ACTIVE STAFFING RESOURCE INC.

Application for Employment

To Applicant: We deeply appreciate your interest in our organization and we are interested in your qualification. A clear understanding of your background and work history will aid us in offering the best position suited for you. Applicants are considered for all positions without regard to race, color, religion, sex, nationality, age, marital or veteran status, or the presence of a non related medical condition or handicap.

Classification _____ Specialty _____ Date of Application _____

Name _____ _____
Last First MI Email Address

Address_____
Number Street City State ZIP

Home Telephone ( ) _____ Cell Phone ( ) _____

Social Security Number _____ Driver's License No. _____ State _____

Average days available for work _____ Preferred Shift(s): _____

Su [ ] M [ ] T [ ] W [ ] Th [ ] F [ ] Sa [ ] [ ] 7am-3pm [ ] 3pm -11p [ ] 11pm-7am
[ ] 7am-7pm [ ] 7pm-7am

Emergency Contact Name & Number: _____ Relationship: _____

Will you work with AIDS patients? Yes/No Will you work with Hepatitis patients? Yes/No

Are you presently employed? Yes/No May we contact your employer? Yes/No

Have you ever been injured on the job? Yes/No

If yes, give date and explain: _____

Have you ever filed a worker's compensation case? Yes/No

If yes, give date and explain: _____

Do you have a physical condition which might limit your ability to perform or will prevent you from fulfilling your duties of the job for which you are applying? Yes/No

If yes, please explain: _____

Are you a US citizen? Yes/No Are you a resident? Yes/No Card # _____

Upon submittal of this application you must provide with proof of your ability to be legally employed in the U.S.A

If referred, name of the referring person: _____

Best time to contact: _____

EDUCATION *This section cannot be left blank*

Name of School/University____

Complete Address of School/University____

Dates Enrolled: From ________________ (mm/yy) To ________________ (mm/yy)

Diploma/Degree Level: [ ] Graduate Diploma [ ] Associate [ ] Bachelor [ ] Master

Field of Study or Major: ____

Diploma/Degree Date Issued: ________________ (mm/yy)

EMPLOYMENT HISTORY

Please document employment history for at least the prior 3 years – "see resume" is not acceptable – you must fill in the information below. ** If additional space is required please continue on the back of this page**

Please start with your most recent position.

Facility: ____
Address: ____
City: ____________________________ State: _____________________ Zip: ________________
Trauma Facility? [ ] Yes [ ] No If yes, what level? ______________________________
Was this a travel assignment? [ ] Yes [ ] NoIf yes, what agency? ____________________________
Dates: From: ___________________ To: ___________________ Type of Unit __________________
Reason for Leaving: ____
Reference/Supervisor: _______________________________ Phone: ___________________________

Facility: ____
Address: ____
City: ____________________________ State: _____________________ Zip: ________________
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Address: ____
City: ____________________________ State: _____________________ Zip: ________________
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Was this a travel assignment? [ ] Yes [ ] NoIf yes, what agency? ____________________________
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Reason for Leaving: ____
Reference/Supervisor: _______________________________ Phone: ___________________________

ACTIVE STAFFING RESOURCE INC.

PROFESSIONAL LICENSES

Type of License	License #	Expiration Date	Issuing State

PROFESSIONAL CERTIFICATIONS

Certification	✓	Expiration Date	Comments	Certification	✓	Expiration Date	Comments
ACLS	[ ]			CCRN	[ ]		
AWHONN AFM	[ ]			CEN	[ ]		
BCLS/BLS/CPR	[ ]			CHEMO	[ ]		
CPI	[ ]			CNOR	[ ]		
FIRE CARD	[ ]			IV CERT	[ ]		
MAB	[ ]			NALS	[ ]		
NIHSS	[ ]			OCN	[ ]		
NRP	[ ]			OTHER	[ ]		
PALS	[ ]						

Related courses/certification (i.e. chemotherapy, EKG, balloon pump, etc.) Please attach certifications

I certify that answers given herein are true and complete to the best of my knowledge. I authorize investigation of all statement contained in this application to be conducted to all licensing/certification agencies. I understand and agree my false statement or misrepresentation in this application will result for refusal to hire or immediate dismissal of my services.

