

Respiratory Therapist Application Checklist

This application packet contains most of the forms you will need to fill out in order to apply for the job of Respiratory Therapist. After completing the application and signing the required forms, please call Professional Medical Staffing at 410-827-5051 to schedule an interview.

Please print your name

Primary Phone #

Date

- Driver's License or Photo ID
- Social Security Card (signed)
- Respiratory License (signed)
- CPR (front & back)
- MMR & Varicella Titers
- PPD (Chest X-ray & TB questionnaire required for "+" PPD)
- Physical Exam (annual)
- Hepatitis B Vaccination (or signed waiver)
- Authority for Release of Information
- Employment Reference Request (two)
- JCAHO Acknowledgement Document (signed & dated)
- JCAHO Quiz (nine quizzes completed, signed & dated)
- Skills Checklist
- Drug screen (negative ten panel)
- Tax Forms (I-9, W-4, and MW-507)

Application for Employment

Applications are evaluated on the information supplied. Therefore, it is important to complete the application legibly and in its entirety. Incomplete applications will be not be considered.

Position/Specialty Desired: _____ Date Available: _____

I. PERSONAL INFORMATION (please print)

Name: Last		First	Middle	Maiden	Social Security Number:
Present Address:			City, State, Zip:	Years/Months lived there?	
Permanent Address:			City, State, Zip:	Years/Months lived there?	
Phone:	Alternate Phone:			Are you a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Have you ever pled guilty or "no contest" to a crime, had adjudication withheld, or been convicted of a felony? Yes No

(NOTE: Answering "yes" to this question does not constitute an automatic bar to employment.)

If yes, please give date and details of each:

II. PROFESSIONAL INFORMATION

If you are applying for a position as a healthcare professional including Registered Nurse, please complete Sections II and III. If not, please proceed to Section 4, "Record of Previous Employment."

1st Specialty: _____ Years Exp: _____ 3rd Specialty: _____ Years Exp: _____
2nd Specialty: _____ Years Exp: _____ 4th Specialty: _____ Years Exp: _____

Region/State/City Preferences:

Have you worked travel assignments before? Yes No For which agency(s): _____

If yes, please attach a list of the dates of all travel assignments and the facilities in which you worked.

List all states in which you are currently licensed or have been licensed:

State/Country	License #	Exp. Date	State/Country	License #	Exp. Date

List any inactive licenses you may have: _____

Has your professional license ever been suspended, revoked, or investigated? Yes No

If yes, attach a separate sheet with explanation and any documentation related to license suspension, reinstatement, etc.

III. PROFESSIONAL CERTIFICATIONS

CPR (BLS) Exp. Date: _____	NALS Exp. Date: _____
BCLS Exp. Date: _____	CEN Exp. Date: _____
ACLS Exp. Date: _____	CNOR Exp. Date: _____
PALS Exp. Date: _____	CHEMO Exp. Date: _____
NRP Exp. Date: _____	OCN Exp. Date: _____
TNCC Exp. Date: _____	CRRN Exp. Date: _____
CCRN Exp. Date: _____	Critical Care Nurse <input type="checkbox"/> Yes <input type="checkbox"/> No Exp. Date: _____
Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Exp. Date: _____	

Related courses/certification (i.e. chemotherapy, EKG, Balloon Pump, etc. Please attach certification):

IV. RECORD OF PREVIOUS EMPLOYMENT

Please list the names of your present or previous employers in chronological order with present or last employer listed first. Be sure to account for all periods of time including military service and any period of unemployment. If self-employed, give Company name and supply business references.

