



WE ♥ NURSES

Dear Applicant,

Thank you for applying with *Advance Nursing*; we are excited to have you join our team!

Upon completion of your new hire paperwork, please also provide:

- Nursing License (LPN/RN) or CNA or CMA Certification
- Two forms of ID, please see the enclosed I9 form for acceptable documents
- BLS Certification card (and ACLS, PALS, TNCC, if applicable)
- PPD and Immunizations record (MMR, Varicella Titre, & Hep B)
- Physical (statement from a Physician or Nurse Practitioner releasing you to work)

You will be required to take a Urine Drug Screen, if you are taking any prescribed medications, you will be required to go to a Labcorp testing site and present proof of prescription(s).

We are open Monday through Thursday 8am to 5pm, and 8am to 12pm on Friday. You can drop off your application packet in our office or fax it back to (864)331-2090.

Thank you,

Advance Nursing Team

(864)244-1770

(864)331-2090

Self Evaluation Skills Proficiency Checklist

Name _____

CNA Years of Experience: _____

Directions: Place X in the box describes your level of proficiency for each of the skills presented

Level of Proficiency Key: A = Trained and Skilled B = Some Experience C = No Experience

GENERAL SKILLS

	A	B	C		A	B	C
Vital Signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Handwashing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Height and Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gloving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bedmaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restraints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Warm/Cold Application	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Range of Motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Basic ADL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ambulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel and Bladder Basic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intake and Output	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutrition Basics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

STERILE TECHNIQUES

	A	B	C		A	B	C
Enema & Rectal Suppository	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Make Straight & Indwelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Female Straight & Indwelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Catheterization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pori Catheter-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Removal of Catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Sterile Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wet to Dry Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SPECIMEN COLLECTION:

	A	B	C		A	B	C
Fingerstick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pichotomy Venipuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One Touch Breathing Monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sure Step Glucose Monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinalysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Occult Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY:

	A	B	C		A	B	C
Assist Deep Breathing/Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal Cannula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulse Oximeter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incentive Spirometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CARDIAC:

	A	B	C		A	B	C
Monitor Lead Placement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arrhythmia recognition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature _____ Date: _____

Advance Nursing Representative: _____ Date: _____



Employment Application

Name _____
 Last First Middle Initial Maiden Name

Current Address _____
 Street Address City State Zip Code

Home Phone _____ Cell Phone _____

Permanent Address _____
 Street Address City State Zip Code

Phone _____ Email Address _____

License Type _____ Specialty _____ SS Number _____

Driver's License _____ Birth date _____

Date Available to travel _____ how did you learn about us? _____

EDUCATION	Name of School and Location	Month/Year Graduated	Diplomas, Degrees Received
College	_____	_____	_____
Graduate School	_____	_____	_____
Other School (if applicable)	_____	_____	_____

LICENSURE *(Include photocopies of all licenses and certifications held.)*
 State: _____ State: _____ State: _____
 Expiration Date: _____ Expiration Date: _____ Expiration Date: _____

CERTIFICATION (ACLS, BLS, etc.)	Cert. #	Cert. Date	Exp. Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your professional license or certification ever been investigated or suspended? Yes ___* No ___
 Have you ever been investigated by federal or state authorities for an alleged violation of health care law? Yes ___* No ___
 Have you ever been excluded from participation in a federal health care program (Medicare/Medicaid)? Yes ___* No ___
 In the past 7 years, have you been convicted of a crime other than a traffic violation? Yes ___* No ___
 Have you ever been named as a defendant in a professional liability action? Yes ___* No ___
 Can you submit verification of your legal right to work in the U.S.? Yes ___ No ___
 * Any "yes" responses must be explained on a separate sheet of paper.
 If you will be employed on a visa, please specify the type of work visa: _____

Person to notify in case of emergency: _____
 Name Relationship

Street Address City State Zip Code Phone

Work History

Applicant's Name _____

Please indicate all of your employment for the past seven (7) years, beginning with your most recent employer.

Are you employed now? Yes No If so, may we contact your present employer? Yes No

Facility/employer _____ Dept. _____	
Street Address _____	City _____ State _____ Zip Code _____
Dates Employed: From _____ To _____ Reason for Leaving _____	
Position Held _____ Specialty _____	
Supervisor's Name & Title _____ Phone _____	
Travel Assignment? Yes <input type="checkbox"/> No <input type="checkbox"/> Local Staff Agency? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Facility/employer _____ Dept. _____	
Street Address _____	City _____ State _____ Zip Code _____
Dates Employed: From _____ To _____ Reason for Leaving _____	
Position Held _____ Specialty _____	
Supervisor's Name & Title _____ Phone _____	
Travel Assignment? Yes <input type="checkbox"/> No <input type="checkbox"/> Local Staff Agency? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Facility/employer _____ Dept. _____	
Street Address _____	City _____ State _____ Zip Code _____
Dates Employed: From _____ To _____ Reason for Leaving _____	
Position Held _____ Specialty _____	
Supervisor's Name & Title _____ Phone _____	
Travel Assignment? Yes <input type="checkbox"/> No <input type="checkbox"/> Local Staff Agency? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Facility/employer: _____ Dept. _____	
Street Address _____	City _____ State _____ Zip Code _____
Dates Employed: From _____ To _____ Reason for Leaving _____	
Position Held _____ Specialty _____	
Supervisor's Name & Title _____ Phone _____	
Travel Assignment? Yes <input type="checkbox"/> No <input type="checkbox"/> Local Staff Agency? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Other names under which you have been employed _____

Please account for gaps in your employment history (use separate sheet of paper).

