Employment Application Packet

Please complete this Application Packet and send back by either Fax at ***818-241-4242*** *or e-mail at* ***bewellnursing@gmail.com***

To ensure our compliance with the standards of both our clients and the Joint Commission, Be Well Nursing, LLC require the following documentation in our system.

Requirements:

Resume

- explain GAPS IN EMPLOYMENT, if any to avoid delays in your Pre-qualification process
- please indicate the City and State plus month and year per work history
- also if you speak any Language other than English

Application for Employment

- Be Well Nursing, LLC Application Form
- Employment History
- Emergency Contact
- Legal Questionnaire

Employment References (3)

Professional References (2)

Clinical Skills Checklist (Completed & Signed)

Professional Credentials (please attach the following when submitting this Application)

- CA Professional license (front and back copies with signature)
- Driver's License (front and back)
- Social Security Card (front and back)
- BLS/CPR (front and back copies with signature)
- ACLS, PALS, MAB, EKG/Arrhythmia Certification as applicable (front and back copies with signature)
- Fire and Safety Card (front and back)
- Diploma (hospital requirement for education verification)
- Physician Statement, taken within the last 12 months, *Physician Statement with Signature of MD and must state that you are free of communicable diseases and in good physical and mental health (within a year)
- Chest X-ray (with complete **Radiology Report** or PPD Test (within a year with **Lot No.)**
- MMR Vaccine (within the last 10 years) or Titer
- Varicella Vaccine (within the last10 years) or Titer
- TDAP vaccine (within the last 10 years)
- Hepatitis Vaccine (proof of series within the last 10 years) or Declination r Titer
- Flu/H1N1 Vaccine (annually) or Declination

Authorization to Disclose PHI (Personal Health Information)

Background Investigation and Drug Testing Consent (10 panel)

Permanent Tax Home Notification

815 S. Central Ave., Suite 1, Glendale, CA 91204
Tel: (818) 241-9111 or (818) 241-5252 Fax: (818) 2341-4242

Application for Employment

(Please complete event if attaching a resume)

Name (Last, First and Middle Initial) _____ Maiden/Other _____

Street Address _____ City _____ State _____ Zip _____

E-mail Address _____ Social Security No. _____

Date of Birth _____ Driver's License _____ State _____ Expiration Date _____

Home Phone # _____ Alternate Phone # _____ Cell Phone # _____ Preferred call time _____

Primary Emergency Contact Name and Phone # _____ Secondary Emergency Contact Name and Phone # _____

Date Available: _____ Shift Preferred ☐ Day ☐ Night ☐ Mid-Shift

Type of position applying for (check all that apply): ☐ Per Diem ☐ 8 weeks ☐ 13 weeks+ ☐ Permanent

Do you speak any languages other than English? ☐ Yes ☐ No If yes, please list _____

How were you referred to us? ☐ Advertising ☐ Internet Site ☐ Friend/Associate _____

Other _____

Were you recruited by a Be Well Nursing, LLC Staff? ☐ Yes ☐ No If yes, list Recruiter's name _____

Have you done a Travel assignment before? ☐ Yes ☐ No If yes, with which company(s)_____

Are you able to perform the basic functions of the position for which you are applying without any restrictions?
☐ Yes ☐ No If no, please explain _____

Please use the space below to let us know your preferences in terms of Facility, Commute, Restrictions, Pay, etc.

_____

_____

Emergency Contact Information

We would like to have the names of two contacts that we could call in the case of emergency. Please provide that information below for our files and reference.

Primary Contact: _____ Secondary Contact: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

Contact No.: _____ Contact No. _____

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Professional Credentials

Education: _____ To: _____ From: _____
College or University/Location

Education: _____ To: _____ From: _____
College or University/Location

Specialty (list most current experience first)

1. _____ Year of experience _____ as of (indicate date) _____

2. _____ Year of experience _____ as of (indicate date) _____

Professional Licenses (Please attach a copy of each including front and back copies)

1. CA RN License # _____ Expiry Date: _____

2. _____ Expiry Date: _____

Certifications (Please attach a copy of each including front and back copies)

☐ BCLS/CPR	Expiry Date: _____	☐ ACLS	Expiry Date: _____
☐ PALS	Expiry Date: _____	☐ NALS/NRP	Expiry Date: _____
☐ MAB	Expiry Date: _____	☐ CCRN	Expiry Date: _____
☐ CNOR	Expiry Date: _____	☐ TNCC	Expiry Date: _____
☐ EKG Cert.	Expiry Date: _____	☐ CHEMO	Expiry Date: _____
☐ Other	Expiry Date: _____	☐ Other	Expiry Date: _____

Employment History

(Please list in order, most recent first and explain gaps in employment if any)

Facility/Employer Name: _____ Unit/Floor/Dept.: _____

City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____

Dates Employed: From: _____ To: _____ Reason for leaving: _____

Position Held: _____ Discipline: _____ Unit Specialty: _____

Supervisor's Name and Title: _____ Supervisor's Phone: _____

Other Supervisor Name: _____ Phone: _____

Travel Assignment? ☐ Yes ☐ No Travel Company: _____ Local Staff Agency? ☐ Yes ☐ No

If Per Diem or Travel Assignment, list hospitals where you have worked:

_____

_____

Describe your job duties:

_____

_____

_____

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Facility/Employer Name: _____ Unit/Floor/Dept.: _____

