Name (Please Print) Last First Initial Phone - home other

Address (city, state, zip) Major Cross Street

Social Security Number Alien I.D. Number

High School Name and Location

Professional Data

Nursing School or College Name

Address (City, State, Zip)

Degree / Certificate Date Received

Other Education (incl. special courses, special skills, etc.)

Personal Data

Date of Birth Sex (circle) M Fe

Marital Status Children - Ages

General Health Status

Date of last Physical Exam

Notify In Case of Emergency Phone

RN, LVN, License No. Exp. date

State Verified by:

Other License No. Exp. date

State Type:

1. Current or Last Employer

Street Address Phone:

City, State, Zip

Job Title | Salary | Dates Worked | From | To

Name Used While Employed

Job Responsibilities

Immediate Supervisor Reason for leaving

May we contact to obtain reference?

2. Prior Employer

Street Address Phone:

City, State, Zip

Job Title | Salary | Dates Worked | From | To

Name Used While Employed

Job Responsibilities

Supervisor Reason for leaving

3. Prior Employer

Street Address Phone:

City, State, Zip

Job Title | Salary | Dates Worked | From | To

Name Used While Employed

Job Responsibilities

Supervisor Reason for leaving

4. Prior Employer

Street Address Phone:

City, State, Zip

Job Title | Salary | Dates Worked | From | To

Name Used While Employed

Job Responsibilities

Supervisor Reason for leaving

Professional References

1. Reference Phone:

Address

Relationship

2. Reference Phone:

Address

Relationship

3. Reference Phone:

Address

Relationship

4. Reference Phone:

Address

Relationship

How did you hear about Associated Health Professionals?

If Friend or Acquaintance – Whom?

Date Completed: Signature:

Payroll:

Associated Health Professionals, Inc.

PROFESSIONAL REFERENCE CHECK

(Please have form filled completely by your reference before returning to AHP)

I authorize_____
(Name and Title of Professional Healthcare Manager) (Telephone Number)

from_____
(Facility Name and Address)

to release information about me regarding my employment while at that facility to Associated Health Professionals, Inc. for the purpose of supplying a reference check.

_____ _____
Signature Date

PERFORMANCE EVALUATION

(Name of Healthcare Professional)_____has applied for a nursing position with Associated Health Professionals, Inc. and has given us your name as a professional reference. We would appreciate it if you would evaluate the applicant's past performance by filling in the appropriate boxes below, and make any additional comments you feel might assist us in making our decision regarding hiring this healthcare professional. Your comments will be kept in strict confidence.

Name and Title of Reference_____Telephone_____

Facility Name_____

Address:_____City, State, ZIP Code _____

Employment Dates: From_____ To_____ Title During Employment_____

Area(s) / Department(s) Worked_____

	Exceeds Expectations	Meets Expectations	Meets Some Expectations	Does Not Meet Expectations	Comments
Quality of Work	☐	☐	☐	☐	_____
Productivity	☐	☐	☐	☐	_____
Professionalism	☐	☐	☐	☐	_____
Emotional Stability	☐	☐	☐	☐	_____
Flexibility	☐	☐	☐	☐	_____
Dependability	☐	☐	☐	☐	_____
Enthusiasm Toward Job	☐	☐	☐	☐	_____
Leadership Ability	☐	☐	☐	☐	_____
Communication Skills	☐	☐	☐	☐	_____
Attendance/Punctuality	☐	☐	☐	☐	_____
Appearance	☐	☐	☐	☐	_____
Customer Service Skills	☐	☐	☐	☐	_____

Reason this healthcare professional left your facility: ☐ Terminated ☐ Lay-off ☐ Resigned ☐ Completed assignment

Comments (please continue on other side of this form if needed)_____
_____
_____

Would you hire this healthcare professional again? ☐ Yes ☐ No

_____ _____
Signature and Title Date

Please return this form to:
Tel. 800.428.4823`

Associated Health Professionals, Inc
6095 Bristol Parkway - Ste. 200
Culver City, CA 90230

Fax: 310.645.3034

Associated Health Professionals, Inc.

PROFESSIONAL REFERENCE CHECK

(Please have form filled completely by your reference before returning to AHP)

I authorize_____
(Name and Title of Professional Healthcare Manager) (Telephone Number)

from_____
(Facility Name and Address)

to release information about me regarding my employment while at that facility to Associated Health Professionals, Inc. for the purpose of supplying a reference check.

_____ _____
Signature Date

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Facility Name_____

Address:_____City, State, ZIP Code _____

Employment Dates: From_____ To_____ Title During Employment_____

Area(s) / Department(s) Worked_____

	Exceeds Expectations	Meets Expectations	Meets Some Expectations	Does Not Meet Expectations	Comments
Quality of Work	☐	☐	☐	☐	_____
Productivity	☐	☐	☐	☐	_____
Professionalism	☐	☐	☐	☐	_____
Emotional Stability	☐	☐	☐	☐	_____
Flexibility	☐	☐	☐	☐	_____
Dependability	☐	☐	☐	☐	_____
Enthusiasm Toward Job	☐	☐	☐	☐	_____
Leadership Ability	☐	☐	☐	☐	_____
Communication Skills	☐	☐	☐	☐	_____
Attendance/Punctuality	☐	☐	☐	☐	_____
Appearance	☐	☐	☐	☐	_____
Customer Service Skills	☐	☐	☐	☐	_____

Reason this healthcare professional left your facility: ☐ Terminated ☐ Lay-off ☐ Resigned ☐ Completed assignment

Comments (please continue on other side of this form if needed)_____
_____
_____

Would you hire this healthcare professional again? ☐ Yes ☐ No

_____ _____
Signature and Title Date

Please return this form to:
Tel. 800.428.4823`

Associated Health Professionals, Inc
6095 Bristol Parkway - Ste. 200
Culver City, CA 90230

Fax: 310.645.3034

Corporate Office: Los Angeles
6095 Bristol Parkway 2nd Floor
Culver City, CA 90230-6601
310-417-3011 818-981-4454
FAX 310-645-3034

San Diego Office:
3211 Holiday Court Suite 200
La Jolla, CA 92037-1802
619-457-3011
FAX 619-457-0341

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POSITION DESCRIPTION

REGISTERED NURSE

I. RESPONSIBLE TO DIRECTOR OF NURSING AND/OR UNIT MANAGER

II. JOB QUALIFICATIONS

A. A graduate from an accredited school of nursing or proof of successful challenge of the State Board RN examination.
B. Current license to practice as a Registered Nurse
C. Valid CPR card – American Heart Association Basic Life Support for Healthcare Providers.
D. Minimum of 1 year acute care hospital experience within the last 3 years.
E. A current Health Certificate including a TB Mantoux test (if possible, a chest x-ray w/in the last 3 years), vaccination dates or titre results for Measles, Mumps, Rubella, Varicella, Hepatitis (all 3 in a series), hepatitis titre or AHP's declination waiver.
F. Successful completion of AHP NLN pharmacology examination with a score of at least 80%
G. Successful completion AHP NLN nursing examination with a score of at least 80%
H. If specialty nurse, successful completion of AHP NLN specialty nursing examination with a score of at least 80%.
I. Successful completion of the AHP Infection Control, Fire and Safety, Disasters, Body Mechanics, Hazardous Waste & Disaster Preparedness, MSDS, Radiation, Universal Body Substance Precautions, Hepatitis, TB, Domestic Violence, Diagnosis and Treatment Guidelines, Organ Donation Protocol, Patient Restraint Policy, Age Specific Criteria, Cultural Diversity-Spiritual Considerations, Pain Management and Corporate Responsibility Program In-Services.
J. Ability to communicate efficiently, fluent in English

III. CLINICAL FUNCTIONS/RESPONSIBILITIES.

A. Have a working knowledge of the terminology, theory, techniques, and practice of professional nursing.
B. Knowledge of the California Nurse Practice Act.
C. Have a working knowledge of Pharmacology, including therapeutic action, side effects and contraindications. Administers in a timely manner all ordered medications for the patient.
D. Have a working knowledge of IV infusion pumps and specialized equipment as necessary to carry out the treatment plan.
E. Prepares equipment and assists physician during treatment, examination and procedures.
F. Have specialized education to work in nursing departments that require advanced training. Provide AHP with copies of the continuing education certificates received following successful completion of the required course and any updates as necessary.
G. Have a working knowledge to analyze facts and conditions and apply sound nursing principles in making decisions according to the age and health status of the patient.
H. Possess the ability to develop and carry out a nursing plan to meet the patients needs.
I. Have an ability to communicate precisely to physicians and co-workers both oral and written communication regarding the patients conditions and documents according to hospital protocol.
J. Have an ability to establish effective working relationships with physicians, patients, and fellow workers.
K. Have a working knowledge of technical procedures, use good judgements and utilize proper measures in the care of patients.
L. Have a sound working knowledge of Code Blue protocol to respond to a Code Blue situation and begin CPR.
M. Possess the ability to initiate and monitor Intravenous Therapy with appropriate documentation.

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Associated Health Professionals Inc.

2. Visits all patients on team; makes adjustment and clarification of assignment according to instructions given by the professional nursing team leader.
3. Confers with charge nurse and/or supervisor about any problem. Reports observations of any change in patients status.
4. Confers with nurse about nursing care management.
5. Immediately visits after all new admissions, and observes patient's condition, reactions of patient to hospitalization and checks for identification band.
6. Confers with supervisor regarding patient transfer – whether within, onto or off of the unit.
7. Plans and co-ordinates patient discharge via charge nurse.
8. Reports to supervisor any problems regarding housekeeping, maintenance or supplies.
9. Assists with bedside nursing care given to patients in his/her assigned area.
10. Make rounds as frequently as necessary for purpose of observation, assessing and meeting patients needs.
11. Takes vital sign and records information. Reports any abnormal findings to licensed nursing personnel.
12. Records patient's intake and output and records information as requested.

_____ _____

EMPLOYEE DATE

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OCCUPATIONAL HEALTH QUESTIONNAIRE
Interval Health Evaluation

Please Print:

Name:_____ Date of Birth _____
Home Phone: _____Office Phone: _____ Age_____Sex_____
Dept:_____ Position: _____ Shift: _____

Please answer the following questions regarding your Health Status:	YES	NO
1. Have you had any new problem which currently is infectious AND would prevent you from performing your assigned duties at this time? If "yes", please describe.	____	____
2. Have you had an unexplained weight loss in the last year? If "yes", give amount lost: _____	____	____
3. Do you have a persistent cough? (lasting 3 weeks or more)	____	____
4. Do you cough up blood? _____	____	____
5. Do you have persistent, unexplained fevers or night sweats?	____	____
6. Do you have a rash? If "yes", for how long? _____	____	____
7. Have you seen a doctor for any of the above? If "yes", which numbered item? _____	____	____

Answer this question if you have a prior POSTIVE PPD

Persons with a previous reaction to the TB skin test ("positive" PPDs) may have an increased risk of coming down with tuberculosis if certain medical conditions exist, such as:

a. Had part of you stomach removed during surgery
b. Underweight or are malnourished`
c. Infection with HIV/AIDS or are at risk for it
d. On any medications that suppresses the immune system
e. Diabetes
f. Silicosis lung disease
g. Leukemia or lymphoma
h. Kidney failure

Do you have any of the above conditions (a-h)? **YES** **NO**
(It is not required for you to divulge your medical diagnosis)

Has it been more than 10 years since your last tetanus booster? If "No", date of last booster_____

Have you had the Hepatitis B (HB) Vaccine? If "yes", give number of doses: _____

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I understand that by declining this vaccine at this time (because I have already received my series of 3 vaccinations or for any other reason), I continue to be at risk of acquiring Hepatitis B, a serious disease.

Signature_____ Date _____

Sign below to certify that all information provided above is accurate and without omissions.

Signature _____ Date _____

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Associated Health Professionals Inc.

PRE-PLACEMENT HEALTH HISTORY QUESTIONNAIRE AND ASSESSMENT

NAME_____SS#_____SEX___M/F_____DOB_____

HOME ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____NOTIFY IN CASE OF EMERG_____

HEALTH HISTORY

Relative to this job, is there any health-related condition for which you require accommodation? (i.e., job modification, structural changes to the work area). **YES** or **NO** (circle one). If so, please list below:

1. _____
2. _____
3. _____

Please complete the following:

I. Illnesses –If yes, indicate date(s) of occurrence:	YES	NO
Any skin or other health-related condition which causes recurrent eczema, irritated skin or open skin lesions_____	_____	_____
Hearing Problems (loss of hearing, ringing of the ears, other) _____	_____	_____
Vision Problems (Glaucoma, cataract, and color blindness, other) _____	_____	_____
Difficulty breathing (shortness of breath or chronic cough) _____	_____	_____
Hernia_____	_____	_____

Chronic or recurring pain or limited motion associated with: (describe):

Neck_____
Arm_____
Wrist_____
Hand_____
Back_____
Other_____
Heart Condition or Heart Disease_____
Seizure Disorder_____
Diabetes_____

II. ALLERGIES AND EXPOSURES

A. Have you ever had a reaction, allergy, or sensitivity to any drugs (such as codeine, penicillin or sulfa), food, LATEX, plants or chemicals? **YES** or **NO (please circle one)**. If yes, please describe).

