# MASTER STAFFING, INC.

## APPLICANT CHECKLIST

Date

Last Name | First Name | Middle Name/Initial

Address - Street | Apt/Unit | City | State | Zip

Primary Phone | Secondary Phone | Email Address

Social Security # | Date of Birth

**To ensure compliance with our client facilities and the Joint Commission, provide the following:**

- ☐ Resume – please explain any gaps in employment
- ☐ Employment References (at least 2 references)
- ☐ Professional References from Supervisors (at least 2 references)
- ☐ Healthcare Professional License (RN, LVN, RT) or Certificate (CNA, Caregiver)
- ☐ Proof of training (BLS, ACLS, PALS, NRP, MAB, FAS, NIHSS, EKG, etc.)
- ☐ Government issued Photo ID (Driver's License, Passport, Greencard, etc.)
- ☐ Diploma
- ☐ Physical from the past year – must state that you are free of communicable diseases and able to work without restrictions
- ☐ Negative PPD (Tuberculosis) test from the past year OR Positive PPD test and clear chest x-ray
- ☐ Vaccines or Titers showing immunity to MMR (Mumps, Measles, Rubella), Varicella, Hepatitis, Tdap
- ☐ Flu Vaccine from the past year

**The required training material and tests can be found at:**

- ☐ Annual Mandatory Topics: https://goo.gl/H84k7z
- ☐ RN Basic Proficiency and Medication Administration: https://goo.gl/XZry4h
- ☐ LVN Basic Proficiency and Medication Administration: https://goo.gl/Aqkmw9
- ☐ Respiratory Therapist: https://goo.gl/nUVi61
- ☐ CNA: https://goo.gl/jSY5H1
- ☐ Caregiver/Nursing Assistant: https://store.ipced.com/caregiver-core-certification.html

143 S Glendale Ave, Suite 208 | Glendale, CA 91205 | Phone: (818) 244-3188 | Fax: (818) 244-8599 | Text: (818) 392-4861
Website: http://master-staffing.com | Email: staffing.dept@master-staffing.com

# MASTER STAFFING, INC.

# APPLICATION

## PERSONAL INFORMATION

Last Name _____ First Name _____ Middle Name/Initial _____

Address - Street _____ Apt/Unit _____ City _____ State _____ Zip _____

Primary Phone _____ Secondary Phone _____ Email Address _____

Social Security # _____ Date of Birth _____ Driver's License # _____ State _____ Expiration Date _____

Preferred method of contact for availability and confirmation: ☐ Phone Call ☐ Text ☐ Either/No preference

**Master Staffing, Inc. is an Equal Opportunity Employer.**
All applicants are considered for employment regardless of race, religion, gender, national origin, age, marital status, disability or any other factor prohibited by law.

☐ White
☐ Black/African American
☐ Hispanic
☐ Pacific Islander
☐ Asian
☐ American Indian/ Alaskan Native
☐ Two or more races

## CREDENTIALS *(Please attach copies of the fronts and backs of these licenses/certificate/training cards)*

☐ RN ☐ LVN ☐ CNA ☐ RT ☐ Other _____ License/Certificate # _____ State _____ Expiration Date

☐ RN ☐ LVN ☐ CNA ☐ RT ☐ Other _____ License/Certificate # _____ State _____ Expiration Date

☐ BLS ☐ FAS ☐ MAB ☐ ACLS ☐ PALS ☐ NRP ☐ EKG ☐ NIHSS ☐ ☐

## SHIFT PREFERENCES

☐ Day
☐ Night
☐ Mid-shift

☐ 8 hour shifts
☐ 12 hour shifts

☐ Monday
☐ Tuesday
☐ Wednesday
☐ Thursday
☐ Friday
☐ Saturday
☐ Sunday

☐ Per Diem
☐ Travel

## UNITS

Unit 1 _____ Years of experience to date _____

Unit 2 _____ Years of experience to date _____

Unit 3 _____ Years of experience to date _____

Date available _____

Please specify any preferred hospitals, geographic areas, etc.

Please list any hospitals you cannot go to (due to current employment, Do Not Return status, etc.)

# MASTER STAFFING, INC.

| Last Name | First Name | Middle Name/Initial |
|---|---|---|
| | | |

**EDUCATION** *(List the last 3 educational institutions you attending starting with the most recent one)*

| Name of College/Educational Inst. | City, State | Degree | Start Date (mm/yy) | End Date (mm/yy) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**EMPLOYMENT** *(List the last 3 employers starting from recent employer)*

| Name of Employer | Position | Specialty/Units | Start Date (mm/yy) | End Date (mm/yy) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Have you previously worked for Master Staffing, Inc.?

☐ Yes If yes, when? _____

☐ No If not, how were you referred to Master Staffing, Inc.? _____

Have you ever been licensed or practiced professionally under a different name?

☐ Yes If yes, explain: _____

☐ No

**EMERGENCY CONTACTS**

| Primary Contact Name | Relationship | Phone |
|---|---|---|
| | | |
| Secondary Contact Name | Relationship | Phone |
| | | |

# MASTER STAFFING, INC.

Last Name _____ First Name _____ Middle Name/Initial _____

☐ I, the undersigned, hereby certify that the information provided on this application is accurate. I understand that misrepresentation or omission of facts called for may result in refusal to hire or cause for dismissal. I understand and agree that if I am offered employment by Master Staffing, Inc., it will be on an at-will basis and will be for no definite period. Master Staffing, Inc. or I may terminate my employment at any time, for any reason, with or without notice. I also understand and agree that only an officer of Master Staffing, Inc. 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, the undersigned, hereby authorize investigation of all statements contained in this application. I agree that any decision to hire me is contingent upon the results of my report. I further understand and waive my right of privacy in this investigation and release and hold harmless Master Staffing, Inc. from any liability.