PRESENT OR LAST EMPLOYER:		Position:
Address:		Employed From (month/year): To (month/year):
City, State, Zip:		Starting pay: Final Pay: \$ \$
Last Supervisor name/title:	Phone:	May we contact them? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for leaving:	Duties/Responsibilities:	
PREVIOUS EMPLOYER 2:		Position:
Address:		Employed From (month/year): To (month/year):
City, State, Zip:		Starting pay: Final Pay: \$ \$
Last Supervisor name/title:	Phone:	May we contact them? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for leaving:	Duties/Responsibilities:	
PREVIOUS EMPLOYER 3:		Position:
Address:		Employed From (month/year): To (month/year):
City, State, Zip:		Starting pay: Final Pay: \$ \$
Last Supervisor name/title:	Phone:	May we contact them? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for leaving:	Duties/Responsibilities:	
PREVIOUS EMPLOYER 4:		Position:
Address:		Employed From (month/year): To (month/year):
City, State, Zip:		Starting pay: Final Pay: \$ \$
Last Supervisor name/title:	Phone:	May we contact them? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for leaving:	Duties/Responsibilities:	
PREVIOUS EMPLOYER 5:		Position:
Address:		Employed From (month/year): To (month/year):
City, State, Zip:		Starting pay: Final Pay: \$ \$
Last Supervisor name/title:	Phone:	May we contact them? <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for leaving:	Duties/Responsibilities:	

If there are any employers listed above whom you do not wish for us to contact, please explain circumstances:

Have you ever been terminated or asked to resign from any job? Yes No

If yes, please explain circumstances:

Please explain fully any gaps in employment history:

V. EDUCATIONAL HISTORY

List ALL of the schools attended since high school in chronological order, starting with the most recent.

School Name	Years Completed <i>(circle one)</i>	Diploma/Degree	Describe Course of Study or Major	Describe Specialized Training Experience, Skills, and Extracurricular Activities
High school:	9 10 11 12			
College/University:	1 2 3 4			
Graduate/Professional:	1 2 3 4			
Other:				

VI. EMERGENCY INFORMATION

In case of accident or other emergency, whom should we contact?

Name: _____ Relationship: _____

Home Address: _____ Phone: _____
Street City State Zip

Work Address: _____ Phone: _____
Street City State Zip

VII. PERSONAL REFERENCES

Please list two persons who know you well who are not previous employers or relatives:

Name of Reference 1:	Relationship:	Years known:
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Street Address: _____

City, State, Zip: _____

Phone:	Occupation:
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Name of Reference 2:	Relationship:	Years known:
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Street Address: _____

City, State, Zip: _____

Phone:	Occupation:
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VIII. DRIVING INFORMATION

Do you have a current driver's license? Yes No

Country: _____ State: _____ License #: _____ Exp. Date: _____

Has your driver's license ever been suspended or revoked? Yes No If yes, please explain circumstances:

IX. CONDITION OF HEALTH/CERTIFICATION

Excellent Good Fair Height: _____ Weight: _____ Date of last physical: _____
Are you now or have you ever applied for/received worker's compensation? Yes No Suffered from: Back injury? Yes No
Hernia? Yes No Alcoholism? Yes No Drug Addiction? Yes No Emotional/Psychological illness? Yes No
If yes to any question, please explain separately: _____
Please list any medications you take and explain: _____
Have you had any chronic illness or disability, including psychological? Yes No If yes to this question, please provide Professional Medical Staffing, Inc. with a physician's statement releasing to return to work without limitations (able to perform all duties as RT).

X. APPLICANT ACKNOWLEDGEMENT AND AUTHORIZATION

I understand that if I am hired by Professional Medical Staffing, Inc. (hereafter referred to as "the Company"), my employment will be for no definite period, regardless of the period of payment of my wages. I further understand that I have the right to terminate my employment at any time with or without notice, and the Company has the same right. No one other than the President or Director of Human Resources of the Company has authority to modify this relationship or make any agreement to the contrary. Any such modification or agreement must be in writing.

I understand that the Company reserves the right to require me to submit to a drug test at any time and also reserves the right to require me to submit to an alcohol test and/or medical examination to the extent permitted by law. I authorize the Company to investigate my driving record, my criminal record and my credit history, and I understand that an investigative consumer report may be prepared whereby information is obtained through personal interviews with neighbors, friends and others with whom I am acquainted. This inquiry would include information as to my character, general reputation, personal characteristics and mode of living. I understand that I have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

I further understand that the Company may contact my previous employers, and I authorize those employers to disclose to the Company all records and other information pertinent to my employment with them. I also authorize the Company to provide truthful information concerning my employment with it to my future prospective employers, and I agree to hold it harmless for providing such information.