B. Have you ever worked with any of the following, YES or NO and give date:

Antineoplastic/ Cytotoxic Drugs _____
Asbestos/Silicosis _____
Formaldahyde _____
Ethylene Oxide _____
BCG _____
Radiation _____
Gluteraldehyde (such as Cidex) _____
Anesthetic Gas _____
Lasers _____
Any other hazardous substance (please identify _____

III. MEDICATIONS

A. Are there any other medications or any medical conditions we should know about?

_____

B. Do you take medications while at work or before work which could affect your physical or mental function or performance? _____

IV. SKIN TESTING

Persons with damaged immune systems are at risk for tuberculosis (including the TH that does not respond to many current treatments, Multidrug resistant TB). You are at a higher risk for acquiring TB if your immune system has been damaged by:

a. Chemotherapy, steroid medication, or medication to prevent transplant rejection
b. Disease such as HIV/AIDS, cancer and sarcoidosis
c. Any other medical condition that may suppress your immune system. Individuals at higher risk for acquiring TB may require close monitoring and follow-up. Please indicate whether or not your immune system may have been damaged by any of the above conditions. YES OR NO. (It is not required for you to divulge your medical diagnosis

Date of last TB test: _____ Have you ever had a positive TB skin test? _____
Results: _____ Have you ever taken medication for a + TB test? _____
Have you ever had Tuberculosis? _____ When? _____

MASK FIT TESTED

Have you been mask fit tested? YES NO When? _____
Brand of Mask _____ Size _____ Where Tested? _____
Do you have your FIT TESTED Card? YES NO

4. IMMUNIZATIONS

A. Have you had the BCG vaccine for TB?	YES (date)	NO
B. Have you ever received a Hepatitis B vaccine series?	YES	NO
C. Last Tetanus Booster	DATE:	

5. COMMUNICABLE DISEASE

Indicate whether you currently have or recently have had any of the following?

	YES	NO
Hepatitis A		
Hepatitis B		
Hepatitis Non-A, Non-B		
Herpes Simplex		
Herpes Zoster		
Rubeola (Measles)		
Mumps		
Rubella (German Measles)		
Chickenpox		
Skin Infection (boils, impetigo)		
Conjunctivitis (eye infection)		
Diarreha		
Strep Throat		
Scabies		

6. CERTIFICATION

I hereby certify that the answers given by me to the foregoing questions and statements are true and complete and without omissions. I understand that if employed, any false statements of material fact, or omissions on this form may be considered sufficient cause for dismissal.

SIGNATURE_____ **DATE**_____

Respirator Medical Evaluation Questionnaire

To the employer:
Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee: Can you read (check one): ☐ Yes ☐ No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory)

Every employee who has been selected to use any type of respirator must provide the following information.

Name: _____ Title: _____ Date: _____

Age: _____ Sex: ☐ Male ☐ Female Your height: _____ ft. _____ in. Weight_____

A phone number where the health care professional who reviews this questionnaire can reach you. Phone: _____ best time to phone you at this number: _____

Has your employer told you how to contact the health care professional who will review this questionnaire (Check one): ☐ Yes ☐ No

Check the type of respirator you will use (you can check more than one category):
a. ___X___ N, R, or P disposable respirator (filter-mask, non- cartridge type only).
b. _____ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, Self-contained breathing apparatus).
Have you worn a respirator (Check one): ☐ Yes ☐ No
If yes what type: _____

Part A. Section 2. (Mandatory)
Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please check "yes" or "no").

1. **Do you currently smoke tobacco, or have you smoked tobacco in the last month: ☐Yes ☐No**
2. **Have you ever had any of the following conditions?**

a) Seizures: ☐Yes ☐No
b) Diabetes: ☐Yes ☐No
c) Trouble smelling odors: ☐Yes ☐No
d) Claustrophobia: ☐Yes ☐No
e) Allergic reactions that affect your breathing: ☐Yes ☐No

3. **Have you ever had any of the following pulmonary or lung problems?**

a) Asbestosis: ☐Yes ☐No
b) Asthma: ☐Yes ☐No
c) Emphysema: ☐Yes ☐No
d) Pneumonia: ☐Yes ☐No
e) Tuberculosis: ☐Yes ☐No
f) Silicosis: ☐Yes ☐No
g) Pneumothorax: ☐Yes ☐No
h) Lung cancer: ☐Yes ☐No
i) Chronic bronchitis: ☐Yes ☐No
j) Broken ribs: ☐Yes ☐No
k) Any chest injuries or surgeries: ☐Yes ☐No
l) Any other lung problem that you've been told about: ☐Yes ☐No

4. **Do you currently have any of the following symptoms of pulmonary or lung illness?**

a) Shortness of breath: ☐Yes ☐No
b) Shortness of breath when walking fast on level ground or walking up a slight hill or incline: ☐Yes ☐No
c) Shortness of breath when walking with other people at an ordinary pace on level ground: ☐Yes ☐No
d) Have to stop for breath when walking at your own pace on level ground: ☐Yes ☐No
e) Shortness of breath when washing or dressing yourself: ☐Yes ☐No
f) Shortness of breath that interferes with your job: ☐Yes ☐No

g) Coughing that produces phlegm (thick sputum): ☐Yes ☐No
h) Coughing that wakes you early in the morning: ☐Yes ☐No
i) Coughing that occurs mostly when you are lying down: ☐Yes ☐No
j) Coughing up blood in the last month: ☐Yes ☐No
k) Wheezing: ☐Yes ☐No
l) Wheezing that interferes with your job: ☐Yes ☐No
m) Chest pain when you breathe deeply: ☐Yes ☐No
n) Any other symptoms that you think may be related to lung problems: ☐Yes ☐No

5. Have you ever had any of the following cardiovascular or heart problems?

a) Heart attack: ☐Yes ☐No
b) Stroke: ☐Yes ☐No
c) Angina: ☐Yes ☐No
d) Heart failure: ☐Yes ☐No
e) Swelling in your legs or feet (not caused by walking): ☐Yes ☐No
f) Heart arrhythmia (heart beating irregularly): ☐Yes ☐No
g) High blood pressure: ☐Yes ☐No
h) Any other heart problem that you've been told about: ☐Yes ☐No
i) Have you ever had any of the following cardiovascular or heart symptoms: ☐Yes ☐No
j) Frequent pain or tightness in your chest: ☐Yes ☐No
k) Pain or tightness in your chest during physical activity: ☐Yes ☐No
l) Pain or tightness in your chest that interferes with your job: ☐Yes ☐No
m) In the past two years, have you noticed your heart skipping or missing a beat: ☐Yes ☐No
n) Heartburn or indigestion that is not related to eating: ☐Yes ☐No

6. Any other symptoms that you think may be related to heart or circulation problems: ☐Yes ☐No
7. Do you currently take medication for any of the following problems? ☐Yes ☐No

a) Breathing or lung problems: ☐Yes ☐No
b) Heart trouble: ☐Yes ☐No
c) Blood pressure: ☐Yes ☐No
d) Seizures: ☐Yes ☐No

8. If you've used a respirator, have you ever had any of the following problems?

(If you've never used a respirator, check the following space and go to question 9:) ☐ Never used

a) Eye irritation: ☐Yes ☐No
b) Skin allergies or rashes: ☐Yes ☐No
c) Anxiety: ☐Yes ☐No
d) General weakness or fatigue: ☐Yes ☐No
e) Any other problem that interferes with your use of a respirator: ☐Yes ☐No

9. Would you like to talk to the health care professional that will review this questionnaire?

Comments (for Healthcare professional use only_____

_____

_____

_____ _____

Employee Signature Date

ASSOCIATED HEALTH PROFESSIONALS Inc.
6095 BRISTOL PARKWAY 2nd FLOOR
CULVER CITY, CA 90230-6601
PHONE 310-417-3011
FAX 310-645-3034

Latex Allergy Questionnaire

Employee Name: _____

Agency: _____ Date: _____

- O I do have a latex allergy
- O I do not have a latex allergy
- O I have sensitivity to powder and require powder free gloves

My signature below indicates that the above information is correct and I give permission for this information to be shared with InteliStaf Healthcare and Citrus Valley Health Partners for the purpose of staffing Placement at the facility.

_____ _____

Employee Signature Date

Corporate Office: Los Angeles
6095 Bristol Parkway 2nd Floor
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Associated Health Professionals Inc.

HEPATITIS B VACCINE INFORMED CONSENT/ WAIVER

THE DISEASE

Hepatitis B is a viral infection caused by the hepatitis B virus (HBV) which causes death in 1-2% of patients. Most people with Hepatitis B recover completely by approximately 5-10% become chronic carriers of the virus. Most of these people have no symptoms but can continue to transmit the disease to others. Some may develop chronic active hepatitis and cirrhosis. HBV also appears to be a causative factor in the development of liver cancer. Thus, immunization against hepatitis can prevent acute hepatitis and also reduce sickness and death from chronic active hepatitis, cirrhosis and liver cancer.

THE VACCINE

The Hepatitis B vaccine is produced from the plasma of chronic HBV carriers. The vaccine consists of highly purified, malin-inactivated hepatitis B antigen (viral coating material). It has been extensively tested for safety in chimpanzees and safety and efficiency in large-scale clinical trials with human subjects. A high percentage of healthy people who receive three doses of vaccine achieve high levels of surface antibody (anti-HBS) and protection against Hepatitis B. Persons with immune system abnormalities, such as dialysis patients, have less response to the vaccine, but over half of those receiving it develop antibodies. Full immunization requires 3 doses of vaccine over a six-month period, although some persons may fail to develop immunity even after 3 doses. There is no evidence that the vaccine has ever caused hepatitis B or AIDS. However, persons who have been infected with HBV prior to receiving the vaccine may go on to develop clinical hepatitis, in spite of immunization. The duration of immunity is unknown at this time, but is probably long term.

POSSIBLE VACCINE SIDE EFFECTS

The incidence of side effects is very low. No serious side effects have been reported with the vaccine. A few persons experience tenderness and redness at the site of injection. Low-grade fever may occur. Rash, nausea, joint pain and mild fatigue have also been reported. The possibility exists that more serious side effects may be identified in the future.

NAME_____NURSING LICENSE#_____
(PLEASE PRINT)

ADDRESS_____

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been informed and have had the opportunity to ask questions and understand the benefits and risks of the Hepatitis B vaccine. I understand that I must have three doses of vaccine to confer immunity. However, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience an adverse side effect from the vaccine. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

I HAVE ALREADY BEEN VACCINATED FOR HEPATITIS B. BELOW (OR ATTACHED) IS A RECORD OF MY VACCINATION.

SIGNATURE_____

DATE VACCINATED	LOT 3	SITE	GIVEN BY

I HAVE BEEN ADVISED OF THE HEPATITIS B VACCINE PROGRAM, HOWEVER, I CHOOSE NOT TO PARTICIPATE AT THIS TIME

SIGNATURE_____ DATE_____

IMPORTANT INFORMATION ABOUT
MEASLES, MUMPS AND RUBELLA
AND
MEASLES, MUMPS AND RUBELLA VACCINES

Please read this carefully

WHAT IS MEASLES? Measles is the most serious of the common childhood diseases. Usually it causes a rash, high fever, cough, runny nose and watery eyes lasting one to two weeks. Sometimes it is more serious. It causes an ear infection or pneumonia in nearly one of out of 10 children who get it. Approximately one child out of every 1,000 who gets measles has an inflammation of the brain (encephalitis). This can lead to convulsions, deafness or mental retardation. About two children in every 10,000 who get measles die from it. Measles can also cause a pregnant woman to have a miscarriage or give birth to a premature baby.

Before measles vaccine shots were available, there were hundreds of thousands of cases and hundreds of deaths each year. Nearly all children got measles by the time they were 15. Now, wide use of measles vaccine has nearly eliminated measles from the United States. However, if children are not vaccinated they have a high risk of getting measles now or later in life.

WHAT IS MUMPS? Mumps is a common disease of children. Usually it causes fever, headache and inflammation of the salivary glands, which causes the cheeks to swell. Sometimes it is more serious. It causes a mild inflammation of the coverings of the brain and spinal cord (meningitis) in about one child in every 10 who get it. More rarely, it can cause inflammation of the brain (encephalitis) which usually goes away without leaving permanent damage. Mumps can also cause deafness. About one out of every four adolescent or adult men who get mumps develops painful inflammation and swelling of the testicles. While this condition usually goes away, on rare occasions, it may cause sterility.

Before mumps vaccine shots were available, there were more than 150,000 cases each year. Now because of the wise use of mumps vaccine, the number of cases of mumps is much lower. However, if children are not vaccinated, they have a high risk of getting mumps.

WHAT IS RUBELLA? Rubella is also called German measles. It is a common disease of children and may also affect adults. Usually, it is very mild and causes a slight fever, rash and swelling of glands in the neck. The sickness lasts about three days. Sometimes, especially in adult women, there may be swelling and aching of the joints for a week or two. Very rarely, rubella can cause inflammation of the brain (encephalitis) or cause a temporary bleeding disorder (purpura).