I attest that the information provided in the application for employment with *Advance Nursing* is true, correct and complete. I acknowledge that any misstatement or omission of fact on the application may result in my disqualification from employment with *Advance Nursing*. I authorize *Advance Nursing* to release this application and reference information to *Advance Nursing* Client institutions, only after receiving express written or verbal consent for each assignment opportunity. I understand that by giving *Advance Nursing* permission to submit my application for assignment opportunities, I am also agreeing to any criminal background investigation that may be required by certain states of Client institutions.

Signature _____

Date _____

Work Reference

The person below has registered with *Advance Nursing* and has listed you as a previous employer. We would appreciate your assistance in verifying employment and evaluating job performance. All information is CONFIDENTIAL.

Applicant Release

Applicant Name: _____

Last First MI Maiden

Social Security #: _____ Position Held: _____

Dates employed: From _____ to _____ Unit _____

Employer: _____

Evaluator's Name Position Phone #

Facility Name

Address of facility City State Zip

I authorize the person or company completing this form to release all information (including opinion information) regarding my employment. I hereby release and hold harmless any individuals, or company, which is providing this information, both factual, and opinion to Advance Nursing, its representatives and agents, from any legal liability for any damages that may result from the disclosure of this information.

Applicant Signature _____

Date _____

Employer Response

Note to Employer: The person whose name appears at the top of this form has applied with Advance Nursing for employment in the health care field and has submitted your name as the employer for reference. We would appreciate your cooperation in replying to the survey listed below.

1. Do the employment dates above correspond with your records? Yes No (If no, then: _____ to _____)
2. Is there anything in the individual's work history that would pose a threat to patient safety? Yes No
3. Would you rehire this employee? Yes No

Performance Evaluation Exceeds Meets Below Unsatisfactory Not
 Expectations Expectations Expectations Observed

	Exceeds	Meets	Below	Unsatisfactory	Not Observed
Accepts Supervision					
Appearance					
Attendance					
Attitude					
Dependability					
Job Knowledge/Skills					
Judgment					
Quality of Work					

Name and Title (Please print) _____

Signature _____

Date _____

Telephone Verification: By: _____ Date _____ Signature _____

Advance Nursing Emergency Information Form

Employee Information:

Name: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Relationship: _____

2nd Emergency Contact:


Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Relationship: _____

I, _____ authorize Advance Nursing/Nurse Associates to deduct the following from my first check: 

- Urine Drug Screen \$35.00
- Criminal Background Check \$35.00
- BLS/CPR \$55.00
- TB Testing/PPD \$20.00
- 2-Step TB Testing/PPD \$35.00

Total to be deducted: \$ _____

Signature _____ Date _____

Print Name _____

ANNUAL PHYSICAL FORM

APPLICANT NAME: _____

(BY SIGNING THIS FORM I DO AUTHORIZE ADVANCE NURSING TO RECEIVE AND RELEASE THE FOLLOWING INFORMATION ACQUIRED IN MY RECENT MEDICAL EXAMINATION, WHICH IS RELEVANT TO MY EMPLOYMENT.)

I HAVE EXAMINED THE ABOVE INDIVIDUAL AND TO THE BEST OF MY KNOWLEDGE HE/SHE IS IN GOOD PHYSICAL HEALTH AND MENTAL HEALTH. THIS PERSON IS FREE FROM SYMPTOMS INDICATING THE PRESENCE OF AN INFECTIOUS DISEASE AND DOES NOT HAVE ANY CONDITIONS THAT WOULD INTERFERE WITH THE PERFORMANCE OF HIS/HER PROFESSION AT FULL CAPACITY WITHOUT RESTRICTIONS.

PRIMARY CARE PROVIDER/PHYSICIAN _____ SIGNATURE _____ DATE _____

TB SCREEN DATE _____ RESULTS IN (MM) _____

CHEST FILM X-RAY _____ DATE _____ (IF TB SCREEN IS POSITIVE)

PROOF OF HISTORY - VACCINE OR TITER - Attach proof of vaccination or titer.

RUBEOLA Immunization Date _____ (or) Titer Results _____

MUMPS Immunization Date _____ (or) Titer Results _____

RUBELLA Immunization Date _____ (or) Titer Results _____

VARICELLA Hx / TITER _____

GENERAL COMMENTS: _____

Hepatitis B Dates and Declination

PLEASE SIGN APPROPRIATE SECTION BELOW

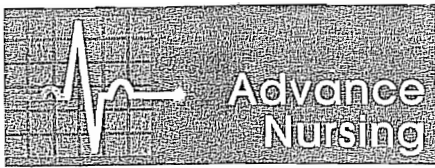
• I have received the series of three vaccinations or titer for Hepatitis-B as listed below (attach documentation):

- 1. Date of First Injection _____
Date _____
- 2. Date of Second Injection _____ Titer Date _____
Date _____
- 3. Date of Third Injection _____
Date _____

Signature _____ Date _____

• I have not received the series of three vaccinations and I understand that due to my occupational exposure to blood or other potentially materials, I may be at risk of acquiring Hepatitis B infection. At this time I decline the hepatitis B vaccination.

Signature _____ Date _____



WE ♥ NURSES

HIPPA Policy Statement

As a user of information at an Advance Nursing Facility you may develop, use, or maintain patient records (for health care, quality improvement, peer review, education, billing, reimbursement, administration, and research) or personnel records (for employment, payroll, or other business purposes). Patient and personnel information from any source and in any form, including paper record, oral communication, audio recording, and electronic display, is strictly confidential. Access to confidential patient and personnel information is permitted only on a need-to-know basis.