I understand and voluntarily agree that, if hired, I will complete all educational courses and take all tests necessary to keep all of my licenses, including driver's license, and certifications current and valid, as required by the Company or local, state or federal law or regulation. I further agree to advise the Company if at any time my licenses or certifications become invalid or expire. I understand that failure to take such tests when required or requested or to keep my licenses, including driver's license, current and valid or to advise the Company that my licenses have expired or become invalid may result in my immediate dismissal.

I certify that all of the information that I provide on this application and in any interview will be true and accurate. I understand that if I am employed and any such information is later found to be false or misleading in any respect, I may be dismissed.

I, the undersigned, do hereby certify by my signature on this document that I am free from infectious/contagious disease(s), that I am free from drug(s) and/or alcohol, and that I am able, without limitation, to practice and perform all of the duties of an RN.

I CERTIFY THAT ALL OF THE INFORMATION THAT I HAVE PROVIDED ON THIS APPLICATION IS TRUE AND ACCURATE.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS

Applicant's Signature _____ Date _____

Questions regarding employment opportunities with Professional Medical Staffing, Inc. or items on this application form can be directed to:
Professional Medical Staffing, Inc., Human Resources Director, 410-827-5051; or E-mail: deb.waldrip@professionalmedstaff.com

PROFESSIONAL MEDICAL STAFFING, INC. IS AN EQUAL OPPORTUNITY EMPLOYER.

Clinical Competency Profile: Respiratory Care



Name: _____ Date: _____

Social Security #: _____ Years of RT Experience: _____

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In accordance with the Joint Commission on Accreditation of Healthcare Organizations, the following is a list of responsibilities that you may be responsible to perform. This checklist is meant to serve as a general guideline for our client facilities as to the level of your skills in each of the following areas. Please rate your ability in each area as accurately as possible by filling in the corresponding box. Additional comments welcome.

Experience Levels: 1 = Consistent experience 2 = Perform with supervision 3 = No Experience

1 of 2

ITEM	1	2	3		
Equipment					
Simple face mask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Aerosol face mask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Venturi mask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Non-rebreather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Partial rebreather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Trach collar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Face tent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Aerosol T-piece	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Nasal Cannula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Flow meters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Thorpe tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bordon gauge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
H-tank	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
E-tank	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Croup tent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Oxyhood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Respiratory Airway and Procedures					
Oral suction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Yankauer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Oral airway	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Nasotracheal suction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Nasal airway	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Trach tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Trach tube change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Trach care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Endotracheal tubes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Saline installation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Minimal leak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Cuff pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Inner cannula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Speaking valves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Intubation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Intubation assist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Extubation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
In-line suction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Suction catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Coude catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Medication Delivery & Treatment Procedures					
Hand-held nebulizer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
MDI with spacer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Nebulizer with vent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
MDI with vent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Chest PT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Incentive spirometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
PEP therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

ITEM	1	2	3		
Medication Delivery & Treatment Procedures (cont'd)					
Flutter therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
IPPB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Continuous Neb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Peak flow meter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Vital capacity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
NIF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Airway resistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Static compliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Pulse oximetry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
ETCO2 monitors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
ABG drawing/analysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Radial stick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Brachial stick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Femoral stick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Nitric oxide devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
The Vest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
ICU Ventilators					
Bear I	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bear II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bear III	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bear 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bear 1000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Adult Star	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bird Mark 7/8	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bird 6400	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bird 8400	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bi-PaP/CPAP systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
PB 7200	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
PB 740	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
PB 760	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
PB 840	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
MA I	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
MA II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
AP 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
PR 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Siemens Servo 900C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Siemens Servo 300/300A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Siemens I-Vent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Drager Evita	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Drager E4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hamilton Amadeus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hamilton Veolar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hamilton Galileo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bag Mask Resuscitator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
VersaMed I-Vent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Clinical Competency Profile: Respiratory Care



