



ANS PRE EMPLOYMENT CHECK LIST

Name: _____ Specialties _____ Availability Date _____

PROFESSIONAL
 California Nursing License (bi-annual)
 License Verification (annual)
 Skill Check List (annual)
 Job Description

CERTIFICATION
 BLS/CPR (Front and Back)
 ACLS (Front and Back)
 PALS (Front and Back)
 NRP (Front and Back)
 AFHM (Front and Back)
 MAB (Front and Back)
 FIRE CARD

EMPLOYMENT
 Complete Application
 Professional References (2)
 Verification of Education
 Employment Verification

Social Security Card
 I-9
 W-4
 Valid Picture ID
 Resume

HEALTH RECORDS
 Pre- Employment Health Questionnaire (annual)
 Physical Statement (annual)
 PPD/ X-Ray (annual)
 Schedule II TB Questionnaire Date: (annual)
 Rubella Titer (MMR)
 Rubeola Titer (MMR)
 Varicella Titer Date
 Hep B Declination/Immunization
 Fit Test
 Ishihara Color Blindness Test

TESTING
 Competencies
 Online Testing @ NurseTesting.com

HOSPITAL ORIENTATION REQUIREMENTS

AAS" Packet
 Kaiser Packet
 Methodist Packet
 Arrowhead Packet
 Henry Mayo Orientation Sign-Off

USC packet
 Glendale Adventist Packet
 Tarzana Ethics & Compliance
 Corona Packet

F: (888) 231-1144 P: (818) 990-3133 E:staffing@allstatenuring.com





ALLSTATE NURSING SERVICES, INC.
APPLICATION FOR EMPLOYMENT

RN

- Per Diem
Traveling Nurses

Date:
Classification:
Preferred Shift (circle one): AM or PM
Preferred Specialty Area: 1st Choice 2nd Choice 3rd Choice

Date of Birth:
Hire Date:

General Profile

Name: (Last) (First) (Middle)

Address: City: State Zip

Home Tel: Cell E-mail

If hired by ANS, can you show proof that you are either a United States Citizen or have other Authorization for employment by the Immigration and Naturalization Service? YES NO

Have you ever been convicted of a crime? YES NO
If YES, please attach a sheet with explanation. A record of convictions does not disqualify you for employment consideration.

Has your nursing license ever been suspended? YES NO
If YES, please attach sheet with explanation. A record of suspended license does not disqualify you for employment consideration.

Do you have a physical, medical or psychological limitation that would make you unable to perform any of the duties of the positions (s) applied for or which may cause you to endanger the health or safety of yourself or others? YES NO
If YES, please attach sheet with explanation.

Have you ever been injured on the job? YES NO
If YES, please attach sheet with explanation. A record of injury on the job does not disqualify you for employment consideration.

Please list all current certificates/Licenses:

Table with 4 columns: State Issue, Name of License, License /Certificate #, Exp. Date



EDUCATIONAL PROFILE

	Name and Location	Years Attended	Degree (s) Obtained	Year Graduated
High School				
College				
Nursing School				
Other				

CREDENTIALS YOU CURRENTLY HOLD

- BLS
 ACLS
 NRP
 PALS
 CHEM
 OCN
 CEN
 CRRN
 MAB
 CRITICAL CARE COURSE
 FIRE CARD
 TNCC

ADDITIONAL SPECIALTY COURSES TAKEN

STATES THAT YOU HAVE RESIDED

EMERGENCY INFORMATION

Emergency Contact: _____ Relationship: _____

Home Tel: _____ Cell Number _____

Address: _____ City: _____ State _____ Zip _____

How did you hear about Allstate Nursing Services Inc?



EMPLOYMENT PROFILE

Please enter employment history for the past 7 YEARS starting with your most recent job. If agency, enter facilities' name below agency's name.

