NEW HIRE CHECKLIST

(FOR OFFICE USE ONLY)

NAME:_____ CLASSIFICATION: RN_____

☐ Completed Application/Emergency Info

☐ Completed & Signed W-4 (check #3, #5

☐ Completed & Signed I-9

☐ Copy of Driver's License & Social Security Card

☐ Name Badge Given

☐ Time Tickets Given

☐ Rates Discussed

☐ Copy of License/Registry

☐ Copy of CPR (American Heart Association – Healthcare Provider)

☐ Copy of PPD

☐ Application Fee $_____

☐ Copy of Flu Shot (*Required*: 10/01 to 4/01)

☐ VOR for CNA's - AHC

☐ Job Description

☐ Resume

☐ OSHA In-Service Record

☐ HIPAA

☐ Immunizations
☐ Covid
☐ Situational Awareness
☐ 5 Year Residency

☐ Signed Screening Policy

☐ Signed Staffing & Cancellation Policies

☐ Signed Substance Abuse Policy

☐ Copy of Hepatitis B Series & Hep B Tithers or signed declination

☐ Copy of Agreement re: Employment

☐ Policy Manual

☐ Release of Info Authorization

☐ AHP Test Score: _____

☐ Skills Checklist: RN LPN CNA

☐ 2 References:_____Employment_____Technical

☐ State Police Background CK or Federal Background CK
☐ OLTC Determination Sheet
☐ AR Adult Maltreatment CR
☐ AR Child Maltreatment CR
☐ Drug Screen Date:_____
_____Neg _____Pos

NAME_____

☐ RN ☐ LPN ☐ CNA

INTERVIEW NOTES

NAME OF APPLICANT: _____

DATE: _____ INTEVIEWED BY: _____

DATE: _____ REVIEWED BY: _____

AHP

ARKANSAS HEALTHCARE PERSONNEL

"Where quality is contagious."

APPLICATION FOR EMPLOYMENT

AHP IS AN EQUAL OPPURTUNITY EMPLOYER

TODAY'S DATE: _____

POSITION DESIRED: _____

AVAILABILITY:

☐ FULL TIME ☐ DAYS ☐ WEEKENDS ☐ PART TIME
☐ EVENINGS ☐ HOLIDAYS ☐ TEMPORARY ☐ NIGHTS

NAME: (PRINT) **LAST** **FIRST** **MIDDLE** **SOCIAL SECURITY NUMBER:**

STREET ADDRESS: **CITY** **STATE** **ZIP** **HOME PHONE NUMBER:**

EMAIL ADDRESS: **CELL PHONE NUMBER:**

NOTIFY IN CASE OF EMERGENCY: **ADDRESS** **PHONE:**

HAVE YOU EVER WORKED FOR ANOTHER TEMPORARY AGENCY? ☐ YES ☐ NO
IF YES, NAME(S): _____

ARE YOU 18 YEARS OR OLDER? ☐ YES ☐ NO

ARE YOU A U.S. CITIZEN? ☐ YES ☐ NO **IF NO, DO YOU HAVE THE LEGAL RIGHT TO REMAIN PERMANENTLY IN THE U.S.?** ☐ YES ☐ NO
(ANY EMPLOYMENT IS CONTINGENT UPON YOU BEING ABLE TO SUBMIT BEFORE YOU BEGIN WORK: PROOF OF U.S. CITIZENSHIP, POSSESSION OF A VISA, AND AN ALIEN REGISTRATION RECEIPT CARD)

HAVE YOU EVER PLEAD GUILTY OR BEEN CONVICTED OF A CRIME OTHER THAN A MISDEMEANOR OR SUMMARY OFFENSE? ☐ YES ☐ NO
IF YES, GIVE DATE AND DETAIL OF EACH CONVICTION. THE NATURE OF THE CRIME WILL BE CONSIDERED IN RELATION TO THE POSITION FOR WHICH YOU ARE APPLYING FOR:

ARE THERE ANY ARRESTS OR CRIMINAL PROCEEDINGS CURRENTLY PENDING AGAINST YOU? ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN:

IS YOUR NURSING LICENSE IN GOOD STANDING? ☐ YES ☐ NO **DO YOU HAVE A DISCIPLINE ON YOUR NURSING LICENSE?** ☐ YES ☐ NO

☐ **SPECIAL DISABLED VETERAN** ☐ **VIETNAM ERA VETERAN** ☐ **OTHER VETERAN**

HAVE YOU EVER USED OR BEEN KNOWN BY ANOHER NAME(S)? ☐ YES ☐ NO
IF YES, PLEASE LIST NAME(S) AND DATE(S):

WHAT NAME IS SHOWN ON YOUR SOCIAL SECURITY CARD?

HOW DID YOU HEAR ABOUT THIS POSITION?

REFERENCES: LIST TWO PEOPLE IN THE MEDICAL FIELD, WHOM WE MAY CONTACT, THAT IS FAMILIAR WITH YOUR NURSING SKILLS:

NAME & POSITION:	**FOR AHP USE ONLY:**
PHONE #:	
NAME & POSITION:	**FOR AHP USE ONLY:**
PHONE #:	

MAY WE CONTACT YOUR CURRENT EMPLOYER FOR REFERENCES? ☐ YES ☐ NO
MAY WE CONTACT YOU AT YOUR PLACE OF EMPLOYMENT? ☐ YES ☐ NO **IF YES, PHONE #:** _____

EMPLOYMENT HISTORY:

LIST ALL JOBS AND ACTIVITIES, INCLUDING PART-TIME EMPLOYMENT WHILE IN SCHOOL, U.S. MILITARY SERVICE, SELF-EMPLOYMENT AND VOLUNTEER WORK. BEGIN WITH THE MOST RECENT. PLEASE PROVIDE A RESUME IF YOU HAVE MORE THAN 3 RECENT EMPLOYERS.

EMPLOYER (PRESENT OR MOST RECENT):	STREET ADDRESS, CITY, STATE, ZIP
AREA CODE/PHONE NUMBER:	SUPERVISOR (NAME & TITLE):
YOUR JOB TITLE:	EXACT EMPLOYMENT DATES FROM: TO:
DESCRIPTION OF YOUR DUTIES:	BASE SALARY RATE PER HOUR START: $ END: $
REASON FOR LEAVING:	
EMPLOYER (PRESENT OR MOST RECENT):	STREET ADDRESS, CITY, STATE, ZIP
AREA CODE/PHONE NUMBER:	SUPERVISOR (NAME & TITLE):
YOUR JOB TITLE:	EXACT EMPLOYMENT DATES FROM: TO:
DESCRIPTION OF YOUR DUTIES:	BASE SALARY RATE PER HOUR START: $ END: $
REASON FOR LEAVING:	
EMPLOYER (PRESENT OR MOST RECENT):	STREET ADDRESS, CITY, STATE, ZIP
AREA CODE/PHONE NUMBER:	SUPERVISOR (NAME & TITLE):
YOUR JOB TITLE:	EXACT EMPLOYMENT DATES FROM: TO:
DESCRIPTION OF YOUR DUTIES:	BASE SALARY RATE PER HOUR START: $ END: $
REASON FOR LEAVING:	

EDUCATION & TRAINING:

SCHOOLS	NAME & ADDRESS OF INSTITION ATTENDED	DATES FROM TO	GRADUATED YES NO	DEGREE YES NO	DEGREE RECEIVED	GPA	AREAS OF SPECIALIZATION
HIGH SCHOOL							
COLLEGE							
OTHER							

PROFFESSIONAL LICENSES AND CERTIFICATES:

TYPE	STATE	NUMBER	EXPIRATION DATE

YEARS OF EXPERIENCE:

OB:	L & D:	REHAB:	PSYCH:	PEDS:	ORTHO:	MED SURGE:
ONCOLOGY:	ER:	OR/PACU:	ICU:	CCU:	CVICU:	LTC:

APPLICANTS AGREEMENT:

I hereby certify that the foregoing statements are true to the best of my knowledge. I understand that any misleading statements or omission of pertinent information from this application may be considered as sufficient cause for rejection of this application, or for dismissal if discovered subsequent to my employment.

____

APPLICANT'S SIGNATURE

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for **qualifying children** and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . 3 $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . 4(a) $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . 4(b) $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . 4(c) $

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2025 if you meet both of the following conditions: you had no federal income tax liability in 2024 **and** you expect to have no federal income tax liability in 2025. You had no federal income tax liability in 2024 if (1) your total tax on line 24 on your 2024 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2025 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 17, 2026.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

4. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

5. Prefer the most accurate withholding for multiple job situations.

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work. Submit a separate Form W-4 for each job.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

Multiple jobs. *Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2025 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $ _____

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $ _____

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $ _____

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $ _____

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . 3 _____

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . 4 $ _____

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2025 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $ _____

2 Enter:
- $30,000 if you're married filing jointly or a qualifying surviving spouse
- $22,500 if you're head of household
- $15,000 if you're single or married filing separately

. . . . . 2 $ _____

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $ _____

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . 4 $ _____

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $ _____

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$700	$850	$910	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	700	1,700	1,910	2,110	2,220	2,220	2,220	2,220	2,220	2,220	3,220
$20,000 - 29,999	700	1,700	2,760	3,110	3,310	3,420	3,420	3,420	3,420	3,420	4,420	5,420
$30,000 - 39,999	850	1,910	3,110	3,460	3,660	3,770	3,770	3,770	3,770	4,770	5,770	6,770
$40,000 - 49,999	910	2,110	3,310	3,660	3,860	3,970	3,970	3,970	4,970	5,970	6,970	7,970
$50,000 - 59,999	1,020	2,220	3,420	3,770	3,970	4,080	4,080	5,080	6,080	7,080	8,080	9,080
$60,000 - 69,999	1,020	2,220	3,420	3,770	3,970	4,080	5,080	6,080	7,080	8,080	9,080	10,080
$70,000 - 79,999	1,020	2,220	3,420	3,770	3,970	5,080	6,080	7,080	8,080	9,080	10,080	11,080
$80,000 - 99,999	1,020	2,220	3,420	4,620	5,820	6,930	7,930	8,930	9,930	10,930	11,930	12,930
$100,000 - 149,999	1,870	4,070	6,270	7,620	8,820	9,930	10,930	11,930	12,930	14,010	15,210	16,410
$150,000 - 239,999	1,870	4,240	6,640	8,190	9,590	10,890	12,090	13,290	14,490	15,690	16,890	18,090
$240,000 - 259,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$260,000 - 279,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$280,000 - 299,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,100	18,300
$300,000 - 319,999	2,040	4,440	6,840	8,390	9,790	11,100	12,300	13,500	14,700	15,900	17,170	19,170
$320,000 - 364,999	2,040	4,440	6,840	8,390	9,790	11,100	12,470	14,470	16,470	18,470	20,470	22,470
$365,000 - 524,999	2,790	6,290	9,790	12,440	14,940	17,350	19,650	21,950	24,250	26,550	28,850	31,150
$525,000 and over	3,140	6,840	10,540	13,390	16,090	18,700	21,200	23,700	26,200	28,700	31,200	33,700

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$200	$850	$1,020	$1,020	$1,020	$1,370	$1,870	$1,870	$1,870	$1,870	$1,870	$2,040
$10,000 - 19,999	850	1,700	1,870	1,870	2,220	3,220	3,720	3,720	3,720	3,720	3,890	4,090
$20,000 - 29,999	1,020	1,870	2,040	2,390	3,390	4,390	4,890	4,890	4,890	5,060	5,260	5,460
$30,000 - 39,999	1,020	1,870	2,390	3,390	4,390	5,390	5,890	5,890	6,060	6,260	6,460	6,660
$40,000 - 59,999	1,220	3,070	4,240	5,240	6,240	7,240	7,880	8,080	8,280	8,480	8,680	8,880
$60,000 - 79,999	1,870	3,720	4,890	5,890	7,030	8,230	8,930	9,130	9,330	9,530	9,730	9,930
$80,000 - 99,999	1,870	3,720	5,030	6,230	7,430	8,630	9,330	9,530	9,730	9,930	10,130	10,580
$100,000 - 124,999	2,040	4,090	5,460	6,660	7,860	9,060	9,760	9,960	10,160	10,950	11,950	12,950
$125,000 - 149,999	2,040	4,090	5,460	6,660	7,860	9,060	9,950	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,090	5,460	6,660	8,450	10,450	11,950	12,950	13,950	15,080	16,380	17,680
$175,000 - 199,999	2,040	4,290	6,450	8,450	10,450	12,450	13,950	15,230	16,530	17,830	19,130	20,430
$200,000 - 249,999	2,720	5,570	7,900	10,200	12,500	14,800	16,600	17,900	19,200	20,500	21,800	23,100
$250,000 - 399,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$400,000 - 449,999	2,970	6,120	8,590	10,890	13,190	15,490	17,290	18,590	19,890	21,190	22,490	23,790
$450,000 and over	3,140	6,490	9,160	11,660	14,160	16,660	18,660	20,160	21,660	23,160	24,660	26,160

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$450	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,870	$1,870	$1,870	$1,890
$10,000 - 19,999	450	1,450	2,000	2,200	2,220	2,220	2,220	3,180	4,070	4,070	4,090	4,290
$20,000 - 29,999	850	2,000	2,600	2,800	2,820	2,820	3,780	4,780	5,670	5,690	5,890	6,090
$30,000 - 39,999	1,000	2,200	2,800	3,000	3,020	3,980	4,980	5,980	6,890	7,090	7,290	7,490
$40,000 - 59,999	1,020	2,220	2,820	3,830	4,850	5,850	6,850	8,050	9,130	9,330	9,530	9,730
$60,000 - 79,999	1,020	3,030	4,630	5,830	6,850	8,050	9,250	10,450	11,530	11,730	11,930	12,130
$80,000 - 99,999	1,870	4,070	5,670	7,060	8,280	9,480	10,680	11,880	12,970	13,170	13,370	13,570
$100,000 - 124,999	1,950	4,350	6,150	7,550	8,770	9,970	11,170	12,370	13,450	13,650	14,650	15,650
$125,000 - 149,999	2,040	4,440	6,240	7,640	8,860	10,060	11,260	12,860	14,740	15,740	16,740	17,740
$150,000 - 174,999	2,040	4,440	6,240	7,640	8,860	10,860	12,860	14,860	16,740	17,740	18,940	20,240
$175,000 - 199,999	2,040	4,440	6,640	8,840	10,860	12,860	14,860	16,910	19,090	20,390	21,690	22,990
$200,000 - 249,999	2,720	5,920	8,520	10,960	13,280	15,580	17,880	20,180	22,360	23,660	24,960	26,260
$250,000 - 449,999	2,970	6,470	9,370	11,870	14,190	16,490	18,790	21,090	23,280	24,580	25,880	27,180
$450,000 and over	3,140	6,840	9,940	12,640	15,160	17,660	20,160	22,660	25,050	26,550	28,050	29,550

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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

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

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

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the Instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)

If you check Item Number 4., enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must examine evidence of identity and employment authorization authorized by the Secretary of DHS. Documentation from List A, or a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box. See the Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)			Additional Information		
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.	First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

Supplement A, Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS Form I-9 Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

General Job Description
RN

- Observe professional ethics in maintaining confidential information acquired concerning the personal, financial, medical or employment of patients and their families.
- Must follow and enforce accepted Safety practices for patients and Hospital.
- Must report safety hazards and initiate appropriate action.
- Must participate in safety instructional programs.
- Must demonstrate leadership to plan, implement and evaluate patient care.
- Provide appropriate communication for patient age and level of understanding.
- Provide education to patient and family within the learning ability of the patient and family.
- Assess patient needs and develop a plan of care as identified by patient, nursing, physician and family interation.
- Interacts with all hospital departments to coordinate patient care.
- Performs duties with little or no supervision
- Uses policy and procedure mainuals, and other reference materials to ensure proper course of action.
- Performs additional tasks as assigned.

