P____
Administration of IV Antibiotics	A____	P____
Administration of TPN	A____	P____

Care of Patients With:

Cerebral Palsy	Yes____	No____
Cardiac Surgery	Yes____	No____
CHF	Yes____	No____
Cancer	Yes____	No____
Casts	Yes____	No____
Diabetes	Yes____	No____
Failure to Thrive	Yes____	No____
Jaundice	Yes____	No____
Muscular Dystrophy	Yes____	No____
Prematurity	Yes____	No____
BPD	Yes____	No____
RSV	Yes____	No____
Seizures	Yes____	No____
Tracheomalacia	Yes____	No____
Feeing Intolerance	Yes____	No____
Hypotonia	Yes____	No____
Visual/Hearing Impairment	Yes____	No____

____

Print Name Date