Nurse Professionals
Home Care

9927 Stephen Decatur Hwy, Ste G15
Ocean City, MD 21842
Phone: 443-664-6915
Fax: 443-664-6879
Email: nurseprof@comcast.net
nurseprofessionalshomecare.com

Dear Applicant:

Thank you for your interest in Nurse Professionals Home Care, L.L.C. We are looking forward to you joining our community of quality health care providers. We are an established nursing staffing agency that provides quality RNs, LPNs, GNAs, CMAs, and CNAs to clients who either need skilled nursing care or additional nursing assistant care in a home setting. We have placements available in pediatric and adult care. We are hiring reputable, reliable and compassionate care givers on the Eastern Shore of Maryland. Our emphasis on placement of nursing staff is based on the nursing staff's need and specialty. Whether you desire to work full-time or just on occasion, we will make every effort to find you a desirable assignment.

To complete the application process, please fill out the enclosed paperwork. If you have any questions, please contact us at: **443-664-6915.** We will also need you to send a **copy of your current CPR card – the front and back of this card is needed, a copy of your latest PPD or chest x-ray, a copy of your social security card and a copy of your driver's license.** Upon completion of this required paperwork, please call us to set up an interview. You also may mail the completed packet back and we will then contact you for an interview.

We look forward to hearing from you. Good luck in your chosen career.

Best Regards,

Anita Logsdon Battista, RN, BS

Anita Logsdon Battista, R.N., B.S.

President, Nurse Professionals Home Care

Nurse Professionals Home Care, L.L.C.

Employment Application

Name _____
Last First Middle initial

Current address _____
Street address City State Zip code

Home phone _____ Work phone _____
At this location until

Permanent address _____
Street address City State Zip code

Phone _____
Best time/day to reach you

Professional discipline _____ Specialty _____

Social Security number _____ Date available to travel _____

How did you learn about Nurse Professionals, L.L.C.? _____ Email address _____

LICENSURE *(Include photocopies of all license held.)*

State: State: State:

Expiration date: Expiration date: Expiration date:

CERTIFICATION *(Include photocopies of all licenses held.)*

Check one:

○ Certified ○ Registered ○ Registry Eligible ○ Other: _____

Certificate: Registration / Registration number: _____ Expiration date: _____

Has your professional license or certification ever been investigated or suspended? ○ Yes ○ No
If yes, attach separate sheet with explanation.

Have you ever been convicted of a crime other than a minor traffic violation? ○ Yes ○ No
If yes, attach separate sheet with explanation.

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

If you will be employed on a visa, please specify type of work visa: _____

EDUCATION	Name and Location of School	Month/Year Graduated	Diplomas, Degrees received
College			
Graduate School			
Other School (If applicable)			

Person to notify in case of emergency: _____ _____
Name Relationship

_____
Street address City State Zip code Phone

EMPLOYMENT PROFILE

____
Applicant's Name

Please indicate all of your employment for the past ten (10) years. beginning with your most recent employer.
Are you employed now? O Yes O No If so, may we contact your present employer? O Yes O No

Facility / employer ______________________ Dept. __________
Street address ______________________ City __________ State ______ Zip code ______
Dates employed: From __________ To __________ Reason for leaving __________
Position held ______________________ Specialty __________
Supervisor's name and title ______________________ Phone __________
Other supervisor? ______________________ Phone __________
Travel assignment? O Yes O No Local staff agency? O Yes O No

Facility / employer ______________________ Dept. __________
Street address ______________________ City __________ State ______ Zip code ______
Dates employed: From __________ To __________ Reason for leaving __________
Position held ______________________ Specialty __________
Supervisor's name and title ______________________ Phone __________
Other supervisor? ______________________ Phone __________
Travel assignment? O Yes O No Local staff agency? O Yes O No

Facility / employer ______________________ Dept. __________
Street address ______________________ City __________ State ______ Zip code ______
Dates employed: From __________ To __________ Reason for leaving __________
Position held ______________________ Specialty __________
Supervisor's name and title ______________________ Phone __________
Other supervisor? ______________________ Phone __________
Travel assignment? O Yes O No Local staff agency? O Yes O No

Other Names under which you have been employed ______________________

Please document reasons for periods you were not employed.