Signature _____ **Date** _____

NEW EMPLOYEE ORIENTATION AND YEARLY
IN-SERVICE ATTENDANCE RECORD

I hereby certify that I have attended/read the following in-services:

INSERVICES	DATE	LOCATION
FIRE SAFETY & DISASTER PLANNING/SAFETY HEALTH PLAN REVIEW		
INFECTION CONTROL/CDC HAND HYGIENE GUIDELINES		
UNIVERSAL PRECAUTIONS		
BLOODBORNE PATHOGENS		
EMPLOYEE RIGHT TO KNOW/TOXIC SUBSTANCES/GSH		
JOINT COMISSION NATIONAL SAFETY GOALS		
CULTURAL DIVERSITY		
AGE SPECIFIC COMPETENCIES		
ISOLATION STANDARDS/TB FIT TEST		
PATIENT/RESIDENT RIGHTS/ETHICS		
JOB DESCRIPTION		
BACK SAFETY		
ELECTRICAL SAFETY		
RESTRAINTS		
PATIENT/RESIDENT ABUSE/NEGLECT/THEFT		
REHAB & RESTORATIVE NURSING		
SAFETY AND HEALTH PLAN REVIEW		
INCIDENT OR SENTINEL EVENTS REPORTING		
CHAIN OF COMMAND		

HEREBY CERTIFY THAT I HAVE ATTENDED/READ THE ABOVE INSERVICES:

PRINT NAME: _____

SIGNATURE: _____

ARKANSAS HEALTHCARE PERSONNEL INC

HEALTH AND SAFETY PLAN

REVISED

SEPTEMBER 2023

TABLE OF CONTENTS

MANAGEMENT COMPONENT

It is the policy of Arkansas Healthcare Personnel, Inc. to work continually toward improving our safety program and safety procedures and actively pursue a safer work environment.

It is the company's intent to provide a safe working environment in all areas for our employees. It is our belief that all accidents and injuries can and should be prevented by controlling the environment and the actions of our employees. Safety will take precedence over expediency and shortcuts. Every attempt will be made to reduce the possibility of accidents or injuries.

Employee safety is our number one priority as we do business. We will pledge to train and equip our employees with the tools and knowledge to be able to do their jobs safely. We will ensure the policies adopted by our company are implemented and adhered to by all employees, while at the same time, employees must take personal responsibility for the prevention of injuries.

_____

Kathy Edward, President/CEO

_____

Date

ASSIGNMENT OF RESPONSIBILITIES

The President/CEO will be the primary person responsible for the implementation and for enforcement of the company safety policy. In her absence the Office Manager will assume the responsibility for enforcing the program.

The Office Manager will be responsible for all documentation and records, hazard reports, accident investigations and reporting of all accidents to Workers comp and any follow up needed.

The President/CEO determine training and counseling needed for the employee and will provide retraining in-services and one on one counseling of employee.

Human Resources/Staffing Specialist will maintain training records for new hires and also yearly in-services of all employees and will update employee training in staffing program.

ACCIDENT/INJURY ANALYSIS COMPONENT

INJURY ANALYSIS

The President/CEO will review the company's health and safety injury trends on a quarterly-basis. If any trends are identified corrective action will be taken.

The following will be reviewed while determining the trend analysis:

First Report of Injury Forms

Incident reports from facility

Loss Runs provided by insurance carrier

OSHA 300 LOG

Trends will be reviewed. The Office Manager will work with location contact and will make recommendations for corrective actions. These issues will be discussed in quarterly safety meetings.

DOCUMENTATION

The President/CEO will be responsible for documenting and retention of Quarterly Loss Run reports and minutes of quarterly safety meeting.

RECORDKEEPING COMPONENT

The President/CEO will be responsible for maintaining all documentation of accident reports, OSHA logs, Incident Reports, Loss Runs, and any other documentation required for the implementation of the health and safety plan.

Human Resources will maintain training records for new hire orientation, these forms are kept in employee files, and on the Teambridge platform. These training records are updated on a yearly basis.

1. **Injury Records**
   An injury log will be maintained by the President/CEO. Injury records are maintained for 5 calendar years.

2. **Inspection Records**
   If it determined that a site inspection is needed, this will be coordinated through the facility and records will be maintained for a period of at least one year.

3. **Safety Meetings/training Records**

Safety meeting minutes will be maintained by the President/CEO
Human Resources will maintain training records for new hire and yearly training, and both will be placed in employee file and in Teambridge.

4. **Accident Investigation Records**

Accident investigation records and reports will be maintained by the President/CEO for a period of at least one year.

Education and Training Component

1. **Training and Education**

The company is committed to providing safety and health related orientation and training to all employees at all levels of the company. The President/CEO will be responsible for identifying education and training need on a quarterly basis after reviewing incidents and loss run reports.

New hire orientation and training will be conducted by HR and Staffing Specialist.

And

In addition, employees will receive on site facility specific training at each facility.

2. **Employee Orientation**

The company will conduct orientation for employees when:

Health and Safety plan is changed

New employees and newly assigned to a new facility

New hazards or a previously unrecognized hazard is found

The orientation will consist of all required training programs as well as on the job and site specific safety and health information.

Staffing coordinators will contact facility and schedule facility orientation.

Training and Education Documentation

Safety Education and training will be documented and records will be maintained as follows and documents will be retained for a period of 24 months.

Orientation documents will be placed in Employee files and maintained on Teambridge Staffing Platform.

Ongoing Inservices will be maintained by the President/CEO

Documentation will include:

1. Date of training
2. Subjects Covered

Safety and Health Inspection Component

1. Safety Inspections

Inspections will be conducted at a facility is during trend reviews it is a found a specific facility has ongoing safety issues or employee injuries. Inspections will be coordinated by President/CEO.

Items checked will be dependent on reported claims at the location and their causes, general facility conditions and observations,

2. Documentation

Records of an inspections will be maintained by the President/CEO. Records will maintained for a period of 12 months.

Accident/Investigation Component

Accident/Incident Investigation

An accident may be defined as an unexpected and usually undesirable event that may cause injury to people, damage to property or the environment, or a combination of both. Accidents usually arise form a combination of unsafe conditions and unsafe acts.

The company requires all employees to immediately report to their supervisor at the facility and to AHP. All accidents will be investigated to determine cause and contributing factors. From this investigation and discussion with the facility and

employee a plan of corrective action will be determined and the employee will receive inservice accordingly.

The investigation will include the facility specific accident report form, witness statements if witnessed, and coordinating medical assistance as needed, along with a drug screen.

1. **General Procedure**

    1. The employee reports the accident to the location supervisor and AHP.
    2. Office Manager or On Call Staff ensures proper medical attention.
    3. Office Manager or On Call Staff arranges for transportation if needed for Medical treatment.
    4. Facility supervisor completes the accident investigation form. The Office Manager completes the First report of Injury and reports to the Insurance carrier.
    5. The Employee completed the Employee Notice of Injury Form as soon as possible.
    6. A drug screen is ordered by Office Manager or On Call Person by contacting treating facility.

2. **Documentation**

    The accident investigation will be reviewed by President/CEO to determine corrective actions needed. Accident reports will be maintained for at least 2 years.

Review and Revision Component

The President/CEO will revise the components of the Health and Safety Plan at a minimum in January of each year. The purpose of the review will be to determine if all areas of exposure are addressed in the Health and Safety Plan.

Annual reviews will be documented showing the date of review and any corrective actions made to the Health and Safety Plan.

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AHP
ARKANSAS HEALTHCARE PERSONNEL

RE: HIPAA Privacy Standards

Dear AHP Employee:

Arkansas Healthcare Personnel (the "Agency") must comply with the Standards for Privacy of Individual Identifiable Health Information implementing the privacy requirements of the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) set forth at 45 CFR Parts 160 and 164 (the "HIPAA Privacy Standards") no later than April 14th, 2003. This compliance includes entering into written agreements with "business associates" (AHP employees).

Under the HIPAA Privacy Standards, business associates are organizations and individuals which provide services to hospitals and which, in connection with the provisions of those services, the hospital provides or gives access to health care and financial information about the hospital patients (this information is referred to in the HIPAA Privacy Standards and "protected health information" or "PHI". The written agreement with business associates must include certain provisions in order to ensure the confidentiality of the PHI provided to the business associates.

Because you perform services for hospitals and receive or have access to PHI; you are a business associate of the hospital and the Agency. Therefore, the written agreement between you and the Agency must meet the requirements established by the HIPAA Privacy Standards for agreements with business associates.

Please call Kathy Edwards, RN, DON, is you are not familiar with "PHI" or "HIPAA" or if you need clarification on the following agreement. As an AHP employee, you are required to read, sign, and abide by the HIPAA Privacy Standards while working at any facility through AHP.

Thank you for your cooperation.

The staff of Arkansas Healthcare Personnel, Inc.

425 N. University
Little Rock, AR 72205
1-800-959-4625 501-666-1825
Fax: 501-666-8544

Confidentiality and Compliance With Laws

The parties hereto shall hold in confidence the information contained in this agreement. Arkansas Healthcare Personnel, Inc (**AHP**) and the Business Associate (**BA**)* hereby acknowledge and agree that all information related to this Agreement, not otherwise known to the public, is confidential and proprietary and is not to be disclosed to third persons without the prior written consent of each of the parties except to comply with any law, rule or regulation or the valid order of any governmental agency or any court of competent jurisdiction; as part of its normal reporting or review procedure, to its auditors and its attorneys; to the extent necessary to obtain appropriate insurance, to its insurance agent; or as necessary to enforce its rights and perform its agreements and obligations under this Agreement.

Business Associate (BA**) defined as: Any Registered Nurse, Licensed Practical Nurse or Certified Nursing Assistant employed by **AHP***

In providing the services hereunder, the **BA** warrants that he/she shall fully comply with all applicable federal, state and local statutes, rules and regulations, and JCAHO requirements and that it shall be deemed a material breach of this Agreement by the Associate if he/she fails to observe this requirement.

WHEREAS AHP provides services to various local healthcare facilities, and the **BA** receives, has access to or creates Protected Health Information (PHI) in order to provide those services;

WHEREAS, Arkansas Healthcare Personnel (**AHP**) is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1998, and regulations promulgated thereunder, including the standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations parts160 and 164 ("Privacy Regulations");

WHEREAS, the Privacy Regulations require **AHP** to enter into a contract with the BA to mandate certain protections for the privacy and security of Protected Health Information, and those regulations prohibit the disclosure to or use of Protected Health Information (PHI) by the **BA** if such a contract is not in place;

NOW, THEREFORE, in consideration of the foregoing, and for other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, the parties agree as follows:

a) ***BA** warrants that all Services to be provided hereunder directly, shall fully comply with all applicable federal, state and local statutes, rules and regulations, and that it shall be deemed a material breach of the Agreement by the **BA** if he/she shall fail to observe this requirement. If such a breach is not cured in accordance with this Agreement, **AHP** may terminate Agreement without penalty and without limiting any other rights and remedies set forth in this Agreement.*

b) *Specifically, but not by way of limitation, the **BA** warrants that the Services to be provided hereunder shall comply with all applicable rules, regulations and accreditation standards or requirements of: Medicare or Medicaid or other federal or state health programs, the Joint Commission on Accreditation of Healthcare Organizations; the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"); the National Committee for Quality Assurance; and updates to incorporate any changes to such laws; rules, regulations, requirements and standards.*

c) ***Business Associate Assurances**: More specifically, but not by way of limitation, insofar as **AHP** is required to comply with the HIPPA final Privacy Standards and insofar as the **BA** has access to, has been provided with, or will be creating PHI for **AHP's** clients, he/she warrants and agrees as follows:*

d) ***Permitted Uses and Disclosures of PHI**: **BA** shall Use and Disclose PHI solely as necessary to perform the Services. **BA** shall not Use or Disclose PHI for any other purpose.*

e) ***Adequate Safeguards for PHI**: BA warrants that he/she shall implement and maintain appropriate safeguards to prevent the Use and Disclosure of PHI in any manner other than as permitted by the Agreement.*

f) ***Reporting Non-Permitted Use or Disclosure**: **BA** shall immediately notify **AHP** of each Use or Disclosure, of which he/she becomes aware, that is made by **BA**, or **AHP** employees, representatives or agents that is not specifically permitted by this Agreement.*

Business Associate **(BA)**: Nurse/Provider	Agency **(AHP)**: Arkansas Healthcare Personnel
_____ Signature	_____ Signature
_____ Date	_____ Date

. ARKANSAS HEALTHCARE PERSONNEL INC

INSERVICE TRAINING

HEALTH AND SAFETY PLAN

SITUATIONAL AWARENESS

Date:_____

Employee_____

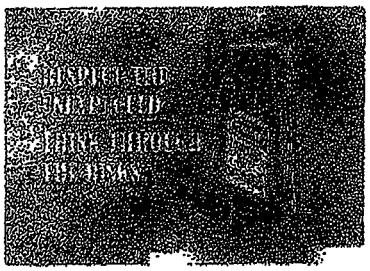
Please read the attached information and sign below.