City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____

Dates Employed: From: _____ To: _____ Reason for leaving: _____

Position Held: _____ Discipline: _____ Unit Specialty: _____

Supervisor's Name and Title: _____ Supervisor's Phone: _____

Other Supervisor Name: _____ Phone: _____

Travel Assignment? ☐ Yes ☐ No Travel Company: _____ Local Staff Agency? ☐ Yes ☐ No

If Per Diem or Travel Assignment, list hospitals where you have worked:

_____

_____

Describe your job duties:

_____

_____

_____

Facility/Employer Name: _____ Unit/Floor/Dept.: _____

City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____

Dates Employed: From: _____ To: _____ Reason for leaving: _____

Position Held: _____ Discipline: _____ Unit Specialty: _____

Supervisor's Name and Title: _____ Supervisor's Phone: _____

Other Supervisor Name: _____ Phone: _____

Travel Assignment? ☐ Yes ☐ No Travel Company: _____ Local Staff Agency? ☐ Yes ☐ No

If Per Diem or Travel Assignment, list hospitals where you have worked:

_____

_____

Describe your job duties:

_____

_____

_____

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Facility/Employer Name: _____ Unit/Floor/Dept.: _____

City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____

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Supervisor's Name and Title: _____ Supervisor's Phone: _____

Other Supervisor Name: _____ Phone: _____

Travel Assignment? ☐ Yes ☐ No Travel Company: _____ Local Staff Agency? ☐ Yes ☐ No

If Per Diem or Travel Assignment, list hospitals where you have worked:

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Describe your job duties:

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Facility/Employer Name: _____ Unit/Floor/Dept.: _____

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Supervisor's Name and Title: _____ Supervisor's Phone: _____

Other Supervisor Name: _____ Phone: _____

Travel Assignment? ☐ Yes ☐ No Travel Company: _____ Local Staff Agency? ☐ Yes ☐ No

If Per Diem or Travel Assignment, list hospitals where you have worked:

_____

_____

Describe your job duties:

_____

_____

_____

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Name: _____ Date: _____

Position Applied For: _____

LEGAL QUESTIONNAIRE

Have you ever:

1. been named as a defendant in a professional liability claim? ☐ Yes ☐ No If yes, when? _____

   Who was your employer at that time? _____

2. had a license or certification in any jurisdiction limited, suspended, revoked or voluntarily relinquished?
   ☐ Yes ☐ No If yes, when? _____ In what state? _____

3. been licensed or practiced professionally under a different name? ☐ Yes ☐ No

   If yes, under what name? _____ and what state? _____

4. Are you eligible to work in the U.S.? ☐ Yes ☐ No Alien ID number: _____ (if applicable)

5. been denied a license? ☐ Yes ☐ No If yes, what state? _____ when? _____

   What reason? _____

6. been convicted by misdemeanor, felony including traffic violations? ☐ Yes ☐ No

   If yes, when? _____ in 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 misdemeanor while under the age of 18, if the records were sealed under the Penal code 1203.45b. 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).

7. been arrested and are you out on bail on your own recognizance and still awaiting trial? ☐ Yes ☐ No

8. been released or discharged from employment or resigned to avoid such release or discharged? ☐ Yes ☐ No

   If yes, please provide dates and circumstances? _____

   _____

   _____

9. had your driver's license suspended or revoked? ☐ Yes ☐ No ☐ Yes If yes, when? _____

   Please explain why? _____

My signature certifies that all information contained within my application is correct and maybe verified by Be Well Nursing, LLC in compliance with the California Law. It also acknowledges that I am aware that it is my responsibility to review the policy and procedure documents of each hospital/facility in which I work, prior to beginning my initial shift.

Applicant's Signature: _____ Date: _____ Position: _____

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Application for Employment

Be Well Nursing, LLC ("Company") is an Equal Opportunity Employer. All applicants are considered for employment regardless of age, race, gender, religion, national origin, disability, marital status or any other factor prohibited by law.

Please take a moment to review and acknowledge your understanding and acceptance of this Agreement.

☐ I certify that the information provided on this Application is accurate. I understand that the withholding of information or the giving of false information on this Application may result in a refusal to hire or disciplinary action including, but not limited to, termination. I understand and agree that if I am offered employment by the company, it will be on an at-will basis. This means that either the Company or I may terminate the employment relationship at any time, for any reason, with or without cause or notice. I also understand and agree that only an officer of the Company can enter into an agreement on any other terms and he/she can only do so in writing signed by the officer and me. I have read the above before signing this Application.

☐ I further understand and waive my right of privacy in this investigation and release and hold harmless Be Well Nursing, LLC from any liability.

☐ I agree that any decision to hire me is contingent upon the results of my report, and certify that all statements and answers on my Application, resume, or interview are true and complete to the best of my knowledge. I understand that if any statements are false or that if information has been omitted, this will cause for disqualification and immediate termination of my employment. I further authorize Be Well Nursing, LLC to check my conviction record as needed, on a continuous basis as it relates to my employment.

☐ I authorize Be Well Nursing, LLC to release any employment records, including health records submitted to them in consideration of employment at the customer facility where I am being placed at.

Applicant's Full Name: _____

Applicant's Signature: _____ Date: _____

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Employment Reference Check #1

* Clinical references must provide dates of employment, give a rating of work history, state the position or specialty that the candidate worked. State the title of the person giving the reference such as Charge RN, RN Supervisor, DON, Nurse Manager. This reference MUST be someone who the candidate reported to directly on the floor unit.*

Applicant's Name _____ Position Held _____

Dates of Employment: From/To _____ Current/Former Employer _____

City _____ State _____ Supervisor's Name _____

☐ I hereby give permission to the above named employer to release information to Be Well Nursing, LLC regarding my performance while employed at that facility.

