NATIONAL STAFFING SOLUTIONS

925 South Semoran Blvd., Suite 108
Winter Park, FL 32792
Phone 888-830-1050
Fax 800-521-9608

Employment Application

National Staffing Solutions does not discriminate based on age, race, religion, color, sex, national origin, marital status, physical or mental disability or any other lawfully protected status. Therefore, in order to consistently consider applicants, all portions of the application form must be completed. Omission, misrepresentations, or falsifications will be cause for disqualification for, or discharge from, employment. Thank you for taking time to accurately apply for employment with National.

Name: _____ Date: _____
(Last) (First) (Middle)

Present Address: _____

_____
(City) (State) (Zip) (County)

Telephone: ( )_____ Cell Phone: ( )_____

Email Address: _____@_____._____

Social Security Number: _____-_____-_____ D.O.B._____/_____/_____

Are you eligible to work in the United States? Yes _____ No _____

Have you ever been convicted of a crime? Yes _____ No _____ If yes, please explain
_____

Have you ever filed a Workers Compensation claim? Yes ___ No _____ If yes, please explain
_____

What position are you applying for? _____

Expected Wages _____

What date are you able to begin work? _____

Contact Person in case of EMERGENCY _____

Telephone: ( )_____

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EDUCATION
Please list high school, college, and university

Name and location Of school	Attendance From To	Degree or diploma	Major Subject

PREVIOUS EMPLOYMENT

Please account for all periods of employment and unemployment (List most current employment first)

From	To	Employer	Address	Duties	Reason for leaving

May we contact the employers listed above? Yes_____ No _____

If not, indicate which ones you do not wish us to contact _____

_____

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I certify that the information in this application is correct and understand that falsification of this document in any detail or omission of information is grounds for disqualification from further consideration or for dismissal from employment. I agree to conform to the rules and regulations of this establishment, and understand that my employment and compensation can be terminated, with or without cause, and with or without notice, at any time, at the option of either the company or myself.

Therefore, my signature below authorizes you, to make such initial investigations you deem necessary as to personal character, reputation, credit record, convictions or other such lawful inquiries to or during employment.

I understand that this application will be active for 60 days if not employed; thereafter I will have to reapply.

Signature _____ Date _____

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ACKNOWLEDGMENT AND AUTHORIZATION FOR CONSUMER REPORTS

In connection with your application for employment (including contract for services), National Staffing Solutions, you understand that consumer reports or investigative consumer reports may be requested about you including information about your character, general reputation, personal characteristics and mode of living, employment record, education, qualifications, criminal record, driving record, credentials, and/or credit and indebtedness, and may involve personal interviews with sources such as supervisors, friends, neighbors, associates, public record or various Federal, State, or Local agencies. A consumer report containing injury and/or medical information may be obtained after an tentative offer of employment has been made.

You hereby authorize the obtaining of such consumer reports and investigative consumer reports at any time after receipt of this authorization. By signing below, you hereby authorize without reservation, any party or agency contacted by this employer, or the consumer reporting agency acting on behalf of the employer, to furnish the above mentioned information.
You further authorize ongoing procurement of the above mentioned reports at any time during your continued employment or contract for services. You also agree that a fax or photocopy of this authorization with your signature shall be accepted with the same authority as the original.

For California, Minnesota or Oklahoma applicants only, if you would like to receive a copy of the consumer report, if one is obtained, please check this box. ☐

For California applicants only, if public record information is obtained without using a consumer reporting agency, you will be supplied a copy of the public record information unless you check this box waiving your right to obtain a copy of the report. ☐

Printed Name:_____

Signature: _____

Date: _____

Social Security #: _____

Current Address: _____

_____

City **State** **Zip**

Date of Birth _____ **DL #**_____**ST**_____

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National Direct Deposit Application Form

(Be sure to attach a copy of a voided check)

I, _____, elect to take advantage of National's free direct deposit service. This allows my paycheck to automatically be deposited into my account on *Friday* of each pay week (note: holidays may effect actual deposit date).