☐ I, the undersigned, hereby authorize Master Staffing, Inc. to contact any company, person, or educational institution I listed as a reference on my employment application to disclose any information they may have regarding my qualifications for employment, including but not limited to employment dates, descriptions of jobs performed, salary and wage rates and personal attributes

☐ As I may use Master Staffing, Inc. as a future reference I, the undersigned, hereby authorize Master Staffing, Inc. to disclose any employment related information that Master Staffing, Inc., in its sole discretion and judgment, may determine is appropriate to any companies, persons, or educational institutions that I have authorized to contact Master Staffing, Inc. Such employment related information may include, but is not limited to, job duties, opinions regarding job performance and salary and wage rates,

☐ I, the undersigned, hereby release and discharge Master Staffing, Inc. and Master Staffing, Inc.'s successors, employees, officers, and directors for all claims, liabilities, and causes of action, known or unknown, fixed or contingent, that may result from the disclosure of employment related information to prospective employers. This release includes, but is not limited to, claims of defamation, libel, slander, negligence, or interference with contract or profession.

☐ I, the undersigned, hereby authorize Master Staffing, Inc. to release any employment records, including medical records submitted to them, for the purpose of verifying that I meet the requirements specified in their agreement for temporary/supplemental staffing with the customer facility at which I am being placed. This authorization remains valid for the duration of my employment with Master Staffing, Inc. I have the right to receive a copy of this information.

☐ I, the undersigned, hereby confirm that Master Staffing, Inc. or any of its office employees did not directly or indirectly initiate contact with me to work for them.

☐ I, the undersigned, hereby understand that Master Staffing, Inc. does not hire subcontractors and/or independent contractors in all healthcare disciplines.

Employee's Signature _____ Date _____

Verified & Checked by Master Staffing, Inc. _____ Date _____

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# MASTER STAFFING, INC.

# PAYROLL RECORD

Last Name _____ First Name _____ Middle Name/Initial _____

Email Address _____

## PAYMENT DELIVERY

Stipend is paid once a week in accumulation of all unpaid shifts worked prior to that day. Meals and incidental expenses shall be paid accordingly.

☐ Deposit I, the undersigned, understand that checks are deposited directly at the counter on the afternoon of issue.

Bank Name _____ Bank Account _____

☐ Pick-up I, the undersigned, understand that checks will be available for pick-up during office hours, after 1 pm on date of issue.

☐ Mail I, the undersigned, understand that Master Staffing, Inc. is not responsible for the delivery of my check after it is mailed. I also accept responsibility to pay the current bank stop-payment fees placed on lost checks.

☐ I, the undersigned, agree to return to Master Staffing, Inc., **within seven (7) days** any payment received in excess of my actual hours worked, as documented on hospital/facility timesheets. This overpayment will be paid by working a shift and an adjustment will be made on my next paycheck. Otherwise, I agree to pay Master Staffing, Inc. the amount due. This also applies to any expenses related to my employment with the company.

Employee's Signature _____ Date _____

**PAY RATES** (Internal office use only – to be given to Accounting with employee's W-4 form)

| PAYDAY: | SPECIAL INSTRUCTIONS: | | |
|---|---|---|---|
| HOSPITAL / UMBRELLA GROUP | UNIT: | UNIT: | UNIT: |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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# MASTER STAFFING, INC.

## APPLICANT DRUG AND ALCOHOL TEST CONSENT

Last Name _____ First Name _____ Middle Name/Initial _____

☐ As a prospective employee of Master Staffing, Inc., I, the undersigned, understand that the use of drugs, alcohol and other controlled substances in the workplace creates a safety concern for all employees. In the interest of creating a safe working environment, I hereby give my consent for Master Staffing, Inc. to conduct the drug and alcohol tests it considers necessary as outlined in the Drug Test policy.

☐ I, the undersigned, hereby authorize Master Staffing, Inc. to take the necessary specimens from me to test for drugs, alcohol and other controlled substances, and I authorize laboratory or medical personnel retained by Master Staffing, Inc. for these tests to release the results to Master Staffing, Inc. I further understand that if the tests are positive, and for this reason I am not hired, I will be given the opportunity to explain the results of this test.

☐ I, the undersigned, 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 Master Staffing, Inc. I understand that if I at any time refuse to submit to these examinations, or if the test results indicate that I was under the influence of alcohol or drugs, these findings will result in immediate removal from the worksite and the appropriate disciplinary action, up to and including termination.

☐ I, the undersigned, release the laboratory or medical personnel conducting the drug test, Master Staffing, Inc., or Master Staffing, Inc.'s employees, directors, officers and successors from any liabilities, claims and causes of action, known or unknown, contingent or fixed, that may result from these tests and I agree not to file any lawsuits or other actions to assert a claim.

Employee's Signature _____ Date _____

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# MASTER STAFFING, INC.