Agency/Hospital _____

Immediate Supervisor _____ Number of Beds _____
Address _____ Phone _____
City/State/Zip _____ Date Employed From: _____ To _____
Position Held: _____ Charge Experience? _____
Specialty _____ Reason for leaving: _____

Agency/Hospital _____

Immediate Supervisor _____ Number of Beds _____
Address _____ Phone _____
City/State/Zip _____ Date Employed From: _____ To _____
Position Held: _____ Charge Experience? _____
Specialty _____ Reason for leaving: _____

Agency/Hospital _____

Immediate Supervisor _____ Number of Beds _____
Address _____ Phone _____
City/State/Zip _____ Date Employed From: _____ To _____
Position Held: _____ Charge Experience? _____
Specialty _____ Reason for leaving: _____

Agency/Hospital _____

Immediate Supervisor _____ Number of Beds _____
Address _____ Phone _____
City/State/Zip _____ Date Employed From: _____ To _____
Position Held: _____ Charge Experience? _____
Specialty _____ Reason for leaving: _____



VERIFICATION OF EMPLOYMENT

Company: _____

Address: _____

Telephone: _____

Contact Person: _____

One of your former employees has applied for employment with ALLSTATE NURSING SERVICES, INC. She/he has authorized the collection of any information concerning past performance. We would appreciate your prompt reply.

Enclose additional information if you wish. All information is CONFIDENTIAL and thanks you for your assistance.

Applicant's Name: _____

Name used while employed: _____

Date of Employment – From: _____ To: _____

I hereby authorize the release of any information requested on this form:

Applicant's Signature: _____ Date: _____

EMPLOYMENT VERIFICATION

- Is the above information correct? YES NO If not, please explain

- Type: Full Time Part Time Contract
Condition of Release: Still Employed Resignation Retirement Discharged Lay-Off
Reason for leaving: _____
Did employee give proper notice? YES NO
Would you rehire? YES NO If not, please explain

Verbal Verification (previous Empl. Rep) _____

Written Verification by _____ Name Title

Agency Representative _____ Name Title Date



VERIFICATION OF EMPLOYMENT

Company: _____

Address: _____

Telephone: _____

Contact Person: _____

One of your former employees has applied for employment with ALLSTATE NURSING SERVICES, INC. She/he has authorized the collection of any information concerning past performance. We would appreciate your prompt reply.

Enclose additional information if you wish. All information is CONFIDENTIAL and thanks you for your assistance.

Applicant's Name: _____

Name used while employed: _____

Date of Employment – From: _____ To: _____

I hereby authorize the release of any information requested on this form:

Applicant's Signature: _____ Date: _____

EMPLOYMENT VERIFICATION

- Is the above information correct? YES [] NO [] If not, please explain

- Type: Full Time [] Part Time [] Contract []
Condition of Release: Still Employed [] Resignation [] Retirement [] Discharged [] Lay-Off []

Reason for leaving: _____

- Did employee give proper notice? YES [] NO []
Would you rehire? YES [] NO [] If not, please explain

Verbal Verification (previous Empl. Rep) _____

Written Verification by _____ Name Title

Agency Representative _____ Name Title Date



VERIFICATION OF EDUCATION

SCHOOL NAME: _____

ADDRESS: _____

PHONE: _____

The applicant below has applied for employment with ALLSTATE NURSING SERVICES, INC, he/she has authorized the collection of any information concerning past education. We would appreciate your prompt reply. Please include any pertinent information, all information is confidential and THANK YOU for your assistance.

Applicant's Name: _____

Date of Birth: _____ Last 4 Digits of SS# _____

Name used while at School: _____

Graduation Date: _____

I hereby authorize the release of any information requested on this form:

Applicant's Signature: _____ Date: _____

FOR VERIFICATION ONLY

• Is the above information correct: YES NO

• Type of Degree obtained _____

Verbal Verification (School Representative) _____

Name

Title

Agency Representative _____ Date _____



PROFESSIONAL REFERENCE CHECK

APPLICANT INFORMATION:

Applicant's Name: _____ Position Held: _____

Charge Experience: Yes No Travel assignment: Yes No Unit/Dep: _____

Facility: _____

Address _____ City _____ State _____ Zip Code _____

Telephone Number: _____ Fax Number: _____

Contact Person* _____ Title _____ Unit Worked _____

**(A manager/supervisor who worked in the same unit for which you are applying)*

EVALUATION:

Employment Dates: From _____ To _____

Eligible for Re-hire:

Category	Meet Standards	Does not Meet Standards	Category	Meet Standards	Does not Meet Standards
Clinical Performance	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/> ¹⁹ 20
Cooperation	<input type="checkbox"/>	<input type="checkbox"/>	Appearance	<input type="checkbox"/>	<input type="checkbox"/> 21
Initiative	<input type="checkbox"/>	<input type="checkbox"/>	Emergency Protocols	<input type="checkbox"/>	<input type="checkbox"/> 22
Attendance	<input type="checkbox"/>	<input type="checkbox"/>	Accurate Documentation	<input type="checkbox"/>	<input type="checkbox"/> 23
Communication Skills	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> 24
					<input type="checkbox"/> 25
					<input type="checkbox"/> 26

COMMENTS: _____

ATTESTATION FOR VERBAL VERIFICATION:

I, _____ employee of Allstate Nursing Services, Inc. attest that I have personally called the professional reference of the Nurse mentioned above.

Evaluator: _____ Title: _____ Date: _____

Applicant Name/Signature: _____ / _____ Date: _____



PROFESSIONAL REFERENCE CHECK

APPLICANT INFORMATION:

Applicant's Name: _____ Position Held: _____

Charge Experience: Yes No Travel assignment: Yes No Unit/Dep: _____

Facility: _____

Address _____ City _____ State _____ Zip Code _____

Telephone Number: _____ Fax Number: _____

Contact Person* _____ Title _____ Unit Worked _____

**(A manager/supervisor who worked in the same unit for which you are applying)*

EVALUATION:

Employment Dates: From _____ To _____

Eligible for Re-hire:

Category	Meet Standards	Does not Meet Standards	Category	Meet Standards	Does not Meet Standards
Clinical Performance	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/> ¹⁹ 20
Cooperation	<input type="checkbox"/>	<input type="checkbox"/>	Appearance	<input type="checkbox"/>	<input type="checkbox"/> 21
Initiative	<input type="checkbox"/>	<input type="checkbox"/>	Emergency Protocols	<input type="checkbox"/>	<input type="checkbox"/> 22
Attendance	<input type="checkbox"/>	<input type="checkbox"/>	Accurate Documentation	<input type="checkbox"/>	<input type="checkbox"/> 23
Communication Skills	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/> 24
					<input type="checkbox"/> 25
					<input type="checkbox"/> 26

COMMENTS: _____

ATTESTATION FOR VERBAL VERIFICATION:

I, _____ employee of Allstate Nursing Services, Inc. attest that I have personally called the professional reference of the Nurse mentioned above.

Evaluator: _____ Title: _____ Date: _____

Applicant Name/Signature: _____ / _____ Date: _____



PRE-EMPLOYMENT HEALTH QUESTIONNAIRE

Name:	(Last)	(First)	(Circle Applicable)	
			MARITAL STATUS: S M WD SEP	DOB: DATE:
Address:		City:	State:	Zip:
Occupation:	Employer:	Employer's Phone #		
Home Tel:	Work:			
Spouse Name:				
Emergency Contact (other than Spouse):				Phone:
Social Security #:	Driver's License#			Phone:

FAMILY HISTORY (If any blood relative has suffered any of the following - Please check the number and indicate which relative)

1. Epilepsy	6. Thyroid	11. Cancer	_____
2. Migraine	7. Asthma	12. Heart Disease	_____
3. Mental Illness	8. Hypertension	13. Alcoholism	_____
4. Glaucoma	9. Stroke	14. Hay Fever	_____
5. Diabetes	10. High Cholesterol	15. Osteoporosis	_____

Hospital Admission (not including Pregnancy)	Year	ILLNESS OR OPERATION	Year	ILLNESS OR OPERATION

LIST OF MEDICATIONS YOU ARE NOW TAKING (PRESCRIBED / OVER THE COUNTER MEDICATIONS)	ALLERGIES	VACCINE YEAR OF LAST	TEST / EXAM YEAR OF LAST