I understand I will still receive my "check stub" via U.S. Mail, which will describe gross pay as well as the net deposit amount (for informational use).

Bank Name: _____

Account Routing Number (ABA#): _____
Account Number: _____

Please allow 2 pay periods from date of this application for direct deposit service to be set up for you.

Employee Signature: _____

Date: _____

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Emergency Notification Form

In the event that we need to contact someone on your behalf, or have failed to reach you at your listed address/phone number, National Staffing Solutions requires you to provide us with the name, address, and phone number of a contact person. Please advise us of any changes in this information as they occur.

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Name of Contact Person: _____

Relationship: _____

Contact Person's Address: _____

_____

Contact Person's Telephone: _____

Employee Signature: _____ Date_____

National Staffing Solutions will not release the above information without consent

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TO: ALL STAFF MEMBERS

SUBJECT: DRUG-FREE WORK PLACE ACT

In the later part of 1988, the federal government passed into law a requirement that all government contractors establish guidelines which specifically identify a company's posture regarding the use, possession, and sale of drugs and alcohol by its employees. National Staffing Solutions is fully committed to the idea of keeping drugs/alcohol out of the workplace and has established the following policy:

It is the policy of National Staffing Solutions to prohibit in the workplace the unlawful possession; use, dispensation, distribution, or manufacture of controlled substances, illegal drugs and alcohol. Violation of this policy will result in disciplinary action up to, and including, termination of employment. Depending upon the circumstances, other action, including notification of appropriate law enforcement agencies, may be taken against any violator of his policy. In accordance with the Drug-Free Workplace Act of 1989, as a condition of employment, staff members must comply with this policy and notify management within five (5) days of conviction for any criminal drug violation occurring in the workplace. Failure to do so will result in immediate termination of employment. Any staff member arrested in connection with a criminal drug violation occurring in the workplace will be placed on personal leave of absence without pay and subject to termination of employment pending the outcome of any legal investigation and conviction.

At present time, we do not require mandatory drug/alcohol testing of all employees, but do conduct random tests when the safety of employees or clients may be in question. Such tests may be deemed necessary based on observed inconsistent or erratic behavior that constitutes a health or safety hazard to other employees and/or clients, or the personal safety of the employee displaying the behavior.

I have received a copy of the National Staffing Solutions policy on Substance abuse, have read and understood the provisions of the policy, and will comply with all aspects of the policy.

_____ _____

SIGNATURE Date

_____

(PLEASE PRINT YOUR NAME)

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Acknowledgement of Understanding Patient's

Bill of Rights and Responsibilities

You have the right to:

- Exercise these rights without regard to age, race, color, ancestry, language, creed, religion, gender, sexual orientation, marital status, citizenship, veteran status, physical or mental disability, cultural, economic, educational background or the source of payment.
- Considerate and respectful care and to be made comfortable.
- Request pastoral or spiritual support and guidance.
- Know the name of the physician who has primary responsibility for coordinating the care and the names and professional relationships of other physicians and non-physicians who will see you.
- Receive information about any proposed treatment of procedure in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information will include description of the procedure or treatment, the medically significant risks involved in each treatment, alternate courses of treatment or non-treatment and to know the name of the person who will carry out the procedure or treatment.
- Participate actively in decisions regarding medical care. This includes the right to refuse treatment to the extent permitted by law.
- Consultation with a member of the hospital ethics committee regarding ethical questions or concerns.
- Formulate Advanced Directives and appoint a surrogate to make health care decisions on your behalf to the extent permitted by law.
- Have your personal privacy respected, and to have visitors be asked to leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used.
- Be advised as to the reason for the presence of any individual. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly.
- Confidential treatment of all communications and records pertaining to care and your stay in the hospital. Medical records will not be made available to anyone not directly concerned with your care without your written permission (e.g., the Terms and Conditions of Service), except to the extent allowed by law.
- Access to information contained in your clinical records within a reasonable time frame (except in certain circumstances regulated by law).
- Reasonable responses to any reasonable requests made for service.
- Designate visitors of your choosing, whether or not the visitor is related by blood or marriage, unless: no visitors are allowed, or the visitor is considered to be disruptive and/or an endangerment, or you indicate that you no longer want this person to visit.