Applicant's Signature: _____ Date: _____

Employment History

The person above is applying for an employment with Be Well Nursing, LLC and has listed you as previous employer. We would appreciate your assistance in verifying employment and evaluating job performance. All information will be treated with utmost confidentiality.

Is this employee eligible for rehire? ☐ Yes ☐ No

Personal Evaluation	Excellent	Above Average	Average
Demonstrates technical proficiency			
Consistent in quality of work			
Adheres to facility policies and procedures			
Flexibility and adaptability			
Attendance and punctuality			
Overall professionalism			

Comments: _____

_____

Employer's Signature _____ Title _____ Date _____

Note to the Staffer--Please indicate if this is a Verbal Verification: _____

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Employment Reference Check #2

* Clinical references must provide dates of employment, give a rating of work history, state the position or specialty that the candidate worked. State the title of the person giving the reference such as Charge RN, RN Supervisor, DON, Nurse Manager. This reference MUST be someone who the candidate reported to directly on the floor unit.*

Applicant's Name _____ Position Held _____

Dates of Employment: From/To _____ Current/Former Employer _____

City _____ State _____ Supervisor's Name _____

☐ I hereby give permission to the above named employer to release information to Be Well Nursing, LLC regarding my performance while employed at that facility.

Applicant's Signature: _____ Date: _____

Employment History

The person above is applying for an employment with Be Well Nursing, LLC and has listed you as previous employer. We would appreciate your assistance in verifying employment and evaluating job performance. All information will be treated with utmost confidentiality.

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Demonstrates technical proficiency			
Consistent in quality of work			
Adheres to facility policies and procedures			
Flexibility and adaptability			
Attendance and punctuality			
Overall professionalism			

Comments: _____

_____

Employer's Signature _____ Title _____ Date _____

Note to the Staffer--Please indicate if this is a Verbal Verification: _____

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BACKGROUND INVESTIGATION and DRUG/ ALCOHOL TESTING AUTHORIZATION

I, _____ , hereby authorize ***Be Well Nursing, LLC*** and/or its agents to make an independent investigation of my background, references, characters, past employment, education, criminal or police records, including those maintained by both public and private organizations and all public records for the purpose of confirming the information contained on my application and/or obtaining other information which may be material to my qualifications for employment now and, if applicable, during the tenure of my employment with Company.

As part of the application process, I understand that according to the ***Be Well Nursing, LLC's*** Substance Abuse Policy and Control Program, I am required to participate in a fit for duty examination, including urine and/or blood screens or other medical examinations for alcohol, drugs and controlled substances. I understand that if the test results indicate that I have been consuming any illegal or non-prescribed drugs, these findings will disqualify me from employment with ***Be Well Nursing, LLC***.

I also understand as a condition of any offer of employment, that I will be required to participate in any requested future fit for duty examinations based upon "reasonable suspicion", "for cause", or any other lawful reason(s). These tests may be, but are not limited to urine, and/or blood screens or other medical examinations and will test for any use of alcohol, drugs or controlled substances.

I also understand, as a condition of employment, that I may be subject to random drug testing. I consent to these future examinations, including specimen collection and the release of test results to the company. I understand that if at any time refuse to submit to, release the results of, these examinations or if the test results indicate that I was under the influence of alcohol or that I was consuming any illegal or non-prescribed drugs, these findings will result in immediate removal from the worksite and the appropriate disciplinary action, up to and including termination. I further understand that all drug/alcohol testing will be conducted by a certified laboratory with all data to be held in confidence except as otherwise necessary to carry out the terms and objectives of this policy.

I consent to the release of the results of any drug test to authorized representatives of ***Be Well Nursing, LLC*** for appropriate review. I release ***Be Well Nursing, LLC*** and/or its agents and any person or entity, which provides information pursuant to this authorization, from any and all liabilities, claims or law suits in regards to the information obtained from any and all of the above referenced sources used.

_____ _____

Signature Today's Date

_____ _____

Please Print Full Name Please Print Other Names You Have Used

_____

Social Security Number - Your social security number will be used to confirm your identity for completing the investigation testing.

_____

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

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Authorization for Use Disclosure of Health Information

I authorize the use or disclosure of my health information as described below.

1. Person(s) or class of persons authorized to use or disclose the information: (Note: e.g. Name of Provider, lab, etc. that will disclose the information)

Please List: _____

2. Person(s) or class of persons authorized to receive the information: **Be Well Nursing, LLC and its authorized employees only**

3. Description of information that may be used or disclosed: (Note: e.g. all information related to a specific test or type of evaluation)

Please List: _____

4. The information will be used or disclosed for the following purposes:
For use by **Be Well Nursing, LLC** and its clients in evaluating my qualifications for employment opportunities and related activities.

5. I understand that if the person or entity that receive the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

6. I understand that I may revoke this authorization at any time by sending a written request to the party identified in paragraph 1, except to the extent that action has been taken in reliance on this authorization.

7. This authorization expires _____ [Please insert a date or described the termination of an event or activity related to the individual or to the purpose of the authorization. This date relates to the termination of the right to the provider to disclose the information and not to **Be Well Nursing, LLC** right to use this information, which, once the information is disclosed, does not terminate].

☐ I acknowledge, understood and accept this Agreement/Statement.

_____ _____
Signature Date

_____
Applicant's Full Name

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Form W-4 (2012)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2012 expires February 18, 2013. See Pub. 505, Tax Withholding and Estimated Tax.