Name: _____ Date: _____

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Experience Levels: 1 = Consistent experience 2 = Perform with supervision 3 = No Experience

2 of 2

ITEM	1	2	3		
Ventilator Humidifiers					
Cascade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Concha Park	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Fisher Paykel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
HME	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Ventilator Humidifiers					
Control/Assist control.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
SIMV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Pressure support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
CPAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Mask CPAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
MMV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
APRV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
PRVC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Volume support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Inverse ratio ventilation.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Flow by.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Flow sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
PEEP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Working pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Pressure control.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
% Rise time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Mean airway pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Peak airway pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Minute volume	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Tidal volume.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Ventilator Alarms					
High pressure limit.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Low pressure limit.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
High respiratory rate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
High/low minute volume.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Low PEEP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
High/low FiO2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Apnea alarm.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Low gas pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Please list any procedures or assessment items (not listed above) that you feel you may need a review of:

Additional Comments:

ITEM	1	2	3		
Pediatric/Neonatal Ventilation					
Bear Cub	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bird VIP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Baby Bird II.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bird VIP Gold.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Nasal CPAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Sensor Medics 3100A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Drager Babylog	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Infant Star Series	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bunnel Jet Vent.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Medications					
Albuterol (Proventil/Ventolin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Ipratropium bromide (Atrovent).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bronkosol (Isoetheraine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Acetylcystine (Mucomyst).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Sodium bicarbonate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Atropine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Racemic Epi.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Metaproterenol (Alupent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Terbutaline sulfate (Bricanyl).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bitolterol (Tornalate).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Normal saline.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Dornase.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Dexamethasone (Decadron).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Beclamethasone (Vanceril)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Flunisolide (Aerobid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Triamcinolone (Azmacort).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Cromolyn sodium (Intal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Serevent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Theophylline.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Prednisone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Solumedrol.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Lasix.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Applicant Acknowledgement and Authorization

The information I gave above is true and accurate to the best of my knowledge. I acknowledge that some facilities utilizing relief staff services require information concerning my clinical competency. Therefore, I authorize Professional Medical Staffing, Inc. to release this information as necessary to those facilities.

Applicant's Printed Name

Credentials

Applicant's Signature

Date

Welcome

This packet will introduce you to Professional Medical Staffing (PMS) as well as make you aware of communication patterns to facilitate a mutually beneficial relationship.

Communication is the most important aspect of any relationship. It is equally important with your relationship with PMS. Please communicate your availability to the office as soon as possible so that we can arrange assignments for you. After the office receives your availability, we will look for facilities to fill your time. We will then contact you with the facility name. After you accept the assignment, we will contact the facility to confirm the assignment. You will then receive a call from us confirming the shift. After confirmation is made, you must be available for the shift. In the event of illness when you cannot meet the obligation, you must notify the office at least 3 hours before your shift begins.

The Hospital(s) which you are assigned to has the option of canceling your assignment up to 2 hours prior to the start of your shift.

If you are cancelled after that 2 hour period, you will receive 2 hours inconvenience pay. In the event that your are cancelled, the office will make every attempt to locate you an alternative assignment.

Please be advised that for whatever reason you must cancel your scheduled shift within 2 hours (within the 2 hour window it was supposed to start), a two hour fee (late cancellation fee) will be charged to you. This fee will be deducted from your next paycheck.

In the event you are scheduled for an assignment and do not show, PMS reserves the right to terminate this relationship. It is important that we honor the assignments so that the facilities have confidence that we will meet their needs.

Customer service is an important aspect of the services we provide. We at PMS expect our employees to be professional and courteous at all times. If the facilities are not pleased with your manner or performance, they will request that you not be assigned to return. In this event, PMS would be reluctant to reassign you to any of our contracted facilities.

Professional attire is also an important aspect of the image we present. Please dress appropriately for your work assignments.

We hope that we will have a long and mutually prosperous relationship.