## REFERENCE

### EMPLOYEE AUTHORIZATION

Last Name | First Name | Middle Name/Initial

Social Security #

I, the undersigned, request and authorize the release of all employment information requested by Master Staffing, Inc.

Employee's Signature | Date

### EMPLOYER INFORMATION

Company Name | Supervisor Name | Supervisor Title

Street Address | Apt/Unit | City | State | Zip

Human Resources Phone | Human Resources Fax | Human Resources Email

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### VERIFICATION – *to be completed by Employer*

This person is applying for employment with Master Staffing, Inc. and has listed you as a previous employer. We would appreciate your assistance in verifying employment and evaluating job performance. This information shall be confidential.

Position of Employee | Specialty/ Units | Pay Rate | Start Date | End Date

| **Evaluation –** *please rate on a scale from 1 to 10* | **Rating** | **Comments** |
|---|---|---|
| Quality of performance of required skills for position | | |
| Follows facility policies and procedures | | |
| Flexibility and adaptability | | |
| Professionalism - dependability, punctuality, and attendance | | |

This employee is eligible for rehire: ☐ Yes ☐ No ☐ N/A

Name of Employer representative completing this verification | Title/Position of Employer representative

Signature of Employer representative | Date

# MASTER STAFFING, INC.

## REFERENCE

### EMPLOYEE AUTHORIZATION

Last Name | First Name | Middle Name/Initial

Social Security #

I, the undersigned, request and authorize the release of all employment information requested by Master Staffing, Inc.

Employee's Signature | Date

### EMPLOYER INFORMATION

Company Name | Supervisor Name | Supervisor Title

Street Address | Apt/Unit | City | State | Zip

Human Resources Phone | Human Resources Fax | Human Resources Email

---

### VERIFICATION – *to be completed by Employer*

This person is applying for employment with Master Staffing, Inc. and has listed you as a previous employer. We would appreciate your assistance in verifying employment and evaluating job performance. This information shall be confidential.

Position of Employee | Specialty/ Units | Pay Rate | Start Date | End Date

| **Evaluation –** *please rate on a scale from 1 to 10* | **Rating** | **Comments** |
|---|---|---|
| Quality of performance of required skills for position | | |
| Follows facility policies and procedures | | |
| Flexibility and adaptability | | |
| Professionalism - dependability, punctuality, and attendance | | |

This employee is eligible for rehire: ☐ Yes ☐ No ☐ N/A

Name of Employer representative completing this verification | Title/Position of Employer representative

Signature of Employer representative | Date

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# MASTER STAFFING, INC.

## POLICIES AND PROCEDURES CHECKLIST

| Last Name | First Name | Middle Name/Initial |
|---|---|---|

I, the undersigned, hereby acknowledge that I have received a copy of the Policies and Procedures for Master Staffing, Inc. and I understand that it is up to me to read and familiarize myself with its contents.

Master Staffing, Inc. reserves the right to make changes to the Policies and Procedures without prior notice.

Criteria for Hiring
Code of Conduct
Personnel Policies & Procedures
Placement, Late Call, Presentation of Photo ID, License/Certificate and Training cards.
Sign-in, Overtime, Tardiness, Cancellation, No Show/No Call, Active/Inactive Status,
Do Not Return/Do Not Send, Performance Evaluation,
Problems & Emergencies at the Client/Hospital Facility,
Gaining Employment at the Client/Hospital Facility (Conflict of Interest),
Payroll, Dress Code, Phone Calls, Patient Tips/Gifts, Witnessing Documents
Condition of Employment
Continuous Quality Improvement
Patient Rights
Confidentiality of Information
Do Not Use List
Hand and Fingernails
Illegal Drug Use
Sexual Harassment
Complaints and Grievances
Sick Leave Policy
Work-Related Accidents and Injury Reporting
Capping
Jury Service

| Employee's Signature | Date |
|---|---|
| Verified & Checked by Master Staffing, Inc. | Date |

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# MASTER STAFFING, INC.

# PERSONNEL POLICIES REVIEW SHEET

Last Name _____ First Name _____ Middle Name/Initial _____

**SCHEDULING - Master Staffing, Inc. will contact you regularly to get your availability.**

I agree to give my current contact information to Master Staffing, Inc. to ensure that they can reach me for scheduling. By not updating my contact information I forfeit my employment with Master Staffing.

Applicant Initials

I understand that Master Staffing will contact me for confirmation 2-3 hours before the start of the shift.

Applicant Initials

I understand that I will lose a confirmed shift if I do not answer calls and/or texts (trying to inform me of the confirmation) less than two (2) hours before the start of the shift.

Applicant Initials

I understand that I should cancel my availability directly to Master Staffing at least three (3) hours before the start of the shift to allow the staffers ample time to notify the hospital/facility. I will be charged a late cancellation fee if I cancel for work less than two (2) hours before the start of the shift. If I repeatedly cancel, I may be counseled and/or terminated.

Applicant Initials

I understand that a "No Show/No call" for an assigned shift at a hospital/facility is unacceptable and will likely result in immediately being placed on a "DO NOT RETURN/SEND" list by that facility.

Applicant Initials

## AT THE HOSPITAL/FACILITY

I understand that I need to bring my original credentials and wear my Master Staffing badge whenever I am on assignment at a hospital/facility.

Applicant Initials

I understand that I will report to the nursing office to sign-in and out for my shift, and for breaks.