Applicant's Signature: _____

ACTIVE STAFFING RESOURCE INC.
17315 Studebaker Road, Suite 110, Cerritos, CA 90703
Tel. No. (562) 865-3222 Fax no. (562) 865-5142

EMPLOYMENT & REFERENCE CHECK

Name of Applicant: _____

Healthcare Facility Name: _____ Tel. no: _____

Address: _____

Reference Contact Person Name: _____ Employment Date From: _____

To: _____

Reference Title/Position of Contact Person: _____ Discipline: [ ] RN [ ] LVN [ ] CNA

Have you worked with this employee within last year? [ ] Yes [ ] No Area of Specialty: _____

PLEASE CHECK THE APPROPRIATE RATING

PERFORMANCE	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
Quality of Work			
Dependability			
Teamwork			
Customer Service			
Attendance/Punctuality			
Function independently or with minimal assistance.			
Able to demonstrate clinical competency in assigned work area.			

Documentation performance, and safety patient care related concerns: [ ] Yes or [ ] No

Completed By: _____ Date: _____

Position: _____

Remarks: _____

Would you rehire? [ ] Yes [ ] No If No, why not? _____

Employee Authorization

I have applied for employment with Active Staffing Resource, Inc. and authorize them to collect any information concerning my qualifications and past performances. Further, I hereby release the company or person completing this form from any and all liability in providing the requested information.

_____ _____

Print Name and Signature Date

Revised: 7/03/18

ACTIVE STAFFING RESOURCE INC.
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_____ _____

Print Name and Signature Date

Revised: 7/03/18

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

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

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

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

ACTIVE STAFFING RESOURCE INC.

_____ (Initials) I. I acknowledge that I have received and read the Company Employee Orientation Policy and Procedure Manual (Handbook). In consideration for employment with Active Staffing Resource Inc. I agree (a) to become familiar with its term; and (b) if I do not understand or agree with any provision of the Handbook, I will discuss the provision with my organization within five (5) days from the signing of this acknowledgement.

_____ (Initials) II. In consideration for my employment with the Active Staffing Resource Inc., I agree to the following:

a) The Company employee Orientation Policy and Procedure Manual(Handbook) is a set of guidelines for the implementation of personnel policies and does not constitute an employment contract for a specific period of time or for termination only for cause;

b) The Company may modify any provisions of the Handbook at any time, and such modifications shall become effective on the date announced by written notice or upon re-issue of the Handbook;

c) I will conform to the rules and regulations of Active Staffing Resource Inc.

d) I am employed on an at-will basis and any oral statement or conduct by a supervisor or manager of the company will not alter my at-will employment;

e) On the President/CEO or its designee has the authority to enter into an agreement modifying my at-will status or creating employment for a specific time period or for termination only for cause, and such agreement must be in writing;

f) My employment may be terminated at any time, either by me or by Active Staffing Resource Inc. with or without cause.

The process of my being employed by Active Staffing Resource Inc. will not be complete until both the Company and I have signed this document.

Print Name: _____ Date: _____

Signature: _____

Active Staffing Resource Inc.: _____ Date: _____

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Tel. No. (562) 865-3222 | Fax No. (562) 865-5142
asristaffing@yahoo.com

Employee Acknowledgement the JOINT COMMISSION and OSHA Standards Competency Assessment

1. Abbreviations – Do Not Use
2. Advanced Directiveness
3. Age Specific and Cultural Competencies
4. Body Mechanics
5. Blood borne Pathogens
6. Capping
7. Confidentiality
8. Cultural Diversity and Sensitivity
9. Customer's Policies and Procedures
10. Domestic Violence, Sexual Harassment
11. Drug in a Workplace
12. End of Life Care
13. Emergency Preparedness
14. EMTALA Training
15. Fire Safety, Environmental Safety
16. Ethics of Care, Treatment and Services
17. Event of An Appropriate Reassignment
18. Guidelines on Restraints
19. Hand Washing CDC Guidelines
20. Healthcare Hazardous/Chemical Training - HAZMAT
21. Infection Control
22. National Patient Safety
23. Pain Management
24. Patient Rights
25. Patient Fall Prevention
26. Preventing Medical Error
27. Safety Orientation
28. Suspected Child, Dependent, Elder Abuse Reporting
29. Tuberculosis Control Program
30. Workplace Violence, Abuse

I have read, understand, and had been given all JCAHO and OSHA standard requirements and agree to comply with all regulations. I understand that annual compliance is expected for all requirements for ACTIVE STAFFING RESOURCE, INC.