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- Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.
- Receive assessment and appropriate management of pain, including the right to accept or reject any or all modalities to relieve pain.
- Be informed that there are physicians who specialize in the treatment of pain.
- Be provided with information about accessing protective services (that is: guardianship and advocacy services, conservatorship and child or adult protective services).
- Leave the hospital against the advice of physicians, to the extent permitted by law.
- Reasonable continuity of care and to know in advance the time and location of all appointments as well as the identity of persons providing care.
- Be advised if the hospital/personal physician proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.
- Be informed of continuing health care requirements following discharge from the hospital or after an outpatient visit.
- Examine and receive an explanation or the bill regardless of the source of payment.
- Know which medical unit rules and policies apply to your conduct while a patient.
- Have all patients' rights apply to the person who may have legal responsibility to make decisions regarding medical care on your behalf.
- File a grievance/complaint about care, service or discrimination based on physical or mental disability and be informed of the action taken, with assurance that your future access to and quality of care will not be affected. This may be done in writing or by calling the appropriate hospital department.
- File a complaint with the State Bureau of Licensure & Certification.

You have the responsibility to:

- Make informed decisions. Gather as much information as you need. You may be asked to consent in writing to certain tests, procedures, or operations. Ask questions to fully understand each document you are asked to sign.
- Understand. If the explanation of your medical condition or treatment is not clear, ask such questions as:
    - Why a treatment is recommended?
    - What are the potential benefits or risks?
    - What side effects are involved?
    - What alternatives are available?
    - Will the treatment cause discomfort or pain?
- Be honest. Give accurate, complete medical history and report changes in your health to your medical practitioner. This includes reporting your degree of pain and the effects or limitations of treatment for pain.

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- Not engage in rude, inappropriate, abusive or disruptive behavior toward physicians, staff, other patients or visitors.

- Respect others. Be considerate of others by allowing them privacy, limiting visitors, and maintaining a quiet atmosphere. Telephones, televisions, radios, and lights should be used in a manner agreeable to others. Respect the property of others and the hospital.

- Follow the treatment plan. Tell your doctor if you believe you cannot follow through with the treatment plan and why you cannot. Find out about the consequences of refusing treatment or of selecting an alternative treatment not recommended by your medical team.

- Recognize the effect of lifestyle on your personal health.

- You do not have the right to receive treatment and service that are considered medically unnecessary or inappropriate.

My signature constitutes below constitutes that I have read and am familiar with the Patients Bill of Rights.

_____ _____

(Signature) *(Date)*

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Physician's Statement of Health

Patient Name: _____

Social Security Number: _____-_____-_____

Street Address: _____

City: _____ State _____ Zip _____

The patient above has been examined by me and found to be in good physical and mental health, free from communicable diseases, and able to function at full capacity.

ALL of the following must be completed prior to employment. Please attach copy of results if available.