It is the policy of Hospital that users (i.e., employees, medical staff, students, volunteers, and outside affiliates) shall respect and preserve the privacy of confidentiality of patient and personnel information. Violations of this policy include, but are not limited to:

- accessing information that is not within the scope of your job;
- misusing, disclosing without proper authorization, or altering patient or personnel information;
- disclosing to another person your sign-on code and password for accessing electronic or computerized records;
- using another person's sign-on code and password for accessing electronic or computerized records;
- leaving a secured application unattended while signed on; and
- attempting to access a secured application without proper authorization.

Violation of this policy by employees, staff, or volunteers of Hospital may constitute grounds for corrective action up to and including termination of employment or loss of Hospital privileges in accordance with applicable Hospital procedures and/or federal or state law. Violation of this policy by you may constitute grounds for corrective action in accordance with applicable Hospital procedures.

I have read and agree to comply with the terms of the above statement and will read and comply with the Hospitals' policies and standards.

I further certify that I have received training and instruction on the confidentiality provisions of the Medical Record Security and Privacy Regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or any other applicable patient confidentiality laws.

Name: _____
(Please Print)

SS#: _____

Signature: _____

Date: _____

I, _____, the undersigned, hereby certify to Nurse Associates, LLC that I am an independent contractor and that I am self-employed. I acknowledge and agree that I am not an employee of Nurse Associates, LLC, and that Nurse Associates, LLC is not responsible for: (1) the payment of Federal Insurance Contribution Act (FICA) taxes on payments made by Nurse Associates, LLC to me, (2) the payment of Federal Unemployment Tax Act (FUTA) taxes on payments made by Nurse Associates, LLC to me, (3) the payment of social security, medicare, or other payroll taxes on payments made by Nurse Associates, LLC to me, (4) the withholding of federal, state, local or other income taxes or payroll taxes on payments made by Nurse Associates, LLC to me, (5) unemployment compensation benefit coverage, or (6) any other benefits of any type available to an employee. I understand and agree that payments from Nurse Associates, LLC to me will be reported by Nurse Associates, LLC to the Internal Revenue Service and state tax authorities as payments made to an independent contractor.

I further agree: (1) that I will not hold myself out as an employee of Nurse Associates, LLC, (2) I will not claim I am an employee of Nurse Associates, LLC for unemployment compensation benefits purposes, tax purposes, or any other purpose, (3) I will not file for unemployment compensation benefits based on the assertion I am an employee of Nurse Associates, LLC, and (4) to file all government reports including, but not limited to, federal, state, and local tax returns consistent with being an independent contractor (and not an employee) of Nurse Associates, LLC.

I further acknowledge and agree that Nurse Associates, LLC, will act solely to place me as an independent contractor, and that if I am placed I am solely responsible for my actions relating to such placement. I will not attempt to hold Nurse Associates, LLC liable or responsible for any incident that may occur relating to my placement.

I acknowledge and agree that Nurse Associates, LLC is relying on this Self-Employment Attestation and that Nurse Associates, LLC would not agree to place me or attempt to place me without my prior execution of this Self-Employment Attestation.

I agree to indemnify Nurse Associates, LLC for any taxes, costs, expenses, liabilities, attorneys' fees, or other damages incurred by Nurse Associates, LLC arising from, attributable to, resulting from, or relating to (directly or indirectly) my failure to comply with the terms, provisions and statements above.

Social Security Number

Signature of Independent Contractor

Date

Printed Name

The undersigned, Nurse Associates, LLC, hereby signifies its reliance on the above Self-Employment Attestation by its signature below.

NURSE ASSOCIATES, LLC

By: _____

Date

Its: _____

Long Term Care National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The Goals focus on problems in health care safety and how to solve them.

Identify residents correctly

Use at least two ways to identify residents. For example, use the resident's name and date of birth. This is done to make sure that each resident gets the medicine and treatment meant for them.

Use medicines safely

Take extra care with residents who take medicines to thin their blood.

Prevent infection

Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization.

Use proven guidelines to prevent infection of the blood from central lines.

Check resident medicines

Find out what medicines each resident is taking. Make sure that it is OK for the resident to take any new medicines with their current medicines.

Give a list of the resident's medicines to their next caregiver. Give the list to the resident's regular doctor before the resident goes home.

Give a list of the resident's medicines to the resident and their family before they go home. Explain the list.

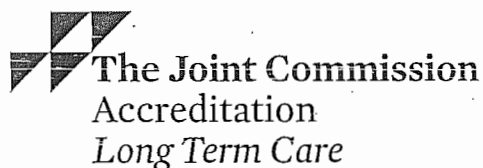
Some residents may get medicine in small amounts or for a short time. Make sure that it is OK for those residents to take those medicines with their current medicines.

Prevent residents from falling

Find out which residents are most likely to fall. For example, is the resident taking any medicines that might make them weak, dizzy or sleepy? Take action to prevent falls for these residents.

Prevent bed sores

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



This is an easy-to-read document. It has been created for the public. The exact language of the Goals can be found at www.jointcommission.org.

National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The Goals focus on problems in health care safety and how to solve them.

Identify patients correctly

Use at least two ways to identify patients. For example, use the patient's name and date of birth. This is done to make sure that each patient gets the medicine and treatment meant for them.