Name & Signature: _____ Date: _____

Active Staffing: _____ Date: _____

Certification of
Health Insurance Portability & Accountability Act (HIPAA)
Privacy Training

TO BE USED WHEN RECEIVING HIPPA TRAINING VIA
VIDEO OR **PRINTED MATERIALS**

I, _____ (Print name) have received the HIPAA Privacy Training as required by Active Staffing Resource, Inc. and certify the following:

Date of Training: _____

Type of training: _____ Video

_____ Printed Materials

I further certify that I understand the material presented and will follow the guidelines. Active Staffing Resource, Inc. and contract hospitals for confidentiality and handling of patient medical information.

If I have any questions about handling confidential and/or protected health information at any hospital facility assignment, I may contact the Hospital's Privacy Official or Active Staffing Resource, Inc.

_____ _____
Signature Date

_____
Printed Name

*Initial*_____

ACTIVE STAFFING RESOURCE INC.

HIPAA EXAM

Name:_____ Date: _____ Score _____

Choose the correct answer:

1. What is HIPAA?
   a. The federal rules for Medicare payments.
   b. The federal standards for the protection of health information.
   c. The federal rules for Medicaid payments.
   d. The state rules for Medicaid.
2. What does the Privacy Rule do?
   a. The privacy rule limits the use and disclosure of protected information that is available to the patient.
   b. The privacy rule prohibits the use and disclosure of protected information to law enforcement.
   c. The privacy rule addresses the use and disclosure of an individual's (patient) health information.
   d. The privacy rule limits the use of living wills.
3. Who is not covered by the Privacy Rule?
   a. Health Plans
   b. Health Providers
   c. Business Associates
   d. Family Members
4. Which of the following is not Individually Identifiable Information?
   a. The individual's past, present or future physical or mental health or condition
   b. The provision of health care to the individual
   c. The past, present, or future payment for the provision of health care to the individual
   d. Employments records that the covered entity maintains in its capacity as an employer.
5. The "covered entity" may use or disclose protected health information when:
   a. The individual who is subject of the information (or the individual's personal representative) authorizes in writing.
   b. The information is requested by a family member
   c. The information is requested by the spouse.
6. If patients refuse to allow the agency to share his patient information with family members, the agency can refuse to provide services to this patient.
   a. True
   b. False
7. The maximum disclosure accounting period is:
   a. One year immediately preceding the accounting request.
   b. Two years immediately preceding the accounting request.
   c. Four years immediately preceding the accounting request.
   d. Six years immediately preceding the accounting request
8. Individuals have the right to request that a covered entity restrict use or disclosure of protected health information.
   a. True
   b. False

9. The covered entity must accept all requests by the patient for restrictions to the release of the patient information – no exceptions.
    c. True
    d. False
10. The individual may request that the "protected" information on file be changed.
    a. True
    b. False
11. The covered entity must accept the changes requested.
    a. True
    b. False
12. Worker's Compensation is not entitled to the protected information unless approved by the patient.
    a. True
    b. False
13. The Privacy Rule requires that every risk or an incidental use of disclosure or protected information be eliminated.
    a. True
    b. False
14. Under no circumstance can the covered entity disclose protected health information without written consent from the patient.
    a. True
    b. False
15. The covered entity must post the privacy rules in a prominent place easily seen by the patients.
    a. True
    b. False
16. The covered entity must have all of the following except:
    a. Privacy policies
    b. Workforce training and management policies
    c. Mitigation procedure
    d. Employee personnel policies
17. A legally authorized personal representative is authorized to make health care decision on an individual's behalf.
    a. True
    b. False
18. I talk about my patients if I don't use their names or any other identifiable information?
    a. True
    b. False
19. The Privacy Rule gives the patients the right to all but which one of the following:
    a. Ask to see and get a copy of her health records
    b. Have corrections added to her health information
    c. Receive notice that tells her how her health information may be used and shared
    d. Ask to see a get a copy of health records of her spouse.
20. In order to do her job well, a nurse must make reasonable efforts to use, disclose, and request the maximum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request.
    a. True
    b. False

*Initial*_____

ACTIVE STAFFING RESOURCE INC.