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

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

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

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

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2012. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. The IRS has created a page on IRS.gov for information about Form W-4, at *www.irs.gov/w4*. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted on that page.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E** _____
F	Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to seven eligible children or **less** "2" if you have eight or more eligible children. • If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child	**G** _____
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

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

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2012

1	Your first name and middle initial	Last name	**2** **Your social security number**
	Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	**4** **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	
5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)		**5**
6	Additional amount, if any, you want withheld from each paycheck		**6** $
7	I claim exemption from withholding for 2012, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►		**7**

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ► **Date** ►

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

OMB No. 1615-0047; Expires 08/31/12

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

Form I-9, Employment Eligibility Verification

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

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

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

Print Name: Last	First	Middle Initial	Maiden Name

Address *(Street Name and Number)*	Apt. #	Date of Birth *(month/day/year)*

City	State	Zip Code	Social Security #

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

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

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

Employee's Signature | Date *(month/day/year)*

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

Preparer's/Translator's Signature	Print Name

Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

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

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

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

Signature of Employer or Authorized Representative	Print Name	Title

Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

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

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____ Document #: _____ Expiration Date *(if any)*: _____

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

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

Payroll Check Agreement

1. **Payroll Authorization**

   Please initial the appropriate response.

   Direct Deposit (_____) Mail (_____) Pick-up (_____)

   I, _____, understand that Be Well Nursing. LLC is not responsible for the delivery of my check after it is mailed, and that any delay in delivery is not the fault of the Registry. I also accept the responsibility of the bank charges for having a Stop Payment Order placed on lost checks. (The charge will be the current fee levied by the bank upon which the payroll checks are drawn.)

2. **Promissory Note**

   I, _____, agree to return to Be Well Nursing, LLC within 72 hours, any payment received in excess of my actual hours worked. This overpayment will be returned by working a shift in which an adjustment can be made to my next paycheck; otherwise, I agree to write a personal check or money order made payable to Be Well Nursing, LLC for the amount due. This also applies to any expenses related to my employment with the company such as but not limited to drug screen, physical, TB test, etc.

3. **Travel Nurse** (Address more than 50 miles from Los Angeles.)

   Please initial the appropriate response.

   (YES) _____ (NO) _____, please initial.

   - Stipend will be paid base on IRS Per Diem Rates in accordance to publication 1542.
   - Stipend is paid every Mondays of the following week in accumulation of all shift worked on prior cut-off, Sunday to Monday. Remainder is paid regularly in accordance to the company's compensation schedule.

In case of any changes in the future, please inform Be Well Nursing, LLC as soon as possible.

*All payroll checks must be cashed within **30 days** from the date on the check.*

_____ _____

Employee Signature Date

815 S. Central Ave., Suite 1, Glendale, CA 91204
Tel: (818) 241-9111 or (818) 241-5252 Fax: (818) 2341-4242

ANNUAL REVIEW OF OSHA/JCAHO GUIDELINES

I have received the Orientation Manual and Annual Review:

MISSION STATEMENT AND POLICY & PROCEDURES

1. Body Mechanics
2. Fire and Electrical Safety
3. Radiation Safety
4. Hazardous Materials Communications
5. Infection Control / Bloodborne Pathogens
6. Emergency Preparedness
7. General Safety / Security
8. Physical Assault – Work Place Violence
9. Domestic Violence
10. Suspected Child Abuse and Neglect
11. Sexual Assault
12. Suspected Elder/Dependent Adult Abuse and Neglect
13. Patient Education
14. Organ and Tissue Donation
15. Restraint Devices
16. Quality Improvement and Risk Management
17. Do not Send Prevention/DNU Abbreviations
18. Pain Management Survey
19. Cultural Diversity
20. Conscious Sedation
21. Age Related Nursing Care Issued
22. Drug Free Workplace
23. Blood Glucose Monitoring
24. Patient Fall Prevention
25. Suicidality and Suicidal Assessment
26. Medication Error Prevention
27. Job Description
28. Capping
29. Patient Rights and Advance Directives
30. National Patient Safety Goals
31. Code of Conduct
32. Confidentiality
33. Nail Policy
34. HIPA
35. End of Life Care

IN SERVICE TO THE FOLLOWING:

1. Client and Agency confidentiality Policy
2. Agency Handbook
3. "Do Not Use List" abbreviations
4. JCAHO Patient Safety Goals
5. 2009 Deficit Reduction Act (DRA)
6. 1991 Patient Self Determination Act
7. Applicant Statement
8. Personnel Guidelines
9. Conditions of Employment
10. Child, Elder and Domestic Violence Abuse Statement
11. Disaster Preparedness/Earthquake
12. Orientation to: Client & Company Policies & Procedures
13. Nursing Code of Conduct
14. California State Code 707007
15. Patient Bill of rights
16. Hand Hygiene & Fingernails/Artificial Nails Guidelines

Printed Name: _____

Signature: _____ Date: _____

Be Well Nursing, LLC:

Staff Name: _____ Signature: _____

Date: _____

BE WELL NURSING, LLC

CALIFORNIA MEAL WAIVER FOR EMPLOYEES IN THE HEALTHCARE INDUSTRY

(Complete only ONE of the following)

Name: _____ Classification: _____

MEAL PERIOD WAIVER

Pursuant to California Law, I understand that I am entitled to take two meal periods if I work in excess of 10 hours. I also understand that California law entitles me to waive one of those two meal periods. Therefore, in accordance with California law, I voluntarily agree to waive one meal period each day that I work in excess of 10 hours. Based on this waiver, I understand that I will receive only one duty-free meal period for which I will not be compensated. I agree to indicate on my timesheet if I fail to take any other required meal period or rest period. I will be paid for all other working time, including the second meal period that I waived. I acknowledge that this Meal Period Waiver will remain in effect until the earlier of: (1) the last day of a 3o-day break following your contract end date or (2) until I revoke it by providing a written notice of such revocation to the Company written at least one day's prior written notice.