MEDICAL HISTORY, Please Mark Current with an X. CHECK AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS / DISEASE

Decreased Hearing	Varicose veins / Phlebitis	Urethral discharge	Depression
Ringing in ears	Loss of appetite – recent	Chronic fatigue	Nervousness
Ear infections	Difficulty swallowing	Weight loss	Moodiness
Dizziness	Heartburn	Weight loss – recent	Phobias
Fainting Spell	Peptic Ulcer	Weight gain	Feeling of worthlessness
Double or blurred vision	Persistent nausea/vomiting	Weight gain – recent	Memory loss
Nose Bleeds-recurrent	Abdominal Pain - Chronic	Cancer	Mental Illness
Sinusitis recurrent	Gall bladder illness	Diabetes	Suicidal thoughts
Pharyngitis-recurrent	Diarrhea	Thyroid disease	Rheumatic fever
Hoarseness-prolonged	Constipation	Seizure disorder	Scarlet fever
Hay fever / Allergies	Crohn's disease	Stroke	Chicken Pox / Measles/ Polio
Pneumonia / Pleurisy	Bloody / tarry stools	Tremor/ hands shaking	Measles
Bronchitis / chronic cough	Hemorrhoids	Numbness / tingling sensation	German measles
Asthma / Wheezing	Diverticulosis	Headaches – frequent	Rubella
Shortness of breath	Hernia	Arthritis / Rheumatism	Polio
Chest Pain	Recurrent urine infections	Anemia	Herpes
Ankle Injury	Back Injury	Difficulty concentrating	Bruise easily
High Blood pressure	Blood in urine	Bone fracture / joint injury	Smoking
Heart Murmur	Kidney stones	Gout / osteoporosis	Alcoholism
Hepatitis B	Painful urination	Foot pain / numb feet	Other:
Hepatitis C	Urination > 2x / Night	Rashes	FEMALES ONLY (circle + or -)
Irregular pulse	Loss of urinary control	Hives	Last PAP test pos neg
Palpitations	Decrease in urinary flow	Psoriasis	Last Mammogram pos neg
Swollen ankles	Decrease in urinary force	Sleepiness	Birth Control Yes No
Leg pains	Venereal diseases	Filed for disability	LMP / /
			Dysmenorhea Yes No

PRINT NAME	SIGNATURE	DATE
------------	-----------	------



STATEMENT OF HEALTH CERTIFICATE

NAME: _____ SEX _____ DOB: ____ / ____ / ____

ADDRESS: _____ CITY: _____ STATE ____ ZIP _____

The above named patient has been examined by me and found to be in good physical and mental health, free from any Back/Neck problems, free from communicable disease and able to function without physical limitations as a Healthcare Professional (Nurse).

PHYSICIAN'S NAME	PHYSICIAN'S SIGNATURE	PHYSICIAN'S LIC NUMBER
HOSPITAL / CLINIC'S NAME	ADDRESS	CITY STATE ZIP CODE
TELEPHONE: _____	DATE: _____	

As a healthcare provider, ANS is required to provide documentation of your Hepatitis B Status to our client facilities. We require one of the following:

1. A signed declination
2. Results of immune titer
3. Vaccination series

Hepatitis B Declination: I understand that, due to my occupational exposure to blood and / or other potentially infectious material, I may be at risk of inquiring Hepatitis B Virus (HBV) infection and decline vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B Virus (HBV) infection, a serious disease and I understand that I cannot hold the Agency, Client facility or Physician responsible.

Signature

____ / ____ / ____
Date

Flu Declination: I understand that, due to my occupational exposure to flu patients and / or other potentially infectious material, I may be at risk of inquiring the Flu and decline vaccination at this time.

Signature

____ / ____ / ____
Date

T-dap Declination: I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring infection with any of the above listed diseases. However, I decline the vaccination to the diseases or pathogens. I understand that by declining these vaccines, I continue to be at risk of acquiring these diseases.

Signature

____ / ____ / ____
Date

Varicella Declination: I understand that due to my occupational exposure to chicken pox patients and/or other potentially infectious material, I may be a risk of acquiring chicken pox and, I decline the vaccination to the diseases at this time.