_____

Employee Signature

SITUATIONAL AWARENESS IS AN IMPORTANT SKILL TO KEEP WORKERS SAFE

Situational awareness is an on-the-job safety skill that is critical for hazard identification, effective decision making, and accident prevention.



Situational Awareness means paying attention and being aware of what's going on around you. No matter what your role is at work, situational awareness is an important key to keeping everyone safe.

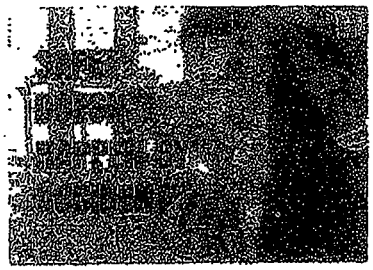
When you practice situational awareness at work, you remain alert and aware of things like:

- where your co-workers are while they are working and what they are doing
- where operational heavy equipment is and how it is moving

- where you are supposed to be
- what sounds you hear
- what potential hazards are nearby
- what you are supposed to be doing
- what are the safe procedures for the tasks you are completing
- what changes are happening that might affect your actions
- what is going on above and behind you
- what unusual smells are in the air
- what do you see that is out of the ordinary
- what is the weather like, if you are working outdoors

Situational awareness involves three elements which are observation, comprehension, and anticipation.

1. You observe what is happening around you and take in all the elements of your environment.
2. You comprehend the situation you are experiencing.
3. You anticipate what is likely to occur next based on what you understand to be happening now.



There are many factors that will reduce situational awareness that workers must be aware of and make an effort to avoid, including:

- Rushing through a task
- Mental or physical fatigue
- Complacency

- Poor communication
- Distractions
- Daydreaming, loss of focus
- Stress

Situational awareness is something that should be happening all the time, throughout the workday. But there may be times when you should increase awareness of your surroundings and your actions, for example, when:

- starting new or non-routine tasks
- working with new co-workers
- visitors are at the work site
- the work environment may have changed
- there is high stress, or a high workload situation
- you have a gut reaction that something may be off
- beginning work on a project, even if you have performed the tasks before
- high hazard operations are taking place (examples: near electrical, at heights, in confined spaces)

Think about some specific examples of what situational awareness may look like on the job...

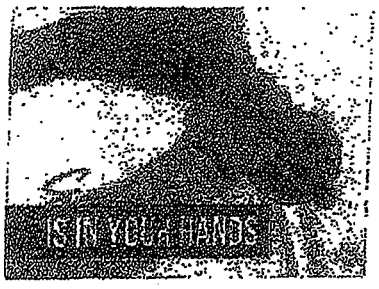
Not walking into the "line of fire" when other workers nearby are using tools or equipment.

Noticing that a co-worker forgot to put on PPE or missed a safety step and speaking up to ensure they follow the correct procedure.

Stopping a task to make adjustments that will get the job done safe and efficiently.

Correcting hazards on the spot if you notice something that can be fixed immediately.

Reporting hazard observations and near miss incidents to management.



Just looking around from time to time is not enough. At all times you must have an increased awareness of what is going on around you so if conditions change, you can respond quickly, communicate effectively, and avoid the risk of injury or damage.

When things are running smoothly, there may be a relaxed awareness as everyone completes their work tasks safely and efficiently. As situations change throughout the day, some find a simple trick known as the SLAM method to be helpful at promoting situational awareness.

STOP - Think before you act. Consider the task and make sure you understand what needs to be done.

LOOK - Carefully observe the work area to find potential hazards.

ASSESS - Evaluate the hazards and make sure you have the proper tools, training, and PPE to be safe.

MANAGE - Make changes, ask questions, and take the actions you need to continue to work safely.

There are many safety tips workers can practice to increase situational awareness.

Pay attention to what is going on all around you, including above, to the sides, and also behind you and then create a habit of regularly assessing the tasks you are doing and your work environment.

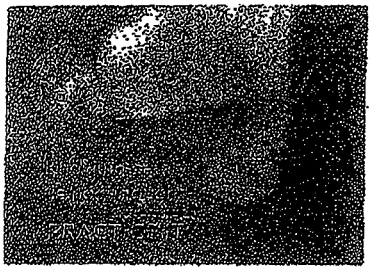
Acknowledge cues you are getting from your co-workers, which may be verbal, emotional, or

physical and also observe all warning, danger, and information signs – they are posted for a reason.

Be proactive when it comes to communicating with your supervisor and co-workers. Ask for assistance if you need it, or if it could be helpful.

Understand the pace of the work environment. Watch for unexpected scenarios and adjust accordingly.

Ensure complacency is not creeping into the workday. Avoid using electronic devices including cell phones and headphones. Prevent fatigue by maintaining a consistent sleep schedule.



Weeklysafety.com is giving away 10 free safety topics, no credit card required! Take advantage and grab your free set of safety meeting topics today by clicking the button below.

OTHER SAFETY ARTICLES

ARKANSAS HEALTHCARE PERSONNEL SCREENING POLICY

AHP seeks to employ the most qualified professional staff available. We require that each of our supplemental staff be a Licensed Registered Nurse, Licensed Practical Nurse, or Certified Nurse's Assistant. We require that each employee present proof of current licensure, health status, educational background, skill level and experience. AHP reserves the right to do drug testing.

Our professional staff must have worked in the area of experience for at least one year. We require that these professionals pass a written test. A successful completion of the written test will be required of each employee and will be subject to review. Each professional must maintain certification in Cardiac Life Support, if working in Critical Care Areas, Advanced Cardiac Life Support will be required. We will encourage our employees to participate in continuing education opportunities based on recommendations set forth by the Joint Commission of Accreditation of Hospitals.

Please sign below if you understand AHP screening policy.

_____ _____

Signature Date

STATEMENT OF SATISFACTORY HEALTH

I, _____ state that I am in good health and free from any work restrictions as of today's date.

_____ _____

Signature Date

I am fluent in the *ENGLISH LANGUAGE*

_____ _____

Signature Date

AHP STAFFING AND CANCELLATION POLICIES

Thank you for choosing Arkansas Healthcare Personnel (AHP) as your supplemental staffing agency. You are a very important part of our company.

You are representing AHP when you work an assignment. Please acknowledge the following policies:

1. You are required to contact AHP with your availability.
2. Only accept assignments you are qualified to work and are available to work. It is your responsibility to look at your calendar before accepting a shift.
3. You have the right to refuse any shift, but if you accept a shift:
    A. You are expected to work it.
    B. You are expected to abide by all policies of AHP and the facility in which you are working.
    C. You are expected to be there on time, appropriately dressed, and wearing your AHP name badge.
4. Cancellations are only accepted for emergencies and sickness. If you must cancel, you must notify AHP at least four (4) hours before the start of the shift by calling **501-666-1825**. **Cancellations by text message will NOT be accepted**.
5. Upon accumulation of cancellations, AHP may take the following disciplinary actions:
    a. One shift at a time – Employee may only accept one shift at a time and must work that shift before accepting another.
    b. Shift suspension – Employee cannot accept shifts for a period to be determined by AHP.
    c. Employment termination – All shifts will be canceled, and employee will be ineligible for rehire.
6. NO CALL NO SHOWS **will not be tolerated**. You will immediately be taken off our roster.
7. You are required to leave a copy of your time ticket at the facility at the end of your shift.
8. You are required to turn in your time tickets to AHP on time.
9. You may not accept employment from an AHP client or another staffing agency at the same facility for 120 days after the last day you worked there through AHP. **If you violate the provisions of this paragraph, you will owe AHP a finder's fee of $8000.00.**

It is the purpose of AHP to provide you with the amount of work you need/desire. Our ability to provide this service to you depends on our being able to contact you at any given time or place. If you have a change in your availability, telephone number, or change of address, please give this information to our staffing coordinators.

I have read and understand the above policies.

_____	_____
Employee Print Name	AHP Personnel Signature
_____	_____
Employee Signature	Date

PERSONAL APPEARANCE

It is the policy of AHP that all employees are well groomed (including hair) and have good personal hygiene. Your hair must be of a natural color to maintain a professional image. This means no Purple Green, Blue, Red, Orange, Pink and Yellow (unnatural blonde hue). Nails should be clean, short in length, and any polish should be pale to neutral in color. Then the length of nails should not extend past the tip of the finger. No strong perfumes/colognes are to be worn. Scrubs are the required uniform of AHP employees at all facilities along with closed toe shoes, such as sneakers or nursing shoes. NO CROCS ARE ALLOWED. Shoes must be sensible enough for the employee to respond to an emergency. Heels are not appropriate for this reason. Scrubs and shoes must be clean and neat with no tears or rips. Scrubs should not be excessively tight fitting, sheer, or revealing, nor excessively loose so that it hangs off the body in a manner as to impede movement. Undergarments should be worn but may not be exposed or worn on top of uniform. Jewelry should be kept to a minimum. There should be no piercings on the face or tongue. Earrings should be kept to small studs, thus no hoop earrings or cartilage piercings. Tattoos that may be considered offensive must be covered. Sunglasses, caps, hats, bandanas, scarves, bonnets etc. may not be worn while on the clock at a facility. Please always wear your name badge identifying you as an employee of AHP.

SHIFTS FROM CLIENTS

You may NOT contact the facility for shifts. You must go through AHP. If you see shifts available, please call AHP, 501-666-1825. We will do our best to arrange these shifts for you.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES.

_____	_____
Employee print	AHP personnel signature
_____	_____
Employee signature	Date

Substance Abuse Policy

It is the policy of Arkansas Healthcare Personnel (AHP) to provide a drug free environment for our clients and employees. The following policy has been established for existing and future employees.

1. **PROHIBITED ACTIVITIES:**

   The use, possession, solicitation or sale of any illegal or legal drugs or alcohol that adversely affects the employee's performance, his/her own or other's safety at the workplace, or the employer's reputation.

2. **DRUG TESTING:**

   AHP may conduct drug testing under the following circumstances:

   NEW APPLICANT: ALL applicants will be required to pass a drug screen prior to employment.

   RANDOMLY: ALL unannounced random selection of employees for testing may be conducted as deemed appropriate by AHP management.

   FOR CAUSE: When it is the belief of AHP or the "facility" that a drug problem exists, such as evidence of drugs, medication discrepancies, accidents, injuries in the workplace, fights, or other behavioral problems of drug abuse, negative performance patterns such as absenteeism or tardiness, or other behavior deemed to be inappropriate by AHP management, for cause testing will be required.

3. **POLICY COMPLIANCE:**

   Applicants who fail to pass a pre-employment drug test will not be eligible for employment with AHP.

   Employees of AHP who test positive, or who admit to substance abuse, will be subjected to AHP's disciplinary action up to and including termination of employment with AHP.

   Applicants and employees who refuse to submit to drug testing under this policy will be terminated.

_____ _____

Initial Date

AGREEMENT REGARDING EMPLOYMENT

This Agreement Regarding Employment (hereinafter referred to as the "**Agreement**") is made and entered in to on this _____ day of_____ 2024, by and between Arkansas Healthcare Personnel, Inc. , an Arkansas corporation (hereinafter referred to as "**AHP**"), and _____, an employee of AHP (hereinafter referred to as the "**Employee**").

WHEREAS, AHP employs the Employee in the course of operating the AHP business; and

WHEREAS, AHP employs the Employee as of the date of this agreement; and the Employee agrees that any credentials sent to a client on the Employees' behalf constitutes an agreement that the Employee cannot and will not make any agreement with the client directly for employment; once the Employees' credentials are sent to the Client this agreement is set in motion even if the Employee has not actually worked a shift at the Client's facility. _____ (initial)

WHEREAS, AHP and the Employee desire to enter into this Agreement for the purpose of defining the Employee's obligations in the event the Employee accepts a position of employment with one of AHP's competitors. _____ (initial)

NOW, THEREFORE, for and in consideration of the covenants set forth below, and other good and valuable consideration, including the Employee's employment by AHP, the receipt and sufficiency of which are hereby acknowledged, AHP and the Employee, intending to be legally bound, hereby agree as follows:

1. The Employee hereby agrees that he/she, for a period of 120 days from the date of termination of Employee's employment with AHP, will not accept a position of employment of any kind with any of the following: (i) any health facility in which the Employee has been placed by AHP at any time; (ii) any staffing or temporary service agency or company that is engaged in competition with AHP; (iii) any other entity, business, or organization that is engaged in competition with AHP. _____ (initial)

2. In the event that the Employee violates the prohibitions described in paragraph 1 above, the Employee hereby stipulates and agrees that he/she will be responsible for the payment of the sum of $8,000.00 to AHP to compensate AHP for the loss of income, cost of screening, preparing, and/ or training the Employee for employment, in the healthcare facility(s). _____ (initial)

3. In the event the Employee does not pay AHP the sum identified in paragraph 2 above within fifteen (15) days of the date that AHP makes demand therefor as a result of the Employee's violation of paragraph 1 above, AHP will be entitled to all rights and remedies available to AHP under Arkansas law for the Employee's breach of this Agreement, including the right to maintain an action for damages for breach of contract. _____ (initial)

IN WITNESS WHEREOF, AHP and the Employee have executed this Agreement as of the day and year first written above.