I acknowledge that (1) have read this waiver, (2) have had an opportunity to ask the Company any questions I may have with respect hereto and (3) understand the terms of this waiver and agree hereto.

Signature: _____ Date: _____

DECLINATION OF MEAL PERIOD WAIVER

Pursuance to California law, I understand that I am entitled to take two meal periods if I work in excess of 10 hours. I also understand that California law entitles me to waive one of those two meal periods, however, I do not wish to waive any meal periods. Accordingly, I agree to take all me timesheet if I fail to take any required meal period.

Signature: _____ Date: _____

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BE WELL NURSING, LLC

HEALTH QUESTIONNAIRE

Name: _____ Age: _____ Sex: _____

Address: _____ Home Tel.: _____ Cell No.: _____

Check Yes or No if you have had or do have any of the following illness or injuries. If yes, please explain in detail and include any medication you take on a daily basis prescribed by a physician.

Disease or Injury of:	Yes	No	**History of:**	Yes	No
Brain-CVA or permanent injury			Dizziness, fainting spells		
Eyes-glaucoma or other			Frequent Headaches		
Ears-loss of hearing			Frequent Cough/Cold/Sore Throat		
Throat-esophagitis or varicies			Unexplained nausea and vomiting		
Heart-CAD, MI, angina, congenital			Chest pain		
Lungs-emphysema, COPD, cancer			Shortness of breath		
Stomach-Ulcer, gastric reflux			Palpitation		
Intestines-Ulcer, Crohn's, Colitis			Supraventricular Tachycardia		
Liver-Hepatitis, Cancer			Poor appetite		
Spleen-blood, dyscrasia, injury			Significant weight Loss (20 lbs. or <)		
Gallbladder-cholecystitis			Significant weight Gain (20 lbs. or >)		
Kidneys-recurrent UTI, pyelonephritis, cancer			Asthma		
Bladder-incontinence, cancer			Night sweats		
Bones-osteomyelitis, osteoporosis			Blood in sputum or emesis		
Joint-rheumatic arthritis, osteoarthritis			Chronic constipation		
Spine-osteoporosis, kyphosis			High blood pressure		
Lymph nodes-cancer, chronic inflammation			Diabetes type 1 or type 2		
1. Have you ever been injured on the job?			Cancer		
2. Are you currently being treated for any illness/injury?			Tuberculosis		
3. Do you have a physical condition which may limit your ability to perform?			Allergies (please list)		
Do any of these diseases/ injuries/ histories prevent you from wearing protective equipment:					
TB Mask			Mask and Shield		
Latex Gloves			Isolation Gown		
Respirator					

Please explain if you have checked yes to any of the above:

_____

_____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Signature: _____ Date: _____

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BE WELL NURSING, LLC

PHYSICAL STATEMENT

Printed Name: _____ Sex: _____ DOB: _____

Address: _____

Physician Statement:

I have examined the patient and found to be in good physical and mental health, free from any back/neck problems, free from communicable disease and able to function without physical limitations as a Healthcare Professional.

Immunization Status
Documents Date Vaccine or Titer Given / Results

TEST	DATE	RANGE
Rubella Vaccine / Titer		
Rubeola Vaccine / Titer		
Mumps Vaccine / Titer		
Varicella Vaccine / Titer		
Hepatitis-B Series / Vaccine / Titer		
TDAP Vaccine		
Drug Test (10 panel)		

Does this client have any latex allergies? ☐ Yes ☐ No

Vision Screening: Right _____ Left _____

Color Blind Screening: ☐ Normal ☐ Abnormal

_____ _____ _____
Physician's Printed Name/Signature License # Date

_____
Hospital/Clinic Name and Address

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TUBERCULOSIS HEALTH SCREENING & ASSESSMENT

Name: _____ Date: _____

Date of Birth: _____ __ New Hire ___ Annual Hire Date: _____

1. Do you have a documented negative PPD skin test?	__Yes	__No	Date: _____
2. Do you have a documented history of positive PPD skin test at any time?	__Yes	__No	Date: _____
3. Have you ever received INH (isoniazid) treatment?	__Yes	__No	Date: _____
4. Did you have a chest x-ray at any time in the past (in this hospital)?	__Yes	__No	Date: _____
5. Have you had BCG immunization before?	__Yes	__No	Date: _____
6. Do you have a sign or symptom of the following:			
Productive cough which has lasted at least three weeks?	__Yes	__No	
Weight loss without dieting?	__Yes	__No	
Night sweats?	__Yes	__No	
Loss of appetite (anorexia)?	__Yes	__No	
Coughing up blood?	__Yes	__No	
Tire easily?	__Yes	__No	
Chest pain?	__Yes	__No	
Other symptoms? (if "Yes", please specify)	__Yes	__No	Specify: _____
7. (a) Are you a recent PPD skin test converted (within 2 years)?	__Yes	__No	
(b) Are you in close contact with person(s) who has active TB (outside hospital)	__Yes	__No	
(c) Do you have HIV infection?	__Yes	__No	
(d) Do you use injectable drugs?	__Yes	__No	

Persons with altered immune response because of immune deficiencies, HIV infection, leukemia, lymphoma, generalized malignancy, or immunosuppressive therapy with corticosteroids, alkylating drugs, antimetabolities, radiation, or chronic debilitating disease may be more susceptible to tuberculosis.