Make sure that the correct patient gets the correct blood type when they get a blood transfusion.

Improve staff communication

Quickly get important test results to the right staff person.

Use medicines safely

Label all medicines that are not already labeled. For example, medicines in syringes, cups and basins.

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

Prevent infection

Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization.

Use proven guidelines to prevent infections that are difficult to treat.

Use proven guidelines to prevent infection of the blood from central lines.

Use safe practices to treat the part of the body where surgery was done.

Check patient medicines

Find out what medicines each patient is taking. Make sure that it is OK for the patient to take any new medicines with their current medicines.

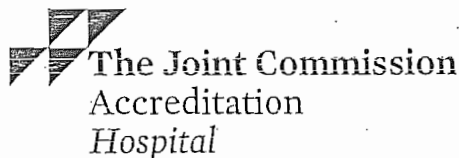
Give a list of the patient's medicines to their next caregiver or to their regular doctor before the patient goes home.

Give a list of the patient's medicines to the patient and their family before they go home. Explain the list.

Some patients may get medicine in small amounts or for a short time. Make sure that it is OK for those patients to take those medicines with their current medicines.

Identify patient safety risks

Find out which patients are most likely to try to kill themselves.



This is an easy-to-read document. It has been created for the public. The exact language of the Goals can be found at www.jointcommission.org.

Do Not Use	Potential Problem	Use Instead
U (unit)	Mistaken for "O" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily)	Mistaken for each other	Write "daily"
Q.O.D., QOD, q.o.d, qod (every other day)	Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS	Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate" Write "magnesium sulfate"
MSO ₄ and MgSO ₄	Confused for one another	

¹ Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

*Exception: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Additional Abbreviations, Acronyms and Symbols
(For possible future inclusion in the Official "Do Not Use" List)

Do Not Use	Potential Problem	Use Instead
> (greater than) < (less than)	Misinterpreted as the number "7" (seven) or the letter "L"	Write "greater than" Write "less than"
Abbreviations for drug names	Confused for one another Misinterpreted due to similar abbreviations for multiple drugs	Write drug names in full
Apothecary units	Unfamiliar to many practitioners Confused with metric units	Use metric units
@	Mistaken for the number "2" (two)	Write "at"
cc	Mistaken for U (units) when poorly written	Write "ml" or "milliliters"
µg	Mistaken for mg (milligrams) resulting in one thousand-fold overdose	Write "mcg" or "micrograms"

NAME

SIGNATURE

Per Diem Policies & Procedures

1. Your certifications, credentials, and medical documents must remain up to date and compliant with JCAHO requirements at all times in order to work, or your shifts will be cancelled.
2. Your shift time must be recorded on an Advance Nursing timesheet and **MUST** be signed by the Charge RN. **Timesheets with no signature of approval / not recorded on an Advance Nursing timesheet will NOT be paid.**
3. Attendance and punctuality are crucial – please be on time for all shifts and notify Advance Nursing if otherwise. **Excessive tardiness and no call / no show will result in Termination.**
4. If you must cancel a shift, you must notify Advance Nursing at least 4 hours prior.
5. Shifts must be scheduled through Advance Nursing **ONLY**. **Do not sign up or accept shifts directly at the facility.**
6. Advance Nursing provides emergency service for after-hours & weekends. Please handle your scheduling and payroll issues during regular business hours. Our On-Call Coordinator can be reached by contacting our office at 864.244.1770, then press 1. **This feature is strictly for emergencies ONLY (ie: “day-of” cancellations, reporting an incident, etc ...)**
7. Lastly, Advance Nursing's hours of operation are as follow:

Monday – Thursday	8am – 5pm
Friday	8am – 12pm
Saturday and Sunday	CLOSED

I, _____, understand and agree to follow the policies and procedures outlined above.

Name: _____ Date: _____

Universal Protocol For Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™

Wrong site, wrong procedure, wrong person surgery can be prevented. This universal protocol is intended to achieve that goal. It is based on the consensus of experts from the relevant clinical specialties and professional disciplines and is endorsed by more than 40 professional medical associations and organizations.

In developing this protocol, consensus was reached on the following principles:

- Wrong site, wrong procedure, wrong person surgery can and must be prevented.
- A robust approach—using multiple, complementary strategies—is necessary to achieve the goal of eliminating wrong site, wrong procedure, wrong person surgery.
- Active involvement and effective communication among all members of the surgical team is important for success.
- To the extent possible, the patient (or legally designated representative) should be involved in the process.
- Consistent implementation of a standardized approach using a universal, consensus-based protocol will be most effective.
- The protocol should be flexible enough to allow for implementation with appropriate adaptation when required to meet specific patient needs.
- A requirement for site marking should focus on cases involving right/left distinction, multiple structures (fingers, toes), or levels (spine).
- The universal protocol should be applicable or adaptable to all operative and other invasive procedures that expose patients to harm, including procedures done in settings other than the operating room.