I undersigned have read and understand and agree to the above agency modus operand.

Please print your name

Please sign your name

Date

Primary Condition of Employment

PLEASE READ CAREFULLY AND SIGN

I understand and agree that if an offer of employment is made, I will abide by the policies of Professional Medical Staffing, Inc. which comply with the conditions of the Drug Free Workplace Act of 1988. A conditional offer of employment is based on passing a drug screening, physical examination, and where applicable, a background check as required by Maryland Law.

I understand and agree that if made an offer of employment, I must produce documents as required by the Federal Government to verify my identity and authorization for employment in the U.S. in compliance with the Immigration Reform and Control Act of 1986.

I understand that prior to being offered employment with Professional Medical Staffing, Inc., I may be requested to take an employment test. In the event that I have a disability which will affect my ability to take the test, I will inform Professional Medical Staffing, Inc. prior to the administration of the test so that a reasonable accommodation can be made. Professional Medical Staffing, Inc. reserves the right to require medical documentation concerning the need for accommodation.

I understand that if employed, policies and rules which are issued are not conditions of employment and that Professional Medical Staffing, Inc. may revise or revoke policies or procedures, in whole or in part, at any time. If an employment relationship is established, I understand that I have the right to terminate my employment at any time and that Professional Medical Staffing, Inc. has the same right.

I certify that the information given by me on the application is true and correct without omissions in all aspects. I agree that if the information given is to be found false in any way, it shall be cause for denial of employment or discharge. I authorize Professional Medical Staffing, Inc. to use any information in this application to verify my statements, and I authorize past employers, references and any other persons to answer all questions asked concerning my ability, character, reputation, and previous employment record. I release all such persons from any liability or damages on my account for having furnished such information.

Applicant's name (printed)

Applicant's signature

Date

Mandatory Hepatitis B Vaccination Declination Form

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus, (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Applicant's name (printed)

Applicant's signature

Date

Position

PMS Witness' name (printed)

PMS Witness' signature

Date

Mandatory Varicella Waiver Form

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring varicella. I have been given the opportunity to be vaccinated with the varicella vaccine, at no charge to myself. However, I decline varicella vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring varicella, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the varicella vaccine, I can receive the vaccination series at no charge to me.

Applicant's name (printed)

Applicant's signature

Date

OSHA Blood-borne Pathogen Control

I have received the mandatory inservice information regarding OSHA's Blood-borne Pathogen Control Plan. I understand that this material is available for my review on an annual basis. Further, I understand that Professional Medical Staffing, Inc. utilizes universal precautions for practice in all settings. The OSHA manual is available for my review at any time.

I have received Professional Medical Staffing, Inc.'s non-discrimination policy and understand the contents.

Applicant's name (printed)

Applicant's signature

Date

TB Screening Questionnaire

Fill out only if you have a positive PPD

Name: _____ Today's date: _____

Positive PPD Date: _____ Last CXR date: _____ (Please attach report)

Please indicate if you are having any of the following problems for three to four weeks or longer:

- | | |
|---|--|
| 1. Chronic cough (greater than 3 weeks) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Production of sputum | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Blood streaked sputum | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Unexplained weight loss | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Fatigue/tiredness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Night sweats | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Shortness of breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |

No evidence of Pulmonary Tuberculosis or Contagium

Applicant's name (printed)

Applicant's signature

Date

Physician's name (printed)

Physician's signature

Date

HIPAA Compliance

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated regulations that govern privacy, security, and electronic transactions standards for health care information. In August 2002, the Department of Health and Human Services (DHHS) published specific rules governing the privacy of personal healthcare information. These rules are designed to protect all medical records and other health information held or disclosed by entities such as hospitals, whether communicated electronically, on paper or in oral conversations. Hospitals to which you will be assigned must comply with these Privacy Rules as of April 2003. Failure to comply or breach of a rule can result in penalties, including fines and imprisonment.