Arkansas Healthcare Personnel, Inc.

_____ _____

Signature of Employee: Witnessed By AHP Office Staff:

_____ _____

Printed Name of Employee/Title: Witness AHP Office Staff Title:

I confirm I have read & understand this agreement, any questions have been resolved & I have received a copy of this agreement for my records _____ (initial)

ARKANSAS HEALTHCARE
PERSONNEL

Hepatitis B Vaccine Declination Statement

Employee Name (please print) _____ Social Security Number _____

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to me; however, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine 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 can receive the vaccination series at no charge to me.

Employee Signature _____ Date _____

Hepatitis B Vaccine Declination Statement

THE DISEASE

Hepatitis B is an infection caused by the Hepatitis B virus (HBV) which may result in death in 1-2% of cases. Most people with Hepatitis B will recover completely, but approximately 5-10% becomes a chronic carrier of the virus. Most of these people have no symptoms but can continue to transmit the disease to others. Some may develop chronic active Hepatitis and Cirrhosis. The Hepatitis B virus also appears to be a causative factor in the development of liver cancer. This immunization against Hepatitis B can prevent acute viral Hepatitis as well as reduce sickness and death from chronic active Hepatitis, Cirrhosis and Liver cancer.

THE VACCINE

The vaccine against Hepatitis B is prepared from recombinant yeast cultures. The vaccine is free of charge if you are in association with human blood or blood products. A high percentage of all healthy people who receive the vaccine series achieve a high level of surface antibodies and protection against Hepatitis B.

POSSIBLE SIDE EFFECTS

Hepatitis B vaccine is generally well tolerated. No serious side effects have been reported. However, a few persons experienced tenderness and redness at the site of the injection. Low grade fever, rash, nausea, joint pain and mild fatigue has also been reported. The possibility exists that more serious side effects may be identified with more extensive use of the vaccine.

CONTRAINDICATIONS

1. *For yeast derived vaccine:* Hypersensitivity to yeast or to any component of the vaccine. Also there is a risk (approximately 2%*) of Guillain-Barre Syndrome.
2. *Pregnancy:* It is not known whether the Hepatitis B vaccine can cause fetal harm when administered to a pregnant woman. It is also not known whether it can affect reproductive capacity. Therefore, women who are pregnant or who are planning to become pregnant with the six month vaccination period should NOT receive the vaccine.
3. *Nursing Mothers:* It is not known whether this drug is secreted in human milk; hence, nursing mothers should NOT receive the vaccine.

**VIDEO OFFERED

DECLINED: _____ WATCHED: _____

* 1999 Physician's Desk Reference

Acknowledgement of Personnel Policies

I, the undersigned, have received a policy manual containing rules and regulations of AHP (Arkansas Healthcare Personnel, INC). It is my responsibility to read and ask any questions about any of the contents of the policy manual that I do not understand.

_____ _____

Print Name Date

_____

Signature

ARKANSAS HEALTHCARE PERSONNEL, INC.

PERSONNEL POLICIES

revised
09/25/2023

AHP PERSONNEL POLICIES

INTRODUCTION

Each person who serves as a part of our team is an important link between AHP (Arkansas Healthcare Personnel, Inc.) and the client/facilities it serves.

These personnel policies are a guide and do not represent an employment contract and should not be construed as creating a contractual agreement. Employment thru AHP is to be defined as "employment at will". The nature of our business requires that employees directly involved in the provision of these healthcare services, etc. through AHP be employed on a part-time, on-call basis. This is termed by the agency as "intermittent" employment.

This is not an attempt to cover all situations that may arise. Please consult our office Staffing Coordinators or Director of Nursing (D.O.N.) for clarification and specific information.

HIRING POLICY

AHP is an equal opportunity employer (EEOE). No person shall be discriminated against in employment because of that individual's race, color, religion, sex, age, natural origin, or handicap. It is our intent to follow all local, state, and federal guidelines and laws.

Applications are accepted on a continuing basis. We hire employees for the sole purpose of assigning them to facilities on an "as needed" basis and all employees are classified as a temporary worker. Upon registering with AHP, you are not hired for one specific assignment. At the conclusion of each shift, employees are required to contact our office Staffing Coordinators to schedule additional shifts. Please note that failure to contact AHP and/or refusal of available shifts can result in the denial of unemployment benefits.

Please bring in your current Registered Nurse License or Licensed Practical Nurse License or Certified Nursing Assistant Certificate from the State of Arkansas. Please provide proof of your up to date immunizations, to include Tuberculin (TB) Skin Test, MMR, Varicella, and Hepatitis B Vaccine. Surveillance of positive Tuberculin reactors is governed by guidelines from the Arkansas Department of Health. We also need a copy of your Driver's License and Social Security Card.

Each applicant is required to pass a 10 panel Drug Screen. If the applicant shows a positive, they will be required print out the prescription from their Physician or Pharmacy. Prescription bottles will not be accepted.

All applicants and employees are required to fill out the Arkansas State Police Background check form. All applicants are required to have a clear background check from the Arkansas State Police/Office of Long Term Care.

It is required that each employee report immediately any changes to their background such as arrest, any charges, etc.

All employees are required to report any changes immediately to their Nursing Licenses or Certification such as Flags, Probation, Suspension. To report changes call Arkansas Healthcare Personnel (501)666-1825 or 1-800-959-4625 24/7 and speak to any office staff.

TERMINATION

An employee may be terminated for any of the listed reasons of for reasons or for reasons judges unacceptable by the D.O.N.. The reasons may include: misrepresentation of information given in the agency job application form; falsification of work records or reports, e.g. patient visits/patient records; violation of the confidentiality of patient records or agency records (HIPPA); absence without notice (NO CALL/NO SHOW); sleeping on the job; negligence in the care of a patient; verbal or physical abuse of a patient; theft; sale, possession and/or use of an illegal drug(s); use of alcoholic beverages while on duty or reporting to work under the influence of alcohol; possession and/or use of a weapon or firearm on the job site; and insubordination, e.g. the refusal by an employee to follow management's instructions concerning a job related matter by given either AHP staffing coordinators or a representative of the client.

No personal gift, personal payment, or service is to be accepted by any employee from the families or individuals served by the agency. Please note: any exception must be preceded with a call to the agency and be noted in your records. An exception may be made for a small gift of little monetary value when the individual offering the gift might be offended by rejection of the offer or when the presentation of the gift offers therapeutic value to the patient, such as a handcrafted gift, garden vegetables, or flowers. ALL GIFTS MUST BE REPORTED!

No employee is to solicit or sell to patients or members of their families any commercial or handmade religious items.

CANCELLATION

If you cancel you must notify AHP at least four (4) hours before the start of the shift. After two (2) cancellations, you will be given a verbal warning. After three (3) cancellations, you will be given a written warning. After four (4) cancellations, you will be removed from our roster. A doctor's excuse may be required for any absence. (see AHP Staffing and Cancellations Policies)

INTERACTION WITH FACILITY

It is very important that AHP employees be courteous and professional when working at a client's facility. It is very important to blend in with their employees and not cause conflicts.

If an employee is involved in an incident at a facility it will be noted in our records and a notice will be verbally issues. The employee may choose to reply to the charge and have the reply entered into their record. After four valid complaints, the employee will be put on probation.

ORIENTATION

While at the facility or the client's place of business you will be under the direct supervision of the facility/client. The client has the responsibility for orienting you to their facility. Please be sure to ask for clarity on instructions, etc. that concern you. All state facilities require 2-3 days of orientation. Orientation is paid at half rate for nurses and at minimum wage for CNAS.

SHIFTS FROM CLIENTS

You may NOT contact the facility for shifts. You must go through AHP. If you see shifts available, please call AHP. We will do our best to arrange these shifts for you.

PERSONAL APPERANCE

It is the policy of AHP that all employees are well groomed (including hair) and have good personal hygiene. Hair must be of a natural color to maintain a professional image. This means no Purple, Green, Blue, Red, Orange, Pink, and Yellow (unnatural blonde hue). Nails should be clean, short in length, and any polish should be pale to neutral in color. The length of nails should not extend past the tip of the finger. No strong perfumes/colognes are to be worn. Scrubs are the required uniform of AHP employees at all facilities along with closed toe shoes such as sneakers and clogs. Shoes must be sensible enough for the employee to respond to an emergency. Heels are not appropriate for this reason. Scrubs and shoes should be clean and neat with no tears or rips. Scrubs should not be excessively tight fitting, sheer, or revealing, nor excessively loose so that it sags off the body in a manner as to impede movement. Undergarments should be worn but may not be exposed or worn on top of the uniform. Jewelry should be kept to a minimum. There should be no piercings on the face and tongue. Earrings should be kept to small studs, thus no hoop earrings or cartilage piercings. Tattoos that may be considered offensive must be covered. Sunglasses, caps, hats, bandanas, scarves, bonnets etc. may not be worn while on the clock at a facility. Please wear your name badge identifying you as an employee of AHP.

WORKERS COMP INSURANCE/PROFESSIONAL LIABILITY INSURANCE

Employee Responsibilities

Employees have the responsibility to follow safety procedures, including wearing proper safety equipment and completing appropriate training. Employees must use situational awareness at all times and also recognize and correct hazards (when possible) or report hazards to the appropriate supervisor. If you have safety concerns and the facility supervisor does not address those concerns it is your responsibility to report these issues to AHP.

All employees are covered by Workers Compensation. In the case of an accident IMMEDIATELY notify the supervisor at the facility and AHP, if after hours, call 501-666-1825 and speak to on call person. If an emergency you will be directed to the nearest ER, if not an emergency you will be given instructions on what to do. You will be required to do a Drug Screen as soon as possible. All required paperwork must be completed by the facility, including witness statements. You will also be required to complete an employee form. All injuries must be reported immediately to AHP, we are require by law to report to WC within 24 hours. NOT FOLLOWING THESE INSTRUCTIONS COULD AFFECT YOUR COVERAGE.

Arkansas Healthcare Personnel, Inc. is covered by a professional liability insurance policy, which covers many situations involving nurses, sitters and CNAs. However, we recommend that employees carry additional liability insurance.

TRANSPORTATION

Prospective employees must provide their own transportation. As a temporary/intermittent employee you are not considered employed and on AHP's time clock until you check in at a client's facility. Please refer to the above section on WORK HOURS.

CLIENT TRANSPORTATION

Do not drive the client, patient, or "sit" person or leave the facility with the client, patient or "sit" person without clearing it with AHP and the facility's supervisor. The client and AHP must sign waivers and releases.

OUTSIDE EMPLOYMENT

Outside employment or self-employment is certainly your choice. We are an intermittent employer and do not consider ourselves your sole and primary employer. However, we ask that you notify us of your other job(s) and the hours you will not be available. It is important that your job(s) do not affect your performance, timely arrival on a shift for AHP, nor should it conflict with the interests of this agency. Please do not present yourself as representing AHP outside of an AHP shift.

APPEALS AND GRIEVANCES

1. Please contact the Staffing Coordinator with your problem, or appeal following a disciplinary action or unresolved issue.
2. If you do not feel the situation has been settled to your satisfaction, you may appeal in writing to our Director of Nursing.
3. As a final appeal you may send a letter to Kathy Edwards, President, Arkansas Healthcare Personnel, Inc., 425 N University, Little Rock AR 72205

HOURS/RATES/PAYDAY

AHP offers shifts 24 hours a day, seven days a week, year round. It is necessary to be sure we have your schedule and phone number. Please keep us updated on your availability.

AHP staffing coordinators are available 24 hours a day, seven days a week, year round at 501-666-1825. You are obligated to inform AHP if you will be late arriving for a shift as soon as possible. Please let us know if an emergency or problem arises involving a shift or client/facility or personal injury.

WORK HOURS begin at the time of arrival at the client's facility (typically 30 minutes prior to shift time) and ends when the employee leaves the client's facility. Lunch breaks are 30 minutes unless otherwise indicated and should be noted on your time ticket, otherwise, 30 minutes will be deducted. If you DO NOT take a lunch break it needs to be noted, authorized & initialed on your time ticket by the client. ALL TIME TICKETS MUST BE SIGNED by the client & by the employee. You are not considered employed during traveling time or during overnight stays away from the facility or during travel time between clients. You are an employee only during the period you are actually working at the client's facility. If for any reason, you would leave the facility, including lunch, breaks, or errands, you are not considered working and you need to note it on your time ticket.

PAY RATES are determined based on skill, distance and may vary by client. Do not discuss your rate of pay with anyone at the client's facility.

AHP PAYDAY the pay week ends on Saturday and time tickets are to be turned in on the following Monday...you have the following options for receiving your pay:

1. DIRECT DEPOSIT is available to your personal bank account. Payroll will be deposited the following week on Friday. NO CASH ADVANCE is permitted when you are on this program. Submit time tickets by mail, fax or email. Follow up to be sure your time tickets are received if you send them by fax (a confirmation on your end does not verify we received your fax) or email. Original time tickets are to be turned in immediately as well. See payroll for more details or to sign up.

2. DAILY DEPOSIT is available Monday thru Friday when you have an account at First Security Bank only. Daily pay will be deposited into your account by noon on the same business day. Submit time

tickets by mail, fax or email. Follow up to be sure your time tickets are received if you send them by fax (a confirmation on your end does not verify we received your fax) or email. Original time tickets are to be turned in immediately as well. See payroll for more details or to sign up.