The most serious problem with rubella is that if a pregnant woman gets this disease, there is a good chance that she may have a miscarriage or that the baby will be born crippled, blind or with other defects. The last big rubella epidemic in the United States was in 1964. Because of that epidemic, about 25,000 children were born with serious problems such as heart defects, deafness, blindness or mental retardation because their mothers had rubella during the pregnancy.

Before rubella vaccine shots were available, rubella was so common that most children got the disease by the time they were 15. Now, because of the wide use of rubella vaccine, the number of cases of rubella is much lower. However, if children are not vaccinated, they have a high risk of getting rubella and possibly exposing a pregnant woman to the disease. If an unvaccinated woman later becomes pregnant and catches rubella, she may have a defective baby.

I have read the information on this form about measles, mumps and rubella, and measles, mumps and rubella vaccines. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of measles, mumps and rubella vaccines and choose to decline the measles, mumps and rubella vaccines.

I also choose to decline to receive the varicella (chicken pox) vaccine and to take the varicella antibody test.

_____ _____

Signature Date

Corporate Office : Los Angeles
6095 Bristol Parkway, Suite 200
Culver City, CA 90230-6601
310-417-3011 800-451-4454
FAX 310-645-3034

Apple Valley Branch Office :
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Apple Valley, CA 92307
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FAX : (760) 242-4823

Associated Health Professionals Inc.

DIPTHERIA, TETANUS, PERTUSSIS INFORMED CONSENT/WAIVER

I have read the attached CDC Vaccine Information Statement about Tetanus, Diptheria and Pertussis vaccines and understand the risks and benefits of being vaccinated.

I have been offered the Tetanus, Diphtheria and Pertussis vaccination by AHP, however, I choose not to participate at this time.

Signature: _____ **Date:** _____

Medical/Surgical Skills Checklist

First name:

Last name:

Social Security number: ___ - ___ - ___

This profile is for use by Medical/Surgical nurses with more than one year of experience in their discipline and specialty. It will not be a determining factor for the program.

Please mark your level of experience

- A — Theory, no practice
- B — Intermittent experience
- C — One - two years experience
- D — Two plus years experience

A. CARDIOVASCULAR	A	B	C	D
1. Assessment				
a. Auscultation (rate, rhythm)	☐	☐	☐	☐
b. Blood pressure/non-invasive	☐	☐	☐	☐
c. Doppler	☐	☐	☐	☐
d. Heart sounds/murmurs	☐	☐	☐	☐
e. Pulses/circulation checks	☐	☐	☐	☐
2. Equipment & procedures				
a. Telemetry				
(1) Basic 12 lead interpretation	☐	☐	☐	☐
(2) Basic arrhythmia interpretation	☐	☐	☐	☐
(3) Lead placement	☐	☐	☐	☐
b. Pacemaker				
(1) Permanent	☐	☐	☐	☐
(2) Temporary	☐	☐	☐	☐
3. Care of the patient with:				
a. Abdominal aortic bypass	☐	☐	☐	☐
b. Aneurysm	☐	☐	☐	☐
c. Angina	☐	☐	☐	☐
d. Cardiac arrest	☐	☐	☐	☐
e. Cardiomyopathy	☐	☐	☐	☐
f. Carotid endarterectomy	☐	☐	☐	☐
g. Congestive heart failure (CHF)	☐	☐	☐	☐
h. Femoral-popliteal bypass	☐	☐	☐	☐
i. Myocarditis	☐	☐	☐	☐
j. Post acute MI (24-48 hours)	☐	☐	☐	☐
k. Post angioplasty	☐	☐	☐	☐
l. Post cardiac cath	☐	☐	☐	☐
m. Post cardiac surgery	☐	☐	☐	☐
n. Thrombophlebitis	☐	☐	☐	☐
4. Medications				
a. Heparin drip	☐	☐	☐	☐
b. Oral anticoagulants	☐	☐	☐	☐
c. Oral & IVP antihypertensives	☐	☐	☐	☐
d. Oral & topical nitrates	☐	☐	☐	☐

B. PULMONARY	A	B	C	D
1. Assessment				
a. Breath sounds	☐	☐	☐	☐
b. Rate and work of breathing	☐	☐	☐	☐
2. Interpretation of lab results				
a. Blood chemistry	☐	☐	☐	☐
b. Blood gases	☐	☐	☐	☐
3. Equipment & procedures				
a. Airway management devices/suctioning				
(1) Endotracheal tube/suctioning	☐	☐	☐	☐
(2) Nasal airway/suctioning	☐	☐	☐	☐
(3) Oropharyngeal/suctioning	☐	☐	☐	☐
(4) Sputum specimen collection	☐	☐	☐	☐
(5) Tracheostomy/suctioning	☐	☐	☐	☐
b. Assist with intubation	☐	☐	☐	☐
c. Assist with thoracentesis	☐	☐	☐	☐
d. Care of the patient on a ventilator	☐	☐	☐	☐
e. Care of the patient with a chest tube				
(1) Assist with set-up & insertion	☐	☐	☐	☐
(2) Measuring and emptying	☐	☐	☐	☐
(3) Removal	☐	☐	☐	☐
f. Chest physiotherapy	☐	☐	☐	☐
g. Incentive spirometry	☐	☐	☐	☐
h. O_2 therapy & medication delivery systems				
(1) Bag and mask	☐	☐	☐	☐
(2) External CPAP	☐	☐	☐	☐
(3) Face masks	☐	☐	☐	☐
(4) Inhalers	☐	☐	☐	☐
(5) Nasal cannula	☐	☐	☐	☐
(6) Portable O_2 tank	☐	☐	☐	☐
(7) Trach collar	☐	☐	☐	☐
i. Oximetry	☐	☐	☐	☐

First name: Last name:

	A	B	C	D
4. Care of the patient with:				
a. Bronchoscopy	☐	☐	☐	☐
b. COPD	☐	☐	☐	☐
c. Fresh tracheostomy	☐	☐	☐	☐
d. Lobectomy	☐	☐	☐	☐
e. Pneumonectomy	☐	☐	☐	☐
f. Pneumonia	☐	☐	☐	☐
g. Pulmonary embolism	☐	☐	☐	☐
h. Thoracotomy	☐	☐	☐	☐
i. Tuberculosis	☐	☐	☐	☐
C. NEUROLOGICAL				
1. Assessment				
a. Glasgow coma scale	☐	☐	☐	☐
b. Level of consciousness	☐	☐	☐	☐
2. Equipment & procedures				
a. Assist with lumbar puncture	☐	☐	☐	☐
b. Use of hyper/hypothermia blanket	☐	☐	☐	☐
3. Care of the patient with:				
a. Aneurysm precautions	☐	☐	☐	☐
b. Basal skull fracture	☐	☐	☐	☐
c. Closed head injury	☐	☐	☐	☐
d. Coma	☐	☐	☐	☐
e. CVA	☐	☐	☐	☐
f. DTs	☐	☐	☐	☐
g. Encephalitis	☐	☐	☐	☐
h. Externalized VP shunts	☐	☐	☐	☐
i. Meningitis	☐	☐	☐	☐
j. Neuromuscular disease	☐	☐	☐	☐
k. Post craniotomy	☐	☐	☐	☐
l. Seizures	☐	☐	☐	☐
m. Spinal cord injury	☐	☐	☐	☐
4. Administration of anticonvulsants	☐	☐	☐	☐
D. ORTHOPEDICS				
1. Assessment				
a. Circulation checks	☐	☐	☐	☐
b. Gait	☐	☐	☐	☐
c. Range of motion	☐	☐	☐	☐
d. Skin	☐	☐	☐	☐
2. Equipment & procedures				
a. Continuous passive motion devices	☐	☐	☐	☐
b. Support devices				
(1) Cane	☐	☐	☐	☐
(2) Cervical collar	☐	☐	☐	☐
(3) Gait belt	☐	☐	☐	☐
(4) Prosthetic	☐	☐	☐	☐
(5) Sling	☐	☐	☐	☐
(6) Transfer boards	☐	☐	☐	☐
(7) Walker	☐	☐	☐	☐
(8) Wheelchair	☐	☐	☐	☐
c. Traction	☐	☐	☐	☐
3. Care of the patient with:				
a. Amputation	☐	☐	☐	☐
b. Arthroscopic surgery	☐	☐	☐	☐
c. Cast	☐	☐	☐	☐
d. Osteoporosis	☐	☐	☐	☐
e. Pinned fractures	☐	☐	☐	☐
f. Rheumatic/arthritic disease	☐	☐	☐	☐
g. Total hip replacement	☐	☐	☐	☐
h. Total knee replacement	☐	☐	☐	☐
E. GASTROINTESTINAL				
1. Assessment				
a. Abdominal/bowel sounds	☐	☐	☐	☐
b. Fluid balance	☐	☐	☐	☐
c. Nutritional	☐	☐	☐	☐
2. Interpretation of blood chemistry	☐	☐	☐	☐
3. Equipment & procedures				
a. Administration of tube feeding				
(1) Feeding pump	☐	☐	☐	☐
(2) Gravity feeding	☐	☐	☐	☐
(3) Saline lavage	☐	☐	☐	☐
b. Flexible feeding tube (i.e., Corpak, Dobhoff)	☐	☐	☐	☐
c. Management of				
(1) Gastrostomy tube	☐	☐	☐	☐
(2) Jejunostomy tube	☐	☐	☐	☐
(3) T-tube	☐	☐	☐	☐
d. Placement of nasogastric tube	☐	☐	☐	☐
e. Salem sump to suction	☐	☐	☐	☐
4. Care of the patient with:				
a. Bowel obstruction	☐	☐	☐	☐
b. Colostomy/ileostomy	☐	☐	☐	☐
c. GI bleeding	☐	☐	☐	☐
d. GI surgery	☐	☐	☐	☐
e. Hepatitis	☐	☐	☐	☐
f. Inflammatory bowel disease	☐	☐	☐	☐
g. Invasive diagnostic testing	☐	☐	☐	☐
h. Liver failure	☐	☐	☐	☐
i. Paralytic ileus	☐	☐	☐	☐
F. RENAL/GENITOURINARY				
1. Assessment				
a. Arterio venous fistula/shunt	☐	☐	☐	☐
b. Fluid balance	☐	☐	☐	☐
2. Interpretation of lab results				
a. BUN & creatinine	☐	☐	☐	☐
b. Electrolytes	☐	☐	☐	☐
3. Equipment & procedures				
a. Insertion & care of straight and Foley catheter				
(1) Female	☐	☐	☐	☐
(2) Male	☐	☐	☐	☐

First name: Last name:

	A	B	C	D
b. Catheter care				
(1) 3-way Foley	☐	☐	☐	☐
(2) Supra-pubic	☐	☐	☐	☐
c. Bladder irrigations				
(1) Continuous	☐	☐	☐	☐
(2) Intermittent	☐	☐	☐	☐
d. Specimen collection				
(1) Routine	☐	☐	☐	☐
(2) 24 hour	☐	☐	☐	☐
4. Care of the patient with:				
a. Hemodialysis	☐	☐	☐	☐
b. Nephrectomy	☐	☐	☐	☐
c. Peritoneal dialysis	☐	☐	☐	☐
d. Renal failure	☐	☐	☐	☐
e. Renal transplant	☐	☐	☐	☐
f. TURP	☐	☐	☐	☐
g. Urinary diversion/ ileal conduit nephrostomy	☐	☐	☐	☐
h. Urinary tract infection	☐	☐	☐	☐
G. ENDOCRINE/METABOLIC				
1. Assessment				
a. S/S diabetic coma	☐	☐	☐	☐
b. S/S insulin reaction	☐	☐	☐	☐
2. Equipment & procedures				
a. Blood glucose monitoring				
(1) Electronic measuring device type _____				
(2) Performing finger stick	☐	☐	☐	☐
(3) Visual blood glucose strips	☐	☐	☐	☐
b. Indwelling insulin pump	☐	☐	☐	☐
3. Care of the patient with:				
a. Diabetes mellitus	☐	☐	☐	☐
b. Disorders of adrenal gland (Addison's disease)	☐	☐	☐	☐
c. Disorders of pituitary gland (Diabetes insipidus)	☐	☐	☐	☐
d. Hyperthyroidism (Grave's disease)	☐	☐	☐	☐
e. Hypothyroidism	☐	☐	☐	☐
f. Thyroidectomy	☐	☐	☐	☐
4. Medications (administration and teaching)				
a. Insulin	☐	☐	☐	☐
b. Oral hypoglycemics	☐	☐	☐	☐
c. Steroids	☐	☐	☐	☐
d. Thyroid	☐	☐	☐	☐
H. WOUND MANAGEMENT				
1. Assessment				
a. Skin for impending breakdown	☐	☐	☐	☐
b. Stasis ulcers	☐	☐	☐	☐
c. Surgical wound healing	☐	☐	☐	☐
2. Equipment & procedures				
a. Air fluidized, low airloss beds	☐	☐	☐	☐
b. Sterile dressing changes	☐	☐	☐	☐
c. Wound care/irrigations	☐	☐	☐	☐
3. Care of the patient with:				
a. Burns	☐	☐	☐	☐
b. Pressure sores	☐	☐	☐	☐
c. Staged decubitus ulcers	☐	☐	☐	☐
d. Surgical wounds with drain(s)	☐	☐	☐	☐
e. Traumatic wounds	☐	☐	☐	☐
I. ONCOLOGY				
1. Assessment				
a. Nutritional status	☐	☐	☐	☐
b. Pain control	☐	☐	☐	☐
2. Interpretation of lab results				
a. Blood chemistry	☐	☐	☐	☐
b. Blood counts	☐	☐	☐	☐
3. Equipment & procedures:				
a. Reverse isolation	☐	☐	☐	☐
4. Care of the patient with:				
a. Bone marrow transplant	☐	☐	☐	☐
b. Fresh oncologic surgery	☐	☐	☐	☐
c. Inpatient chemotherapy	☐	☐	☐	☐
d. Inpatient hospice	☐	☐	☐	☐
e. Leukemia	☐	☐	☐	☐
f. Radiation implant	☐	☐	☐	☐
5. Medications: Chemotherapy certification?		☐ Yes	☐ No	
J. INFECTIOUS DISEASES				
1. Interpretation of lab results: blood count	☐	☐	☐	☐
2. Equipment & procedures				
a. Fever management	☐	☐	☐	☐
b. Isolation	☐	☐	☐	☐
3. Care of the patient with:				
a. AIDS	☐	☐	☐	☐
b. Hepatitis	☐	☐	☐	☐
c. Lyme disease	☐	☐	☐	☐
K. PHLEBOTOMY / IV THERAPY				
1. Equipment & procedures				
a. Administration of blood/blood products				
(1) Albumin	☐	☐	☐	☐
(2) Cryoprecipitate	☐	☐	☐	☐
(3) Packed red blood cells	☐	☐	☐	☐
(4) Plasma	☐	☐	☐	☐
(5) Whole blood	☐	☐	☐	☐
b. Drawing blood from central line	☐	☐	☐	☐
c. Drawing venous blood	☐	☐	☐	☐
d. Starting IVs				
(1) Angiocath	☐	☐	☐	☐
(2) Butterfly	☐	☐	☐	☐
(3) Heparin lock	☐	☐	☐	☐