Signature: _____

Referred for PPD skin test
5 TU PPD Site: R L Forearm
Date given: _____ By: _____
Date read: _____ By: _____
Erythema: _____ mm Induration: _____ mm
Reactive Non-Reactive
Manufacturer: _____
Lot No.: _____ Exp. Date: _____

Referred for 2nd step PPD in 2 weeks from 1st step
5 TU PPD Site: R L Forearm
Date given: _____ By: _____
Date read: _____ By: _____
Erythema: _____ mm Induration: _____ mm
Reactive Non-Reactive
Manufacturer: _____
Lot No.: _____ Exp. Date: _____

Offer oral INH 300 mg, daily for 6 months is strongly recommended.
No need for chest x-ray this year.
Referred to designated employee health physician for follow-up.

No need for PPD skin test.
Referred to personal physician for follow-up.

Referred for Chest X-ray Impression: _____ Date: _____

PPD skin test is required annually by Be Well Nursing, LLC Chest X-Ray is only accepted with proof of a positive PPD skin test.

I have reviewed the above referenced employee's test results. Evidence of communicable disease?
Impression: _____

Nurse Practitioner/MD/PA/RN Name: _____

Signature: _____ Date: _____

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VACCINE DECLINATION

Name: _____ Classification: _____

Decline Hepatitis B Vaccine?

☐ Yes (Please read the statement and sign below) ☐ No (Please provide us proof of vaccination or titer)

I understand that due to my exposure to blood or other potentially infectious material, I may be at risk acquiring Hepatitis B virus (HBV) infection. I understand that by declining this vaccination, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I will get the vaccination from my physician.

Signature: _____ **Date:** _____

Decline Tetanus, Diphtheria and Pertussis (TDAP) Vaccine?

☐ Yes (Please read the statement and sign below) ☐ No (Please provide us proof of vaccination or booster)

I understand that due to my clinical placement, I may be at risk of exposure to Tetanus, acellular pertussis also known as Whooping Cough, and diphtheria. I have been advised to be vaccinated with the TDAP, however I decline the vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Pertussis, a serious disease, and may also expose others to the disease if I become ill.

I have read the above information and understand that I may be excluded from my clinical placement for a designated length of time if I am exposed to TDAP. I also understand that I am required to report any possible exposures to Be Well Nursing, LLC as soon as I am aware of being exposed to TDAP.

Signature: _____ **Date:** _____

Decline H1N1/Flu Vaccine?

☐ Yes (Please read the statement and sign below) ☐ No (Please provide us proof of vaccination)

My employer, Be Well Nursing, LLC, has recommended that I receive influenza/H1N1 vaccination in order to protect myself and the patients I serve.

I acknowledge that I am aware of the following facts: (1) Influenza/H1N1 is a serious respiratory disease and is recommended for me and all other healthcare workers to prevent influenza/H1N1 disease and its complications, including death. (2) If I contract influenza/H1N1, I will shed the virus for 24–48 hours before influenza symptoms appear. My shedding the virus can spread influenza/H1N1 infection to patients in this facility. (3) I understand that the strains of virus that cause influenza/H1N1 infection change almost every year, which is why a different influenza/H1N1 vaccine is recommended each year. (4) The consequences of my refusing to be vaccinated could endanger my health and the health of those with whom I have contact, including patients in this healthcare setting, my co-workers, my family, and my community.

Despite these facts, I am choosing to decline influenza/H1N1 vaccination right now. I understand that I may change my mind at any time and accept influenza/H1N1 vaccination, if vaccine is available.

Signature: _____ **Date:** _____

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BE WELL NURSING, LLC

Respiratory Fit Test Form

I have been Fit Tested within the past year. (*Please submit evidence of Fit Testing*)

Name of Facility : _____

Respirator Type : ☐ N951860S ☐ N951860 Size : ☐ Small ☐ Regular

Name: _____ Date: _____

Signature: _____

Respiratory Fit Test Declination

I understand that by declining the Respiratory Fit Test, I am potentially exposing myself to the tuberculosis bacteria and the risk of acquiring the disease. I have been given the opportunity to receive the Respiratory Fit Testing at this time. I do understand by declining this, I will continue to be at risk of acquiring Tuberculosis while caring for patients with this disease or suspected of having the disease.

Name: _____ Date: _____

Signature: _____

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BE WELL NURSING, LLC

THE ISHIHARA COLOR TEST FOR COLOR BLINDNESS

ANSWER SHEET

Name : _____ Date: _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____

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BE WELL NURSING, LLC

RESTRAINTS EVALUATION TEST

Name: _____ Date: _____ Score: _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____

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HIPAA PRIVACY TEST

Name: _____ Date: _____ Score: _____

Please encircle the correct answer to each question:

1. What is HIPAA?
   a. Health Insurance Portability and Accountability Act
   b. Health Information Publicity Amendment
   c. Healthcare Information Act

2. What is the purpose of the HIPAA Privacy Standards?
   a. Provide patients more control over the use and disclosure of their medical information.
   b. Provide hospitals and doctors with a way to organize documents
   c. Provide patients with a way to organize documents
   d. Provide patients with a unique healthcare number

3. What is PHI?
   a. Patient Health Information
   b. Protected Health Information
   c. Patient Health Insurance

4. Where is PHI in the organization?
   a. In the medical record
   b. Everywhere – on paper, computers and in conversations
   c. On the nursing unit

5. What should you do if you find PHI on a counter or on the floor?
   a. Call housekeeping.
   b. Step over it.
   c. Secure it immediately, pick it up either file or discard it.