In concert with these principles, the following steps, taken together, comprise the Universal Protocol for eliminating wrong site, wrong procedure, wrong person surgery:

- Pre-operative verification process
 - Purpose: To ensure that all of the relevant documents and studies are available prior to the start of the procedure and that they have been reviewed and are consistent with each other and with the patient's expectations and with the team's understanding of the intended patient, procedure, site and, as applicable, any implants. Missing information or discrepancies must be addressed before starting the procedure.
 - Process: An ongoing process of information gathering and verification, beginning with the determination to do the procedure, continuing through all settings and interventions involved in the preoperative preparation of the patient, up to and including the "time out" just before the start of the procedure.
- Marking the operative site
 - Purpose: To identify unambiguously the intended site of incision or insertion.
 - Process: For procedures involving right/left distinction, multiple structures (such as fingers and toes), or multiple levels (as in spinal procedures), the intended site must be marked such that the mark will be visible after the patient has been prepped and draped.
- "Time out" immediately before starting the procedure
 - Purpose: To conduct a final verification of the correct patient, procedure, site and, as applicable, implants.
 - Process: Active communication among all members of the surgical/procedure team, consistently initiated by a designated member of the team, conducted in a "fail-safe" mode, i.e., the procedure is not started until any questions or concerns are resolved.

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Print Name: _____

Signature: _____

Date: _____

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

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

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

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

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

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

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

Employee's Signature	Date (month/day/year)
----------------------	-----------------------

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

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

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

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

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

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code)		Date (month/day/year)

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

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)
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C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

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

Signature of Employer or Authorized Representative	Date (month/day/year)
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LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A

Documents that Establish Both
Identity and Employment
Authorization

LIST B

Documents that Establish
Identity

LIST C

Documents that Establish
Employment Authorization

OR

AND

1. U.S. Passport or U.S. Passport Card	1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	1. Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa	2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address	2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
4. Employment Authorization Document that contains a photograph (Form I-766)	3. School ID card with a photograph	3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form	4. Voter's registration card	
	5. U.S. Military card or draft record	
	6. Military dependent's ID card	5. Native American tribal document
	7. U.S. Coast Guard Merchant Mariner Card	
	8. Native American tribal document	6. U.S. Citizen ID Card (Form I-197)
	9. Driver's license issued by a Canadian government authority	
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI	For persons under age 18 who are unable to present a document listed above:	7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
	10. School record or report card	8. Employment authorization document issued by the Department of Homeland Security
	11. Clinic, doctor, or hospital record	
	12. Day-care or nursery school record	

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

Instructions

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the United States) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration Related Unfair Employment Practices at 1-800-255-8155.

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and noncitizen) hired after November 6, 1986, is authorized to work in the United States.

When Should Form I-9 Be Used?

All employees, citizens, and noncitizens hired after November 6, 1986, and working in the United States must complete Form I-9.

Filling Out Form I-9

Section 1, Employee

This part of the form must be completed no later than the time of hire, which is the actual beginning of employment. Providing the Social Security Number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). The employer is responsible for ensuring that Section 1 is timely and properly completed.

Noncitizen Nationals of the United States

Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

Employers should note the work authorization expiration date (if any) shown in Section 1. For employees who indicate an employment authorization expiration date in Section 1, employers are required to reverify employment authorization for employment on or before the date shown. Note that some employees may leave the expiration date blank if they are aliens whose work authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia or the Republic of the Marshall Islands). For such employees, reverification does not apply unless they choose to present

in Section 2 evidence of employment authorization that contains an expiration date (e.g., Employment Authorization Document (Form I-766)).

Preparer/Translator Certification

The Preparer/Translator Certification must be completed if Section 1 is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete Section 1 on his or her own. However, the employee must still sign Section 1 personally.

Section 2, Employer

For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors. Employers must complete Section 2 by examining evidence of identity and employment authorization within three business days of the date employment begins. However, if an employer hires an individual for less than three business days, Section 2 must be completed at the time employment begins. Employers cannot specify which document(s) listed on the last page of Form I-9 employees present to establish identity and employment authorization. Employees may present any List A document **OR** a combination of a List B and a List C document.

If an employee is unable to present a required document (or documents), the employee must present an acceptable receipt in lieu of a document listed on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employees must present receipts within three business days of the date employment begins and must present valid replacement documents within 90 days or other specified time.

Employers must record in Section 2:

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification in Section 2. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they must be made for all new hires. Photocopies may only be used for the verification process and must be retained with Form I-9. Employers are still responsible for completing and retaining Form I-9.

For more detailed information, you may refer to the *USCIS Handbook for Employers* (Form M-274). You may obtain the handbook using the contact information found under the header "USCIS Forms and Information."

Section 3, Updating and Reverification

Employers must complete Section 3 when updating and/or reverifying Form I-9. Employers must reverify employment authorization of their employees on or before the work authorization expiration date recorded in Section 1 (if any). Employers **CANNOT** specify which document(s) they will accept from an employee.

- A. If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- B. If an employee is rehired within three years of the date this form was originally completed and the employee is still authorized to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- C. If an employee is rehired within three years of the date this form was originally completed and the employee's work authorization has expired or if a current employee's work authorization is about to expire (reverification), complete Block B; and:
 - 1. Examine any document that reflects the employee is authorized to work in the United States (see List A or C);
 - 2. Record the document title, document number, and expiration date (if any) in Block C; and
 - 3. Complete the signature block.

Note that for reverification purposes, employers have the option of completing a new Form I-9 instead of completing Section 3.

What Is the Filing Fee?

There is no associated filing fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

USCIS Forms and Information

To order USCIS forms, you can download them from our website at www.uscis.gov/forms or call our toll-free number at 1-800-870-3676. You can obtain information about Form I-9 from our website at www.uscis.gov or by calling 1-888-464-4218.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from our website at www.uscis.gov/e-verify or by calling 1-888-464-4218.

General information on immigration laws, regulations, and procedures can be obtained by telephoning our National Customer Service Center at 1-800-375-5283 or visiting our Internet website at www.uscis.gov.