First name: _____ Last name: _____

	A	B	C	D
2. Care of the patient with:				
a. Central line/catheter/dressing				
(1) Broviac	☐	☐	☐	☐
(2) Groshong	☐	☐	☐	☐
(3) Hickman	☐	☐	☐	☐
(4) Portacath	☐	☐	☐	☐
(5) Quinton	☐	☐	☐	☐
b. Peripheral line/dressing	☐	☐	☐	☐

L. PAIN MANAGEMENT	A	B	C	D
1. Assessment of pain level/tolerance	☐	☐	☐	☐
2. Care of the patient with:				
a. Epidural anesthesia/analgesia	☐	☐	☐	☐
b. IV conscious sedation	☐	☐	☐	☐
c. Narcotic analgesia	☐	☐	☐	☐
d. Patient controlled analgesia (PCA pump)	☐	☐	☐	☐

Please check the boxes below for each age group for which you have expertise in providing age-appropriate nursing care.

AGE SPECIFIC PRACTICE CRITERIA

A. Newborn/Neonate (birth - 30 days)	**D. Preschooler (3 - 5 years)**	**G. Young adults (18 - 39 years)**
B. Infant (30 days - 1 year)	**E. School age children (5 - 12 years)**	**H. Middle adults (39 - 64 years)**
C. Toddler (1 - 3 years)	**F. Adolescents (12 - 18 years)**	**I. Older adults (64+)**

EXPERIENCE WITH AGE GROUPS:	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**
Able to adapt care to incorporate normal growth and development.	☐	☐	☐	☐	☐	☐	☐	☐	☐
Able to adapt method and terminology of patient instructions to their age, comprehension and maturity level.	☐	☐	☐	☐	☐	☐	☐	☐	☐
Can ensure a safe environment reflecting specific needs of various age groups.	☐	☐	☐	☐	☐	☐	☐	☐	☐

My experience is primarily in: (Please indicate number of years.)

☐ Medical ____ year(s) ☐ Oncology ____ year(s) ☐ OB/GYN ____ year(s)

☐ Surgical ____ year(s) ☐ Neurology ____ year(s) ☐ Psychiatry ____ year(s)

☐ Telemetry ____ year(s) ☐ Pediatrics ____ year(s) ☐ Rehabilitation ____ year(s)

☐ Orthopedics ____ year(s) ☐ Other (type) _____ ____ year(s)

Certification: (mo/day/yr)

☐ BCLS Exp. date: ____ / ____ / ____

☐ Computerized charting system: _____ Date: ____ / ____ / ____

☐ Medication administration system: _____ Date: ____ / ____ / ____

☐ Other (type): _____ Exp. date: ____ / ____ / ____

The information I have given is true and accurate to the best of my knowledge. I hereby authorize the Company to release this Medical/Surgical Skills Checklist to their Client facilities in relation to consideration of employment as a Traveler with those facilities.

_____ ____ / ____ / ____

Signature Date

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6095 Bristol Parkway 2nd Floor
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FAX 310-645-3034

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La Jolla, CA 92037-1802
619-457-3011
FAX 619-457-0341

Associated Health Professionals Inc.

AGE SPECIFIC CRITERIA
JOB DESCRIPTION/PERFORMANCE

EMPLOYEE NAME:_____ DATE:_____

The above staff member must be able to demonstrate the knowledge and skills necessary to provide care based on physical psych/social, educational, safety, and related criteria, appropriate to the age of the patients served in his/her assigned service area. The skills and knowledge needed to provide such care may be gained through education, training or experience.

HOW TO SCORE:
E = Experienced and competent to work with this age group
O = Not Experienced
Your entry demonstrates the knowledge, skills and abilities for the following patient population(s):

	0-1mo Neo-Natal	1mo-1yr Infant	1-12yrs Pediatric	12-18yrs Adolescent	18-65yrs Adult	65+yrs. Geriatric
1. Knowledge of growth and development						
2. Ability to assess age specific health needs						
3. Ability to assess age specific safety issues						
4. Ability to assess age specific social development						
5. Exhibits communication skills to interpret age specific response						
6. Ability to involve family/ significant other in decision making related to plan of care						
7. Ability to obtain & interpret information in the terms of the patients needs and nursing care related to physical development						

Note: The above criteria is designed to assure that the individual performing this job, demonstrates competencies appropriate to the age of the patient served.

Employee Signature:_____ Date:_____

DOMESTIC ABUSE REPORTING REQUIREMENT

California Penal Code §11160 requires all health practitioners employed by UCLA Healthcare to make an immediate report to a local law enforcement agency when in their professional capacity or within the scope of their employment, they provide medical services for physical conditions to patients who they know or reasonable suspect to be persons described as follows:

1. Any patient whose wound or injury was inflicted by his/her own act, by means of a firearm.
2. Any patient whose wound or injury was inflicted by someone else, by means of a firearm.
3. Any patient whose wound or injury is the result of assaultive/abusive conduct.

State law requires that an immediate report be made to local law enforcement followed by a written report sent within (2) working days of receiving the information concerning the incident.

A health practitioner is defined as a: physician, surgeon, psychiatrist, psychologist, resident, intern, dentist, podiatrist, chiropractor, licensed nurse (LVN's and RN's), dental hygienist, optometrist, social worker or any other person who is currently licensed under the Business and Professional Code §500 et seq.; any marriage, family and child counselor, marriage, family and child counselor trainee or unlicensed marriage, family and child counselor registered intern; a psychological assistant; emergency medical technician I or II, paramedics or any other person certified pursuant to Health and Safety Code §1797 et seq.; state or county public health employee; coroner, medical examiner, or any other person who performs autopsies; and religious practitioners (P.C.§11165.85)

The law provides that any health practitioner shall not incur either civil or criminal liability for any report required to be made under the law.

Failure to report an incident as defined above constitutes a misdemeanor and is punishable by up to six (6) month's imprisonment or a maximum fine of $1,000 or both fine and imprisonment.

Reports made under the law are confidential and may be disclosed only to the agencies specified by law.

I certify that I have read and understand this statement and will comply with my obligations under this reporting law.

_____ _____

Name Date

UCLA Healthcare

CHILD ABUSE REPORT

California Penal Code Section 11166.5 requires UCLA Healthcare to provide all "child care custodians," "medical practitioners," and "nonmedical practitioners" who commence employment on or after January 1, 1985, with the following statement. California law requires that this statement be signed by the employee as a prerequisite to employment and retained by UCLA Healthcare.

Section 11166 of the Penal Code requires any child care custodian, medical practitioner, nonmedical care practitioner 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 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 and to prepare and send a written report therefore within 36 hours of receiving the information concerning the incident.

Child care custodian means a teacher, administrative officer, supervisor of child welfare and attendance, or certificated pupil, personnel employee or any public or private school; an administrator of a public or private day camp; a licensee, an administrator, or an employee of community care facility licensed to care for children; head start teacher; a licensing worker or licensing evaluator; public assistance worker; employee of a child care institution, including, but not limited to, foster parents, group home personnel and personnel of residential care facilities; a social worker or a probation officer.

Medical practitioner means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any Emergency Medical Technician I or II, paramedic or other person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, or a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code.

Non-Medical Practitioner means a state of county public health employee who treats a minor for venereal disease or any other condition; a coroner; a paramedic; a marriage, family or child counselor or a religious practitioner who diagnoses, examines, or treats children.

I certify that I have read and understand this statement and will comply with my obligations under the child abuse reporting law.

Name *(Please Print)* _____ **Signature** _____

Date _____

Policy No. 0006 of the Medical Center Policy Manual outlines the instructions for reporting specific instances of child abuse.

ELDER/DEPENDENT ADULT ABUSE REPORT DEFINITIONS

(Please read carefully before signing Elder/Dependent Adult Abuse Reporting Statement.)

ELDER - A person residing in the state who is 65 years of age or older.

DEPENDENT ADULT - Any person residing in the state who is between the ages of 18 and 64, who has physical or mental limitations which restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. ALSO INCLUDES ANY PERSON BETWEEN THE AGES OF 18 AND 64 WHO IS ADMITTED AS AN IN-PATINET TO A 24-HOUR HEALTH FACILITY.

ABUSE - Physical abuse, neglect, intimidation, cruel punishment, fiduciary abuse, abandonment, or other treatment with resulting physical harm or pain or mental suffering, or the deprivation by a care custodian of goods and services which are necessary to avoid physical harm or mental suffering.

CARE CUSTODIAN - An administrator or an employee, EXCEPT PERSONS WHO DO NOT WORK DIRECTLY WITH ELDERS OR DEPENDENT ADULTS AS PART OF THEIR OFFICIAL DUTIES, including members of support staff and maintenance staff, of any of the following public or private facilities:

1. 24-hour health facilities
2. Clinics
3. Home health agencies
4. Adult day health care centers
5. Secondary schools which serve 18-22-year-old dependent adults and postsecondary educational institutions which serve dependent adults or elders
6. Sheltered workshops
7. Camps
8. Community facilities and residential care facilities for the elderly
9. Respite care facilities
10. Foster homes
11. Regional centers for persons with developmental disabilities
12. State Department of Social Services and State Department of Health Services licensing divisions
13. County welfare departments
14. Office of patients' rights advocates
15. Office of the long-term ombudsman
16. Office of public conservators and public guardians
17. Any other protective or public assistance agency which provides medical services or social services to elders or dependent adults.

HEALTH PRACTITIONER - Physician, surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker, marriage, family and child counselor or any person who is currently licensed under Division 2 of the Business and Professions Code, any emergency medical technician I or II, paramedic, a person certified pursuant to Division 2.5 of the Health and Safety Code, a psychological assistant, a marriage, family and child counselor trainee, or an unlicensed marriage, family and child counselor intern, a state or county public health employee who treats an elder or a dependent adult for any condition, a coroner, or a religious practitioner who diagnoses, examines, or treats elder or dependent adults.

ELDER/DEPENDENT ADULT ABUSE REPORTING STATEMENT

Section 15632 of the Welfare and Institutions Code is amended to read:

Any person who enters into employment on or after January 1, 1986, as a care custodian, health practitioner, or with an adult protective services agency or a local law enforcement agency, prior to commencing his or her employment and as a prerequisite to that employment shall sign a statement on a form, which shall be provided by the prospective employer, to the effect that he or she has knowledge of the provisions of Section 15630 and will comply with its provisions. The signed statements shall be retained by the employer.

Section 15630 of the Welfare and Institutions Code is amended to read:

(a) Any elder or dependent adult care custodian, health practitioner, or employee of a county adult protective services agency or a local law enforcement agency, who in his or her professional capacity or within the scope of his or her employment, either has observed an incident that reasonable appears to be physical abuse, has observed a physical injury where the nature of the injury, its location on the body, or the repetition of the injury, clearly indicates that physical abuse has occurred, or is told by an elder or dependent adult that he or 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 either the 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 shall prepare and send a written report thereof within 36 hours.

(b) Any care custodian, health practitioner, or employee of an adult protective services agency or local law enforcement agency who has knowledge of or reasonably suspects that other types of elder or dependent adult abuse have been inflicted upon an elder or dependent adult or that his or her emotional well-being is endangered in any other way, may report such known or suspected instance of abuse either to a long-term care ombudsman coordinator or to a local law enforcement agency when the abuse is alleged to have occurred in a long-term care facility, or to either the county adult protective services agency or to a local law enforcement agency when the abuse is alleged to have occurred anywhere else.