OVERTIME pay must be approved by the client. Overtime begins after 40 hours of regular pay, all 40 hours worked must be completed with the same client, and pay rate is 1.5 x regular rate.

HOLIDAY pay is from 12:00 a.m. to 11:59 p.m. on designated holidays, holidays recognized by client may vary, not all of our clients pay for holidays, and pay rate is 1.5 x regular rate.

PICKING UP CHECKS is available Monday thru Friday during normal office hours. Please do not leave a client during a break to pick up a check from AHP. If you are unable to pick up your check or authorize someone else to pick up your check, you must call and inform payroll. Authorized person must be able to provide valid identification.

LOST CHECKS – **IF YOUR CHECK IS LOST IN THE MAIL, IT IS NOT OUR RESPONSIBILITY!** It is vital that we maintain your current address. If your address changes, you must complete a new W-4 FORM. A 30-day waiting period is required before replacement checks are issued. If you elect to waive the 30-day waiting period, a stop payment fee of $30.00 will be charged to you.

AHP OFFICE HOLIDAYS – the AHP Office will be closed for the following holidays:

New Year's Eve (partial day), New Year's Day, Good Friday, Memorial Day, July 4th, Labor Day, Thanksgiving, Day After Thanksgiving, Christmas Eve and Christmas Day

WE THANK YOU FOR APPLYING AT ARKANSAS HEALTHCARE PERSONNEL, INC., AND LOOK FORWARD TO A LONG AND PROSPEROUS RELATIONSHIP. WELCOME ABOARD!!

Revised 09/25/2023

RN / BASIC
ANSWER SHEET

1. A B C D
2. A B C D
3. A B C D
4. A B C D
5. A B C D
6. A B C D
7. A B C D
8. A B C D
9. A B C D
10. A B C D
11. A B C D
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18. A B C D
19. A B C D
20. A B C D
21. A B C D
22. A B C D
23. A B C D
24. A B C D
25. A B C D

Name: _____ Date: _____

EMPLOYMENT TEST FOR RN'S

1. Initial measures for the treatment of angina pectoris include all of the following EXCEPT:
   A. Rest
   B. Morphine
   C. Oxygen
   D. Nitroglycerine

2. Mr. Clark is 2 days post MI. During his first time getting out of bed his pulse increases from 86/min to 95/min. Based on this response the nurse should:
   A. Ask him to slow his pace
   B. Allow him to continue as this is an appropriate cardiac response
   C. Have him lie down immediately
   D. Check his vital signs and question him about chest pain

3. In dealing with a depressed patient during the first days post MI, the most appropriate nursing action would be:
   A. Encourage the patient to ventilate his concerns
   B. Restrict visits from the family
   C. Provide for privacy by leaving the patient alone
   D. Provide a quiet environment

4. Before administering Morphine Sulfate, the nurse should check the patient's:
   A. Apical and radial pulse
   B. Respiratory rate
   C. Urinary output
   D. Skin color and turgor

5. You receive a telephone order for Morphine 12 mg IM Stat. You find that the MS you have in supply is in an ampule labeled ¼ grain per ml. How many ml should this patient receive?
   A. 0.8 ml
   B. 0.6 ml
   C. 0.5 ml
   D. 0.45 ml

6. Before starting chest physical therapy (PT) on a post-operative patient with a chest tube, you ausculate the lung fields bilaterally and note that you hear diminished breath sounds in the right posterior base. This would most likely be due to:
   A. Pleuritis
   B. Consolidation
   C. Atelectasis
   D. The chest tube

7. The earliest sign of increased intracranial pressure generally involves changes in:
   A. level of consciousness
   B. heart rate
   C. equality of pupils
   D. respiration

8. The nursing care of a patient during the ACUTE period after a stroke included all of the following expect:
   A. providing a quiet environment
   B. control of secretions
   C. preventing further injury
   D. increasing sensory input

9. All of the following are including in an hourly neuro check except:
   A. motor strength
   B. urinary output

C. response to stimulation
D. pupillary response to light

10. Signs and symptoms of diabetic ketoacidosis include:
A. dry warm skin, fruity breath, deep and rapid breathing
B. vomiting, hyperactive, diaphoresis
C. slow and shallow breathing, pallor, headache
D. dilated pupils, coma, flushed skin

11. Impending Insulin shock should be suspected when the diabetic patient complains or manifest:
A. decreased skin turgor, abdominal pain, fever
B. flushed skin, tachycardia, Kussmaul breathing
C. thirst, hypotension, fruity order to breath
D. weakness, headache, diaphoresis

12. Measures that would be taken to treat a patient in diabetic ketoacidotic coma would include all of the following EXCEPT:
A. dextrose 50% IV infusion
B. insulin IV infusion
C. potassium replacement
D. sodium bicarbonate administration

13. A newly diagnosed diabetic patient who is on a sliding scale of regular insulin complains of feeling very nervous and afraid that she is going to faint. Nursing actions might include all of the following EXCEPT:
A. testing the urine for acetone
B. administering the PRN order for regular insulin
C. drawing a blood sample for sugar
D. giving her a glass of juice to drink

14. Which of the following types of insulin will have action within 2 to 4 hours:
A. Lente
B. NPH
C. Regular
D. Ultralente

15. A patient is admitted with a diagnosis of acute renal failure. The minimal acceptable urinary output per hour is:
A. 60cc
B. 45cc
C. 30cc
D. 10cc

16. Following the first exchange of peritoneal dialysis solution, the outflow drainage return is brownish in color. Which of the following observations is correct?
A. Commonly seen following the first exchange
B. Characteristic finding in peritonitis
C. Indicates possible bowel perforation
D. Indicates possible abdominal bleeding

17. Nursing care measures for the patient receiving peritoneal dialysis include all of the following EXCEPT:
A. careful intake and output
B. warming the dialysis fluid
C. maintaining sterility to the dialysate
D. maintaining immobility

EMPLOYMENT TEST FOR RN'S

18. Which of the following best describes the proper procedure to assess for the correct position of a nasogastric tube?
   A. After measuring the tube and placing a piece of tape at the correct mark, you should assume the tube is in the proper position when the tape is reached and the tube is not curled up in the mouth.
   B. Hold the proximal end of the tube next to your ear as you pass the tube, and id you hear nothing, you are in the correct place.
   C. When the patient vomits gastric aspirate, you have hit the splenic spinchter.
   D. By auscultating over the gastric air bubbles and introducing air into the tube with a toomey syringe, an air or gastric gurgle should be very loudly heard.

19. To determine the absence of bowel sounds by auscultation, the examiner must listen for at least:
   A. 1 min
   B. 3 min
   C. 5 min
   D. 8 min

20. Which of the following IM sites is most likely to be used on aged patients?
   A. Vastus lateralis
   B. Dorsogluteal
   C. Deltoid
   D. Ventrogluteal

21. The administered rate of Phenytoin should not exceed:
   A. 50 mg/min
   B. 100 mg/min
   C. 75 mg/min
   D. 50 mg/min

22. If a physician orders an IV of D5W, 250ml to run in over 12 hours, what will be the drip rate per minute with minidrip tubing?
   A. 2037 ml/hr
   B. 20.8 gtts/min
   C. 126 gtts/hr
   D. 63 gtts/min

23. Mr. Smith has an order for antacids due to a duodenal ulcer, every 2 hours. At 2am when you go to his room to give him the antacid, he is asleep. What action is most appropriate?
   A. Wake him and give him the medication
   B. Let him sleep but wake him at 4am and give him a double dose.
   C. Let him sleep until he wakes up and then resume the antacid every 2 hours
   D. Wake him but give him a double dose of medication so you do not have to wake him at 4pm

24. Two ways to most correctly open a patients airway are:
   A. head tilt/ chin lift and modified jaw thrust
   B. tongue jaw lift and heal lift/neck lift
   C. modified head left and jaw thrust
   D. head tilt/chin tilt and modified jaw lift

25. If given an order to give 1000ml D5W IV over 8 hours and your drip set delivers 10 drops per ml. How should the IV be regulated in drops per minute?
   A. 10 drops/min
   B. 21 drops/min
   C. 42 drops/min
   D. 125 drops/min

ARKANSAS HEALTHCARE PERSONNEL, INC.

One of your former or current employees has applied for employment with **ARKANSAS HEALTHCARE PERSONNEL** and has authorized this request for information about employment and performance. Information you provide will be held in strict confidence. Please complete this form at your earliest convenience.

I hereby authorize the release of all information requested on this form.

_____ _____

APPLICANT PRINTED NAME **APPLICANT SIGNATURE AND DATE**

Verifying Employer_____

Employment Dates From: _____ To: _____

Position: _____ Eligible for Rehire? _____

Reason for leaving if applicable: _____

PLEASE EVALUATE THE APPLICANT ON THE FOLLOWING:

	Excellent	Good	Average	Poor
Performance	_____	_____	_____	_____
Attendance	_____	_____	_____	_____
Cooperation	_____	_____	_____	_____
Personal Appearance	_____	_____	_____	_____
Judgement	_____	_____	_____	_____
Initiative	_____	_____	_____	_____

SIGNATURE OF EVALUATOR _____ **DATE** _____

425 N. UNIVERISTY ~ LITTLE ROCK, AR 72205 ~ HOURS: Monday – Friday 7AM-3:30PM

501-666-1825 ~ FAX 501-666-8544 ~ WWW.AHPNURSES.COM

AHP
ARKANSAS HEALTHCARE PERSONNEL

NOTICE

The Arkansas Legislature passed **Act 516 of 2011**, which became effective on **July 27, 2011**. For background checks requested for Development Disability Services (DDS), Child Care and Long Term Care (LTC) after that date, the Arkansas State Police will release certain sealed and pardoned offenses to those requestors.

These are convictions that probably did not appear on previous background checks.

If you have questions about disqualification from employment, please contact the licensing agency directly.

LTC-DHS	Rhonda Hetland	501-682-6285
LTC-Health	Regina Wilson	501-661-2696
DDS	Shelley Lee	501-682-8677
Child Care	Brandi Phillips	501-682-0408

425 N. University ~ Little Rock, Arkansas 72205 ~
501-666-1825 ~ Fax 501-666-8544

AHP
ARKANSAS HEALTHCARE PERSONNEL

Before making an offer of employment, Arkansas Healthcare Personnel advise all applicants that employment is contingent on the satisfactory results of a criminal history record check. AHP will not knowingly employ or hire a person who has been found guilty or who has pled guilty or nolo contendere to any of the offenses listed below by any court in the State of Arkansas or any similar offense by a court in another state or any similar offense by a federal court.

1. Capital murder, § 5-10-101;
2. Murder in the first and second degree, §§ 5-10-102 and 5-10-103;
3. Manslaughter, § 5-10-104;
4. Negligent homicide, § 5-10-105;
5. Kidnapping, § 5-11-102;
6. False imprisonment in the first degree, § 5-11-103,
7. Permanent detention or restraint, § 5-11-106;
8. Robbery, § 5-12-102;
9. Aggravated robbery, § 5-12-103;
10. Battery in the first, second and third degree, §§ 5-13-201, 5-13-202, and 5-13-203;
11. Aggravated assault, § 5-13-204; and assault in first and second degree, §§ 5-13-205 and 5-13-206;
12. Introduction of controlled substance into body of another person § 5-13-210;
13. Terroristic threatening in the first and second degree, § 5-13-301;
14. Rape, § 5-14-103;
15. Sexual assault in the first, second, third and fourth degree, §§ 5-14-124 - 5-14-127;
16. Sexual indecency with a child, § 5-14-110;
17. Violation of a minor in the first and second degree, §§ 5-14-120 and 5-14-121;
18. Incest, § 5-26-202;
19. Domestic Battery (all degrees), §§ 5-26-303 – 5-26-306;
20. Endangering the welfare of incompetent person in the first and second degree; §§ 5-27-201 and 5-27-202;
21. Endangering the welfare of a minor in the first and second degree, § 5-27-205 and 5-27-206;
22. Permitting abuse of a minor, § 5-27-221;
23. Engaging children in sexually explicit conduct for use in visual and print media, transportation of minors for prohibited sexual conduct, or pandering or possessing visual or print medium depicting sexually explicit conduct involving a child, or employing or consenting to the use of a child in a sexual performance by producing, directing or promoting a sexual performance by a child, §§ 5-27-303, 5-27-304, 5-27-402, and 5-27-403;
24. Felony abuse of an endangered or impaired person, §5-28-103;
25. Theft of property, § 5-36-103;
26. Theft by receiving, § 5-36-106;
27. Arson, § 5-38-301;

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ahpnurses@sbcglobal.net

28. Burglary, § 5-39-201;
29. Felony violation of the Uniform Controlled Substance Act, §§ 5-64-101-5-64-501 et seq;
30. Prostitution, § 5-70-102, Patronizing a prostitute, § 5-70-103, or Promotion of prostitution (all degrees), §§ 5-70-104-5-70-106;
31. Stalking, § 5-71-229;
32. Criminal attempt, criminal complicity, criminal solicitation, or criminal conspiracy, § 5-3-201, 5-3-202, 5-3-301, and 5-3-401, to commit any of the offenses listed in this section.
33. Forgery, § 5-37-201;
34. Breaking or enter, § 5-39-202;
35. Obtaining a controlled substance by fraud, § 5-64-403;
36. Computer child pornography, § 5-27-603;
37. Computer exploitation of a child in the first and second degree, § 5-27-605;
38. Coercion, § 5-13-208;
39. Terroristic act, § 5-13-310;
40. Voyeurism, § 5-16-102;
41. Communicating death threat concerning a school employee or student, § 5-17-101;
42. Interference with visitation or interference with court-ordered custody, §§ 5-26-501 and 5-26-502;
43. Contributing to the delinquency or a minor or juvenile, §§ 5-27-209 and 5-27-220;
44. Soliciting money or property from incompetents, § 5-27-229;
45. Theft of services, § 5-36-104;
46. Criminal impersonation, § 5-37-209;
47. Financial identity fraud, § 5-37-227;
48. Resisting arrest, § 5-54-103;
49. Felony interference with a law enforcement officer, § 5-54-104;
50. Cruelty to animals, § 5-62-101;
51. Public display of obscenity, § 5-68-205;
52. Promoting obscene materials, § 5-68-303 or Promoting obscene performance, § 5-68-304;
53. Obscene performance at a live public show, § 5-68-305;
54. Public sexual indecency, § 5-14-111;
55. Indecent exposure, § 5-14-112;
56. Bestiality, § 5-14-122;
57. Exposing another person to human immunodeficiency virus (HIV), § 5-14-123;
58. Registered sex offenders, §§ 5-14-128 – 5-14-132;
59. Criminal use of a prohibited weapon, § 5-73-104;
60. Simultaneous possession of drugs and firearms, § 5-74-106 and
61. Unlawful discharge of a firearm from a vehicle, § 5-74-107.