FLOATING POLICY

Client may reassign Employees initially requested for a particular area to other areas after arriving at Hospital, subject to Employees professional qualifications and competency. If employee refuses an assignment and Employee has not commenced work. The contracted facility shall not owe Agency any amounts in connection with the said Employee. If Employee refuses as assignment after commencing work, the contracted facility shall owe Agency amounts only for actual hours worked by Employee and shall not owe any penalties or other fees as a result of any termination of Employees assignment.

_____ _____

Printed Name & Signature Date

ACTIVE STAFFING RESOURCE INC.

FINGERNAILS POLICY

Hands are highly visible part of a man's or woman's professional image, so fingernails should always be cleaned and neatly trimmed and, if polished is worn, smooth and unchipped and a single color. Departmental policies and procedures should take into consideration occupation-specific and profession-specific requirements pertaining to safety and infection control in specifying guidelines for fingernail length, use of nail polish and artificial nails. In the health care setting, the length of fingernails should be modest, not exceeding one-quarter inch beyond the end of the finger. Artificial nails are restricted in all patient care areas.

_____ _____

Printed Name & Signature Date

ACTIVE STAFFING RESOURCE INC.

INITIAL/ANNUAL COMPETENCIES

I. SAFETY
Joint Commission National Patient:
True False

1. ___ ____ Use at least 2 ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.
2. ___ ____ Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines t take when they are home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.
3. ___ ____ You must make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.

II. BODY MECHANICS:
True False

4. ___ ____ You should lift with your back, not your legs.
5. ___ ____ Keep the eight of the patient as far from your body as possible.
6. ___ ____ If the load is too heavy, get help.

III. HAND HYGIENE:
True False

7. ___ ____ You must wash your hands before eating
8. ___ ____ You must wash your hands before and after having direct contact with a patient's intact skin (taking a pulse or blood pressure, performing physical examinations, lifting the patient in bed)
9. ___ ____ You must wash your hands after contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings.
10. ____ ____ You must wash your hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient
11. ____ ____ You must wash your hands if hands will be moving from a contaminated-body site to a clean-body site during patient care
12. ____ ____ You must wash your hands after glove removal
13. ____ ____ You must wash your hands after using a restroom

IV. UNIVERSAL PRECAUTIONS/BLOODBORNE PATHOGEN STANDARD:
Mix and Match: Please select the correct response to the answer below

14. Contact precautions _____ **A.** Used for diseases or germs that are spread in tiny droplets caused by coughing and sneezing (examples: pneumonia, influenza, whooping cough, bacterial meningitis).
15. Droplet precautions _____ **B.** Used for diseases or very small germs that are spread through the air from one person to another (examples: Tuberculosis, measles, chicken pox).
16. Airborne precautions _____ **C.** Used for infections, diseases, or germs that are spread by touching the patient or items in the room (examples: MRSA, VRE, diarrheal illness, open wounds, RSV)

True False

17. ___ ____ Standard precautions assume that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting and apply Hand Hygiene infection control practices during the delivery of health care.
18. ___ ____ Personal protective equipment should be worn when you anticipate patient contact with blood or body fluids may occur.

V. FIRE SAFETY

True False

19. ___ ____ The Occupational Safety and Health Administration (OSHA) requires employers to implement fire protection and prevention programs in the workplace
20. ___ ____ OSHA requires that all employees be trained to use fire extinguishers. Training is required upon employment and at least every two years upon hire and at least annually thereafter.
21. ___ ____ Class A - fires involving ordinary combustibles, such as paper, trash, some plastics, wood and cloth. A rule of thumb is if it leaves behind ash, it is a Class A fire.

VI. DISASTER:

True False

22. ___ ____ Disaster procedure plan for individual locations should be reviewed at the time of orientations.
23. ___ ____ Evacuation, if directed, requires patients to be moved from immediate danger.
24. ___ ____ In the event of an emergency each hospital must have an emergency disaster plan established.
25. ___ ____ Hospital Incident Command System (HCIS) is only required for certain hospitals since its inception in the late 1980's the (HCIS) has served as an important emergency management foundation for hospitals in the United States and worldwide.

VII. CARDIOPULMONARY RESUSCITATION (CPR) REVIEW

True False

26. ___ ____ At the time of orientation it is a requirement to review the cardiac arrest procedure.
27. ___ ____ Ventilate adequately (2 breaths after 30 compressions, each breath delivered over 1 second, each causing chest rise)
28. ___ ____ It is necessary to know the location of emergency equipment in your work area.