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Form I-9s for three years after the date of hire or one year after the date employment ends, whichever is later.

Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR 274a.2.

Privacy Act Notice

The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 12 minutes per response, including the time for reviewing instructions and completing and submitting the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529-2210. OMB No. 1615-0047. Do not mail your completed Form I-9 to this address.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)	
Business name, if different from above	
Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code	
List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
or
Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here	Signature of U.S. person ▶	Date ▶
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General Instructions

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

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
- Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

trust, and
• The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,

withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form-W-9.

Also see *Special rules for partnerships* on page 1.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). Check the "Limited liability company" box only and enter the appropriate code for the tax classification ("D" for disregarded entity, "C" for corporation, "P" for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

For an LLC classified as a partnership or a corporation, enter the LLC's name on the "Name" line and any business, trade, or DBA name on the "Business name" line.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the business name, sign and date the form.

from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
2. The United States or any of its agencies or instrumentalities,
3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,
7. A foreign central bank of issue,
8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
9. A futures commission merchant registered with the Commodity Futures Trading Commission,
10. A real estate investment trust,
11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
12. A common trust fund operated by a bank under section 584(a),
13. A financial institution,
14. A middleman known in the investment community as a nominee or custodian, or
15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt payees 1 through 7

¹See Form 1099-MISC, Miscellaneous Income, and its instructions.

²However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at www.ssa.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/businesses and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting www.irs.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: spam@uce.gov or contact them at www.consumer.gov/idtheft or 1-877-IDTHEFT(438-4338).

Visit the IRS website at www.irs.gov to learn more about identity theft and how to reduce your risk.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee
b. So-called trust account that is not a legal or valid trust under state law	The actual owner
5. Sole proprietorship or disregarded entity owned by an individual	The owner ³
For this type of account:	Give name and EIN of:
6. Disregarded entity not owned by an individual	The owner
7. A valid trust, estate, or pension trust	Legal entity ⁴
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴ List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; cancellation of debt; or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. 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 must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

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

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2010 expires February 16, 2011. See Pub. 505, Tax Withholding and Estimated Tax.

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

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

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

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

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax

payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2010. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for yourself if no one else can claim you as a dependent. A _____

B Enter "1" if: B _____

- o You are single and have only one job; or
- o You are married, have only one job, and your spouse does not work; or
- o Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.

C Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) C _____

D Enter number of dependents (other than your spouse or yourself) you will claim on your tax return D _____

E Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) E _____

F Enter "1" if you have at least \$1,800 of child or dependent care expenses for which you plan to claim a credit F _____
(Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. G _____

- o If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children.
- o If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children.

H Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) H _____

For accuracy, complete all worksheets that apply. H _____

- o If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.
- o If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$18,000 (\$32,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.
- o If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

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

Form W-4 Department of the Treasury Internal Revenue Service	<h2 style="margin:0;">Employee's Withholding Allowance Certificate</h2> <p style="font-size: small; margin: 5px 0;">▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-0074 <h1 style="font-size: 2em; margin: 0;">2010</h1>
1 Type or print your first name and middle initial.	Last name	2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withheld at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 _____
6 Additional amount, if any, you want withheld from each paycheck		6 \$ _____
7 I claim exemption from withholding for 2010, and I certify that I meet both of the following conditions for exemption. o Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and o This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here		7 _____
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (Form is not valid unless you sign it.) ▶		Date ▶
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional) 10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2010 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	\$ _____
2	Enter: { \$11,400 if married filing jointly or qualifying widow(er) \$8,400 if head of household \$5,700 if single or married filing separately }	2	\$ _____
3	Subtract line 2 from line 1. If zero or less, enter "-0-"	3	\$ _____
4	Enter an estimate of your 2010 adjustments to income and any additional standard deduction. (Pub. 919)	4	\$ _____
5	Add lines 3 and 4 and enter the total. (Include any amount for credits from <i>Worksheet 6</i> in Pub. 919.)	5	\$ _____
6	Enter an estimate of your 2010 nonwage income (such as dividends or interest)	6	\$ _____
7	Subtract line 6 from line 5. If zero or less, enter "-0-"	7	\$ _____
8	Divide the amount on line 7 by \$3,650 and enter the result here. Drop any fraction	8	_____
9	Enter the amount from the <i>Personal Allowances Worksheet</i> , line H, page 1	9	_____
10	Add lines 8 and 9 and enter the total here. If you plan to use the <i>Two-Earners/Multiple Jobs Worksheet</i> , also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1	10	_____

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the <i>Deductions and Adjustments Worksheet</i>)	1	_____
2	Find the number in Table 1 below that applies to the LOWEST paying job and enter it here. However, if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than "3."	2	_____
3	If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. Do not use the rest of this worksheet	3	_____

Note. If line 1 is *less than* line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4-9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	_____
5	Enter the number from line 1 of this worksheet	5	_____
6	Subtract line 5 from line 4	6	_____
7	Find the amount in Table 2 below that applies to the HIGHEST paying job and enter it here	7	\$ _____
8	Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	\$ _____
9	Divide line 8 by the number of pay periods remaining in 2010. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2009. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	\$ _____