Please complete the following:

X Have you ever been convicted of a felony?
Yes_____ Date_____ No_____

X Have you ever been turned into SCAN/AR State Police Hotline?
Yes_____ Date_____ No_____

X Is there is currently a flag/infraction on your license? **(RN/LPN Only)**
Yes_____ Date_____ No_____

ARKANSAS STATE POLICE

ASP 122
(Rev. 02/19/2019)

Identification Bureau
Individual Record Check Request Form

Last Name _____ First Name _____ Middle Name _____ Jr./Sr./III _____

List **ALL** other names ever used (married, maiden, shortened, etc.)

Daytime Phone #: _____

Date of Birth: _____ (Month/Day/Year) State of Birth: _____ Race: _____ Sex: _____

Social Security #: _____ Driver's License #: _____ State _____

Mailing Address: _____ Street/P.O. Box

City _____ State _____ Zip Code _____

APPLICANT RECORD NOTICE

Obtaining Copy: Procedures for obtaining a copy of the FBI criminal history record are set forth in Title 28, Code of Federal Regulations (CFR) Section 16.30 through 16.33 or the FBI website at http://www.fbi.gov/about-us/cjis/background-checks.

Change, Correction, or Updating: Procedures for obtaining a change, correction, or updating of an FBI criminal history record are set forth in Title 28, Code of Federal Regulations (CFR), Section 16.34.

I give my consent for the Arkansas State Police to conduct a criminal record search on myself and release any results to the following person or entity:

Signature: _____ (First/MI/Last Name) Date: _____ (Month/Day/Year)

Release to: _____ (First/MI/Last Name) **OR** Full Name of Agency

Mailing Address: _____ Street/P.O. Box

City _____ State _____ Zip Code _____

WHEN THIS PROPERLY COMPLETED REQUEST FORM IS SUBMITTED (OTHER THAN IN PERSON BY THE SUBJECT OF THE CHECK) THIS REQUEST FORM MUST BE NOTARIZED

STATE OF _____

COUNTY OF _____

Subscribed and sworn before me, a Notary Public, in and for the county and state aforesaid, this is the

_____ day of _____, 20 _____.

_____ Notary Public

BELOW FOR OFFICE USE ONLY

☐ 82005 State Record Check

Back

ARKANSAS DEPARTMENT OF HUMAN SERVICES
AUTHORIZATION FOR ADULT MALTREATMENT CENTRAL REGISTRY

Print all information in ink

Name	Date of Birth
Maiden and/or Any Names Formerly Used	Social Security Number
Current Address (Street, City, State, Zip)	

List all previous addresses for the past five years	Dates (From/To)

I authorize Department of Human Services/Adult Protective Services to release information from the Adult Maltreatment Central Registry in accordance with Arkansas Code [ACA 12-12-1717] to:

Name

ARKANSAS HEALTHCARE PERSONNEL

Mailing Address (Street or PO Box,City, State, Zip)

425 N. UNIVERSITY AVE.
LITTLE ROCK, AR 72205

Agency type:
- ☐ Volunteer (no charge)
- ☐ Non-Profit (no charge)
- ☐ State Agency (no charge)
- ☒ All Others ($10.00 Fee)

I further certify that the information provided on this form is true and correct.

Signature_____ Date _____

Notarization Required

COUNTY OF _____
STATE OF ARKANSAS

Acknowledged before me this _____ day of _____, 20_____.

_____ _____
(Notary Public) (My Commission Expires)

The above listed applicant was_____/was not_____ found in the Adult Maltreatment Central Registry.

Adult Protective Services – Slot W240
Adult Maltreatment Central Registry
PO Box 1437
Little Rock, AR 72203

APS-0001 (05/09)

Authorization for Release of Confidential Information
Contained Within the Arkansas Child Maltreatment Central Registry

I hereby request that the Arkansas Child Maltreatment Central Registry, PO Box 1437, Slot S 566, Little Rock, Arkansas 72203, release any information their files may contain indicating the undersigned applicant as an offender of true report of child maltreatment.

Arkansas law now permits Central Registry to charge a fee for child maltreatment background checks, investigative files, photos, audio and video recordings. This fee applies to everyone except potential employees, non-profit organizations and indigent persons. This request will be processed if you return it to us with a check or money order for $10.00 made payable to the Department of Human Services. **We are unable to accept cash.** If you feel that you should not have to pay this fee, please provide us with your proof of 501C3. **Please allow 7-10 business days for processing.**

This information should be addressed to:
(Please include a contact person's name and phone number.)
Name of Person Making the Request: Angie Miller
Company Name: Arkansas Healthcare Personnel
Address 425 N. University Ave., Little Rock, AR 72205
(Include Post Office Box and Street Address)
Telephone Number: 501-666-1825 Fax Number: 501-666-8544

I understand that the name of any confidential informants, or other information which does not pertain to the applicant as alleged perpetrator, will not be released.

Applicant's Name (print or type) _____ Social Security Number _____

Maiden Name/Aliases _____ Race _____ Age _____ DOB _____

Child's Full Name, DOB, and Social Security Number _____ Child's Full Name, DOB, and Social Security Number _____

Child's Full Name, DOB, and Social Security Number _____ Child's Full Name, DOB, and Social Security Number _____

(Please provide the last ten (10) year)
Present Address:
From_____to_____ From_____to_____

From_____to_____ From_____to_____

_____ Applicant's Signature _____ Date

County of _____ State of Arkansas Acknowledges before me this_____day of _____20_____. My commission expires:_____

_____
Notary Public

Updated 04/08/2014

Long Term Care RN/LPN
Self-Assessment Competency/Skills Checklist

Please check the appropriate boxes to describe your experience level with each skill listed below.

Date: _____ **Name:** _____

Signature: _____

Key to Competency Levels

0 – No Experience
1 – Minimal experience, need review and supervision, have performed at least once
2 – Comfortable performing with resource available
3 – Competent to perform independently and safely
4 – Expert, able to act as resource to others

	0	1	2	3	4
Communicates and obtains information while respecting the rights and privacy and confidentiality of information in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).					
Involves the patient and family and respects their role in determining the nature of care to be provided, including Advance Directives					
Complies with nursing staff responsibility included in the hospital policy related to Organ Donation					
Meets patient and family's needs regarding communication, including interpreter services					
Provides accurate information to patient and families in a timely manner					
Neuro Assessment / Neuro Vitals					
Seizure Precautions					
Halo Traction					
Caring for Patient with:					
Spinal Cord Injury					
Pre / Post Neurological Surgery					
CNS Infections					
Parkinson's					
Alzheimer's					
Autonomic Dysreflexia					
Head Injury					
Chronic C.V.A. / T.I.A.					
Rehabilitation of the Neuro Patient					
Using Glasgow Coma Scale					
Assessment:					
Capillary Refill					
Edema					
Heart Tones					
Pulses					
Angina (Acute and Chronic)					
Assessing and Treating Orthostatic BP					
Assessing Abnormal Heart Tones					
Antiembolic Devices					

Long Term Care RN/LPN
Proficiency Skills Checklist

	0	1	2	3	4
Assessing the Respiratory System Including:					
Breath Sounds					
Breathing Pattern/Effort					
Assessing the Respiratory System Including:					
Cough effort					
Skin and Nail bed color					
Sputum (color/character)					
Administering and Monitoring 02 including:					
Nasal Cannula					
Mask					
02 Sats					
Demonstrating Proper Use of the Ambu Bag					
Care of Ventilator Dependent Patient:					
Suctioning: Length of time suctioning					
Hyperventilation					
Documentation					
Caring for a Patient with:					
Respiratory Failure					
Respiratory Infections					
Status Asthmatics					
Respiratory Distress Syndrome					
Pulmonary Edema					
Pulmonary Emboli					
Tension Pneumothorax					
Tracheostomy					
Use of Incentive Spirometer					
Assessing Bowel Sounds					
Identifying Abnormalities					
Caring for Patient on Total Parenteral Nutrition					
Inserting/Maintaining Feeding Tubes/NG Tubes					
Administering Wounds or Infections					
Ileostomy/Colostomy care					
Stool Tests					
I & O: Shift volumes and totals including marking and/or measuring amount of urine, gastric fluid, NG drainage, emesis, diarrhea.					
Inserting/Maintaining Urinary Drainage Tubes:					
Insertion of Foley					
Managing Suprapubic Catheter					
Manage Suprapubic Catheter					
Placing Condom Catheter					
Caring for patients with Chronic Renal Failure					
Caring for patients receiving Dialysis					
Assessing fluid and electrolyte problems					
Knowledge of UA Values					
Collecting Specimens					

Long Term Care RN/LPN
Proficiency Skills Checklist

	0	1	2	3	4
Caring for the Diabetic Patient:					
Checking Capillary Blood Glucose					
Diabetic Teaching					
Treating Hypo/Hyperglycemia					
Insulin Administration					
Hormone Therapy					
Traction					
Braces					
Casts					
Collars					
Slings/Splints					
Skeletal and Skin Traction					
Beds i.e. Cliniton, Roto Rest, Circelectric					
Crutch Walking/Walkers					
Arthroscopy/Arthrotomy					
Caring for a Patient with:					
Joint/Bone disorders					
Total Knee Replacement					
Total Hip Replacement					
Amputation					
Obtaining and Recording:					
BP, Including Orthostatic					
Pulse, Radial					
Temperature, Oral					
Temperature, Rectal					
Temperature, Axillary					
Temperature, Tympanic					
Respirations					
Weight: Pounds and Kilograms					Q
Use of Electronic vs Equipment:					
Automatic BP Machine (Dynamap)					
Electronic Thermometer					
Recognizing Cardiac Arrest					
Cardioversion Defibrillation					
Activating Code Team					
Bringing Emergency Equipment to Room					
DNR Status					
Applying for Oximeter					
Scale Use					
Standing					
Chair					
Bed					
Recoding and Reporting Information					
Risk Factors for Skin Breakdown					
Observing, recording, reporting pressure points for redness and breakdown					
Recording and Reporting Hygiene/Skin Breakdown					

Long Term Care RN/LPN
Proficiency Skills Checklist

	0	1	2	3	4
Bathing/Daily Hygiene:					
Bathing (Shower/Tub/Arjo)					
Use of shower chair					
Use of Bath/Shower hair					
Oral Care including patients who are NPO, comatose, with dentures					
Peri Care					
Foot Care for patients with impaired circulation or sensation					
Incontinence Care					
Shaving and Precautions					
Use of Pressure and Friction Reduction Devices:					
Special beds/mattresses					
Heels and Elbow Protection					
Foot cradles					
Estimating Intake					
Setting up for Meals					
Aspiration Precautions					
Nourishments					
Feeding Patients					
Counting calories					
Fluid Restriction					
NPO					
Recording and reporting nutrition information					
New Admissions and Transfers:					
Room preparation					
VS. Height and Weight					
Inventory and Disposition of Belongings, Use of checklist					
Room Orientation, call bell					
Basic Comfort Measures					
Preparing for and explaining routines to patient					
Postmortem Care					
Determining patient ID					
Identifying and responding to safety hazards					
Determining need for additional help					
Recognizing abuse (substance, physical, emotional, etc.)					
Maintaining clean, orderly work areas					
Handling Hazardous Materials					
Proper Body Mechanics					
ROM Exercises					
Transferring to Bed, WC, Commode, etc., with or without device					
Turning and Positioning					
Ambulating with or without device					
Patient Safety Module					
Reporting broken equipment					
Use of Hoyer Lift (Dextra/Maxi)					
Bed Operation					
Use of Wheel Locks					

Long Term Care RN/LPN
Proficiency Skills Checklist

	0	1	2	3	4
Use of Alarms (Bed, Patient, Unit)					
Use of Call light					
Application and Documentation of Restraints					
Belt, including seat belt					
Wrist/ankle					
Vest					
Use of Seizure pads					
Proper Use of Specific Barrier Methods:					
Gloves					
Gown					
Mask/googles					
Protective/Reverse Isolation					
Body Substance Isolation					
TB Precautions					
MRSA Precautions					
Hand Washing					
Infectious/Hazardous Waste Disposal					
Supply/Equipment Disposal					
Use of Disposable Thermometer					
Use of CPR Mask/Bag					
Disposal of Sharps					
Venipuncture for specimen					
IV Therapy including:					
Starting IV					
Changing IV Sites					
Changing IV Dressings					
Changing IV Tubing					
Administering Fluids on Continuous IV Pumps					
Setting up and monitoring PCA					
Administering Blood and Blood Products					
Obtaining Central Venous/Peripheral Venous Blood					
Using PICC, Hickman, Triple Lumen Caths					
Set up and Monitoring for TPN					
Knowledge of Indications, Actions, Contraindications, Side Effects, Methods of Administration, Calculation of Dose, Rate of Infusion, Caring for and Monitoring patient receiving the following:					
Cimetidine (Tagamet)					
Diazepam (Valium)					
Duramorph					
Furosemide (Lasix)					
Heparin					
Insulin					
Lorazepam (Ativan)					
Morphine					
Naloxone (Narcan)					