PPD (TB Skin Test) Date Completed: _____
Results: _____
Chest X-Ray (Only if Pos PPD) Date Completed: _____
Results: _____
Rubeola Titer/Vaccine (Circle One) Date Completed: _____
Results: _____
Mumps Titer/Vaccine (Circle One) Date Completed: _____
Results: _____
Rubella Titer/Vaccine (Circle One) Date Completed: _____
Results: _____
Varicella Titer/Vaccine (Circle One) Date Completed: _____
Results: _____
Hepatitis B Vaccine/Declination Date Completed: _____
Results: _____

Additional
Comments:_____

X Physician Signature: _____ Date of Exam: _____

License Number: _____

Name of Physician: _____

Physician Address: _____

City: _____ State: _____ Zip Code: _____

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Chicken Pox (Varicella) Waiver

_____
Employee Name (Please Print)

☐ I have been given the opportunity to be vaccinated with the Varicella vaccine, however I decline the Varicella vaccination at this time. I understand that by declining this vaccine, if I am exposed to either chicken pox or herpes zoster, either off or on the job, I will not be compensated by National Staffing Solutions, Inc. or its clients for any time away from work. Furthermore, I understand that I may receive the vaccination series at any time in the future.

☐ I agree to waive any liability of contracting chicken pox at any assignment with National Staffing Solutions, Inc. due to the fact that I have already had chicken pox and am now immune to the virus.

_____
Signature

_____
Date

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Hepatitis B Declination Statement

☐ **DECLINATION (GENERAL):** I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine. 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, while actively working, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can receive it at no charge to me, if National is verified to be my primary employer.

☐ **DECLINATION (SPECIFIC):** I have previously received the complete Hepatitis B vaccination series or I had antibody testing (titer) that revealed I am immune to Hepatitis B. *(You must provide dates of vaccination series or antibody testing below.)*

VACCINATION - TITER RECORD

	DATE VACCINATED OR TESTED	***ADMINISTERED***
1st Dose:	_____	_____
2nd Dose:	_____	_____
3rd Dose	_____	_____
Booster:	_____	_____
Titer:	_____	_____

Employee Name: _____

Employee Social Security Number: _____

Employee Signature: _____

Date: _____

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HIPAA Confidentiality Statement

I, _____ understand that in the performance of my duties as an employee of National Staffing Solutions, I am/may be required to have access to, and/or be involved in the processing of patient health care information while on contract assignment at various Health Care facilities. I understand that I am obligated to maintain the confidentiality of this information at all times, both at work and off duty. I understand that a violation of confidentiality may result in disciplinary action, including termination. I further understand that I could be subject to legal action for failure to maintain confidentiality of patient information per HIPAA regulations.

_____ _____

Signature Date

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Physical Therapist

- Plan, prepare and carry out individually designed programs of physical treatment to maintain, improve or restore physical functioning, alleviate pain and prevent physical dysfunction in patients.
- Perform and document an initial exam, evaluating the data to identify problems and determine a diagnosis prior to intervention.
- Evaluate effects of treatment at various stages and adjust treatments to achieve maximum benefit.
- Administer manual exercises, massage and/or traction to help relieve pain, increase the patient's strength, and decrease or prevent deformity and crippling.
- Instruct patient and family in treatment procedures to be continued at home.
- Confer with the patient, medical practitioners and appropriate others to plan, implement and assess the intervention program.
- Review physician's referral and patient's medical records to help determine diagnosis and physical therapy treatment required.
- Record prognosis, treatment, response, and progress in patient's chart or enter information into computer.
- Obtain patients' informed consent to proposed interventions.
- Discharge patient from physical therapy when goals or projected outcomes have been attained and provide for appropriate follow up care or referrals.
- Test and measure patient's strength, motor development and function, sensory perception, functional capacity, and respiratory and circulatory efficiency and record data.
- Identify and document goals, anticipated progress and plans for reevaluation.
- Provide information to the patient about the proposed intervention, its material risks and expected benefits and any reasonable alternatives.
- Inform the patient when diagnosis reveals findings outside their scope and refer to an appropriate practitioner.
- Direct and supervise supportive personnel, assessing their competence, delegating specific tasks to them and establishing channels of communication.
- If I sustain an injury on the job, I will inform the client and this National Staffing Solutions immediately, and the healthcare staffing company will coordinate with the client (if applicable) and myself the proper procedures for treatment and reporting of the accident
- Other duties as assigned.