Signature

____ / ____ / ____
Date



TB Questionnaire

EMPLOYEE NAME: _____

COMPANY NAME: Allstate Nursing Services Inc. DATE: _____

STEP I
If you have had a positive PPD in the past, go to step II. If you receive PPD's on an annual basis, complete **Step I ONLY**.

DATE OF LAST PPD: _____ RESULTS OF LAST PPD IN MM: _____

STEP II
Since you have had a positive/sensitive PPD and are no longer required to have an annual chest x-ray, the following is to be completed annually and maintained in the personnel file. However, you must have the results of at least one XRAY on File.

DATE OF LAST XRAY: _____
Please read and put a checkmark in the correct Yes/No space if you are experiencing any of the following symptoms or if any of the following apply to you:

	YES	NO
1. Unplanned loss of weight (>10% of body weight).....	_____	_____
2. Night sweats.....	_____	_____
3. Fever lasting several weeks	_____	_____
4. Frequent coughing in the absence of a cold or flu.....	_____	_____
5. Coughing blood-streaked sputum.....	_____	_____
6. Unusual tiredness or weakness lasting weeks	_____	_____
7. Pain in chest when taking a breath.....	_____	_____
8. Have you been recently diagnosed with diabetes, silicosis, HIV disease, renal disease or liver disease?.....	_____	_____
9. Have you been recently been exposed to a family member or others with active TB?.....	_____	_____

If you checked YES to any of the above question, are you currently treating with a physician?: (Circle one) YES NO Please explain: _____

IF YOU DEVELOP ANY OF THE SYMPTOMS LISTED ABOVE, PLEASE CONTACT YOUR PHYSICIAN AND AGENCY **IMMEDIATELY**. A CHEST X-RAY **MUST** BE PERFORMED PRIOR TO WORKING AGAIN.

SIGNATURE _____ DATE: _____



AUTHORIZATION STATEMENT

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY. REQUEST INFORMATION FROM ALLSTATE NURSING SERVICES, INC. IF YOU DO NOT UNDERSTAND ANY PART OF THE INFORMATION GIVEN BELOW.

I authorize investigation of all statements contained in this application for employment. I understand that misrepresentation or omission of facts called for herein will be sufficient cause for cancellation of consideration for employment dismissal from the company's service if I have been employed.

I consent to the submission of request for background check and drug testing as required by Allstate Nursing Services, Inc.

I agree to uphold the agency's Drug Free Workplace policy, which has been created in accordance with the 1988, Drug Free Workplace Act created by Congress. I agree to random drug screening in the event of a work place injury or "reasonable suspicion" that I may be working under the influence of alcohol or a controlled substance while on duty or on the premises of a client facility. Refusing to test within the designated time period or submitting an altered specimen will be considered a voluntary resignation of such employment.

Allstate Nursing Services, Inc. abides by an employment-at-will policy, which means either the company or the employee may terminate the employment relationship at anytime, for any reason or for no reason, with or without notice. Nothing contained in this employment application, any employee handbook or conveyed to me during an interview is intended to create an employment contract, implicit or implied. I also understand and agree that any future changes in my title, duties, compensation, working conditions, or company benefits, policies and/or procedures will not alter this at-will agreement. This at-will agreement can only be changed or modified in writing by the CEO of Allstate Nursing Services, Inc. I understand that I am not officially employed by agency until I have worked at least one shift for agency, and agency is in receipt of an approved reference.

If I am applying for a position for which driving a vehicle is a mandatory job duty, I am required to possess a current and valid driver's license and vehicle insurance and I agree to provide a copy to Allstate Nursing Services, Inc.