	0	1	2	3	4
Nitroglycerine					
Pentobarbital					
Phenytoin (Dilantin)					
Potassium Chloride					
Terbutaline					
Theophylline					
Verapamil (Calan)					
Oral Medications					
Topical Medications					
Suppositories:					
Vaginal					
Rectal					
Ordering Meds					
Obtaining Cultures for Septic Work-up (Blood, Sputum, Urine, Catheter Tips)					
Caring for Patient Using Jehovah Witness Protocol					
Overbed frame safety					
Specialty beds (i.e. Kinair)					
Hospital Transport					
Providing education to patient's family related to medical condition, self-care and health care habits					
Communicating discharge needs and arrangement for support though appropriate documentation					
Coordinating Multidisciplinary Plan of Care and Initiating Interdisciplinary Referral for Identified Patient Needs					
Preparing patient for surgery					
Clearly communicating the Plan of Care, Patient responses and outcomes in the patient record according to standards					
Using computerized tools effectively					
Assigning or delegating tasks to another for which that person is prepared and quailed to perform, i.e. LPN's or CNA's					
Using appropriate abbreviations					
Identifying need for alternate communicating mechanisms					
Communicating to Charge RN:					
Changes in patient condition					
Patient needs, complaints and concerns					
Unusual incidents					
Reinforcing RN teaching with patient					
Selecting and using forms appropriately					
Using Alternate Communication Tools/Devices					
Identifying unusual incidents on the unit that require reporting					
Locating and Using Appropriate Reference Materials: Hospital, Patient Care and Unit Standards Manuals, Procedures Textbook					
Charging for Patient Care items					
Completing Risk Management Reports as needed					
Obtaining needed supplies and equipment					
Using telephone system					

Long Term Care RN/LPN
Proficiency Skills Checklist

	0	1	2	3	4
Knowledge of Serum Lab Values including:					
Chem 7 Chem 10					
CBC					
Serum Drug Levels					
Pain Management					
Caring for drains/Tubes (i.e. Hemovac, Penrose)					
Monitoring and assessing I & O					
Performing complex dressing changes					
Alert charting					

AGE SPECIFIC PRACTICE CRITERIA:

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

A. Newborn/Neonate (birth – 30 days)	B. Infant (30 days - 1 year)
C. Toddler (1 - 3 years)	D. Preschooler (3 – 5 years)
E. School age children (5 – 12 years)	F. Adolescents (12 – 18 years)
G. Young Adult (18 – 39 years)	H. Middle Adults (39 – 64 years)
I. Older Adults (64+)	
EXPERIENCE WITH AGE GROUPS:	
Able to adapt care to incorporate normal growth and development.	A B C D E F G H I ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Able to adapt method and terminology of patient instructions to their age, comprehension and maturity level.	A B C D E F G H I ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Can ensure a safe environment reflecting specific needs of various age groups.	A B C D E F G H I ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

☐ Medical/Surgical	Years:	Months:	☐ Hospice	Years:	Months:
☐ Rehabilitation	Years:	Months:	☐ ICF	Years:	Months:
☐ Skilled	Years:	Months:	☐ Alzheimer's	Years:	Months:
☐ Acute	Years:	Months:	☐ Other	Years:	Months:

☐ Oncology	☐ Charge experience
☐ IV Certified	☐ Other

Initials

ARKANSAS HEALTHCARE PERSONNELL, INC.

MEDICAL/SURGICAL CHECKLIST

This profile is for use by Medical/Surgical nurses with more than one year's experience in their discipline and specialty.

FIRST NAME: _____

LAST NAME: _____

SOCIAL SECURTIY NUMBER: _____

EMAIL: _____

SKILL: ☐ **RN** ☐ **LPN**

Please indicate your level of experience:

A. Theory, no practice
B. Intermittent Experience
C. Intermittent experience
D. Two plus years' experience

A. CARDIOVASCULAR				
1. Assessment				
a. Auscultation (rate, rhythm)	A. ☐	B. ☐	C. ☐	D. ☐
b. Blood pressure/non-invasive	A. ☐	B. ☐	C. ☐	D. ☐
c. Doppler	A. ☐	B. ☐	C. ☐	D. ☐
d. Heart sounds/murmurs	A. ☐	B. ☐	C. ☐	D. ☐
e. Pulses/circulation checks	A. ☐	B. ☐	C. ☐	D. ☐
2. Equipment & Procedures				
a. Telemetry				
(1) Basic 12 lead interpretation	A. ☐	B. ☐	C. ☐	D. ☐
(2) Basic arrhythmia interpretation	A. ☐	B. ☐	C. ☐	D. ☐
(3) Lead placement	A. ☐	B. ☐	C. ☐	D. ☐
b. Pacemaker				
(1) Permanent	A. ☐	B. ☐	C. ☐	D. ☐
(2) Temporary	A. ☐	B. ☐	C. ☐	D. ☐
3. Care of patient with:				
a. Abdominal aortic bypass	A. ☐	B. ☐	C. ☐	D. ☐
b. Aneurysm _____	A. ☐	B. ☐	C. ☐	D. ☐
c. Angina	A. ☐	B. ☐	C. ☐	D. ☐
d. Cardiac Arrest	A. ☐	B. ☐	C. ☐	D. ☐
e. Cardiomyopathy	A. ☐	B. ☐	C. ☐	D. ☐
f. Carotid endarterectomy	A. ☐	B. ☐	C. ☐	D. ☐
g. Congestive heart failure (CHF)	A. ☐	B. ☐	C. ☐	D. ☐
h. Femoral-popliteal bypass	A. ☐	B. ☐	C. ☐	D. ☐
i. Myocarditis	A. ☐	B. ☐	C. ☐	D. ☐

Pg. 2 MEDICAL/SURGICAL CHECKLIST				
j. Post-acute MI (24-48 hours)	A. ☐	B. ☐	C. ☐	D. ☐
k. Post angioplasty	A. ☐	B. ☐	C. ☐	D. ☐
l. Post cardiac cath	A. ☐	B. ☐	C. ☐	D. ☐
m. Post cardiac surgery	A. ☐	B. ☐	C. ☐	D. ☐
n. Thrombophlebitis	A. ☐	B. ☐	C. ☐	D. ☐
4. Medications	A. ☐	B. ☐	C. ☐	D. ☐
a. Heparin drip	A. ☐	B. ☐	C. ☐	D. ☐
b. Oral anticoagulants	A. ☐	B. ☐	C. ☐	D. ☐
c. Oral & IVP antihypertensives	A. ☐	B. ☐	C. ☐	D. ☐
d. Oral & topical nitrates	A. ☐	B. ☐	C. ☐	D. ☐
B. PULMONARY				
1. Assessment				
a. Breath sounds	A. ☐	B. ☐	C. ☐	D. ☐
b. Rate and work of breathing	A. ☐	B. ☐	C. ☐	D. ☐
2. Interpretation of lab results				
a. Blood chemistry	A. ☐	B. ☐	C. ☐	D. ☐
b. Blood gases	A. ☐	B. ☐	C. ☐	D. ☐
3. Equipment & Procedures				
a. Airway Management devices/suctioning				
(1) Endotracheal tub/suctioning	A. ☐	B. ☐	C. ☐	D. ☐
(2) Nasal airway/suctioning	A. ☐	B. ☐	C. ☐	D. ☐
(3) Oropharyngeal/suctioning	A. ☐	B. ☐	C. ☐	D. ☐
(4) Sputum specimen collection	A. ☐	B. ☐	C. ☐	D. ☐
(5) Tracheostomy/suctioning	A. ☐	B. ☐	C. ☐	D. ☐
b. Assist with intubation	A. ☐	B. ☐	C. ☐	D. ☐
c. Assist with thoracentesis	A. ☐	B. ☐	C. ☐	D. ☐
d. Care of the patient on a ventilator	A. ☐	B. ☐	C. ☐	D. ☐
e. Care of the patient with a chest tube				
(1) Assist with set-up & insertion	A. ☐	B. ☐	C. ☐	D. ☐
(2) Measuring and emptying	A. ☐	B. ☐	C. ☐	D. ☐
(3) Removal	A. ☐	B. ☐	C. ☐	D. ☐
f. Chest physiotherapy	A. ☐	B. ☐	C. ☐	D. ☐
g. Incentive spirometry	A. ☐	B. ☐	C. ☐	D. ☐
h. O^2 therapy & medication delivery systems				
(1) Bag and mask	A. ☐	B. ☐	C. ☐	D. ☐
(2) External CPAP	A. ☐	B. ☐	C. ☐	D. ☐
(3) Face masks	A. ☐	B. ☐	C. ☐	D. ☐
(4) Inhalers	A. ☐	B. ☐	C. ☐	D. ☐
(5) Nasal cannula	A. ☐	B. ☐	C. ☐	D. ☐
(6) Portable 0^2 tank	A. ☐	B. ☐	C. ☐	D. ☐
(7) Trach collar	A. ☐	B. ☐	C. ☐	D. ☐
i. Oximetry	A. ☐	B. ☐	C. ☐	D. ☐
4. Care of patient with:				
a. Bronchoscopy	A. ☐	B. ☐	C. ☐	D. ☐
b. COPD	A. ☐	B. ☐	C. ☐	D. ☐

Pg. 3 MEDICAL/SURGICAL CHECKLIST				
c. Fresh tracheostomy	A. ☐	B. ☐	C. ☐	D. ☐
d. Lobectomy	A. ☐	B. ☐	C. ☐	D. ☐
e. Pneumonectomy	A. ☐	B. ☐	C. ☐	D. ☐
f. Pneumonia	A. ☐	B. ☐	C. ☐	D. ☐
g. Pulmonary embolism	A. ☐	B. ☐	C. ☐	D. ☐
h. Thoracotomy	A. ☐	B. ☐	C. ☐	D. ☐
i. Tuberculosis	A. ☐	B. ☐	C. ☐	D. ☐
C. NEUROLOGICAL				
1. Assessment				
a. Glasgow coma scale	A. ☐	B. ☐	C. ☐	D. ☐
b. Level of consciousness	A. ☐	B. ☐	C. ☐	D. ☐
2. Equipment and Procedures				
a. Assist with lumbar puncture	A. ☐	B. ☐	C. ☐	D. ☐
b. Use of hyper/hypothermia blanket	A. ☐	B. ☐	C. ☐	D. ☐
3. Care of the patient with:				
a. Aneurysm precautions	A. ☐	B. ☐	C. ☐	D. ☐
b. Basal skull fracture	A. ☐	B. ☐	C. ☐	D. ☐
c. Closed head injury	A. ☐	B. ☐	C. ☐	D. ☐
d. Coma	A. ☐	B. ☐	C. ☐	D. ☐
e. CVA	A. ☐	B. ☐	C. ☐	D. ☐
f. DTs	A. ☐	B. ☐	C. ☐	D. ☐
g. Encephalitis	A. ☐	B. ☐	C. ☐	D. ☐
h. Externalized VP shunts	A. ☐	B. ☐	C. ☐	D. ☐
i. Meningitis	A. ☐	B. ☐	C. ☐	D. ☐
j. Neuromuscular disease	A. ☐	B. ☐	C. ☐	D. ☐
k. Post craniotomy	A. ☐	B. ☐	C. ☐	D. ☐
l. Seizures	A. ☐	B. ☐	C. ☐	D. ☐
m. Spinal cord injury	A. ☐	B. ☐	C. ☐	D. ☐
4. Administration of anticonvulsants	A. ☐	B. ☐	C. ☐	D. ☐
D. ORTHOPEDICS				
1. Assessment	A. ☐	B. ☐	C. ☐	D. ☐
a. Circulation checks	A. ☐	B. ☐	C. ☐	D. ☐
b. Gait	A. ☐	B. ☐	C. ☐	D. ☐
c. Range of motion	A. ☐	B. ☐	C. ☐	D. ☐
d. Skin	A. ☐	B. ☐	C. ☐	D. ☐
2. Equipment & procedures				
a. Continuous passive motion devices	A. ☐	B. ☐	C. ☐	D. ☐
b. Support devices				
(1) Cane	A. ☐	B. ☐	C. ☐	D. ☐
(2) Cervical collar	A. ☐	B. ☐	C. ☐	D. ☐
(3) Gait Belt	A. ☐	B. ☐	C. ☐	D. ☐
(4) Prosthetic	A. ☐	B. ☐	C. ☐	D. ☐
(5) Sling	A. ☐	B. ☐	C. ☐	D. ☐
(6) Transfer Boards	A. ☐	B. ☐	C. ☐	D. ☐
(7) Walker	A. ☐	B. ☐	C. ☐	D. ☐