6. Name 2 rights a patient has that affect the privacy of patient information?

   _____

   _____

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7. Who controls the use and release of patient information?
   a. The Physician
   b. The patient
   c. The Insurance company

8. If a patient has requested his information is not to be released, what do I tell the caller?
   a. Provide caller with any information he requested.
   b. We do not have information on a patient by that name
   c. Ask your supervisor before you release any information

9. Name 2 people you should call if you would like to ask a questions about the privacy of patient information:

   _____

   _____

10. What process should you follow when speaking to individuals on the phone?
    a. Telephone Identity Verification Process
    b. Telephone Connection Process
    c. Fax Connection Process

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NAIL / HAND HYGIENE POLICY

Purpose:

To provide clear guidelines that reflects evidence based medicine and reduce the risk of transmission of pathogens from healthcare workers to patients.

Definitions:

Artificial Nails

- Nail Capping or Overlay – A gel applied to the natural nails which covers and protects, cured under ultraviolet light to harden and secure the bond.
- Nail Extensions – Artificial nail tips added to existing nails and consist of acrylic, fiberglass or silk.
- Wraps – Fiberglass pre-trimmed application used with a resin either as an extension or method of strengthening the natural nail.
- Infills, Refills or Backfills – Fiberglass resin added over the existing nail or nail extension.
- Nail Art – The application of paint to the nails in various designs, suing hand painting and/or air brushing, sealed between a top and bottom coat of enamel.
- Nail Sculpture – A form of 3D nail art, also used to describe the shaping and sizing of nail extensions or creation of custom made nails.
- Nail Repair – Damaged and artificial nails repaired using fiberglass, acrylic or resins.
- Nail Jewelry – Rings, charms or "gem stones" either piercing the nail or applied to the surface of the nail.

Policy:

Artificial fingernails or fingernail enhancements contribute to nail changes that have been found to increase the colonization and transmission of pathogens to patients. Therefore, only well groomed natural nails of reasonable length (no longer than ¼" beyond the finger tip) are permitted for health care workers with direct patient contact or contact with patient food or medical supplies. Fingernails must be neat, of reasonable length, and may be polished. If nails are polished, polish must be intact. No chips or cracks in the polish.

I acknowledge that I have received and read the Department of Health Services' Policy No. 392.3 "Hand Hygiene 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.

Name: _____ Date: _____

Signature: _____

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PROFESSIONAL VERIFICATION

To: CN/Supervisor : _____ Date: _____

Hospital/Facility: _____ Phone #: _____

Applicant's Name: _____

Social Security No. : _____

Dear Employer:

The person listed has applied to Be Well Nursing, LLC for employment and has given your name as a reference. Please complete and return this form as soon as possible. We thank you for your cooperation.

APPLICANT'S SIGNATURE: _____

Other Name(s) under which I have worked: _____

THIS SECTION IS TO BE COMPLETED BY EMPLOYER

Position Held: _____ Specialty: _____ No. of Beds in Unit: _____

Would you rehire? ( ) Yes ( ) No

Employed From: _____ To: _____ Charge Experience? ( ) Yes ( ) No

*Please check appropriate description:

EVALUATION	EXCELLENT	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
Demonstrates technical proficiency				
Consistent in quality of work				
Adheres to facility policies and procedures				
Flexibility and adaptability				
Attendance and punctuality				
Overall professionalism				

Comments: _____

_____

EVALUATOR'S NAME: _____ TITLE: _____

SIGNATURE: _____ DATE: _____

For Agency Use Only: Do not fill in below this line.

Remarks: _____

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PROFESSIONAL VERIFICATION

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Would you rehire? ( ) Yes ( ) No

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*Please check appropriate description:

EVALUATION	EXCELLENT	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
Demonstrates technical proficiency				
Consistent in quality of work				
Adheres to facility policies and procedures				
Flexibility and adaptability				
Attendance and punctuality				
Overall professionalism				

Comments: _____

_____

EVALUATOR'S NAME: _____ TITLE: _____

SIGNATURE: _____ DATE: _____

For Agency Use Only: Do not fill in below this line.

Remarks: _____

815 S. Central Ave., Suite 1, Glendale, CA 91204
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INTERVIEW SHEET

Name: _____ Classification/Specialty: _____

SECTION 1

1. Be Well Nursing will always do its best to get you work at hospitals you prefer. Are you willing to work at other facilities, if your preferred hospitals have no employment to offer?	☐YES ☐NO
2. I agree to follow hospital policy including dress code.	☐YES ☐NO
3. Do you have nursing professional liability insurance? If yes, please furnish Be Well Staffing, LLC a copy of your policy.	☐YES ☐NO
4. Are you currently employed with other registries? If yes, please state what other agencies. a. _____ ☐Per Diem ☐Travel b. _____ ☐Per Diem ☐Travel c. _____ ☐Per Diem ☐Travel	☐YES ☐NO
5. Are you currently employed in any hospital or facility? If yes, please specify a. _____ ☐In-House Staff ☐Travel b. _____ ☐In-House Staff ☐Travel	☐YES ☐NO
6. In the event of employment, Be Well Nursing, LLC will call you weekly/daily to obtain/validate your schedule of available days. Are you willing to accept these phone calls? ☐YES, please specify ☐Cell phone ☐Home Phone ☐NO **By checking YES and signing the box on the right, you agree that it is also your responsibility to call for your available schedule. In this note, you certify that by not giving any schedule might affect your future filings for unemployment benefits.**	Please sign here.
7. What is the best time to contact you? Please specify exact time.	Between _____ to _____
8. How do you want to receive your compensation? ☐Direct Deposit (Please provide us a voided check) ☐Actual Check ☐Pick-up ☐Mail	Please sign here.
9. I agree to inform/update Be Well Nursing, LLC my current contact numbers regularly so that they can call and get my schedules.	Please sign here.
10. I understand that I forfeit employment with Be Well Staffing, LLC if I refuse to disclose my contact numbers.	Please sign here.