Table 1

Table 2

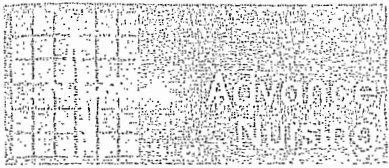
Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$7,000 -	0	\$0 - \$6,000 -	0	\$0 - \$65,000	\$550	\$0 - \$35,000	\$550
7,001 - 10,000 -	1	6,001 - 12,000 -	1	65,001 - 120,000	910	35,001 - 90,000	910
10,001 - 16,000 -	2	12,001 - 19,000 -	2	120,001 - 185,000	1,020	90,001 - 165,000	1,020
16,001 - 22,000 -	3	19,001 - 26,000 -	3	185,001 - 330,000	1,200	165,001 - 370,000	1,200
22,001 - 27,000 -	4	26,001 - 35,000 -	4	330,001 and over	1,280	370,001 and over	1,280
27,001 - 35,000 -	5	35,001 - 50,000 -	5				
35,001 - 44,000 -	6	50,001 - 65,000 -	6				
44,001 - 50,000 -	7	65,001 - 80,000 -	7				
50,001 - 55,000 -	8	80,001 - 90,000 -	8				
55,001 - 65,000 -	9	90,001 - 120,000 -	9				
65,001 - 72,000 -	10	120,001 and over	10				
72,001 - 85,000 -	11						
85,001 - 105,000 -	12						
105,001 - 115,000 -	13						
115,001 - 130,000 -	14						
130,001 - and over	15						

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 who claims no withholding allowances; 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 possessions for use in administering their tax laws, and using it 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.



Advance Nursing
1328 Miller Road
Greenville S.C. 29607

Last Name:

First name:

Middle name or Initial:

S.S.N.:

E-Mail address:

Hire Date:

Agency Name:

Advance Nursing

Role or Title (RN, LPN, C.N.A. CPA, EVS,
etc...)

Location of Service (Check All that Apply)

Acute Care:

Physicians Practice:

Long Term Care:

Other:

Assignment Handout for HealthStream Express

1. Go to: www.healthstream.com/hlc/ghs.

2. Login with your provided user id and password.

User id: The first three letters of your last name and your last four digits of your social security # (without spaces or dashes)

Password: your social security #

3. Complete each of the courses below:

- A Welcome to GHS
- Code of Excellence at GHS for Contractors and Students
- Code React: Responding to the Threat
- Electrical Safety
- Emergency Preparedness
- Fire Safety
- GHS Paging Codes
- GHS Policy Overview
- GHS – Drug-Free Workplace
- GHS – Hand Hygiene
- GHS – Harassment in the Workplace
- GHS – Infection Prevention and Control – or other Infection Control Course(s) specific to your area of practice (i.e. OR, ETC and Ambulatory Care have courses specific to their practice)
- GHS – Information Security
- GHS – Working Safely and Hazardous Materials
- Standard Precautions: Bloodborne Pathogens and Other Potentially Infectious Materials (Unless you are in a position that doesn't have exposure potential)
- Workplace Violence

Please note that there may be additional clinical modules to be completed before you are able to begin work at GHS or additional requirements as they come available during your work assignment at GHS.

Each course will provide an online learning activity for you to complete as required prior to your work assignment. There is also an exam for you to take online once you have completed the learning activity. Should you not pass the exam with an 80% or better you will be remediated and allowed to review the content again before attempting to retake the exam. Once you have successfully completed the course, it will “move” the course completion to your “My Transcript” page where it will remain for you to print as needed whenever you need documentation.

The actual time to complete each course may vary but plan for approximately 5 hours to complete all the courses listed on this letter. Additional training will be required for clinical staff and will require additional hours for completion. Some of that additional training you will see on your My Learning page as you access HealthStream. Your agency will be assisting you with those additional training requirements. Because requirements are different for different work areas and job titles, the amount of time to complete will vary with each staff member.

Each course has a “bookmark” feature so that when you leave the online activity for any reason, you may begin where you left off by answering “Yes” to return to your last visited page when you access the course again. In some courses, you will have the option to “pause” the test and return to it at a later time.

Several of the courses have “attachments” or documents for you to pull up, read and review. You may find it helpful to print these documents for reference at a later time. You may also return to these or any content after the completion of the course by selecting that course off of your My Transcript page in HealthStream.

To run this online program, you must have the additional software to properly display the courses. The most likely situation that alerts you the software’s missing is a white screen that says it’s done.

- Shockwave – To load shockwave go to google.com and search “free shockwave” and follow the instructions to download the software.
- Flash – To load flash go to google.com and search “free flash” and follow the instructions to download the software.
- ActiveX feature – You may be asked to download or enable the ActiveX feature. If so follow the instructions provided to you on your computer when you get that message.

It may be necessary for you to turn your “popup blocker” off to access each course. You should use the option to “Allows Always Access to This Site”. You will most likely get a yellow strip across the top of the screen. If you right mouse click on the bar and select “Always allow access to this site.” that should resolve the popup blocker issue.

We recommend that you disable any Yahoo and Google toolbar.

If you are having problems or wish to “check” your computer to see if it meets the minimal requirements, you may run a “browser check” by going to <http://www.healthstream.com/browsercheck>.

Please note that most, but not all, courses do have sound. You may turn the sound off or back on by selecting the Mute/Speak button located at the bottom of the navigation bar. **There is a routine downtime every Thursday from 8pm CST (9pm EST) until 4am CST (5am EST).** Please plan your training time accordingly. Should you have questions or need assistance, please contact your agency representative. The HealthStream Customer Service number is 1-800-521-0574.