Pg. 4 MEDICAL/SURGICAL CHECKLIST				
(8) Wheelchair	A. ☐	B. ☐	C. ☐	D. ☐
c. Traction	A. ☐	B. ☐	C. ☐	D. ☐
3. Care of the patient with:				
a. Amputation	A. ☐	B. ☐	C. ☐	D. ☐
b. Arthroscopic surgery	A. ☐	B. ☐	C. ☐	D. ☐
c. Cast	A. ☐	B. ☐	C. ☐	D. ☐
d. Osteoporosis	A. ☐	B. ☐	C. ☐	D. ☐
e. Pinned fractures	A. ☐	B. ☐	C. ☐	D. ☐
f. Rheumatic/arthritic disease	A. ☐	B. ☐	C. ☐	D. ☐
g. Total hip replacement	A. ☐	B. ☐	C. ☐	D. ☐
h. Total knee replacement	A. ☐	B. ☐	C. ☐	D. ☐
E. GASTROINTESTINAL				
1. Assessment				
a. Abdominal/bowel sounds	A. ☐	B. ☐	C. ☐	D. ☐
b. Fluid balance	A. ☐	B. ☐	C. ☐	D. ☐
c. Nutritional	A. ☐	B. ☐	C. ☐	D. ☐
2. Interpretation of blood chemistry	A. ☐	B. ☐	C. ☐	D. ☐
3. Equipment & procedures				
a. Administration of tube feeding	A. ☐	B. ☐	C. ☐	D. ☐
(1) Feeding pump	A. ☐	B. ☐	C. ☐	D. ☐
(2) Gravity feeding	A. ☐	B. ☐	C. ☐	D. ☐
(3) Saline lavage	A. ☐	B. ☐	C. ☐	D. ☐
b. Flexible feeding tube (i.e. Corpak, Dobhoff)	A. ☐	B. ☐	C. ☐	D. ☐
c. Management of:				
(1) Gastrostomy tube	A. ☐	B. ☐	C. ☐	D. ☐
(2) Jejunostomy tube	A. ☐	B. ☐	C. ☐	D. ☐
(3) T-Tube	A. ☐	B. ☐	C. ☐	D. ☐
d. Placement of nasogastric tube	A. ☐	B. ☐	C. ☐	D. ☐
e. Salem sump to suction	A. ☐	B. ☐	C. ☐	D. ☐
4. Care of the patient with:				
a. Bowel obstruction	A. ☐	B. ☐	C. ☐	D. ☐
b. Colostomy/Ileostomy	A. ☐	B. ☐	C. ☐	D. ☐
c. GI bleeding	A. ☐	B. ☐	C. ☐	D. ☐
d. GI surgery	A. ☐	B. ☐	C. ☐	D. ☐
e. Hepatitis	A. ☐	B. ☐	C. ☐	D. ☐
f. Inflammatory bowel disease	A. ☐	B. ☐	C. ☐	D. ☐
g. Invasive diagnostic testing	A. ☐	B. ☐	C. ☐	D. ☐
h. Liver failure	A. ☐	B. ☐	C. ☐	D. ☐
i. Paralytic ileus	A. ☐	B. ☐	C. ☐	D. ☐
F. RENAL/GENITOURINARY				
1. Assessment				
a. Arterio venous fistula/shunt	A. ☐	B. ☐	C. ☐	D. ☐
b. Fluid balance	A. ☐	B. ☐	C. ☐	D. ☐
2. Interpretation of lab results				
a. BUN & creatinine	A. ☐	B. ☐	C. ☐	D. ☐

Pg. 5 MEDICAL/SURGICAL CHECKLIST				
b. Electrolytes	A. ☐	B. ☐	C. ☐	D. ☐
3. Equipment & procedures				
a. Insertion & care of straight and Foley catheter				
(1) Female	A. ☐	B. ☐	C. ☐	D. ☐
(2) Male	A. ☐	B. ☐	C. ☐	D. ☐
b. Catheter Care				
(1) 3-way Foley	A. ☐	B. ☐	C. ☐	D. ☐
(2) Supra-public	A. ☐	B. ☐	C. ☐	D. ☐
c. Bladder Irrigations				
(1) Continuous	A. ☐	B. ☐	C. ☐	D. ☐
(2) Intermittent	A. ☐	B. ☐	C. ☐	D. ☐
d. Specimen collection				
(1) Routine	A. ☐	B. ☐	C. ☐	D. ☐
(2) 24 hours	A. ☐	B. ☐	C. ☐	D. ☐
4. Care of the patient with:				
a. Hemodialysis	A. ☐	B. ☐	C. ☐	D. ☐
b. Nephrectomy	A. ☐	B. ☐	C. ☐	D. ☐
c. Peritoneal dialysis	A. ☐	B. ☐	C. ☐	D. ☐
d. Renal failure	A. ☐	B. ☐	C. ☐	D. ☐
e. Renal transplant	A. ☐	B. ☐	C. ☐	D. ☐
f. TURP	A. ☐	B. ☐	C. ☐	D. ☐
g. Urinary diversion/ileal conduit nephrostomy	A. ☐	B. ☐	C. ☐	D. ☐
h. Urinary tract infection	A. ☐	B. ☐	C. ☐	D. ☐
G. ENDOCRINE/METABOLIC				
1. Assessment				
a. S/S diabetic coma	A. ☐	B. ☐	C. ☐	D. ☐
b. S/S Insulin reaction	A. ☐	B. ☐	C. ☐	D. ☐
2. Equipment & procedures				
a. Blood glucose monitoring				
(1) Electronic measuring device: type				
(2) Performing finger stick	A. ☐	B. ☐	C. ☐	D. ☐
(3) Visual blood glucose strips	A. ☐	B. ☐	C. ☐	D. ☐
b. Indwelling insulin pump	A. ☐	B. ☐	C. ☐	D. ☐
3. Care of the patient with:				
a. Diabetes mellitus	A. ☐	B. ☐	C. ☐	D. ☐
b. Disorders of adrenal gland (Addison disease)	A. ☐	B. ☐	C. ☐	D. ☐
c. Disorders of pituitary gland (Diabetes Insipidus)	A. ☐	B. ☐	C. ☐	D. ☐
d. Hyperthyroidism	A. ☐	B. ☐	C. ☐	D. ☐
e. Hypothyroidism	A. ☐	B. ☐	C. ☐	D. ☐
f. Thyroidectomy	A. ☐	B. ☐	C. ☐	D. ☐
4. Medications (administration and teaching)				
a. Insulin	A. ☐	B. ☐	C. ☐	D. ☐
b. Oral hypoglycemics	A. ☐	B. ☐	C. ☐	D. ☐
c. Steroids	A. ☐	B. ☐	C. ☐	D. ☐
d. Thyroid	A. ☐	B. ☐	C. ☐	D. ☐

Pg. 6 MEDICAL/SURGICAL CHECKLIST				
H. WOUND MANAGEMENT				
1. Assessment				
a. Skin for impending breakdown	A. ☐	B. ☐	C. ☐	D. ☐
b. Stasis ulcers	A. ☐	B. ☐	C. ☐	D. ☐
c. Surgical wound healing	A. ☐	B. ☐	C. ☐	D. ☐
2. Equipment & procedures				
a. Air fluidized, low air loss beds	A. ☐	B. ☐	C. ☐	D. ☐
b. Sterile dressing changes	A. ☐	B. ☐	C. ☐	D. ☐
c. Wound care/irrigations	A. ☐	B. ☐	C. ☐	D. ☐
3. Care of the patient with:				
a. Burns	A. ☐	B. ☐	C. ☐	D. ☐
b. Pressure sores	A. ☐	B. ☐	C. ☐	D. ☐
c. Staged decubitus ulcers	A. ☐	B. ☐	C. ☐	D. ☐
d. Surgical wounds with drain (s)	A. ☐	B. ☐	C. ☐	D. ☐
e. Traumatic wounds	A. ☐	B. ☐	C. ☐	D. ☐
I. ONCOLOGY				
1. Assessment				
a. Nutritional status	A. ☐	B. ☐	C. ☐	D. ☐
b. Pain control	A. ☐	B. ☐	C. ☐	D. ☐
2. Interpretation of lab results				
a. Blood chemistry	A. ☐	B. ☐	C. ☐	D. ☐
b. Blood counts	A. ☐	B. ☐	C. ☐	D. ☐
3. Equipment & procedures				
a. Reverse Isolation	A. ☐	B. ☐	C. ☐	D. ☐
4. Care of the patient with:				
a. Bone marrow transplant	A. ☐	B. ☐	C. ☐	D. ☐
b. Fresh oncologic surgery	A. ☐	B. ☐	C. ☐	D. ☐
c. Inpatient chemotherapy	A. ☐	B. ☐	C. ☐	D. ☐
d. Inpatient hospice	A. ☐	B. ☐	C. ☐	D. ☐
e. Leukemia	A. ☐	B. ☐	C. ☐	D. ☐
f. Radiation Implant	A. ☐	B. ☐	C. ☐	D. ☐
5. Medications: Chemotherapy certification?	☐ Yes		☐ No	
J. INFECTIOUS DISEASES				
1. Interpretation of lab results:				
a. Blood count	A. ☐	B. ☐	C. ☐	D. ☐
2. Equipment & procedures				
a. Fever management	A. ☐	B. ☐	C. ☐	D. ☐
b. Isolation	A. ☐	B. ☐	C. ☐	D. ☐
3. Care of the patient with:				
a. AIDS	A. ☐	B. ☐	C. ☐	D. ☐
b. Hepatis	A. ☐	B. ☐	C. ☐	D. ☐
c. Lyme disease	A. ☐	B. ☐	C. ☐	D. ☐
K. **PHLEBOTOMY/IV THERAPY**				
1. Equipment & procedures				
a. Administration of blood/blood products	A. ☐	B. ☐	C. ☐	D. ☐

Pg. 7 MEDICAL/SURGICAL CHECKLIST				
1. Albumin	A. ☐	B. ☐	C. ☐	D. ☐
2. Cryoprecipitate	A. ☐	B. ☐	C. ☐	D. ☐
3. Packed red blood cells	A. ☐	B. ☐	C. ☐	D. ☐
4. Plasma	A. ☐	B. ☐	C. ☐	D. ☐
5. Whole blood	A. ☐	B. ☐	C. ☐	D. ☐
b. Drawing blood from central line	A. ☐	B. ☐	C. ☐	D. ☐
c. Drawing venous blood	A. ☐	B. ☐	C. ☐	D. ☐
d. Starting IVs.				
1. Anglocath	A. ☐	B. ☐	C. ☐	D. ☐
2. Butterfly	A. ☐	B. ☐	C. ☐	D. ☐
3. Heparin lock	A. ☐	B. ☐	C. ☐	D. ☐
2. Care of the patient with:				
a. Central line/catheter/dressing				
1. Broviac	A. ☐	B. ☐	C. ☐	D. ☐
2. Groshong	A. ☐	B. ☐	C. ☐	D. ☐
3. Hickman	A. ☐	B. ☐	C. ☐	D. ☐
4. Portacath	A. ☐	B. ☐	C. ☐	D. ☐
5. Quinton	A. ☐	B. ☐	C. ☐	D. ☐
b. Peripheral line/dressing	A. ☐	B. ☐	C. ☐	D. ☐
L. PAIN MANAGEMENT				
1. Assessment of pain level/tolerance	A. ☐	B. ☐	C. ☐	D. ☐
2. Care of the patient with:				
a. Epidural anesthesia/analgesia	A. ☐	B. ☐	C. ☐	D. ☐
b. IV conscious sedation	A. ☐	B. ☐	C. ☐	D. ☐
c. Narcotic analgesia	A. ☐	B. ☐	C. ☐	D. ☐
d. Patient controlled analgesia (PCA pump)	A. ☐	B. ☐	C. ☐	D. ☐

AGE SPECIFIC PRACTICE CRITERIA:

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

A. Newborn/Neonate (birth - 30 days)	B. Infant (30 days – 1 year)
C. Toddler (1 – 3 years)	D. Preschooler (3 – 5 years)
E. School age children (5 – 12 years)	F. Adolescents (12 – 18 years)
G. Young Adult (18 – 39 years)	H. Middle adults (39 – 64 years)
I. Older adults (64+)	
EXPERINCE WITH AGE GROUPS:	
Able to adapt care to incorporate normal growth and development	A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐ H ☐ I ☐
Able to adapt method and terminology of patient instructions to their age, comprehension and maturity level.	A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐ H ☐ I ☐

Pg. 8 MEDICAL/SURGICAL CHECKLIST	
Can ensure a safe environment reflecting specific needs of various age groups.	A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐ H ☐ I ☐

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

☐ Medical	Year(s):	☐ Neurology	Years(s):
☐ Surgical	Year(s):	☐ Pediatrics	Year(s):
☐ Telemetry	Year(s):	☐ OB/GYN	Year(s):
☐ Orthopedics	Year(s):	☐ Psychiatry	Year(s):
☐ Oncology	Year(s):	☐ Rehabilitation	Year(s):
☐ Other	Type:		Year(s):

Certification: (Month/Day/Year)

☐ BCLS Exp. Date: _____

☐ Other (type) _____ Exp. Date: _____

☐ Computerized charting
System: _____ Exp. Date: _____

☐ Medication
Administration system: _____ Exp. Date: _____

The information I have given is true and accurate to the best of my knowledge. I hereby authorize Arkansas Healthcare Personnel (AHP) to release this Medical/Surgical Skills Checklist to client facilities of AHP in relation to consideration of my employment with those facilities.

_____ _____

Signature: Date:

Long Term Care RN/LPN
Proficiency Skills Checklist

Please check the appropriate boxes to describe your experience level with each skill listed below.

Date: _____ Name: _____

Signature: _____

Key To Competency Levels

0 – No Experience
1 – Minimal experience, need review and supervision, have performed at least once
2 – Comfortable performing with resource available
3 – Competent to perform independently and safely
4 – Expert, able to act as resource to others

	0	1	2	3	4
Communicates and obtains information while respecting the rights and privacy and confidentiality of information in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)					
Involves the patient and family and respects their role in determing the nature of care to be provided, including Advance Directives					
Complies with nursing staff responsibility included in the hospital policy related to Organ Donation					
Meets patient and families needs regarding communication, including interpreter services					
Provides accurate information to patient and families in a timely manner					
Neuro Assessment / Neuro Vitals					
Seizure Precautions					
Halo Traction					
Caring for Patient with:					
Spinal Cord Injury					
Pre / Post Neurological Surgery					
CNS Infections					
Parkinsons					
Alzheimers					
Autonomic Dysreflexia					
Head Injury					
Chronic C.V.A. / T.I.A.					
Rehabilitation of the Neuro Patient					
Using Glascow Coma Scale					
Assessment:					
Capillary Refill					
Edema					
Heart Tones					
Pulses					
Angina (Acute and Chronic)					
Assessing and Treating Orthostatic BP					
Assessing Abnormal Heart Tones					
Antiembolic Devices					