Applicant Initials

I understand that I am required to arrive on time for my assigned shifts, and if I know will arrive late, I should contact Master Staffing so that Master Staffing can inform the hospital/facility. If I am repeatedly late, I may be counseled and/or terminated.

Applicant Initials

I understand that if I do not show up for a confirmed shift, I will immediately be placed on a "DO NOT RETURN/SEND" list by that hospital/facility.

Applicant Initials

I understand that I must wear clean and appropriate clothing (some hospitals require certain colored scrubs for different positions) whenever I am on assignment at a hospital/facility.

Applicant Initials

I understand that artificial fingernails are NOT permitted for those who have direct contact with patients, handle instruments or equipment that will be used by or on a patient, or for those who have contact with food. I also understand fingernail polish must be in good condition and free of chips.

Applicant Initials

I understand that I am prohibited from making or accepting personal phone calls and texts on the nursing units at a hospital/facility.

Applicant Initials

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# MASTER STAFFING, INC.

Last Name _____ First Name _____ Middle Name/Initial _____

I understand that in cases of emergency, or any problem that may occur, I should inform Master Staffing as well as my Supervisor at the hospital/facility.

_____ Applicant Initials

I understand that I am not allowed to accept gratuities or gifts from patients.

_____ Applicant Initials

I understand that I may not act as witness to legal transactions for the patients. Transactions include but are not limited to wills or powers of attorney.

_____ Applicant Initials

## TIMESHEETS

I understand that I will sign in and out on the Master Staffing timesheets unless the hospital/facility directs me otherwise.

_____ Applicant Initials

I understand that I must inform Master Staffing if the hours I worked are different than the expected hours for my shift.

_____ Applicant Initials

I understand the hospital will only pay Master Staffing for the time logged on the timesheet, so if the hours on the timesheet differ than the hours I have reported to Master Staffing, then my payment will be adjusted according to the timesheet.

_____ Applicant Initials

I understand that any overtime must have a written approval of the supervisor at the hospital/facility, otherwise Master Staffing will not be able to pay for the overtime.

_____ Applicant Initials

## CREDENTIALING

I understand that Master Staffing cannot send me on assignment if any of my required credentials (License/Certificate, training certificates) and medical documents (Physical, PPD/Chest x-ray) are expired.

_____ Applicant Initials

I agree to give my credentials (License/Certificate, training certificates) and medical documents (Physical, PPD/Chest x-ray, Immunizations) to Master Staffing, Inc. to ensure compliance with hospital/facilities and the Joint Commission. By not updating these documents, I forfeit my employment with Master Staffing, Inc.

_____ Applicant Initials

## PERFORMANCE

I understand that, to ensure the quality of all personnel, I shall be periodically evaluated for performance by the hospital/facilities where Master Staffing has sent me. These evaluations shall be kept in my file and are available for review anytime upon request by me or by hospital/facility.

_____ Applicant Initials

# MASTER STAFFING, INC.

Last Name _____ First Name _____ Middle Name/Initial _____

I understand that if a hospital/facility complains about my professional and clinical performance, Master Staffing will contact me so that I can explain my side and to counsel me as deemed appropriate by the Director of Nursing. These complaints and counselling will be documented on a Corrective Action Form which may be sent back to the hospital/facility.

_____ Applicant Initials

## SICK LEAVE

I understand that per Master Staffing's Sick Leave Policy, employees accrue one hour of sick time for every 30 hours worked. The number of accrued sick leave hours will show on my paycheck.

_____ Applicant Initials

I understand that I will be able to claim sick time in increments of two hours, up to a maximum of 24 hours per year (July 1 – June 30).

_____ Applicant Initials

I understand that any requested hours in excess of my accrued sick leave hours, or in excess of the maximum of 24 hours per year will not be paid.

_____ Applicant Initials

## INJURY AT HOSPITAL/FACILITY

If I am injured while on assignment, in addition to reporting the incident to the Supervisor and to Master Staffing, I will report to the Emergency Room at the hospital.

_____ Applicant Initials

I have received the "Division of Workers' Compensation Notice to Employees Injuries Caused by Work" DWC 7 Form. The DWC 7 notice form provides information on Master Staffing's Workers' compensation insurer and finding a provider in Master Staffing's Medical Provider Network (MPN).

_____ Applicant Initials

I understand that I must complete incident report forms and return them to Master Staffing the day that any injury occurs.

_____ Applicant Initials

_____ Employee's Signature _____ Date

_____ Interviewed by Master Staffing, Inc. Representative _____ Date

# MASTER STAFFING, INC.

# NATIONAL PATIENT SAFETY GOALS 2020

Last Name _____ First Name _____ Middle Name/Initial _____

**Goal 1: Identify patients correctly**

**Hospital, Nursing Care, Home Care:**

*NPSG.01.01.01* Use at least two (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.

**Hospital:**

*NPSG.01.03.01* Make sure that the correct patient gets the correct blood when they get a blood transfusion.

**Goal 2: Improve staff communication**

**Hospital**

*NPSG.02.03.01* Get important test results to the right staff person on time.

**Goal 3: Use medicines safely**

**Hospital**

*NPSG.03.04.01* 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.

**Hospital, Nursing Care**

*NPSG.03.05.01* Take extra care with patients who take medicines to thin their blood.

**Hospital, Nursing Care, Home Care**

*NPSG.03.06.01* 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.