Be Well Staffing, LLC
815 S. Central Ave. #1, Glendale CA91204
T: 818.241.9111 F:818.241.4242

11. Be Well Staffing, LLC will do its best to get you an assignment and inform you by telephone. I understand that I forfeit employment with Be Well Staffing, LLC if I refused to be contacted thru telephone.	Please sign here.
12. I agree to return calls of Be Well Staffing, LLC. at a very reasonable time.	Please sign here.
13. I understand that rates will vary based on the hospital and assignment that will be given to me.	Please sign here.
14. I agree that my pay will be adjusted based on the actual hours that I have worked, in case the hospital sends me home before my shift is over.	Please sign here.
15. I understand that I will be charged a late cancellation fee if I cancel for work after the confirmation deadline of two (2) hours before the start of the shift.	Please sign here.
16. I agree that Be Well Staffing, LLC will call me for confirmation 2-3 hours before the start of the shift.	Please sign here.
17. I understand that I should cancel as soon as possible but no less than 2 hours before the start of the shift.	Please sign here.
18. I understand that I lose a confirmed shift when I do not answer or return phone calls 2 hours before the start of the shift.	Please sign here.
19. I understand that I need to call Be Well Staffing, LLC for my hours as soon as I sign out if I did not work full 12 hours.	Please sign here.
20. I understand that I need to report to the staffing office to sign-in and out, including breaks.	Please sign here.
21. I understand that I need to bring my original credentials and Be Well Staffing, LLC badge at all times, otherwise I will be sent home.	Please sign here.
22. I understand that any overtime must have a written approval of the supervisor; otherwise, I will get paid based on the actual hours of work.	Please sign here.
23. I agree to call and inform Secure Nursing if the hospital is asking me to work more than 12 hours to clarify the Overtime Rate.	Please sign here.
24. Have you been Mask Fit-tested before? If yes, please give us a copy.	☐YES ☐NO
25. If you have not been fit tested, do you want to be fit-tested by an authorized representative of Be Well Staffing, LLC?	☐YES ☐NO
26. Do you have recent years of experience working in an acute care hospital?	☐YES ☐NO
27. What other specialties do you have experience in? □ MS _____ Yrs □ ER _____ Yrs □ L&D _____ Yrs □ PEDS _____ Yrs □ Tele _____ Yrs □ PSY _____ Yrs □ HH _____ Yrs □ PICU _____ Yrs □ DOU _____ Yrs □ NSY _____ Yrs □ ONC _____ Yrs □ OR _____ Yrs □ ICU _____ Yrs □ PP _____ Yrs □ NICU _____ Yrs □ PACU_____ Yrs □ Ortho _____ Yrs □ Rehab _____ Yrs □Admin _____ Yrs □ Chemo_____ Yrs	□ Geriatrics _____ Yrs □ Dialysis _____ Yrs □ Radiology _____ Yrs □ Admin/Sprvsr _____Yrs □ Case Mgt _____ Yrs □ Anesthesia ____ Yrs □ Heart Transplant ____ Yrs
28. What shift do you prefer? ☐ 7A-7P ☐ 3P-11P/Swing Shift/Mid Shift ☐ 7A-3P ☐ 7P-7A ☐ 11A-7P ☐ 11P-7A	Please sign here.
29. Have you ever been given a DO NOT SEND (DNS) or DO NOT RETURN (DNR) status by a hospital? If YES, please list hospitals. 1. _____ 4. _____ 5. _____	☐YES ☐NO

Be Well Staffing, LLC
815 S. Central Ave. #1, Glendale CA91204
T: 818.241.9111 F:818.241.4242

2. _____

3. _____

6. _____

30. What is your mode of transportation? ☐Car; Do you drive in a freeway? ☐Yes ☐No ☐Public Transport ☐Other, please specify_____	Please sign here.
31. How far are you willing to drive to go to work? ☐10 miles ☐ 20 miles ☐30 miles ☐40 miles ☐More than 50 miles	Please sign here.

31. Do you have any nursing license other than in California?

1. _____ 3. _____

2. _____ 4. _____

32. Please list down three (3) nurses that you would refer to Be Well Staffing, LLC

Name Specialty Telephone Email Address

_____

_____

_____

33. Workers' Compensation and Injury Prevention Information

_____ Inform nurse to call Be Well Staffing, LLC promptly if he/she is injured on the job. (Review 1st flyer in packet **Reporting an Accident**)

_____ Give nurse **Fact about Workers' Compensation** brochure

_____ Give nurse 1 packet of safety flyers

_____ Have nurse complete "Employee Acknowledgement" and put in Secretary's in-box

Printed Name: _____

Signature: _____ Date: _____

Interviewed by BWN Staff:

Printed Name: _____

Signature: _____ Date: _____

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