VIII. HAZARDS COMMUNICATION:

True False

29. ___ ____ All employees have the right to know about hazardous materials in the workplace.
30. ___ ____ The MDS includes safety information regarding hazardous products.

IX. DEPENDENT ADULT, ELDER, SPOUSAL AND CHILD ABUSE REPORTING:

True False

31. ___ ____ Your supervisor should be notified whenever you believe you may be required to Report an incident of abuse.
32. ___ ____ Every nurse is morally and legally responsible to report and provide protective services for the abused child.
33. ___ ____ Most abusing parents do love their children and want the best for them.

IX. SEXUAL ASSAULT/RAPE:

True False

34. ___ ____ Crisis intervention is the primary therapeutic approach to management of rape victims.
35. ___ ____ The State of California requires physicians and hospitals to notify a law enforcement Agency if a rape victim requisite examination and treatment for injuries inflicted, to be Followed by a written report.
36. ___ ____ Proper forensic documentation should be done prior to medical treatment, unless Injuries are life threatening.

X. RESTRAINT:

True False

37. ___ ____ Orders for restraint or seclusion must be by a physician, or other licensed practitioner permitted by the State and the facility to order restraint
38. ___ ____ Each order for restraint or seclusion must: Be limited to no longer than the duration of the emergency safety situation.

XI. PATIENT RIGHTS:

True False

39. ___ ____ The Patient's bill of Rights is legislated through federal and state law.
40. ___ ____ Joint Commission requires that all facilities have systems in place to receive, respond to and document patent complaints.

XII. ADVANCE DIRECTIVES:

True False

41.___ ____ All patients who can participate in a conversation should be approached to discuss advanced directive.
42.___ ____ Older Adults are presumed to have decision-making capacity until deemed otherwise.
43.___ ____ Advanced directives provide medical information based on patients wishes if they should become unable to make decisions.

XIII. END OF LIFE CARE:

True False

44.___ ____ Older people fear that their pain, symptoms, anxiety, emotional suffering, and family concerns will be ignored
45.____ ____ The nurse cannot allow the parents to express their grief.

46.____ ____ Physicians want to preserve hope. They have difficulty saying when a cure is not possible and many are uncomfortable asking about a patient's choices (e.g., hospital or home treatment, breathing machines or feeding tubes, and comfort care).

XIV. EMTALA

True False

47.___ ____ The Emergency Medical Treatment and Active Labor Act is a statute which governs when and how a patient may be (1) refused treatment or (2) transferred from one hospital to another when he is in an unstable medical condition.
48.____ ____ Any patients who "come to the emergency department requesting examination or

treatment for a medical condition must be provided with an appropriate medical screening examination to determine if he is suffering from an emergency medical condition. If he is, then the hospital is obligated to either provide him with treatment until he is stable or to transfer him to another hospital in conformance with statute's directives.

49.____ ____ Emergency medical condition – an attempt is made by the statute to provide a definition, but as usually happens the legal definition leaves much to be desired. The determination is ultimately a medical one rather than a legal one. That is not to say that it is sheltered from review. As is the case with any medical decision, it must often be made quickly with such information as is available, and is subject to critical retrospective review by physicians testifying witness in the alien setting of the courtroom, in the event of litigation.

Name & Signature: _____ Date: _____ Score: _____

Checked by: _____ Date: _____

ACTIVE STAFFING RESOURCE INC.

SEXUAL HARASSMENT EXAMINATION

Name: _____ Date: _____ Score _____

I. Choose the correct answer:

1. What is sexual harassment? Title VII of the Civil Rights Act of 1964 is a federal law that prohibits employers from discriminating against employees on the basis of sex, race, color, national origin, and religion. It generally applies to employers with 15 or more employees, including federal, state, and local governments. Title VII also applies to private and public colleges and universities, employment agencies, and labor organizations.
   A. TRUE
   B. FALSE
2. The following can be considered as Sexual Harassment:
   A. Visual conduct: leering, making sexual gestures, displaying of sexually suggestive objects or pictures, cartoons or posters.
   B. Verbal conduct: making or using derogatory comments, epithets, slurs and jokes. Verbal abuse of a sexual nature, graphic verbal commentaries about an individual's body, sexually degrading words used to describe an individual.
   C. Physical conduct: touching, assault, impeding or blocking movements.
   D. Offering employment benefits in exchange for sexual favors.
   E. All of the above.
3. Do employers have to provide training to Supervisor in California, if there are more than are 50 or more employees?
   A. TRUE
   B. FALSE

Mark the Letters (A) Quid Pro Quo or (B) Hostile Environment by the Correct Definition of Harassment Statement:

_____ Making unwelcome sexual advances or other verbal or physical conduct of a sexual nature with the purpose of, or that creates the effect of, unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment.