I also attest to the following:

1. That I have been informed that I must not have been convicted of a felony crime that would disqualify me from working in the health care industry.
2. That I understand and agree that employment is contingent upon receipt of the information provided on the background check report.
3. I understand and agree that if I am already employed and have been found to have criminal record of a felony crime, my employment WILL be terminated.
4. I am giving my permission to Allstate Nursing Services, Inc. to transfer my information in my file to facilities I may work for via facsimile, verbally, electronically, email or written.
5. I, Undersigned, hereby authorize Allstate Nursing Services to provide my personnel and medical information in my file to Kaiser Foundation Hospitals and Permanente Medical Group and all other Hospitals and Health care Facilities for the purpose of verifying that I meet the requirements specified in the Agreement for Temporary staffing of Nursing Services between Kaiser Foundation Hospitals and Permanente Medical Group. The use of the information supplied is to be restricted to the foregoing stated verification.

Release of transfer of the specified information to any person or entity not specified herein is prohibited. An additional written consent must be obtained for a proposed new use of the information or for its transfer to another person or entity.

This authorization shall be valid until termination date.

Employee Name _____ **Signature** _____ **Date** _____



ADULT/CHILD ABUSE & DOMESTIC VIOLENCE REPORTING REQUIREMENTS

California law requires that medical practitioners, health practitioners and child care custodians working in specified public or private facilities be informed of their duty to report suspected child abuse, suspected dependent adult abuse, and suspected domestic violence.

Please read the following carefully and sign where indicated.

Section 11166 of the Penal code requires any child care custodian, medical practitioner, health practitioner, firefighter, animal control officer, humane society officer, or employee of a child protective agency who has knowledge of, or observes, a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of a **child abuse** to report the known or 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.

Failure to comply with the requirements of Penal Code Section 11166 is a misdemeanor, punishable by up to six months in a county jail, by a fine of one thousand dollars (\$1,000), or by both the imprisonment and fine. The law also provides that a person who does report as required, or who provides a child protective agency with access to a victim, shall not be civilly or criminally liable for doing so.

Section 15630 of the Welfare and Institutions Code requires any care custodian, health practitioner, or employee of a health facility who in his or her professional capacity, or within the scope of his or her employment, has knowledge of or observes a **dependent adult** who he or she knows has been the victim of physical abuse, or who has injuries under circumstances which are consistent with abuse, to report the known or suspected instance of physical abuse to an adult protective services agency or a local law enforcement 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. Reporting is required where the dependent adult's statements indicate, or in the case of a person with developmental disabilities, where his or her statements or other corroborating evidence indicates that abuse has occurred.

Sections 11160-11163 of the California Penal Code require that any health practitioner employed in a health facility, clinic or physician's office who, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a patient whom he or she knows or reasonably suspects has suffered from any wound or injury inflicted as a result of **domestic violence or spousal abuse** shall immediately, or as soon as is reasonably possible, file a telephone report to the local law enforcement agency followed by a written report within two working days.

Failure to comply with these reporting requirements may lead to a fine of up to \$1,000 and/or up to six months in jail. A person who makes a report in accordance with these articles shall not incur civil or criminal liability as result of any report required or authorized by this article.

Your clinical supervisor and Medical Center Administration should be notified whenever you believe that you maybe required to report suspected abuse or violence.

I certify that I have read and understand this statement and will comply with my obligations under the dependent adult abuse, child abuse, and domestic violence reporting laws.