**Goal 6: Use Alarms Safely**

**Hospital**

*NPSG.06.01.01* Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

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**Goal 7: Prevent infection**

**Hospital, Nursing Care, Home Care**
*NPSG.07.01.01* Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning.

**Hospital, Nursing Care**
*NPSG.07.03.01* Use proven guidelines to prevent infections that are difficult to treat.

**Hospital, Nursing Care**
*NPSG.07.04.01* Use proven guidelines to prevent infection of the blood from central lines.

**Hospital**
*NPSG.07.05.01* Use proven guidelines to prevent infection after surgery.

**Hospital, Nursing Care**
*NPSG.07.06.01* Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.

**Goal 9: Prevent patients/residents from falling**

**Nursing Care, Home Care**
*NPSG.09.02.01* Find out which patients and residents are most likely to fall. For example, is the patient or resident taking any medicines that might make them weak, dizzy or sleepy? Take action to prevent falls for these patients and residents.

**Goal 14: Prevent bed sores**

**Nursing Care**
*NPSG.14.01.01* Find out which patients and residents are most likely to have bed sores. Take action to prevent bed sores in these patients and residents. From time to time, re-check patients and residents for bed sores.

**Goal 15: Identify patient safety risks**

**Hospital**
*NPSG.15.01.01* Reduce the risk for suicide.

**Home Care**
*NPSG.15.02.01* Find out if there are any risks for patients who are getting oxygen. For example, fires in the patient's home

**Universal Protocol: Prevent mistakes in surgery**

**Hospital**

*UP.01.01.01* Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.

**Hospital**

*UP.01.02.01* Mark the correct place on the patient's body where the surgery is to be done.

**Hospital**

*UP.01.03.01* Pause before the surgery to make sure that a mistake is not being made.

Employee's Signature

Date

# MASTER STAFFING, INC.

# ANNUAL MANDATORY CORE TOPICS

Last Name | First Name | Middle Name/Initial

I, the undersigned, hereby acknowledge that I have received and reviewed the following Annual Mandatory Core Topics. If I need to refresh my knowledge of the topics, I can find them at http://www.master-staffing.com/training-videos.php

**Abuse & Neglect Reporting:** Elder Abuse, Dependent Adults Abuse, Domestic Abuse, Child Abuse & Neglect
**Age Specific Guidelines:** Neonate, Infant, Child, Adolescent, Adult, Geriatric
**Biohazardous Materials & Toxic Chemicals:** MSDS, Hazardous Substances, Biohazardous Waste, Medical Waste
**Body Mechanics:** Guidelines for Standing, Sitting, Computer Use, Reaching/Pushing/Pulling, Equipment Object Transfer, Twisting/Turning
**Cultural Diversity & Sensitivity**
**Customer Service**
**Emergency Preparedness:** General Safety, Electrical Safety, Fire Safety
**HIPAA** (Health Insurance Portability and Accountability Act, **PHI** (Protected Health Information)
**Impaired Physicians & LIP's** (Licensed Independent Practitioners)
**Infection Control & Bloodborne Pathogens**
**Medication Safety**
**National Patient Safety Goals**
**Needs of Dying Care:** End of Life Care, Palliative Care, Hospice
**Organ and Tissue Donation**
**Pain Management**
**Patient Rights:** Patient participation, Ethical Issues, DNR standards, Advance Directives
**Patient Safety Event Reporting**
**Personal Safety & Assaultive Behavior**
**Radiation Safety**
**Restraints**
**Safe Medical Device Act**
**Safe Patient Handling**
**Sexual Harassment**
**Teamwork**

Employee's Signature | Date

Verified & Checked by Master Staffing, Inc. | Date

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# MASTER STAFFING, INC.

## MEDICAL INFORMATION CONSENT AND RELEASE

Last Name _____ First Name _____ Middle Name/Initial _____

☐ I, the undersigned, understand that I am required to undergo a physical examination to determine my fitness for the job duties, due to the nature of the job. In order to create and maintain a safe work environment, I hereby give my consent for Master Staffing, Inc. to conduct the physical examinations it considers necessary. I fully understand that this exam is a condition for employment.

☐ I, the undersigned, authorize the laboratory or medical personnel to release the results to Master Staffing, Inc. for whatever use Master Staffing, Inc. deems appropriate. Further, I release the laboratory or medical personnel conducting the exam, Master Staffing, Inc., and Master Staffing, Inc.'s employees, directors, officers, and successors from any liabilities, claims, and causes of action, known or unknown, contingent or fixed, that may result from this physical examination. I agree not to file any lawsuit or other action to assert a claim.

☐ I, the undersigned, hereby authorize Master Staffing, Inc. to release information, provide copies of my personal and medical information in my personnel file to client hospitals/institutions, for the purpose of verifying that I meet the requirements specified in their agreement for temporary/supplemental staffing.

☐ I, the undersigned, have read and understood this agreement, and I sign this without any coercion or duress by any individual or institution.

This authorization remains valid for the duration of my employment with Master Staffing, Inc.

I have the right to receive a copy of this information.