Agency Company Name: _____

Clinical Unit Location: _____

Position: RN/LPN UAP Clinical – Other _____ Non-Clinical _____

GHS Online Orientation and Online Training via HealthStream PHASE I			GHS General Orientation Requirements: Current Requirements found on most recent Assignment Handout *see attached transcript for component listing and verification of completion OSHA Requirements: Current Requirements found on most recent Assignment Handout *see attached transcript for component listing and verification of completion GHS Clinical Orientation Requirements <input checked="" type="checkbox"/> Discipline Specific for Clinical-other *see below for component listing <input checked="" type="checkbox"/> Required																																																																																																																																																																																																																																																													
Non-clinical	Clinical Other	Physician Practice	Acute Care		Long Term Care		*Please note designation of requirements by role and location of clinical unit. *Module indicates self-study module and has been provided in paper copy and post test is accessible via HealthStream *CBT indicates computer based training and is accessible via HealthStream *Applicable components to be initiated and dated by agency personnel as verification of completion.																																																																																																																																																																																																																																																									
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It is the expectation of the individual departments utilizing non-clinical and clinical-other agency staff to complete their Phase II orientation to include any Phase I clinical elements required for their specific department/unit.																																																																																																																																																																																																																																																																
<table border="1"> <thead> <tr> <th colspan="7">Phase I Components</th> <th>Initial</th> <th>Date</th> </tr> </thead> <tbody> <tr><td><input checked="" type="checkbox"/></td><td></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td>Medication Policy and Procedure - Module</td><td></td><td></td></tr> <tr><td><input checked="" type="checkbox"/></td><td></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td>Use of Restraints - Module</td><td></td><td></td></tr> <tr><td><input checked="" type="checkbox"/></td><td></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td>GHS – Blood Draw and Sample Labeling – CBT</td><td></td><td></td></tr> <tr><td><input checked="" type="checkbox"/></td><td></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td>Patient Identification and Labeling for UAP - 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Module</td><td></td><td></td></tr> <tr><td><input checked="" type="checkbox"/></td><td></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td>Ethics – Module (No post test-Acknowledgement only)</td><td></td><td></td></tr> <tr><td><input checked="" type="checkbox"/></td><td></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td>Moderate Sedation - CBT</td><td></td><td></td></tr> <tr><td><input checked="" type="checkbox"/></td><td></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td>OmnRx – CBT s</td><td></td><td></td></tr> <tr><td><input checked="" type="checkbox"/></td><td></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td>GHS Pain Management - CBT</td><td></td><td></td></tr> <tr><td><input checked="" type="checkbox"/></td><td></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td>SBAR Communication Tool – CBT</td><td></td><td></td></tr> <tr><td><input checked="" type="checkbox"/></td><td></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td>GHS Blood Transfusion Administration - CBT</td><td></td><td></td></tr> <tr><td><input checked="" type="checkbox"/></td><td></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td>GHS Blood Transfusion Reactions - CBT</td><td></td><td></td></tr> <tr><td><input checked="" type="checkbox"/></td><td></td><td></td><td><input checked="" type="checkbox"/></td><td></td><td><input checked="" type="checkbox"/></td><td><input checked="" type="checkbox"/></td><td>GHS Blood Component Handling, Transportation and Storage at GHS - 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Clinical Unit/Practice Based Orientation Phase II			Skills/Knowledge Self-Assessment *To be given to agency staff on arrival to clinical unit/area for completion. Clinical Unit Educator and/or Manager to facilitate and review. Phase II Clinical Unit/Practice-Specific Orientation Form *Varies per clinical unit/practice. Components to include, but not limited to, any elements/procedures/practices/clinical knowledge/policies not covered in Phase I and specific to clinical area and agency staff's role. Provided to agency staff upon arrival to area and completion facilitated by Manager/Educator and/or area designee. The clinical unit/practice is responsible for documentation of the elements that comprise Phase II Orientation and that it has been completed.																																																																																																																																																																																																																																																													
Signatures: 1. _____ 3. _____ 2. _____ 4. _____																																																																																																																																																																																																																																																																

Staff Name: _____ SS# XXX-XX-_____

Credentials: _____ (eg: RN, LPN, CNA, CPA, EVS, CMA ect...)

Location of Assignment: _____ (eg: hospital unit or department)

Agency Name: _____

ShiftWise Order Number: _____

[Please date and initial each requirement to confirm completion as per the GHS Contract]

<u>Date/initial</u>	<u>Personnel Information</u>	<u>Date/initial</u>	<u>Health screen and Patient Risk Information</u>
	Valid license, registration, and/or certification to work in South Carolina *		Current PPD expiration date: _____ (within past 12-months)
	Current American Heart Association Healthcare Provider BLS Certification* (other AHA approved verifications as needed per specialty)		Proof of immunity: Measles, Mumps, Rubella, Chicken Pox (Require two (2) immunizations or titer
	Minimum two (2) references from area of specialty		GHS Approved Respiratory Fit Testing
	Minimum of one (1) year relevant experience within the last 12-months		Hepatitis B Immunization/Declination
	Documentation of Physical Exam within past year		GHS approved Background Check to include: SLED, GSA, OIG, and relevant licensing boards
	Negative Drug screen		Confidentiality Agreement
	<u>*copies must be attached for top two items listed only</u>		Authorization form signed by agency employee permitting GHS to review all health and employee records
Staff Member Sign/Date		Agency Representative Sign/Date	

Complete and scan to ShiftWise Order

Fax to GHS Representative where ShiftWise is not available

Any item marked "N/A" or left blank must be approved by a GHS representative prior to a worked shift. All blanks must be completed.

Credentialing Checklist Per Diem/Traveler Staff

7/17/09