(c) When two or more persons who are required to report are present and jointly have knowledge of a known or suspected instance of abuse of an elder or a dependent adult, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report.

(d) The reporting duties under this section are individual, and, no supervisor or administrator may impede or inhibit the reporting duties and no person making such a report shall be subject to any sanction for making the report. However, internal procedures to facilitate reporting, ensure confidentiality and apprise supervisors and administrators of reports may be established, provided they are not inconsistent with the provisions of this chapter.

(e) An adult protective services agency shall immediately or as soon as practically possible report by telephone to the law enforcement agency having jurisdiction over the case and to any public agency given responsibility for investigation in that jurisdiction of cases of elder and dependent abuse, every known or suspected instance of physical abuse of an elder or dependent adult. A county adult protective services agency shall also send a written report thereof within 36 hours of receiving the information concerning the incident to each agency to which it is required to make a telephone report under this subdivision.

Only a written report, sent within 36 hours, shall be required in the case of types of elder and dependent adult abuse other than physical abuse.

If any adult protective services agency received a report of abuse alleged to have occurred in a long-term care facility, that adult protective services agency shall immediately inform the person making the report that he or she must make it to the long-term

care ombudsman coordinator or to a local law enforcement agency. The adult protective services agency shall not accept the reports.

ELDER/DEPENDENT ADULT ABUSE REPORTING STATEMENT (Continued)

(f) A law enforcement agency shall immediately or as soon as practically possible report by telephone to the long-term care ombudsman coordinator when the abuse is alleged to have occurred in a long-term care facility or to the county adult protective services agency when it is alleged to have occurred anywhere else, and to the agency given responsibility for the investigation of cases of elder or dependent adult abuse every known or suspected instance of abuse of an elder or a dependent adult. A law enforcement agency shall also send a written report thereof within 36 hours of receiving the information concerning the incident to any agency to which it is required to make a telephone report under this subdivision.

(g) A long-term care ombudsman coordinator may report the instance of abuse to the county adult protective services agency or to the local law enforcement agency for assistance in the investigation of the abuse if the victim gives his or her consent.

(h) When a county adult protective services agency, a long-term care ombudsman coordinator, or a local law enforcement agency receives a report of abuse, neglect, or abandonment of an elder or dependent adult alleged to have occurred in a long-term care facility, that county adult protective services agency, long-term care ombudsman coordinator, or local law enforcement agency shall report the incident to the licensing agency by telephone as soon as possible.

(i) Each long-term care ombudsman coordinator shall report to the county adult protective services agency monthly on the reports it receives pursuant to this chapter. The reports shall be on forms adopted by the department. The information reported shall include, but shall not be limited to, the number of incidents of abuse, the type of abuse, and the actions taken on such reports. For purposes of these reports, sexual abuse shall be reported separately from physical abuse.

(j) Each county adult protective services agency shall report to the State Department of Social Services monthly on the reports received pursuant to this chapter. The reports shall be made on forms adopted by the department. The information reported shall include, but shall not be limited to, the number of incidents of abuse, the number of persons abused, the type of abuse sustained, and the actions taken on the reports. For purposes of these reports, sexual abuse shall be reported separately from physical abuse.

The county's report to the department shall include reports it receives from the long-term care ombudsman coordinator pursuant to subdivision (i)

I certify that I have read and understand this statement and will comply with my obligations under the child abuse reporting law.

Name *(Please Print)*

Signature

Date

See facility Policy Manual for specific instructions for reporting Elder/Dependent Adult Abuse.

CONFIDENTIALITY AGREEMENT
UCLA HEALTHCARE

Applies to all UCLA Healthcare "workforce members" including: employees, medical staff and other health care professionals; volunteers; agency, temporary and registry personnel; and trainees, housestaff, students, and interns (regardless of whether they are UCLA trainees or rotating through UCLA Healthcare facilities from another institution).

It is the responsibility of all UCLA Healthcare workforce members, as defined above, including employees, medical staff, house staff, students and volunteers, to preserve and protect confidential patient, employee and business information.

The federal Health Insurance Portability Accountability Act (the "Privacy Rule"), the Confidentiality of Medical Information Act (California Civil Code § 56 et seq.) and the Lanterman-Petris-Short Act (California Welfare & Institutions Code § 5000 et seq.) govern the release of patient identifiable information by hospitals and other health care providers. The State Information Practices Act (California Civil Code sections 1798 et seq.) governs the acquisition and use of data that pertains to individuals. All of these laws establish protections to preserve the confidentiality of various medical and personal information and specify that such information may not be disclosed except as authorized by law or the patient or individual.

Confidential Patient Care Information includes: Any individually identifiable information in possession or derived from a provider of health care regarding a patient's medical history, mental, or physical condition or treatment, as well as the patients and/or their family members records, test results, conversations, research records and financial information. (Note: this information is defined in the Privacy Rule as "protected health information.") Examples include, but are not limited to:

- Physical medical and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;
- Patient insurance and billing records;
- Mainframe and department based computerized patient data and alphanumeric radio pager messages;
- Visual observation of patients receiving medical care or accessing services; and
- Verbal information provided by or about a patient.

Confidential Employee and Business Information includes, but is not limited to, the following:

- Employee home telephone number and address;
- Spouse or other relative names;
- Social Security number or income tax withholding records;
- Information related to evaluation of performance;

- Other such information obtained from the University's records which if disclosed, would constitute an unwarranted invasion of privacy; or

- Disclosure of Confidential business information that would cause harm to UCLA Healthcare.

Peer review and risk management activities and information are protected under California Evidence Code section 1157 and the attorney-client privilege.

I understand and acknowledge that:

1. I shall respect and maintain the confidentiality of all discussions, deliberations, patient care records and any other information generated in connection with individual patient care, risk management and/or peer review activities.

2. It is my legal and ethical responsibility to protect the privacy, confidentiality and security of all medical records, proprietary information and other confidential information relating to UCLA Healthcare and its affiliates, including business, employment and medical information relating to our patients, members, employees and health care providers.

3. I shall only access or disseminate patient care information in the performance of my assigned duties and where required by or permitted by law, and in a manner which is consistent with officially adopted policies of UCLA Healthcare, or where no officially adopted policy exists, only with the express approval of my supervisor or designee. I shall make no voluntary disclosure of any discussion, deliberations, patient care records or any other patient care, peer review or risk management information, except to persons authorized to receive it in the conduct of UCLA Healthcare affairs.

4. UCLA Healthcare Administration performs audits and reviews patient records in order to identify inappropriate access.

5. My user ID is recorded when I access electronic records and that I am the only one authorized to use my user ID. Use of my user ID is my responsibility whether by me or anyone else. I will only access the minimum necessary information to satisfy my job role or the need of the request.

6. I agree to discuss confidential information only in the work place and only for job related purposes and to not discuss such information outside of the work place or within hearing of other people who do not have a need to know about the information.

7. I understand that any and all references to HIV testing, such as any clinical test or laboratory test used to identify HIV, a component of HIV, or antibodies or

antigens to HIV, are specifically protected under law and unauthorized release of confidential information may make me subject to legal and/or disciplinary action.

8. I understand that the law specially protects psychiatric and drug abuse records, and that unauthorized release of such information may make me subject to legal and/or disciplinary action.

9. My obligation to safeguard patient confidentiality continues after my termination of employment with the University of California.

I hereby acknowledge that I have read and understand the foregoing information and that my signature below signifies my agreement to comply with the above terms. In the event of a breach or threatened breach of the Confidentiality Agreement, I acknowledge that the University of California may, as applicable and as it deems appropriate, pursue disciplinary action up to and including my termination from the University of California.

Dated: _____ Signature: _____

Print Name: _____

Department: _____

Corporate Office : Los Angeles
6095 Bristol Parkway, Suite 200
Culver City, CA 90230-6601
310-417-3011 800-451-4454
FAX 310-645-3034

Apple Valley Branch Office :
18155 Highway 18,
Apple Valley, CA 92307
PH: (760) 242-4483 800-428-1421
FAX : (760) 242-4823

Associated Health Professionals Inc.

2007 Hospital/Critical Access Hospital National Patient Safety Goals

If a JCAHO Surveyor selected you, would you know the 2007 Patient Safety Goals?

Note: Changes to the Goals and Requirements are indicated in **bold.** Gaps in the numbering indicate that the Goal is inapplicable to the program or has been "retired," usually because the requirements were integrated into the standards.

Goal 1	*Improve the accuracy of patient identification.*
1A	Use at least two patient identifiers when providing care, treatment or services.
Goal 2	*Improve the effectiveness of communication among caregivers.*
2A	For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the information record and "read-back" the complete order or test result.
2B	Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.
2C	Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.
2E	Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions.
Goal 3	*Improve the safety of using medications.*
3B	Standardize and limit the number of drug concentrations used by the organization.
3C	Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of these drugs.
3D	Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.
Goal 7	*Reduce the risk of health care-associated infections.*
7A	Comply with current Centers for Disease Control and Prevention

(CDC) hand hygiene guidelines.

7B Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

Goal 8 Accurately and completely reconcile medications across the continuum of care.

8A There is a process for comparing the patient's current medications with those ordered for the patient while under the care of the organization.

8B A complete list of the patient's medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. **The complete list of medications is also provided to the patient on discharge from the facility.**

Goal 9 *Reduce the risk of patient harm resulting from falls.*

9B Implement a fall reduction program including an evaluation of the effectiveness of the program.

Goal 13 ***Encourage patients' active involvement in their own care as a patient safety strategy.***

13A **Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so.**

Goal 15 ***The organization identifies safety risks inherent in its patient population.***

15A **The organization identifies patients at risk for suicide. [Applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.]**

AHP employees should know which Patient Safety Goals are the most current, which hospital policies and procedures govern the goals, and what their role is in helping each health care facility meet their patient safety goals. Look for policies and procedures and posters or flyers that promote information on the current status of patient safety initiatives in the health care facility where assigned.

Name (Please Print) _____ Signature _____ Date _____

Corporate Office: Los Angeles
6095 Bristol Parkway 2nd Floor
Culver City, CA 90230-6601
310-417-3011 818-981-4454
FAX 310-645-3034

Las Vegas Office:
2675 S. Jones Blvd. # 104,
Las Vegas, NV 89146
TEL: 702-435-3011
FAX: 702-889-3020

Associated Health Professionals Inc.

Speak Up
Report a Complaint
Facts about the Complaint Process
Quality Incident Review Criteria
Patient Safety
National Patient Safety Goals
Making Better Health Care Choices
Health Care Links

Report a Complaint

Report a complaint about a Health Care Organization

Click here to submit a new complaint.

Click here to submit an update to a complaint. (You must have your complaint reference number)

Do you have a complaint about the quality of care at a Joint Commission-accredited health care organization? The Joint Commission wants to know about it. Submit your complaint online or send it to us by mail, fax, or e-mail. Summarize the issues in one to two pages and include the name, street address, city, and state of the health care organization.

When submitting a complaint to The Joint Commission about an accredited organization, you may either provide your name and contact information or submit your complaint anonymously. Providing your name and contact information enables The Joint Commission to inform you about the actions taken in response to your complaint, and also to contact you should additional information be needed.

It is our policy to treat your name as confidential information and not to disclose it to any other party. However, it may be necessary to share the complaint with the subject organization in the course of a complaint investigation.

The Joint Commission policy forbids accredited organizations from taking retaliatory actions against employees for having reported quality of care concerns to The Joint Commission.

E-Mail:
complaint@jointcommission.org

Fax:
Office of Quality Monitoring
(630) 792-5636

Mail:
Office of Quality Monitoring
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181

If you have questions about how to file your complaint, you may contact the Joint Commission at this toll free U.S. telephone number, 8:30 to 5 p.m., Central Time, weekdays.

(800) 994-6610

Scope Of Complaint Evaluations

Complaint information is used to strengthen the oversight activities of the Joint Commission and improve the quality of care in accredited facilities. The Joint Commission addresses all complaints that relate to quality of care issues within the scope of our standards. These include issues such as patient rights, care of patients, safety, infection control, medication use and security.

The Joint Commission does not address individual billing issues and payment disputes. Also, we do not have jurisdiction in labor relations issues or the individual clinical management of a patient. The Joint Commission does not review complaints of any kind in unaccredited organizations.

How The Joint Commission Responds To Complaints

The Joint Commission encourages you to first bring your complaint to the attention of the health care organization's leaders. If this does not lead to resolution, bring your complaint to us for review.

The Joint Commission's response to a complaint begins with a review of past complaints about the organization, if any, and the organization's accreditation survey report. Depending on the nature of the complaint, the Joint Commission will take one or more of the following actions:

- Where serious concerns have been raised about patient safety or standards compliance, the Joint Commission will conduct an unannounced, on-site evaluation of the organization.
- The Joint Commission may ask the health care organization to provide a written response to the complaint.
- The Joint Commission may incorporate the complaint in the quality monitoring database that is used to continuously track the performance of health care organizations over time.
- The Joint Commission may review the complaint at the time of the health care organization's next scheduled accreditation survey if it is scheduled in the near future.
- For more information about how the Joint Commission analyzes and follows up on complaints, see the Quality Incident Review Criteria.