By signing this document, you agree that:

1. You will abide by each hospital's rules on privacy and disclosure of healthcare information.
2. You acknowledge that it is a condition of your employment with Professional Medical Staffing, Inc. that you will abide by each hospital's rules on privacy and disclosure of healthcare information.
3. You will not discuss or disclose any patient healthcare information to Professional Medical Staffing' staff, except with the written permission by the hospital.
4. You will report any known breaches of a hospital's privacy rules to both a hospital supervisor and to Professional Medical Staffing, Inc.

Acknowledgement of Confidentiality of Patient Health Care Information

I acknowledge the confidentiality of patient health care information ("Confidential Patient Information") that I may receive or have access to in the course of providing patient care services at participating hospitals at which I am assigned through Professional Medical Staffing. I shall maintain the confidentiality of Confidential Patient Information, and in doing so, shall comply with all applicable State and Federal laws and regulations, including, without limitation, the privacy provisions under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the policies and procedure of each participating hospital where I am assigned. My agreement to maintain the confidentiality of Confidential Patient Information shall survive the termination of my employment with Professional Medical Staffing and the conclusion of any assignment at a participating hospital or nursing homes through Professional Medical Staffing, Inc.

I have read, understood and agree to the contents of this document.

 Applicant's Name (printed)

 Soc. Security #

 Applicant's signature

 Date

 PMS Witness' name (printed)

 PMS Witness' signature

 Date

Cancellation Policy

When shifts are confirmed, it is expected that the employee will fulfill the commitment unless cancelled by the facility.

Cancellation by the Contracted Facility

1. Facilities who cancel a scheduled shift with less than 2 hours notice will be charged a 2 hour late cancellation fee, and the employee will be reimbursed for 2 hours inconvenience pay.
2. When a facility cancels with more than 2 hours notice, the employee does NOT receive inconvenience pay.
3. Agency has a 15 minute grace period to cancel an employee without giving the cancelled employee the 2 hour inconvenience fee. (e.g. Facility cancels 8 employees at 5pm, and it may take PMS at least 5 minutes or more to reach and notify all of them.)

Cancellation by the Employee

1. When a shift is confirmed, it is expected that staff will fulfill their commitment.
2. In the event of illness or extreme emergency, the employee must notify the office at least 6 hours prior to the start of the shift so that a replacement can be located.
3. Unexcused cancellation can result in the employee being placed on the “Inactive List.”
4. If employee cancels scheduled shift within 2 hours of the shift starting, the employee will be penalized a 2 hour late cancellation fee due to the agency. (Facility will charge the agency a late cancellation fee of **2 hours pay which the Agency will then charge to the employee.**)
5. Application to reactivate once on the “Inactive List” can occur only after 30 days and must be approved by the President.

Applicant's name (printed)

Applicant's signature

Date

Expectations

Many times we are asked what our nurses can expect from us. We are confident that at Professional Medical Staffing, Inc. you can expect the following from our staff:

What you should expect from us:

- Courteous and professional service by our staff
- 24/7 Telephone and office coverage to meet your needs
- Work expeditiously with you to follow through on your new hire process to put you to work as soon as possible
- To provide you with every possible opportunity to work at all of PMS's hospital client facilities
- To contact you weekly to inquire about your availability so as to provide you with as many hospital shifts as possible
- To contact you on a timely basis should a hospital request a change to your scheduled time shift
- To compensate you competitively, accurately and timely on a daily basis

What we expect from our professional workers:

- Provide our staffing office with your availability on a weekly basis
- Work with our staff to constantly update all phone numbers should there be a change as to be able to contact you efficiently
- While we expect and understand that changes can and may occur to your schedule, our expectation is that all cancellations be kept to a minimum.
- Zero tolerance for "no call no shows"
- Work with our staff to make sure that your license and other credentials remain current and updated

PMS understands that by working in different facilities under various conditions that there may be some issues and/or concerns that come up from time to time. Therefore, the following policies are put in place to help counsel a nurse and/or clear up any misunderstandings with the facilities.