Signature

Date



HAND HYGIENE/FINGERNAIL GUIDELINES

Hand Hygiene

- Improved adherence to hand hygiene (i.e. hand washing or use of alcohol based hand rubs) has been shown to terminate outbreaks in health care facilities, to reduce the transmission of antimicrobial resistant organisms (e.g. methicillin resistant staphylococcus aureus) and reduce overall infection rates.
- CDC is releasing guidelines to improve adherence to hand hygiene in health care settings. In addition to traditional hand washing with soap and water, CDC is recommending the use of alcohol based hand rubs by health care personnel for patient care because they address some of the obstacles that health care professionals face when taking care of patients.
- Handwashing with soap and water remains a sensible strategy for hand hygiene in non-health care settings and is recommended by CDC and other experts.
- When health care personnel's hands are visibly soiled, they should wash with soap and water.
- The use of gloves does not eliminate the need for gloves. Gloves reduce hand contamination by 70 percent to 80 percent, prevent cross-contamination and protect patients and health care personnel from infection. Handrubs should be used before and after each patient just as gloves should be changed before and after each patient.
- When using an alcohol based handrub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. Note that the volume needed to reduce the number of bacteria on hands varies by product.
- Alcohol based handrubs significantly reduce the number of microorganisms on skin, fast acting, with less skin irritation.
- Health care personnel should avoid wearing artificial nails and keep natural nails less than one quarter of an inch long if they care for patients at high risk of acquiring infections (e.g. patients in intensive care units or in transplant units)
- When evaluating hand hygiene products for potential use in health care facilities, administrators or product selection committees should consider the relative efficacy of antiseptic agents against various pathogens and the acceptability of hand hygiene product by personnel. Characteristics of a product that can affect acceptance and therefore usage include its smell, consistency, color, and the effect of dryness on hands.
- As part of these recommendations, CDC is asking for health care facilities to develop and implement a system for measuring improvements in adherence to these hand hygiene recommendations. Some of the suggested performance indicators include: periodic monitoring of hand hygiene adherence and providing feedback to personnel regarding their performance, monitoring the volume of alcohol based handrub used per 1000 patients days, monitoring adherence of the adequacy of health care personnel hand hygiene when outbreaks of infection occur.
- Allergic contacts dermatitis due to alcohol handrubs is very uncommon. However, with increasing use of such products by health care personnel, it is likely that true allergic reactions to such products will occasionally be encountered.
- Alcohol based handrubs take less time to use than traditional hand washing. In an eight hour shift, an estimated one hour of an ICU nurses time will be saved by using alcohol based handrub.
- These guidelines should not be construed to legalize product claims that are not allowed by the FDA product approval by FDA's Over-the-Counter Drug Review. The recommendations are not intended to apply to consume use of the products discussed.

Fingernails and Artificial Nails

It has been shown that nails, including chipped nail polish, can harbor potentially harmful bacteria. Keeping nails clean and short is a key factor in maintaining good hand hygiene because the majority of organisms are found underneath and around the fingernails. Caring for nails helps prevent the harboring of microorganisms, which could then be transmitted to those who are receiving care. Nails should be kept short enough for allow for access for skin cleansers to assist in cleaning underneath the nail thoroughly and to prevent gloves from tearing.

Signature

Date



ORIENTATION AND IN-SERVICE ATTESTATION

IN SERVICE TO THE FOLLOWING:

Los Angeles County Child Support Compliance Program	Client and Company policies and procedures	Personnel Guidelines
Agency Handbook	Safely Surrendered Baby Law	Unlawful Solicitation
Conditions of Employment	Nursing Code of Conduct	Jury Duty Policy
2009 Deficit Reduction Act (DRA)	Nondiscrimination In Service	Restrictions in Lobbying
Fair Labor Standards Act	Nondiscrimination in Employment	Employee Information Regarding Federal Earned Income Credit
Specific Facility Orientation Requirements		

ANNUAL OSHA/HOSPITAL REQUIRED COMPETENCIES

Biological Threats		Advance Directives	
Blood Bourne Pathogens		Age Specific Care Guidelines	
Drug Free Workplace		Child, Elder/Abuse/ Neglect	
Emergency Evacuation/Preparedness		Cultural Diversity	
Environmental Awareness		Customer Service	
Ergonomics		Domestic Abuse	
Patient Safety-Fall Prevention		Do Not Use Abbreviations	
Fire and Safety Review		HIPAA Compliance	
Hazardous Communication/MSDS		Latex Allergy	
Healthcare Violence		National Patient Safety Goals	
Infection Control Review		Pain Management	
Restraints		Patient Rights	
Tuberculosis		Preventing Medication Errors	
Safety Orientation		Sexual Harassment	
Confidentiality Policy		Do not Return Prevention	
Hand Hygiene & Fingernails Guidelines		ISMP's List of Confused Drug Names	
Radiation Therapy		Organ Donation	
End of Life			

Employees Name _____ Signature _____ Date ____ / ____ / ____

Agency Representative: _____ Signature _____ Date ____ / ____ / ____

*In accordance with the policies and procedures of Joint Commission,
 Staff members can report any concerns with the actions of Allstate Nursing Services, Inc without fear of retribution.
 By Phone: 800.994.6600 By Email: complaint@jointcommission.org*

**Form I-9, Employment
Eligibility Verification**

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification (To be completed and signed by employee at the time employment begins.)