_____ _____

Employee Signature Date

_____

Employee Name Printed

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PHYSICAL THERAPIST/PTA SKILLS CHECKLIST

LEVEL OF PROFICIENCY KEY
1 = No Experience
2 = Intermittent Experience
3 = Experienced
4 = Supervise and Teach

Therapist Name: _____ Date: _____

Orthopedic

1___2___3___4___ Back syndromes
1___2___3___4___ Hip fractures
1___2___3___4___ Total upper joint replacement
1___2___3___4___ Total hip replacement
1___2___3___4___ Hand Injury
1___2___3___4___ TMJ
1___2___3___4___ Arthritis Programs
1___2___3___4___ Mobilization techniques

Neurological

1___2___3___4___ Stroke rehabilitation
1___2___3___4___ Head trauma
1___2___3___4___ Spinal cord injury
1___2___3___4___ Functional splinting
1___2___3___4___ Adaptive equipment

Modalities

1___2___3___4___ CPM
1___2___3___4___ Whirlpool
1___2___3___4___ Hubbard tank
1___2___3___4___ Therapeutic pool
1___2___3___4___ Biofeedback
1___2___3___4___ TENS
1___2___3___4___ Muscle stimulation
1___2___3___4___ Ultrasound
1___2___3___4___ Diathermy
1___2___3___4___ Cryotherapy
1___2___3___4___ Acupuncture
1___2___3___4___ Cervical traction
1___2___3___4___ Lumbar traction
1___2___3___4___ Massage
1___2___3___4___ Wound Dressing

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Sports Medicine

1___2___3___4___ Biodex
1___2___3___4___ Cybex
1___2___3___4___ Orthotron
1___2___3___4___ LIDO
1___2___3___4___ Nautilus/Eagle
1___2___3___4___ Bracing/Joint immobilization
1___2___3___4___ Taping/Strapping

Pediatrics

1___2___3___4___ Neurodevelopment testing
1___2___3___4___ Disability sequence test
1___2___3___4___ Orthotics
1___2___3___4___ Equip. Assessment adaptive
1___2___3___4___ Activities of daily living

Prosthetics/Orthotics

1___2___3___4___ Above knee prosthetics
1___2___3___4___ Below knee prosthetics
1___2___3___4___ Upper extremity prosthetics
1___2___3___4___ Orthoplast
1___2___3___4___ Resting splints
1___2___3___4___ Dynamic splints
1___2___3___4___ Ankle foot orthosis

Other

1___2___3___4___ Work capacity evaluation
1___2___3___4___ Functional capacity evaluation
1___2___3___4___ Cardiac rehabilitation
1___2___3___4___ Chest physiotherapy

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Payroll Information

Payroll Process

For your convenience, National Staffing processes payroll on a *weekly* basis. Pay periods begin on Sunday and end on Saturday. In order to process payroll, all time sheets must be received by National every Monday by 12:00 PM EST. In the event your time sheet is not received by this deadline, please be aware those hours worked may be processed and paid in the following pay period.

To insure optimal service to our Travelers, National utilizes America's premier payroll service company. Because payroll information is sent electronically according to a strict deadline on Monday of each payroll week, please be sure your nurse manager or authorizing agent signs your timesheet and **faxes it to National at 800-521-9608 before the Monday, 12:00 PM EST deadline of each week.**

Payroll will be processed and your check will be sent out the Wednesday of each pay week. Paychecks are sent via the US Postal Service 2-3 day Priority mail. Therefore, you should receive your check on Friday. Depending on your location, it may take a day or two longer.

National encourages the use of our direct deposit system and offers it at no charge to you. It is a safe and convenient way to receive your pay. To elect direct deposit of your paycheck to your bank account, fill out the brief **National direct deposit application form** below and fax it along with a voided check to us at 800-521-9608. Once in effect, a check "stub" will be mailed out on the Wednesday of each pay week via regular mail. Employees utilizing direct deposit will have their payroll funds available in their accounts on the Friday of each pay week.