Employee's Signature _____ Date _____

143 S Glendale Ave, Suite 208 | Glendale, CA 91205 | Phone: (818) 244-3188 | Fax: (818) 244-8599 | Text: (818) 392-4861
Website: http://master-staffing.com | Email: staffing.dept@master-staffing.com

# MASTER STAFFING, INC.

## MEDICAL HISTORY QUESTIONNAIRE

Last Name _____ First Name _____ Middle Name/Initial _____

Have you had any of the following? Please check YES or NO.

| | | | | | |
|---|---|---|---|---|---|
| Head Injury | ☐ Yes | ☐ No | Kidneys – Recurrent UTI, Pyelonephritis | ☐ Yes | ☐ No |
| Epilepsy | ☐ Yes | ☐ No | Bone Disease – Osteomyelitis, Osteoporosis | ☐ Yes | ☐ No |
| Eyes – Glaucoma or other | ☐ Yes | ☐ No | Joint Rheumatic Arthritis (Osteoarthritis | ☐ Yes | ☐ No |
| Ears – Loss of Hearing | ☐ Yes | ☐ No | Hernia | ☐ Yes | ☐ No |
| Lung Disease (Asthma, COPD, Emphysema) | ☐ Yes | ☐ No | Mental Disorder | ☐ Yes | ☐ No |
| Heart Disease (CAD, MI, Angina, Congenital HD | ☐ Yes | ☐ No | Sinus Infection | ☐ Yes | ☐ No |
| Stomach – Ulcers, Gastric Reflux | ☐ Yes | ☐ No | Skin Disease | ☐ Yes | ☐ No |
| Intestines – Crohn's, Colitis | ☐ Yes | ☐ No | Spine – Osteoporosis, Kiphosis | ☐ Yes | ☐ No |
| Liver – Hepatitis, Jaundice | ☐ Yes | ☐ No | Thyroid Disorder | ☐ Yes | ☐ No |
| Spleen – Blood Discrasia, Innury | ☐ Yes | ☐ No | Surgeries | ☐ Yes | ☐ No |
| Gall Bladder – Cholecystitis | ☐ Yes | ☐ No | Other _____ | ☐ Yes | ☐ No |

Do you have a history of the following?

| | | | | | |
|---|---|---|---|---|---|
| Dizziness, Fainting Spells | ☐ Yes | ☐ No | Blood in Sputum/Emesis | ☐ Yes | ☐ No |
| Frequent Headaches | ☐ Yes | ☐ No | High Blood Pressure | ☐ Yes | ☐ No |
| Frequent Cough, Sore Throat | ☐ Yes | ☐ No | Diabetes Type I/Type II | ☐ Yes | ☐ No |
| Chest Pain | ☐ Yes | ☐ No | Cancer | ☐ Yes | ☐ No |
| Shortness of Breath | ☐ Yes | ☐ No | Tuberculosis | ☐ Yes | ☐ No |
| Palpitation | ☐ Yes | ☐ No | Back Injury | ☐ Yes | ☐ No |
| Night Sweats | ☐ Yes | ☐ No | Chronic Back Pain | ☐ Yes | ☐ No |
| Significant Weight Loss (more than 20 lbs) | ☐ Yes | ☐ No | Other _____ | ☐ Yes | ☐ No |

| | | | |
|---|---|---|---|
| Are you currently being treated for illness/injury? | ☐ Yes | ☐ No | Specify: _____ |
| Have you been hospitalized for any illness/injury? | ☐ Yes | ☐ No | Specify: _____ |
| Do you have any long-term disability or any limitations due to health problems? | ☐ Yes | ☐ No | Specify: _____ |
| Are you allergic to any drug(s)? | ☐ Yes | ☐ No | Specify: _____ |

I, the undersigned, have read the above and declared that I have no injury, illness, or ailment other than as has been specifically herein noted. Any falsification or misrepresentation will be sufficient grounds for my release from employment.

This authorization remains valid for the duration of my employment with Master Staffing, Inc.

I have the right to receive a copy of this information.

Employee's Signature _____ Date _____

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# MASTER STAFFING, INC.

## PHYSICAL

A physical examination is required on persons working in the health care field by the state law on Title XXII of the State of California.

**You can bring this form to your physician OR provide your own physical that states you are free from any communicable diseases, and are able to function as a Healthcare Professional.**

### PERSONAL INFORMATION

Last Name _____ First Name _____ Middle Name/Initial _____

Social Security # _____ Date of Birth _____

### IMMUNIZATION STATUS

| Test | | | Date | Results |
|---|---|---|---|---|
| Mumps | ☐ Vaccine | ☐ Titer | | |
| Rubeola | ☐ Vaccine | ☐ Titer | | |
| Rubella | ☐ Vaccine | ☐ Titer | | |
| Varicella | ☐ Vaccine | ☐ Titer | | |
| Hepatitis B | ☐ Vaccine | ☐ Titer | | |
| Tdap | ☐ Vaccine | ☐ Titer | | |
| Influenza | ☐ Vaccine | | | |

### TUBERCULOSIS

A PPD test is required annually. If the PPD test is positive, employee must provide a clear chest x-ray.

Date of last TB Skin Test (PPD) _____ Date Given _____ Date Read _____ Induction _____ Results _____

***Attach lab results of Chest X-Ray and TB Questionnaire**

Date of Chest X-Ray* _____ Results _____

### OTHER

| | | |
|---|---|---|
| Latex Allergy | ☐ Yes | ☐ No |
| Color Blind Screening | ☐ Normal | ☐ Abnormal |
| 10 Panel Drug Screen | ☐ Negative | ☐ Positive |

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# MASTER STAFFING, INC.