Release Of Complaint-Related Information

Upon request, the Office of Quality Monitoring provides the number of complaints an organization has had and the category by contacting (800) 994-6610. In addition, if an on-site review of an organization results in a change of accreditation status to conditional or preliminary denial of accreditation, these changes will be reflected in the organization's Quality Report, available in Quality Check on this website or by calling the Customer Service Center at (630) 792-5800.

After the Joint Commission completes its review of a complaint, we inform the complainant of the actions we have taken if contact information has been provided.

I have read and understand how to Report a Quality of Care Complaint to the Hospital and to The Joint Commission.

_____

Signature

_____

Print Name

_____

Date

Corporate Office: Los Angeles
6095 Bristol Parkway 2nd Floor
Culver City, CA 90230-6601
310-417-3011 818-981-4454
FAX 310-645-3034

San Diego Office:
3211 Holiday Court Suite 200
La Jolla, CA 92037-1802
619-457-3011
FAX 619-457-0341

Associated Health Professionals Inc.

ACKNOWLEDGMENT

DHS Policy No. 392.3, "Hand Hygiene in Healthcare Settings- JCAHO Requirements"

I acknowledge that I have received and read the Department of Health Services' policy No. 392.3, "Hand Hygiene in Healthcare Settings- JCAHO Requirements" and agree to abide by the provisions of this policy. If I fail to comply with this policy, I will be subject to disciplinary action, up to and including discharge.

_____
Employee Name (Please Print)

_____ _____
Employee Signature **Date**

Corporate Office: Los Angeles
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Culver City, CA 90230-6601
310-417-3011 818-981-4454
FAX 310-645-3034

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2675 S. Jones Blvd. # 104,
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TEL: 702-435-3011
FAX: 702-889-3020

Associated Health Professionals Inc.

Valley Health System
Hemet Valley Medical Center
Waste Management Program

I, _____ have read and understand my responsibilities for disposal of waste generated at Hemet Valley Medical Center. I understant that if it have any questions I can ask the Department Manager, The Infection Control Professional, the Environmental Services Manager or the Safety Officer.

_____ _____
Signature(employee) Date

As Department Manager (or designee), I have reviewed the exam and found the employee to have an understanding of the proper disposal of waste generated at Hemet Valley Medical Center.

_____ _____
Signature (manager/designee)

UCLA Healthcare

VERIFICATION CHECKLIST

for

Registry / Contract / Temporary Staff

_____ **UCLA Medical Center** _____ **Santa Monica - UCLA Medical Center**

The following Orientation and Education requirements and documents must be completed at the agency in order to work at UCLA Healthcare as a registry, contract or temporary staff member:

1. Copy of completed Agency Application
2. Verification of (3)signed Abuse Reporting Statements (child, domestic, elder)
3. Verification of signed Confidentiality Statement
4. Verification of completed HIPAA Training Module and Post Test
5. Evidence of Physical Examination/TB Testing/ Drug Screening Completion
6. Evidence of Background Check completion
7. Verification of valid License/Certification/CPR Card (if applicable)
8. Santa Monica-UCLA Medical Center Requirements:
   a. Annual Education Guide and Post Test
9. UCLA Medical Center (Westwood) Requirements:
   a. Self Study Orientation and Staff information Handbook and Post Test
   b. Infection Control Module and Post Test
10. Age Specific Education Module and Post Test
11. Review of Restraints Competency Module

An **original** license, certification and/or CPR card must be presented to UCLA Healthcare personnel before starting any assignment. These documents must be current at all times.

I, _____ have completed, signed and understand the above required documents and requirements and am ready to begin my assignment at UCLA Healthcare. I am aware that my personnel file can be audited at any time by UCLA Healthcare Human Resources or Nursing staff for compliance purposes.

_____ _____

Temporary Staff Employee Signature Date

_____ _____

Temporary Agency Representative Date

_____ _____

Agency Name Agency Phone Number

Corporate Office: Los Angeles
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Culver City, CA 90230-6601
310-417-3011 818-981-4454
FAX 310-645-3034

Las Vegas Office:
2675 S. Jones Blvd. # 104,
Las Vegas, NV 89146
TEL: 702-435-3011
FAX: 702-889-3020

Associated Health Professionals Inc.

SOLICITATION & DISTRIBUTION ACKNOWLEDGEMENT

Employees may not solicit other employees, patients, residents or clients for any cause or purpose during the working time of employees or at any time while working with patients, residents, clients or customers. When permitted, solicitation may only be done in non-work areas. For purposes of this policy, working time does not include rest breaks and meal periods and times before and after work.

Employees also may not distribute literature for any cause or purpose during their working time or the working time of other employees. When permitted, distribution may only be done in non-work areas.

Non-employees are prohibited from soliciting or distributing literature to employees anywhere on Company premises at any time for any purpose.

I acknowledge that I have received and understand the above policy in regards to solicitation and distribution and that I am expected to comply with this policy at all times while contracted to Associated Health Professionals, Inc.

_____ _____

Employee Signature Date

Corporate Office: Los Angeles
6095 Bristol Parkway 2nd Floor
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310-417-3011 818-981-4454
FAX 310-645-3034

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Associated Health Professionals Inc.

DISCRIMINATION /HARRASSMENT POLICY ACKNOWLEDGEMENT

Associated Health Professionals, Inc. will not tolerate unlawful discrimination against or harassment of an applicant, employee, patient, resident, client or customer. Harassment may include verbal or physical conduct and/or the display of written or graphic materials that denigrates an individual because of their race, color, sex, religion, national origin, veteran status, age, disability or any other protected status and creates an intimidating, hostile or offensive environment.

Any type of unlawful harassment, whether in the workplace or during outside work-sponsored activities is unacceptable and will not be tolerated. Associated Health Professionals encourages individuals who believe they are being harassed or discriminated against to promptly advise the offender that his or her behavior is inappropriate and/or unwelcome and then report the situation to their supervisor.

I acknowledge that I have received and understand the above policy in regards to discrimination and harassment and that I am expected to comply with this policy at all times while contracted to Associated Health Professionals, Inc.

_____ _____

Employee Signature Date

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Associated Health Professionals Inc.

CONFLICTS OF INTEREST ACKNOWLEDGEMENT

Employees must ensure that none of their outside personal, business or investment interests conflict with the interests of Associated Health Professionals, Inc. Conflicts of interest may exist where and employee's conduct results in improper personal gain or advantage or in any other adverse effect on the Company's interest. Situations that create an actual or apparent conflict of interest also should be avoided. For example, conflicts of interest can arise from outside employment, becoming involved in ourside commercial interests, or referring business to any firm where you have a personal interest or family relationship. You should also not accept gift or benefit that could be viewed as creating conflict of interest by resulting in improper personal gain.

You must promptly advise your supervisor or manager of any situation that may be considered a conflict of interest.

I acknowledge that I have received and understand the above policy in regards to conflicts of interest and that I am expected to comply with this policy at all times while contracted to Associated Health Professionals, Inc.

_____ _____

Employee Signature Date

Corporate Office: Los Angeles
6095 Bristol Parkway 2nd Floor
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310-417-3011 818-981-4454
FAX 310-645-3034

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Associated Health Professionals Inc.

PROTECTION OF CONFIDENTAL INFORMATION ACKNOWLEDGEMENT

Associated Health Professionals, Inc. considers its proprietary and confidential business information to be a valuable asset that must be protected against theft, loss or improper disclosure. Examples of proprietary or confidential information include but are not limited to the following materials:

1. Employment records;
2. Patient, resident, client or customer records or list;
3. Financial information;
4. Pricing Data;
5. Contracts;
6. Business plans, including marketing or development strategies;
7. Policies, procedures and manuals;
8. Internal communications; an
9. Trade secrets

This duty to maintain the confidentiality of Company Information continues to apply to you even after you leave the Company. Any employee who discloses trade secrets or confidential business information will be subject to disciplinary and legal action, even if the employee does not actually benefit from the disclosed information.

Any inquiry from the media or any outside individual should be directed to senior management.

I acknowledge that I have received and understand the above policy in regards to the protection of confidential information and that I am expected to comply with this policy at all times while contracted to Associated Health Professionals, Inc.

_____ _____

Employee Signature Date

Corporate Office: Los Angeles
6095 Bristol Parkway 2nd Floor
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310-417-3011 818-981-4454
FAX 310-645-3034

Las Vegas Office:
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Las Vegas, NV 89146
TEL: 702-435-3011
FAX: 702-889-3020

Associated Health Professionals Inc.

ACKNOWLEDGEMENT OF EMPLOYER

I, _____ acknowlege that Associated Health Professionals, Inc (AHP) is my employer and agree to uphold the rules , regulations, policies and procedures of AHP while on contract assignment at King Drew Medical Center and/or Los Angeles County Women's and Children's Hospital as an employee of Associated Health Professionals,

_____ _____
Signature Date

_____
Title

Notice To Employees About Our Mutual Arbitration Policy

Associated Healthcare Professionals, Inc. ("the Company") has adopted and implemented a new arbitration policy, requiring mandatory, binding arbitration of disputes, for all employees, regardless of length of service. This memorandum explains the procedures, as well as how the Arbitration Policy works as a whole. Please take the time to read this material. IT APPLIES TO YOU. It will govern all existing or future disputes between you and the Company that are related in any way to your employment.

Arbitration Policy & Procedures

The Company sincerely hopes that you will never have a dispute relating to your employment here. However, we recognize that disputes sometimes arise between an employer and its employees relating to the employment relationship. We also recognize that not every dispute can be successfully resolved informally. The Company believes that it is in the best interests of the employees and the Company to resolve those disputes in a forum that provides the fastest and fairest method for resolving them. Therefore, the Company has adopted and implemented this Mutual Arbitration Policy ("MAP") as a mandatory condition of employment.

The MAP applies to Company employees, regardless of length of service or status, and covers all disputes relating to or arising out of an employee's employment with the Company or the termination of that employment unless specifically excluded below. Examples of the type of disputes or claims covered by the MAP include, but are not limited to, claims against employees for fraud, conversion, misappropriation of trade secrets, or claims by employees for wrongful termination of employment, breach of contract, fraud, employment discrimination, harassment or retaliation under the Americans With Disabilities Act, the Age Discrimination in Employment Act, Title VII of the Civil Rights Act of 1964 and its amendments, the California Fair Employment and Housing Act or any other state or local anti-discrimination laws, tort claims, wage or overtime claims or other claims under the Labor Code, or any other legal or equitable claims and causes or action recognized by local, state or federal law or regulations. The MAP does not cover workers' compensation claims, unemployment insurance claims or any claims that could be made to the National Labor Relations Board. The MAP does not cover administrative claims filed with appropriate state agencies under applicable State wage and hour laws or regulations, such as claims filed with the California Department of Labor Standards Enforcement. The MAP also does not prohibit either the Company or any Company employee from filing a claim in small claims court, as long as the claim properly is within the jurisdiction of the small claims court. Because the MAP changes the forum in which you may pursue claims against the Company and effects your legal rights, you may wish to review the MAP with an attorney or other advisor of your choice. The Company encourages you to do so.

Your decision to accept employment or to continue employment with the Company constitutes your agreement to be bound by the MAP. Likewise, The Company agrees to be bound by the MAP. This mutual obligation to arbitrate claims means that both you

and the Company are bound to use the MAP as the only means of resolving any employment-related disputes. This mutual agreement to arbitrate claims also means that both you and the Company forego any right either may have to a judicial forum or a jury trial on claims relating in any way to your employment, and both you and the Company forego and waive any right to join or consolidate claims in court or in arbitration with others or to make claims in court or in arbitration as a representative or as a member of a class or in a private attorney general capacity, unless such procedures are agreed to by both you and the Company. No remedies that otherwise would be available to you individually or to the Company in a court of law, however, will be forfeited by virtue of this agreement to use and be bound by the MAP.

The MAP shall be governed solely by the Federal Arbitration Act ("FAA"), 9 U.S.C. § 1, *et seq.* If for any reason the FAA is deemed inapplicable, only then will the MAP be governed by the applicable State arbitration statutes. The National Rules for the Resolution of Employment Disputes of the American Arbitration Association ("AAA") in place at the time of the dispute will govern the procedures to be used in arbitration, unless you and the Company agree otherwise in writing.

What Is Arbitration?

Arbitration is a process in which a dispute is presented to a neutral third party, the arbitrator, for a final and binding decision. The arbitrator makes this decision after both sides present their evidence and arguments at the arbitration hearing. There is no jury. If you win, you can be awarded anything you might individually have received in a court.

The arbitration process is limited to disputes, claims or controversies that a court of law would be authorized to entertain or would have jurisdiction over to grant relief and that in any way arise out of, relate to or are associated with your employment with the Company or the termination of your employment. The parties in any such arbitration will be limited to you and the Company, unless you and the Company agree otherwise in writing. An impartial and independent arbitrator chosen by agreement of both you and the Company will be retained to make a final decision on your dispute or claim, based on application of the Company's policies and procedures and applicable law. The arbitrator's decision is final and binding on you and the Company.