Policy for "No call no shows," late cancellations, and shifts booked without going through PMS:

- We have zero tolerance for "no call no shows"; this is grounds for immediate termination.
- If a nurse cancels consistently, then disciplinary action and/or a 2-hour inconvenience fee will be paid by the nurse.
- Any shift picked up or changed in any way requires a call to PMS to make the staffers aware. This will prevent mistakes in scheduling.
- Late cancellations and "no call no shows" require proof of documentation. A friend or relative cannot cancel your shift for you. You must speak to someone in person, not by leaving a message on voice mail.

Do Not Return Policy:

- The facility will call and let PMS know about the problem and/or concern. PMS will request that the complaint be faxed or emailed to us.
- An incident report will be filled out detailing who the nurse was, the date and place the incident occurred, and the type of problem (i.e. clinical, personality conflicts, or no call/no show)
- Nurse will be contacted to discuss problem. Nurse will be instructed to write down their side of what happened.
- Both sides of the problem will be reviewed, and if there is any miscommunication or misunderstanding, then PMS will strive to intercede on the nurse's behalf with the facility.
- If it is determined that the nurse was at fault, then the nurse will be a Do Not Return (DNR) at that facility. Nurse will receive corrective counseling on how to improve their performance.
- If a nurse becomes DNR at three facilities, then the nurse will be placed on the "Inactive List" for a period of six months.
- Application to reactivate once on the "Inactive List" must be approved. Nurse will be placed on probation for 30 days after reactivated.

Applicant's name (printed)

Applicant's signature

Date

Respiratory Care Practitioners: Job Description

I. Summary of Responsibilities

Plans, coordinates, implements and evaluates respiratory care in a variety of critical care settings. Adheres to the standards of professional practice and carries out responsibilities based on the policies and procedures of the individual practice setting. Functions as a team player to optimize the patient's clinical outcomes through open, ongoing, interdisciplinary communication. Values the importance of customer service with internal and external customers. Promotes a positive image of respiratory care and maintains professional development through continuing education.

II. Qualifications

- A. Graduate from an accredited School of Respiratory Therapy.
- B. Current license to practice in the designated state.
- C. A minimum of two years of current critical care experience.
- D. Demonstrated ability to provide patient care in accordance with current acceptable professional standards (validated through references and specialty area written competency).
- E. Exceptional customer service skills, professional demeanor and professional appearance.

III. Job Responsibilities

- A. Adheres to the standard of Respiratory Care practice of the American Association of Respiratory Care and the National Board for Respiratory Care.
 - 1. Performs a comprehensive clinical assessment including cardiopulmonary system.
 - 2. Identifies actual or potential respiratory diagnosis and plans care based on clinical knowledge.
 - 3. Formulates outcome-based goals which are designed to facilitate resolution of the patient's health problems.
 - 4. Develops the plan of care in collaboration with other health care professionals to enable the patient to meet their health care goals.
 - 5. Possesses the skills and physical ability necessary to function in the area assigned.
 - 6. Possesses the ability to realistically self-evaluate clinical competency and seeks direction and assistance when needed.
 - 7. Evaluates respiratory care on an ongoing basis and adjusts the plan of care accordingly and promptly.
 - 8. Advocates for the rights of the patient and significant others.
- B. Demonstrates effective communication skills through the use of written and verbal language.
- C. Participates in activities that ensure a safe, therapeutic and supportive environment for the critical ill patient and the personnel who care for them regardless of practice setting.
- D. Conducts self in a professional manner and possesses excellent customer service skills.
- E. Pursues professional development through ongoing continuing education.

Applicant's Name (printed)

Soc. Security #

Applicant's signature

Date

2010 Hospitals' National Patient Safety Goals

Note: New Goals and Requirements are indicated in **bold**.

Goal: Improve the accuracy of patient identification

- Use at least two patient identifiers (neither to be the patient's room number) whenever administering medications or blood products; taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.