Last Name _____ First Name _____ Middle Name/Initial _____

## PHYSICIAN STATEMENT

This confirms that a physical examination and review of health history has been conducted and that the patient is in good health, is free from any communicable diseases, and is able to function as a Healthcare Professional.

Recommendations: ☐ Unlimited ☐ Limited ☐ Rejected

Reasons _____

_____

_____

Physician Signature _____ Date _____

Physician Name _____ Address (Street, City, State, Zip) _____

Physician License Certificate # _____ Phone _____

# MASTER STAFFING, INC.

# TB QUESTIONNAIRE

A physical examination is required on persons working in the health care field by the state law on Title XXII of the State of California.

## PERSONAL INFORMATION

Last Name _____ First Name _____ Middle Name/Initial _____

Social Security # _____ Date of Birth _____

## TUBERCULOSIS

Chest X-Ray is required if the TB skin test is positive or indicated by PMD or symptomatic for convertors

Date of last TB Skin Test (PPD) ☐ Positive ☐ Negative Induction _____ Date Given _____ Date Read _____

Date of Chest X-Ray* ☐ Positive ☐ Negative ***Attach lab results of Chest X-Ray and TB Questionnaire**

Please answer YES or NO if any of the following symptoms apply to you:

| | | |
|---|---|---|
| Loss of weight (more than 10% of body weight) | ☐ Yes | ☐ No |
| Night sweats | ☐ Yes | ☐ No |
| Fever lasting several weeks | ☐ Yes | ☐ No |
| Frequent Coughing | ☐ Yes | ☐ No |
| Coughing blood-streaked sputum | ☐ Yes | ☐ No |
| Unusual tiredness or weakness lasting weeks | ☐ Yes | ☐ No |
| Pain in chest when taking a breath | ☐ Yes | ☐ No |
| Recent diagnosis of diabetes, silicosis, or HIV | ☐ Yes | ☐ No |
| Recent exposure to a family member or others with active TB | ☐ Yes | ☐ No |

Please explain: _____

If you have answered YES to any of the above, are you currently being treated by a physician? ☐ Yes ☐ No

Please explain: _____

History of BCG administration _____

Birth Country _____ # Years in the U.S.A. _____

Recent travel since last PPD? _____

Employee's Signature _____ Date _____

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# MASTER STAFFING, INC.

# INFLUENZA DECLINATION

Last Name _____ First Name _____ Middle Name/Initial _____

In compliance with the California Department of Public Health (CDPH), **Master Staffing, Inc.** requests the confirmation of influenza vaccination and/or informed declination for all nursing personnel. Master Staffing, Inc. must send this information prior to booking.

I have been asked by **Master Staffing, Inc.** to be vaccinated with the influenza vaccine.

**I understand that by declining this vaccine:**

- I continue to be at risk of acquiring influenza, a serious respiratory disease that is recommended for me and all other healthcare workers to prevent influenza and its complications, including death.
- If I contract influenza, I will shed the virus for 24-48 hours before influenza symptoms appear, thus I will be at risk of spreading the virus to patients.
- I may be required to wear a respiratory mask while working at the hospital.
- I will not be able to work at hospitals that require annual influenza vaccinations.
- I will not hold **Master Staffing, Inc.** accountable for any consequences that may arise regarding this matter.

***Please check one of the following:***

☐ I refuse vaccination at this time for personal reason.
☐ I am already immune, and will provide documented proof of my vaccination.
☐ I am pregnant or breast feeding at this time.

Employee's Signature _____ Date _____

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# MASTER STAFFING, INC.

# DECLINATIONS

Last Name _____ First Name _____ Middle Name/Initial _____

## HEPATITIS B VACCINE

☐ I already have proof of vaccination or titer.
☐ I refuse vaccination at this time and understand that by declining this vaccine and due to my exposure to blood and other infectious materials, I continue to be at risk of acquiring Hepatitis B, a serious disease. I will hold **Master Staffing, Inc**. harmless of any consequences that may arise regarding this matter.

## TETANUS, DIPTHERIA, & PERTUSSIS (TDAP) VACCINE

☐ I already have proof of vaccination or titer.
☐ I refuse vaccination at this time and I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring an infection with pertussis (Whooping Cough), a serious disease and may also expose others to the disease if I become ill. I understand I am required to report any possible exposure to **Master Staffing, Inc**.as soon as I am aware of being exposed to Tdap.

## MMR VACCINE

☐ I already have proof of vaccination or titer.
☐ I refuse vaccination at this time and I understand that due to occupational exposure, I may be at risk of acquiring measles, mumps or rubella. I understand that by declining this vaccine, I continue to be at risk of measles, mumps and rubella. I will hold **Master Staffing, Inc**. harmless of any consequences that may arise regarding this matter.

## VARICELLA VACCINE

☐ I already have proof of vaccination or titer.
☐ I refuse vaccination at this time and I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring infection with varicella zoster virus (chickenpox). I understand that by declining this vaccine, I continue to be at risk of acquiring chickenpox, a serious disease. I will hold **Master Staffing, Inc**. harmless of any consequences that may arise regarding this matter.