A neutral party, the American Arbitration Association ("AAA"), runs the proceedings, which are held privately. Since 1926, AAA has handled many thousands of cases. Though arbitration is much less formal than a court trial, it is an orderly proceeding, governed by rules of procedure and legal standards of conduct. AAA's applicable rules provide for reasonable discovery by both parties before the arbitration hearing. The arbitrator's responsibility is to determine whether the applicable law has been complied with in the matter submitted for arbitration. The arbitrator shall render a written decision on the matter within 30 days after the arbitration hearing is concluded and post-hearing briefs, if any, are submitted.

The Company and you will share the cost of the AAA's filing fee and the arbitrator's fees and costs, but your share of such fees and costs shall not exceed an amount equal to your local court civil filing fee. Except as otherwise provided by law, you and the Company will be responsible for the fees and costs of your own respective legal counsel, if any, and any other expenses and costs, such as costs associated with witnesses or obtaining copies of hearing transcripts.

The Company has access to legal advice through its outside lawyers. You may consult with a lawyer or any other adviser of your choice. You are not required, however, to hire a lawyer to participate in arbitration.

The Company will not modify or change the agreement between you and the Company to use final and binding arbitration to resolve employment-related disputes without notifying you and obtaining your consent to such changes, although specific MAP procedures or AAA Rules may be modified from time to time as required by applicable law. Also, the Arbitrator or a court may sever any part of the MAP procedures that do not comport with the Federal Arbitration Act.

Conclusion

If after reading the above summary of the Company's arbitration policy, you have questions, you should direct them to the Company's CEO.

The Company is proud of its strong relationship with its employees, and is confident that most problems, disputes and complaints can be handled either by your immediate supervisor or by a higher level of management. The MAP will compliment these policies, by allowing you and the Company to resolve any remaining disputes in a quick, private and final manner that benefits all of us.

EMPLOYEE AGREEMENT TO ARBITRATE

I acknowledge that I have received and reviewed a copy of the Associated Healthcare Professional Inc.'s (herein "Company") Mutual Arbitration Policy ("MAP"), and I understand that it is a condition of my employment. I agree that it is my obligation to make use of the MAP and to submit to final and binding arbitration any and all claims and disputes that are related in any way to my employment or the termination of my employment with the Company, except as otherwise set forth in the MAP. I understand that final and binding arbitration will be the sole and exclusive remedy for any such claim or dispute against the Company or its parent, subsidiary, sister or affiliated companies or entities, and each of its and/or their employees, officers, directors or agents ("the Company") and that, by agreeing to use arbitration to resolve my dispute, both the Company and I agree to forego any right we each may have had to a jury trial on issues covered by the MAP, and forego any right to bring claims on a representative or class basis. I also agree that such arbitration will be conducted before an arbitrator chosen by me and the Company, and will be conducted under the Federal Arbitration Act and the applicable procedural rules of the American Arbitration Association ("AAA").

I acknowledge that in exchange for my agreement to arbitrate, the Company also agrees to submit all claims and disputes it may have with me to final and binding arbitration, and the Company further agrees that if I submit a request for binding arbitration, my maximum out-of-pocket expenses for the arbitrator and the administrative costs of the AAA will be an amount equal to the local civil court filing fee and the Company will pay all of the remaining fees and administrative costs of the arbitrator and the AAA. If any provision of the MAP is found unenforceable, that provision may be severed without affecting this agreement to arbitrate. I further acknowledge that this mutual obligation to arbitrate may not be modified or rescinded except by the mutual consent of both me and the Company.

Employee Signature Employee Name (please print) Date

Corporate Office: Los Angeles
6095 Bristol Parkway 2nd Floor
Culver City, CA 90230-6601
310-417-3011 818-981-4454
FAX 310-645-3034

Las Vegas Office:
2675 S. Jones Blvd. # 104,
Las Vegas, NV 89146
TEL: 702-435-3011
FAX: 702-889-3020

Associated Health Professionals Inc.

ACKNOWLEDGEMENT OF RECEIPT OF EMPLOYEE NOTIFICATION PACKET
California Medical Provider Network from AIGCS

My signature certifies that I acknowledge and have received the AIGCS/First Health: California Medical Provider Network Employee Notification Packet from Associated Health Professionals, Inc (AHP).

_____ _____

Employee Signature *Date*

_____

Print Name

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Associated Health Professionals Inc.

Associated Health Professionals, Inc's Meal Policy

Meal Period Waiver (Shifts in excess of 8 hours)

When I work a shift in excess of eight hours and no more than twelve hours, I wish to voluntarily waive one of my two unpaid meal periods that I would otherwise be entitled to receive under California law.

If I work more than twelve hours in a day, I must take two ½ hour unpaid meal breaks and I will inform my Manager in order to take 2 meal breaks.

I understand and agree that when I work a twelve hour shift, I must inform my Hospital Manager when I have not taken one 1/2 hour, unpaid meal break in order that accommodation can be made for me to take a ½ hour, unpaid meal break. I will not work without taking one ½ hour, unpaid meal break.

In accordance with the requirements of state law, I hereby voluntarily agree to waive one ½ hour, unpaid meal period each day. I understand that, as a result of this waiver, I will receive only one ½ hour, unpaid meal period during each 12 hour day of work and I will be paid for all working time, but not for the one ½ hour, duty-free meal period I receive. I also understand that I or the hospital in which I work may revoke this "Meal Period Waiver" at any time by providing at least one day's notice in writing to AHP of the decision to do so. This waiver will remain in effect until I exercise or the hospital exercises the option to revoke it.

I acknowledge that I have read this waiver, understand and voluntarily agree to its provisions.

_____ _____

Staff Member Name (Please Print) **Date**

_____ _____

Staff Member (Signature) **Social Security Number**

Approved for Associated Health Professionals, Inc by:

_____ _____

AHP Employee **Date**

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Apple Valley Branch Office :
19031 Highway 18, Suite 220
Apple Valley, CA 92307
Tel: (760) 242-4483 800-428-14
Fax:: (760) 242-4823

Associated Health Professionals Inc.

EMPLOYMENT AGREEMENT

Associated Health Professionals, Inc is a temporary, staff relief nursing agency. The number of hours worked by our employees is based on a combination of the needs at our client hospitals and the availability/flexibility of our nursing staff. AHP cannot guarantee any number of hours in any given week. Even if you have worked a full week, you must not expect the same in the following weeks or months.

Although we will do everything possible to meet your scheduling needs, we are not responsible for your transportation problems. If you do not have a car, we cannot guarantee that you will work close to your home, within walking distance or near a bus line.

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

Signature _____ Print Name _____ Date _____

Associated Health Professionals Inc.

EMPLOYEE ORIENTATION AT TIME OF SCREENING AND HIRE

EMPLOYEE REQUIREMENTS

1. Position Description- Ability to provide safe care with consideration of the age and health status of patients/sensitivity to cultural diversity
2. Personnel Counseling and Termination Policy
3. Confidentiality of Information, including patient, electronic and paper information
4. Patients Rights, Ethics and Responsibiities
5. Insurance Coverages - Workers Compensation, General and Professional Liability Insurance, Unemployment Insurance, SDI.
6. Industrial Injury Policy/Procedures - Reporting 6A. CAL/OSHA Guideliness For Workplace Safety
7. Contract terms for Facilities Rules & Regulations for items stated below:
   Non-County Status | Reporting On/Off- /Uniform Standard | Transcribe Orders | Capping and Running (No Solicitation)
   Medication Administration | Requirement Original Documentation | Job Description | Controlled Substance Accountability
   Documentation of Care | Incident Reporting
8. Corporate Responsibility Program 9. Prevention & Management of Assaultive Behavior Training 10. Safe Arms - Senate Bill 1368
11. Prevention of Sexual Harrassment 12. Prevention of Workplace Violence 14. Drug & Alcohol Free Workplace
15. HIPPA - Health Insurance Portability & Accountability Act requirements - Inservice module, testing and video

PATIENT SAFETY

1. * Fire, Electrical & Patient Safety
   * Hazardous Materials/MSDS/Radiation Regulations
   * Disaster & Evacuation Preparedness
   * Body Mechanics, Back Safety & Ergonomic Safety
   * Latex Allergy Safety Training
   * Patient Restraint/Restrictive Devices Policy
   * Prevention & Management of Patient Falls * Skin Care Assessment & Management for Skin Integrity * Paim Management
   * Respiratory Therapy - Oxygen Safety
2. Child/Elder/Dependent/Resident Adult Abuse Reporting Requirements
3. OSHA Regulations - Universal Blood Precautions/ TB Awareness/ Hepatitis Information/Infection Control-Exposure Control Plan
4. Patient Self Determination Act/ Advance Directives/Durable Power of Attorney/Organ Donor Protocol
5. Bill of Patient Rights and Ethics * Cultural Diversity & Spiritual Considerations
6. Domestic Violence/Diagnosis and Treatment and Reporting Guidelines
7. Competency to Educate Patients in the Use of Medications and Food & Drug Interactions
8. Infant/Child Security Policies for Maternal/Child Personnel
9. Education & Orientation for Age Specific Patient Care - Child, Adolescent, Adult and Geriatric Patients

This form is to verify that you are in receipt of the AHP Nurse Manual and that you have knowledge of and have been advised of your responsibilities regarding the above mentioned policies and procedures which it contains.
AHP is a temporary, staff relief nursing agency. The number of hours worked by our employees is based on a combination of the needs at our client hospitals and the availability/flexibility of our nursing staff. **Therefore, due to the fluctuating nature of the industry, AHP cannot guarantee any number of hours to be worked in any given week.**
Although we will do everything possible to meet your scheduling needs andrequests, AHPis not responsible for your transportation problems. If you do not have a car, we cannot guarantee you work close to your home, within walking distance or near a bus line.

Have you ever:	YES	NO
*Been named as a defendant in a malpractice action? When?_____ Who was your employer? _____	___	___
*Had a license or certification in any jurisdiction limited, suspended, revoked or voluntarily relinquished? When?____In what State?____	___	___
*Been licensed or practiced professionally under a different name? Under What name? _____	___	___
*Been denied a license? When?_____ In What State?_____For what reason? _____	___	___
*Been convicted of a misdeamenor or felony, including traffic violations? When? _____ What State? _____ What County? _____	___	___
(This includes any offense where you were found guilty, plead guilty or plead nolo contendere (no contest).)		
You may OMIT: a. Conviction of a misdeamenor while under the age of 18, if the record was sealed under Penal Code 1203.45		
b. Any conviction specified in Health and Safety Code Section 11361.5 which pertains to various marijuana offenses		
(A conviction will not necessarily disqualify you from consideration for employment)		
* Have you ever been arrested and are you out on bail or on your own recognizance and still awaiting trial	___	___
* Have you ever been released or discharged from employment or resigned to avoid such release or discharge?	___	___
If yes, please provide date(s) and circumstances: _____		
* Do you have a valid Driver's License? In what State(s)? _____ _____	___	___

If you answered YES to any of the above, please explain:

_____

_____

My signature certifies that all information contained within my application is correct and may be verified by AHP in compliance with the California Labor Law. It also acknowledges that I am aware that it is my responsibility to review the policy and procedure documents of each client hospital in which I work, prior to beginning my initial shift.

SIGNATURE:_____ PRINT NAME:_____License No_____ Date:_____

I have reviewed the applicant's qualifications & skills that qualify for the position

SIGNATURE:_____ Print Name: _____Title _____ _____Date:_____

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La Jolla, CA 92037-1802
619-457-3011
FAX 619-457-0341

Associated Health Professionals Inc.

NAME X _____ DATE _____

TO COMPLY WITH JCAHO STANDARDS, ALL NURSE'S FILES MAINTAINED IN THE AHP OFFICE MUST CONTAIN THE FOLLOWING DOCUMENTS. DEFICIENCIES ARE INDICATED BY AN "x". IT IS THE NURSE'S RESPONSIBILITY TO PROVIDE ALL DOCUMENTATION NEEDED TO COMPLY WITH JCAHO.