_____ Making unwelcome sexual advances or submission to other verbal or physical conduct of a sexual nature a term or condition, implicitly, of an individual's employment. Basing employment decisions affecting the individual on his or her submission to or rejection of such conduct.

4. Employees are subject to disciplinary action, up to and including termination for engaging in unlawful harassment or discrimination.
   A. TRUE
   B. FALSE
5. Which of the following is NOT a prevention strategy of Sexual Harassment by a Supervisor?
   A. Dismissing a claims of Harassment, because the employees were identified as friends
   B. Recognize the right to create and preserve a work environment free from sexual harassment
   C. Report all allegation of sexual Harassment
   D. Take immediate action to investigate the allegations
   E. Seek resolutions and document action(s) taken

Initial _____

6. Sexual Harassment Training In California. Employers (those who have 50 or more employees) must provide sexual harassment training to all supervisory employees that work within California. The training must last at least two hours and must be completed within six months of the time the employee assumes the supervisory position. It must also be given again to those employees once every two years.
   A. TRUE
   B. FALSE
7. TRUE OR FALSE
   Quid Pro Quo (Latin for "something for something"): This form of sexual harassment occurs when a supervisor or manager:
   - _____ demands, as an explicit or implied term or condition of employment decisions, a subordinate submit to sexual advances (this may include situations which began as reciprocal relationships, but which later ceased to be reciprocal); and/or;
   - _____ makes requests for sexual favors or other verbal, visual or physical conduct of a sexual nature that is an explicit or implied term or condition of employment decisions.
8. Which of the Following is NOT an Example of quid pro quo harassment:
   A. Requests for sexual favors in exchange for a promotion or raise;
   B. Express or implied statement that a person will be demoted or fired due to excessive attendance problems

II. True of False Questions

_____ 9. Hostile Work Environment: This form of sexual harassment occurs when an individual is subjected to unwelcome sexual advances or other gender-based conduct that is sufficiently severe or pervasive to interfere with the individual's work performance or creates an intimidating, hostile or offensive work environment. The work environment must be both subjectively and objectively perceived as abusive.

_____ 10. If my intentions were good – for example, I meant to compliment someone on how great they looked there is no way my conduct could violate the sexual harassment policy.

_____ 11. It cannot be sexual harassment if both parties are the same gender.

_____ 12. Quid Pro Quo harassment occurs when a female boss tells dirty jokes to the other women in the office.

_____ 13. If someone is offended by my behavior in the break room, they should take their break somewhere else, or at another time, since I am not "working" while I'm on my break and I have a right to freedom of speech.

_____ 14. If most people find a comment amusing and inoffensive, then the one person who is offended does not have a right to complain about harassment.

_____ 15. Harassment based on sex can include making stereotypical remarks about someone's gender.

_____ 16. Sexual harassment can only come from a boss or coworker.

_____ 17. Sexual harassment is prohibited by law and is also prohibited by my employer's policy.

_____ 18. Harassment or discrimination based on sex, race, color, religion, national origin, age, disability, ancestry, or any other characteristic protected by federal, state or local law is unlawful and also violates my employer's policy.

_____ 19. Sexual harassment involves offering job benefits in exchange for sexual favors, or alternatively threatening a person's job it they don't agree to the offer.

_____ 20. It is unlawful, and a violation of the company's policy, to retaliate against someone who resists unwelcome behavior, files a complaint about harassment or perceived harassment, or participates in an investigation.

Initial _____

ACTIVE STAFFING RESOURCE INC.

PHARMACOLOGY EXAMINATION

Name: _____ Date: _____ Score _____

I. Fill in the Blank:

1. The physician ordered: Digoxin 250 mcg po qid. The label reads 1 tablet equals 0.25 mg. How many tablets will you administer to your patient?