Employee's Signature _____ Date _____

# MASTER STAFFING, INC.

# LATEX ALLERGY QUESTIONNAIRE

Last Name _____ First Name _____ Middle Name/Initial _____

**I. Risk Factor Assessment:**

| | | |
|---|---|---|
| Are you a health worker? | ☐ Yes | ☐ No |
| Do you wear latex gloves regularly or are you otherwise exposed to latex regularly? | ☐ Yes | ☐ No |
| Do you have a history of eczema or other rashes on your hands? | ☐ Yes | ☐ No |
| Do you have a medical history of frequent surgeries or invasive medical procedures? | ☐ Yes | ☐ No |
| Did these take place when you were an infant? | ☐ Yes | ☐ No |
| Do you have a history of "hay fever" or other common allergies? | ☐ Yes | ☐ No |
| Do your fellow workers wear latex gloves regularly? | ☐ Yes | ☐ No |
| Do you take a beta-blocker medication? | ☐ Yes | ☐ No |

*Check any foods below that cause hives, itching of the lips or throat, or more severe symptoms when you eat or handle them.*

| | | | | | |
|---|---|---|---|---|---|
| ☐ Apple | ☐ Apricot | ☐ Avocado | ☐ Banana | ☐ Carrot | ☐ Celery |
| ☐ Cherry | ☐ Chestnut | ☐ Fig | ☐ Grape | ☐ Hazelnut | ☐ Kiwi |
| ☐ Melon | ☐ Nectarine | ☐ Papaya | ☐ Passion fruit | ☐ Peach | ☐ Pear |
| ☐ Pineapple | ☐ Plum | ☐ Potatoes | ☐ Tomatoes | | |

**II. Contact Dermatitis Assessment**

| | | |
|---|---|---|
| Do you have itching, cracking, chapping, scaling, or weeping of the skin from latex glove use? | ☐ Yes | ☐ No |
| Have those symptoms recently changed or worsened? | ☐ Yes | ☐ No |
| Have you used different brands of latex gloves? | ☐ Yes | ☐ No |
| If so, have your symptoms persisted? | ☐ Yes | ☐ No |
| Have you used non-latex gloves? | ☐ Yes | ☐ No |
| If so, have you had the same or similar symptoms as with latex gloves? | ☐ Yes | ☐ No |
| Do these symptoms persist when you stop wearing all gloves? | ☐ Yes | ☐ No |

**III. Contact Urticaria (Hives) Assessment:**

| | | |
|---|---|---|
| When you wear or are around others wearing latex gloves do you get hives, red itchy swollen hands within 30 minutes, or "water blisters" on your hands within a day? | ☐ Yes | ☐ No |

**IV. Aerosol Reaction Assessment**

When you wear or are around other wearing latex gloves, have you noted any:

| | | |
|---|---|---|
| Itchy, red eyes, fits of sneezing, runny or stuffy nose, itching of the nose or palate? | ☐ Yes | ☐ No |
| Shortness of breath, wheezing, chest tightness or difficulty breathing? | ☐ Yes | ☐ No |
| Other acute reactions, including generalized or severe swelling or shock? | ☐ Yes | ☐ No |

**V. History or Reactions Suggestive of Latex Allergy:**

| | | |
|---|---|---|
| Do you have a history of anaphylaxis or of intra-operative shock? | ☐ Yes | ☐ No |
| Have you had itching, swelling, or other symptoms following dental, rectal, or pelvic exams? | ☐ Yes | ☐ No |
| Have you experienced swelling or difficulty breathing after blowing up a balloon? | ☐ Yes | ☐ No |
| Do condoms, diaphragms, or latex sexual aids cause itching or swelling? | ☐ Yes | ☐ No |
| Do rubber handles, rubber bands, or elastic bands or clothing cause any discomfort? | ☐ Yes | ☐ No |

Employee's Signature _____ Date _____

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# MASTER STAFFING, INC.

## COLOR BLIND TEST

Last Name _____ First Name _____ Middle Name/Initial _____

*Look at each colored plate and write down the number you see in the corresponding space.*

*If you do not see a number, then leave the space BLANK.*

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

Score / Total

_____ / 16 Passing score is 12 (75%)

Employee's Signature _____ Date _____

Verified & Checked by Master Staffing, Inc. _____ Date _____

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# MASTER STAFFING, INC.

## RESPIRATORY FIT TEST

Last Name _____ First Name _____ Middle Name/Initial _____

Position or Classification ☐ RN ☐ LVN ☐ CNA ☐ RT ☐ Other

Date Fit Tested _____ ☐ New Hire Fit Test ☐ Annual Fit Test

Type of Fit Test: QLFT with Saccharin Solution ☐ Pass ☐ Fail

Respiratory Brand/Model: Kimberly Clark N95, size: ☐ Regular ☐ Small

Is this employee a mandatory user? ☐ Yes ☐ No

Has the employee received the Respiratory Program Fit Test Policies, Procedures, and Protocols? ☐ Yes ☐ No

Has the employee received respiratory in-service education? ☐ Yes ☐ No

Has the employee completed the Medical Evaluation Questionnaire? ☐ Yes ☐ No

Has the employee been cleared by the Employee Health Department for use of a respirator? ☐ Yes ☐ No

**As described in the OSHA respiratory protection standard 29 CFR 1910.134, instruction, demonstration and training for respiratory use was completed, including, but not limited to: proper placement, positioning, and adjustment; user seal check; operations, capabilities and limitations of the respirator; proper care, usage, maintenance; sensitivity test; OSHA approved QLFT test; fit test exercises and completion of the medical evaluation questionnaire.**

Comments _____

_____

_____

Fit Tester's Signature _____ Date _____

Name of Fit Tester _____

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