_____ 1. APPLICATION/ WORK HISTORY/ EDUCATIONAL BACKGROUND/ INTERVIEW - PROOF OF 1 YR ACUTE CARE OR PSYCHIATRIC HOSPITAL EXPERIENCE IN PAST 3 YEARS

_____ 2. SPECIALTY/ HOSPITAL/ SHIFT PREFERENCE LIST

_____ 3. SIGNED/ DATED NURSE FILE CHECKLIST (THIS FORM)

_____ 4. CURRENT CALIFORNIA NURSING/ RCP LICENSE

_____ 5. SOCIAL SECURITY CARD COPIED (FOR I-9)

_____ 6. A) PHOTO I.D. WITH SIGNATURE e.g. VALID DRIVER'S LICENSE OR PASSPORT (FOR I-9)

B) AUTOMOBILE INSURANCE ___YES ___NO COPY OF CERTIFICATE ___ COVERAGE LIMITS____

_____ 7. CURRENT BCLS HEALTH CARE PROVIDER CARD (MUST BE RENEWED ANNUALLY OR SEMI ANNUALLY AS HOSPITAL REQUIRES

_____ 8. PROOF OF IV CERTIFICATION (ALL LVNs)

_____ 9. CURRENT ACLS _____, NALS_____, PALS_____CARDS (MUST BE RENEWED EVERY TWO YEARS)

_____ 10. SPECIALTY CERTIFICATES: ___ICU, ___TELEMETRY, ___CCRN, ___CEN, ___MAB, ___CHEMO, ___HIGH RISK OB, ____ FETAL MONITORING, ___ACCU CHECK, ____I.V. CERTIFIED, ___HEMO MONITOR, ___ DIALYSIS ____NICU, ___PICU, ___ER, ___FIRECARD

_____ 11. RESUME (IF AVAILABLE) AND REFERENCES

_____ 12. ___PHYSICAL EXAMINATION (TAKEN WITHIN THE LAST YEAR) TO INCLUDE:
___PPD RESULT OR CHEST X-RAY
___VARICELLA(VACCINATION OR TITRE)
___MUMPS (VACCINATION OR TITRE)
___RUBELLA (VACCINATION OR TITRE)
___RUBEOLA (VACCINATION OR TITRE)
___HEPATITIS (3 VACCS OR TITRE OR WAVER
__ TB QUESTIONNAIRE(ANNUALLY UPDATED)

_____ 13. HEALTH QUESTIONNAIRE (COMPLETED AT TIME OF HIRE)

_____ 14. CERTIFICATES/ TESTS (RENEWED ANNUALLY): INSERVICE TESTS & CERTIFICATIONS
. FIRE & SAFETY . UNIVERSAL BODY SUBSTANCES/ OSHA . LATEX ALLERGY SAFETY TRAINING . PAIN MANAGEMENT
. INFECTION CONTROL/TB GUIDELINES . BODY MECHANICS . DOMESTIC VIOLENCE . SKIN CARE ASSESSMENT
. DISASTER PREPAREDNESS . HAZARDOUS WASTE/ MSDS . FALLS . RESTRAINT USE PRINCIPLES . AGE SPECIFIC CRITERIA
. CORPORATE RESPONSIBILITY . PREVENTION & MANAGEMENT OF ASSAULTIVE BEHAVIOR . CULTURAL DIVERSITY & SPIRITUAL CONSIDERATIONS

_____ 15. PHARMACOLOGY TEST (RN'S & LVN'S) - NATIONAL LEAGUE OF NURSING "MEDICATION ADMINISTRATION" - 4TH VERSION
- NATIONAL LEAGUE OF NURSING "INTRAVENOUS THERAPY PROFICIENCY"

_____ 16. IV TEST (RN'S)

_____ 17. CONSCIOUS SEDATION EXAMINATION(CEDARS) _____ PROCEDURAL SEDATION (UCLA) _____

_____ 18. BASIC NURSING OR RESPIRATORY THERAPIST SKILLS CHECKLIST (COMPLETED ANNUALLY)

_____ 19. SPECIALTY AREA(S)EXAMS_____ _____ _____ _____

_____ 20. SPECIALTY SKILLS CHECKLIST_____ _____ _____ _____

_____ 21. TWO WORK EXPERIENCE REFERENCE AUTHORIZATIONS VERBAL REFERENCES DONE BY _____

_____ 22. CONTINUING EDUCATION CLASS CERTIFICATES (PAST 2 YEARS) MUST BE TAKEN IN THE AREAS OF CLINICAL SPECIALTY IN WHICH YOU CURRENTLY WORK. HOSPITAL CONTRACTS REQUIRE 30 HOURS OF CEU'S BE PRESENT IN EACH EMPLOYEE FILE.

_____ 23. SIGNED ACKNOWLEDGEMENT OF RECEIPT AND ORIENTATION OF THE FOLLOWING DOCUMENTS:
CHILD/ ELDER/ DEPENDENT/RESIDENT ADULT ABUSE LAW
PATIENT SELF-DETERMINATION ACT
UNIVERSAL BLOOD PRECAUTIONS, HEPATITIS INFO, TB AWARENESS
INFANT/CHILD/SECURITY POLICIES FOR MATERNAL/CHILD PERSONNEL
CONTRACT TERMS FOR COUNTY FACILITIES
BILL OF PATIENT'S RIGHTS & ETHICS
PROCEDURE TO HANDLE UNSOLICITED PHONE CALLS - ST. JOHN'S
DOMESTIC VIOLENCE - DIAGNOSTIC & TREATMENT GUIDELINES
DURABLE POWER OF ATTORNEY
INSURANCE COVERAGES
CAL/OSHA GUIDELINES FOR WORKPLACE SECURITY
. PATIENT RESTRAINT POLICY
ORGAN DONOR PROTOCOL
EMPLOYEE HANDBOOK
CONFIDENTIALITY OF PATIENT, ELECTRONIC AND PAPER INFORMATION
JOB DESCRIPTION
AHP'S TERMINATION POLICY
ADVANCE DIRECTIVE PROCEDURE
AGE SPECIFIC PATIENT CARE EDUCATION & ORIENTATION
INDUSTRIAL INJURY POLICY
PATIENT EDUCATION OF MEDICATION USAGE AND FOOD & DRUG INTERACTIONS
INFANT/CHILD SECURITY POLICIES FOR MATERNAL/CHILD PERSONNEL

_____ 24 EMPLOYMENT ELIGIBILITY VERIFICATION (I-9) 25 W-4 26 AUTHORIZATION TO DISCLOSE INFORMATION

_____ 27. HOSPITAL ORIENTATION CHECK-OFF ST.JOHN'S _____CALIFORNIA HOSP _____UCLA _____OTHERS _____

I ACKNOWLEDGE AND AGREE THAT IT IS MY RESPONSIBILITY TO SUBMIT RENEWED CREDENTIALS, AS NEEDED, TO KEEP MY FILE IN JCAHO COMPLIANCE

SIGNATURE X _____ DATE _____

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Associated Health Professionals Inc.

EMPLOYEE'S AGREEMENT TO COMPLY WITH RETURN TO WORK RESTRICTIONS

In the event I sustain an on the job injury while working for **Associated Health Professionals, Inc** that results in my inability to return to work and perform my full duties, I understand that **Associated Health Professionals, Inc** may offer me work on a modified duty or restricted basis.

I unconditionally agree to comply with all limitations and/or restrictions stipulated by the treating physician, which will allow me to return to employment on this modified or restricted basis. I understand that this modified duty is considered a temporary situation to accommodate by physical limitations due to the work related injury and that **Associated Health Professionals, Inc** is not required to offer modified duty to me on a permanent basis.

It is understood and agreed that any new injury or aggravation of an existing condition resulting from my violation of the medical restrictions could result in disciplinary action up to and including termination of my employment.

MY SIGNATURE CERTIFIES THAT I HAVE READ (OR HAD READ TO ME) AND THAT I UNDERSTAND THE INFORMATION IN THIS DOCUMENT.

_____ _____

Employee Signature Date

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La Jolla CA 92037 1802
619-457-3011
FAX 619-457-0341

Associated Health Professionals Inc.

AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE ASSOCIATED HEALTH PROFESSIONALS, INC. TO UNDERTAKE A BACKGROUND CHECK ON ME, INCLUDING INFORMATION ABOUT EDUCATION, EMPLOYMENT, CONSUMER CREDIT, DEPARTMENT OF MOTOR VEHICLES, CRIMINAL OR HEALTH INFORMATION.

I FURTHER AUTHORIZE ANY ORGANIZATION, INSTITUTION OR PERSON, THAT HAS ANY RECORDS OR KNOWLEDGE OF ME, INCLUDING BUT NOT LIMITED TO EDUCATION, EMPLOYMENT. CONSUMER CREDIT, DEPARTMENT OF MOTOR VEHICLES, CRIMINAL OR HEALTH INFORMATION, TO RELEASE SUCH INFORMATION TO ASSOCIATED HEALTH PROFESSIONALS.

IN ADDITION TO AUTHORIZING THE RELEASE OF ANY INFORMATION, I HEREBY FULLY WAIVE ANY RIGHTS OR CLAIMS I HAVE OR MAY HAVE AGAINST SUCH ORGANIZATION, INSTITUTION OR PERSON, ITS' AGENTS, EMPLOYEES OR REPRESENTATIVES AND RELEASE SUCH ORGANIZATION, INSTITUTION OR PERSON FROM ANY AND ALL LIABILITY, CLAIMS OR DAMAGES THAT MAY DIRECTLY OR INDIRECTLY RESULT FROM THE DISCLOSURE OR RELEASE OF ANY INFORMATION, WHETHER SUCH INFORMATION IS FAVORABLE OR UNFAVORABLE.

A PHOTO COPY OF THIS AUTHORIZATION IS AS VAUD AS THE ORIGINAL

DATE _____

NAME (print) _____

SIGNATURE _____

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858-457-3011
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Associated Health Professionals Inc.

EMPLOYEE AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION ON EMPLOYMENT FILE, BACKGROUND CHECK, MEDICAL RECORDS, RANDOM DRUG SCREENING, AND PAYCHECK DEDUCTIONS

By affixing my signature hereunder, I authorize ASSOCIATED HEALTH PROFESSIONALS, INC. to release any and all confidential employment, background check and medical information contained in my employment file to any medical facility or entity with whom ASSOCIATED HEALTH PROFESSIONALS, INC. has a staffing agreement, and to any other governmental or regulatory agency at such agency's request. For all other purposes, ASSOCIATED HEALTH PROFESSIONALS, INC. shall keep my employment records confidential and shall advise any medical facility or other entity to which records have been provided to also keep such records confidential. I hereby hold ASSOCIATED HEALTH PROFESSIONALS, INC. harmless for any result(s) that arise with regards to the release of this confidential information by ASSOCIATED HEALTH PROFESSIONALS, INC.

Medical records information is confidential and ASSOCIATED HEALTH PROFESSIONALS, INC. will instruct client facilities and/or other entities to treat the provided information confidential as well.

I consent to a urine, blood or breath sample for the purposes of an alcohol, drug, intoxicant, or substance abuse screening tests. Furthermore, I consent to the release of the tests results for purposes of determining the fitness for employment or continued employment.

I authorize ASSOCIATED HEALTH PROFESSIONALS, INC. to deduct from my paycheck for any of the following: unpaid single-supplement housing expenses being the cost incurred for rooming by oneself instead of sharing a room with a roonm non-authorized housing expenses including but not limited to housing items taken from room(s) or other provided housing, telephone and fax charges top room left unpaid at time of depathire, any other room service charges such as movie rentals or dry cleaning costs, any damage/destruction done to room or other housing, and any other expenses due and owing to ASSOCIATED HEALTH PROFESSIONALS, INC..

I AUTHORIZE ASSOCIATED HEALTH PROFESSIONALS, INC. TO CONTACT PAST EMPLOYERS AND REFERENCES REGARDING MY EMPLOYMENT HISTORY. I HEREBY RELEASE ALL PREVIOUS EMPLOYERS AND REFERENCES FROM ANY LIABILITY FOR FURNISHING THIS INFORMATION. I FURTHER AUTHORIZE THE RELEASE OF INFORMATION IN THIS APPLICATION, REFERENCE INFORMATION AND MEDICAL INFORMATION TO ASSOCIATED HEALTH PROFESSIONALS, INC. AND ANY FACILITIES WHERE I MIGHT BE SENT ON ASSIGNMENT.

My signature hereunder further indicates that I have read the EMPLOYEE AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION ON EMPLOYMENT FILE, BACKGROUND CHECK, MEDICAL RECORDS, RANDOM DRUG SCREENING AND DEDUCTION FROM PAYCHECK POLICY in its entirety and understand its contents.

I understand that my employment is "at will" and may be terminated by ASSOCIATED HEALTH PROFESSIONALS, INC. or me at any time, with or without prior notice, for any lawful reason or no reason. I further understand no contract is intended by ASSOCIATED HEALTH PROFESSIONALS, INC. or me and as such my employment is not governed by any contractual relations with ASSOCIATED HEALTH PROFESSIONALS, INC. I certify that the facts contained in this application are true and accurate. I understand that any misrepresentation or omission of facts is cause for dismissal. I authorize the employer to investigate any and all statements contained herein and request the persons, firms and/or corporations named above to answer any and all questions relating to this application. I release all parties from all liability, including but not limited to, the employer and any person, firm or corporation who provides information concerning my prior education, employment or character.

Signature _____ Print Name _____ Date _____

ASSOCIATED HEALTH PROFESSIONALS, INC. Health Services does not discriminate in respect to hiring, firing, compensation, and all other terms and conditions of privileges of employment on the basis of race, color, national origin, ancestry, sex, age, pregnancy or related medical conditions, marital status, religious creed, or disability.

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FAX 619-457-0341

Associated Health Professionals Inc.

Federal law prohibits healthcare organizations such as AHP's client Hospitals who receive reimbursement from federal health care programs or provide services or items to program beneficiaries from employing individuals and utilizing AHP's employees who have been excluded or sanctioned from participation in government programs. The General Services Administration GSA List of Parties Excluded from Federal Programs and the Health and Human Services Office of Inspector General's List of Excluded Individials/Entities will be checked for all potential applicants for positions with Associated Health Professionas. Inc..

Excluded individuals identified through the verification prcess will not be eligibe for hire.

Have you been excluded/sanctioned?

_____ Yes _____ No

If yes, please provide explanation and statusof exclusion

_____

_____

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_____

Signature: _____ Date: _____