   _____

2. The nonsteroidal medication naproxen (Naprosyn) has been prescribed for a patient, 1375 mg/day in divided doses. Each tablet contains 0.275 g. How many tablets equal this daily dose?

   _____

3. The order reads: Ketrolac gr iss. The ampule reads 0.06 g per 1 ml. How many milliliters will you administer to the patient?

   _____

4. The label reads Heparin Sodium 10,000 USP Units/mL. The order is for Heparin 6,000 U q6h sc. How many milliliters will you administer to the patient?

   _____

5. The physician ordered 0.4 mL of potassium iodide (Iostate) expectorant. The label reads 325 mg/tsp. How many milligrams are contained in this dose?

   _____

6. The order is to give 600 mg of Ampicillin IM q8h. The directions for dilution on the 2 gm vial reads: Reconstitute with 4.8 mL of sterile water to obtain a concentration of 400 mg per mL. How many mL will you administer per dose?

   _____

7. The physician ordered 180 mg of Dilantin po q8h. The patient weighs 98 lb. The label of the drug reads 250 mg per 5 mL. How many milliliters will you administer to this patient per dose?

   _____

8. The physician ordered Amoxicillin 10 mg IM q6h. Amoxicillin is supplied in 125 mg per 5 mL. How many milliliters will you administer per dose?

   _____

Initial _____

9. The patient receives Keflex oz ss po q6h. Keflex oral suspension is ordered because he is not able to swallow pills. Keflex oral suspension is avalable as 125 mg per 5 mL.

   Give _____ mg or _____ Tbsp.

10. Ordered: Atropine 0.6 mg IM. Label reads 0.3 mg per 0.5 mL. How many milliliters will you give per dose?

    _____

11. What are the * rights to patient medication administration?

    1._____
    2. _____
    3. _____
    4. _____
    5. _____
    6. _____
    7. _____
    8. _____

II. True of False Joint Commission National Patient Medication Safety Goals

12. Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
    A. True
    B. False
13. Take extra care with patients who take medicines to thin their blood.
    A. True
    B. False
14. Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.
    A. True
    B. False

III. Choose the correct answer:

15. Walter, teenage patient is admitted to the hospital because of acetaminophen (Tylenol) overdose. Overdoses of acetaminophen can precipitate life-threatening abnormalities in which of the following organs?
    A. Lungs
    B. Liver
    C. Kidney
    D. Adrenal Glands

Initial _____

16. A contraindication for topical corticosteroid usage in a male patient with atopic dermatitis (eczema) is:
    A. Parasite infection
    B. Viral infection
    C. Bacterial infection
    D. Spirochete infection
17. The nurse is aware that the patients who are allergic to intravenous contrast media are usually also allergic to which of the following products?
    A. Eggs
    B. Shellfish
    C. Soy
    D. Acidic Fruits
18. Which of the following adverse effects is associated with levothyroxine (Synthroid) therapy?
    A. Tachycardia
    B. Bradycardia
    C. Hypotension
    D. Constipation
19. Which of the following adverse effects is specific to the biguanide diabetic drug metformin (Glucophage) therapy?
    A. Hypoglycemia
    B. GI distress
    C. Lactic acidosis
    D. Somulence
20. The most serious adverse effect of tricyclic antidepressant (TCA) overdose is:
    A. Seizures
    B. Hyperpyrexia
    C. Metabolic acidosis
    D. Cardiac arrhythmias
21. Which of the following is not a side effect of the cholinoreceptor blocker (Atropine)?
    A. Increased pulse
    B. Urinary retention
    C. Constipation
    D. Mydriasis
22. Which of the following are not treated with Hydrochlorothiazide?
    A. CHF
    B. HTN
    C. Nephritis.
    D. Hypercalciuria

Initial _____

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CONSENT TO RELEASE PERSONNEL RECORDS

Name of Employee: _____ Employee ID # _____

Position Held: _____

Organization/Individual Names: _____

Address: _____

Telephone # _____ Fax # _____

Remarks: _____

_____

Contact Person in the Organization: _____

EMPLOYEE AUTHORIZATION

I authorize and grant permission to Active Staffing to release information concerning my qualifications and past performances. Further, I hereby release the company or person completing this form from any and all ability in providing the requested information.

_____ _____

Print Name Date

_____

Signature