Goal: Improve the effectiveness of communication among caregivers

- For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result "read-back" the complete order or test result.
- Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization.
- Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.
- **Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions.**

Goal: Improve the safety of using medications

- Standardize and limit the number of drug concentrations available in the organization.
- Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.
- **Label all medications, medication containers (e.g., syringes, medicine cups, basins), or other solutions on and off the sterile field in perioperative and other procedural settings.**

Goal: Reduce the risk of health care-associated infections

- Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.
- Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

Goal: Accurately and completely reconcile medications across the continuum of care

- Implement a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.
- A complete list of the patient's medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization.

Goal: Reduce the risk of patient harm resulting from falls

- Implement a fall reduction program and evaluate the effectiveness of the program.

Applicant's name (printed)

Applicant's signature

Date

Authority for Release of Information

Please complete this form but DO NOT EMAIL. Form must be signed and mailed/faxed to the Employment Office.

Name:	First	Middle	Last	Maiden name: (if applicable)
Present Address:			City, State, Zip:	Years/Months lived there?
1st Previous Address:			City, State, Zip:	Years/Months lived there?
2nd Previous Address:			City, State, Zip:	Years/Months lived there?
Social Security No.:			Date of Birth: (mm/dd/yyyy)	
Driver's License No.:			State Issued:	

Applicant Authorization

I hereby authorize Professional Medical Staffing, Inc. (hereafter PMS) to utilize a Consumer Reporting Agency (CRA) to verify my present and previous employment information, including salary as well as work ethic. I further authorize the CRA to verify my past and present driving records, education records, and professional credentials. I also authorize the CRA to perform a criminal record search.

Further, I authorize my current and former employers as well as other organizations to provide such information to the CRA, and I hereby release and hold harmless PMS, the CRA, and my current and former employers as well as other organizations who have provided information on account of the collection or use of such information in connection with my consumer report.

Consumer Disclosure

I understand that a pre-employment consumer report may be obtained by Professional Medical Staffing, Inc. from a Consumer Reporting Agency for employment purposes.

Applicant's name (printed)

Applicant's signature

Date

RETURN TO THE ADDRESS ABOVE RIGHT

DO NOT WRITE IN THIS BOX — OFFICE USE ONLY		
Professional Medical Staffing, Inc.	<input type="checkbox"/> Motor vehicle record <input type="checkbox"/> Criminal history	ZZ62117
Employment (1)	(2)	(3)
Criminal (1)	(2)	(3)
Credentials	Education	

Employment Reference Request *(two required)*

The applicant undersigned below has applied to Professional Medical Staffing, Inc. for employment and has furnished your name as a reference. Please note applicant's authorization and provide us with the information below.

Applicant's Name: First Middle Last			Social Security No.:
Position held:	Company Name:		Assigned Unit:
Name of Reference:	Title:	Phone No.:	
Time Employed: (from date started to date ended)			

Reference Consent

I have named the above person/institution as a reference and give my permission for this written reference which evaluates my clinical abilities. I waive any claim against the employer/individual arising out of their response to this employment reference. Furthermore, I agree that this reference may be disclosed to any authorized representative from Professional Medical Staffing, Inc.

Applicant's name (printed)

Applicant's signature

Date

BELOW THIS LINE TO BE COMPLETED BY PREVIOUS EMPLOYER

Are employment dates correct? Yes No If no, FROM: _____ TO: _____

The applicant has expressed interest in joining Professional Medical Staffing, Inc. You have been named as a reference. We would appreciate if you would complete the following information. Please make additional comments on the back of this form. Thank you very much for your time. If you have any questions, please contact our office at the numbers listed at the bottom of this page.

Professional Skills	Above Average	Average	Below Average
1. Knowledge of clinical principles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Physical assessment skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Competence in drug/therapy administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal and Professional Attitude			
1. Performance under pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Working independently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Team player ability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Personal appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Attendance/punctuality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Flexibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is the applicant eligible for rehire? Yes No Reason for leaving/remarks: _____

Referer's name and title (printed)

Referer's signature

Date

OFFICE USE ONLY — Telephone reference? Yes No If yes, PMS employee obtaining reference:

PMS employee's name (printed)

PMS employee's signature

Date