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- A citizen of the United States
- A noncitizen national of the United States (see instructions)
- A lawful permanent resident (Alien # _____)
- An alien authorized to work (Alien # or Admission # _____ until (expiration date, if applicable - month/day/year)

Employee's Signature	Date (month/day/year)
----------------------	-----------------------

Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	Date (month/day/year)

Section 2. Employer Review and Verification (To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)

List A	OR	List B	AND	List C
Document title: _____	OR	_____	_____	_____
Issuing authority: _____		_____	_____	_____
Document #: _____		_____	_____	_____
Expiration Date (if any): _____		_____	_____	_____
Document #: _____		_____	_____	_____
Expiration Date (if any): _____	_____	_____	_____	_____

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code)		Date (month/day/year)

Section 3. Updating and Reverification (To be completed and signed by employer.)

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)	
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.		
Document Title: _____	Document #: _____	Expiration Date (if any): _____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date (month/day/year)
--	-----------------------

Form W-4 (2011)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2011 expires February 16, 2012. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using

Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A _____
B	Enter "1" if: <ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	B _____
C	Enter "1" for your spouse . But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C _____
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D _____
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E _____
F	Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F _____
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children 	G _____
H	Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶ For accuracy, complete all worksheets that apply. <ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. 	H _____

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form W-4 Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="font-size: small; margin: 0;">▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-2159 <div style="font-size: 2em; font-weight: bold; margin: 0;">2011</div>
1 Type or print your first name and middle initial. Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 _____
6 Additional amount, if any, you want withheld from each paycheck		6 \$ _____
7 I claim exemption from withholding for 2011, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶		7 _____
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (This form is not valid unless you sign it.) ▶		Date ▶
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)
		10 Employer identification number (EIN)



Payroll Procedures

Work Week: Allstate Nursing Services Inc. work week is Sunday through Saturday. The week begins with Sunday shifts starting at 7:00am and ending with shifts starting at 11:00pm -7:00am or 7:00pm-7:00am on Saturday.

Sign-In Sheets: Employee must sign-in prior to the start of the shift and sign out at the end of the shift. All overtime has to be approved by appropriate hospital personnel. No lunch time will be paid unless approved by appropriate hospital personnel. Incomplete and/or unsigned sign-in sheets cannot be processed and may delay your paycheck. If there is no sign-in sheet at the facility, employee is advised to please call an Allstate representative at 818-990-3133. If other system is used, make sure to follow procedures. If a discrepancy or missing of hours occur, nurse is responsible to get approval of hours worked. Beginning January 1, 2011, Allstate will no longer pay for missing hours.

Payday: Paychecks are issued weekly through Allstate Nursing Services. Paychecks are available to be picked up at the office every Friday after 12:00pm. Allstate Nursing Services, Inc. will not be liable for lost checks that were permitted to be mailed out. Stop payment fees will be paid by employee. We will not issue another check unless a stop payment is placed on lost check. Should employee request someone else other than them to pick up the check, employee **must call ahead of time**; in addition, send a note with individual picking up check.

I am giving permission to ANS to mail check to address on file: Yes _____ No _____

Direct Deposit: Direct Deposit is available upon request. If employee chooses to utilize the direct deposit option, a direct deposit form with a voided check must be completed and submitted. Please note that direct deposits take two pay periods to activate. It is not possible to do direct deposit the same day.

Advance Pay: A 70% advance pay of gross check from all shifts worked during that **current week** is available to all employees. All advance paychecks are to be picked up the next day after request from the office Monday-Friday during the hours of 9:00am-12:00pm. Every employee is allotted one free advance pay per week. If an employee chooses to request additional advance pay's for the same week, a five (\$5) dollar service fee will be charged.

ID BADGE: ID badges must be worn at the hospital at all times. A total of Two (2) badges will be issued after which a five (\$5) dollar fee will be charged for additional badges.

Signature _____ Date _____