Holiday Pay

National offers holiday pay at a premium rate for all nationally recognized holidays you work. This premium rate is typically 1.5 times your regular rate of pay but may vary by facility. In order to qualify for holiday pay, your shift must start on the actual holiday (12:00 AM - 11:59 PM).

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Timesheet information

Attached, please find the National Timesheet form to utilize when on assignment with us. Please be sure to make an ample number of copies to record and submit hours worked while on assignment. It is very important to fill out each timesheet as accurately and completely as possible to avoid payroll errors and/or delays.

Here are a few simple reminders to help you:

- Ensure that you fill out all of the information completely:
    1. Full Name
    2. Hospital Name (no abbreviations)
    3. City and State you are working in
    4. "Week of"
- Include appropriate unit number or name
- Have a supervisor sign the National timesheet
- Use the quarter hour rule for time worked. This rule tabulates only ¼ hour increments. Example: if you arrived at 7:05, please use 7:00, if you arrived at 7:09, please use 7:15
- Include your break-time information. Please do not leave blank. If blank, our payroll system will assume/process a ½ hour break
- Calculate your total regular and overtime hours worked only. You do not have to separate overtime from regular time
- Include as much information as possible in the notes section of the timesheet. If you have "in-charge" time, were "called off", etc.
- It is important to include any reason why you did not work at least 36 hours in a week in the notes section as well
- Remember that timesheets are due by Monday, 12:00 PM EST of each week. Fax to 800-521-9608.

Please contact your recruiter at 877-430-2772 should you ever have any questions regarding the above policies. Thank you for traveling with us.

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Fax: 800-521-9608

EMPLOYEE NAME: Last Name, First Name (PLEASE PRINT)

TIMESHEET MUST BE IN BY 8:00am MONDAY MORNING
PLEASE FAX TIMESHEETS TO: 800-521-9608

CLIENTS AUTHORIZED SIGNATURE MUST APPEAR DAILY

REQUEST ALTERNATIVE ADDRESS FOR CHECK STUB:
PLEASE PRINT

Mailing Instructions:	
U.S. Mail	
Overnight	
there will be a $25.00 o/n charge	
Other	
(Specify)	

TELEPHONE: ( )- **(Current Employee Number)**

Facility:

PLEASE DO NOT WRITE IN THIS AREA

PLEASE RECORD ALL TIME TO THE NEAREST QUARTER HOUR (.00, .25, .50, .75)

DAY	DATE	Time In	Time Out	Lunch	Total	Charge	CLIENT'S AUTHORIZED SIGNATURE FOR ACTUAL HOURS WORKED	UNIT
Sunday		:	:	:	:	:		
Monday		:	:	:	:	:		
Tuesday		:	:	:	:	:		
Wednesday		:	:	:	:	:		
Thursday		:	:	:	:	:		
Friday		:	:	:	:	:		
Saturday		:	:	:	:	:		

WEEK ENDING		
MONTH	DAY	YEAR

TOTAL HOURS		I CERTIFY THAT THE HOURS SHOWN REPRESENT MY TOTAL HOURS WORKED AND WERE VERIFIED PROPERLY BY AN AUTHORIZED REPRESENTATIVE OF THE CLIENT/FACILITY.
		EMPLOYEE SIGNATURE:

		ON CALL	CALL BACK		CALL BACK		ON CALL			
DAY	DATE	TIME IN	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME OUT	Total Call	Total Call Worked	CLIENT'S AUTHORIZED SIGNATURE
Sunday		:	:	:	:	:	:			
Monday		:	:	:	:	:	:			
Tuesday		:	:	:	:	:	:			
Wednesday		:	:	:	:	:	:			
Thursday		:	:	:	:	:	:			
Friday		:	:	:	:	:	:			
Saturday		:	:	:	:	:	:			