The information provided in the application for employment is true, correct and complete. I acknowledge that any misstatement or omission of fact on the application may result in my disqualification from employment. I authorize Nurse Professionals Home Care, L.L.C. to release this application and reference information to Nurse Professionals Home Care, L.L.C. affiliates, and Nurse Professionals Home Care, L.L.C. client institutions only after receiving my express written or verbal consent for each assignment opportunity. I understand that by giving Nurse Professionals Home Care, L.L.C. permission to submit my application for assignment opportunities. I am also agreeing to any criminal background search that may be required by certain states or client institutions. Nurse Professionals Home Care, L.L.C. does not discriminate on the basis of race, color, religion, sex, marital status, age, handicap, or national origin in the hiring, retention or promotion of employees, not in determining their rank or the compensation or fringe benefits paid to them.

Signature ______________________ Date __________

EMPLOYMENT PROFILE

____
Applicant's Name

Complete for any other positions you have held for the past ten (10) years.

Facility / employer________________________ Dept.____________
Street address ________________________ City____________ State________ Zip code________
Dates employed: From ____________ To____________ Reason for leaving________________
Position held________________________ Specialty ________________
Supervisor's name and title________________________ Phone ____________
Other supervisor? ________________________ Phone ____________
Travel assignment? O Yes O No Local staff agency? O Yes O No

Facility / employer________________________ Dept.____________
Street address ________________________ City____________ State________ Zip code________
Dates employed: From ____________ To____________ Reason for leaving________________
Position held________________________ Specialty ________________
Supervisor's name and title________________________ Phone ____________
Other supervisor? ________________________ Phone ____________
Travel assignment? O Yes O No Local staff agency? O Yes O No

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Street address ________________________ City____________ State________ Zip code________
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Position held________________________ Specialty ________________
Supervisor's name and title________________________ Phone ____________
Other supervisor? ________________________ Phone ____________
Travel assignment? O Yes O No Local staff agency? O Yes O No

Facility / employer________________________ Dept.____________
Street address ________________________ City____________ State________ Zip code________
Dates employed: From ____________ To____________ Reason for leaving________________
Position held________________________ Specialty ________________
Supervisor's name and title________________________ Phone ____________
Other supervisor? ________________________ Phone ____________
Travel assignment? O Yes O No Local staff agency? O Yes O No

EMPLOYMENT PROFILE

____
Applicant's Name

Complete for any other positions you have held for the past ten (10) years.

Facility / employer ____________________ Dept. ________
Street address ____________________ City __________ State ______ Zip code ______
Dates employed: From __________ To __________ Reason for leaving ____________________
Position held ____________________ Specialty ____________________
Supervisor's name and title ____________________ Phone __________
Other supervisor? ____________________ Phone __________
Travel assignment? ○ Yes ○ No Local staff agency? ○ Yes ○ No

Facility / employer ____________________ Dept. ________
Street address ____________________ City __________ State ______ Zip code ______
Dates employed: From __________ To __________ Reason for leaving ____________________
Position held ____________________ Specialty ____________________
Supervisor's name and title ____________________ Phone __________
Other supervisor? ____________________ Phone __________
Travel assignment? ○ Yes ○ No Local staff agency? ○ Yes ○ No

Facility / employer ____________________ Dept. ________
Street address ____________________ City __________ State ______ Zip code ______
Dates employed: From __________ To __________ Reason for leaving ____________________
Position held ____________________ Specialty ____________________
Supervisor's name and title ____________________ Phone __________
Other supervisor? ____________________ Phone __________
Travel assignment? ○ Yes ○ No Local staff agency? ○ Yes ○ No

Facility / employer ____________________ Dept. ________
Street address ____________________ City __________ State ______ Zip code ______
Dates employed: From __________ To __________ Reason for leaving ____________________
Position held ____________________ Specialty ____________________
Supervisor's name and title ____________________ Phone __________
Other supervisor? ____________________ Phone __________
Travel assignment? ○ Yes ○ No Local staff agency? ○ Yes ○ No

Nurse Professionals Home Care, L.L.C.

PHYSICIAN'S STATEMENT

AUTHORIZATION:

I _____ do hereby authorize
(Name)

_____, to release to Nurse Professionals Home Care, L.L.C., its affiliates, and any of its hospitals
(Client Physician)

or institutions any information acquired in my recent medical examination which is relevant to my employment.

_____ _____
Signature Date

TUBERCULOSIS SCREENING/IMMUNIZATION STATUS

(to be completed by physician)

TEST	DATE PLACED	DATE READ	INDURATION	READ BY	RESULT
Step 1 PPD (acceptable only if fully documented)					☐Negative ☐Positive
Step 2 PPD (accepted Only if fully documented)					☐Negative ☐Positive
Chest X-ray (if PPD positive)					Attach written results
BCG Inoculation					

Does individual have a latex allergy? ☐ No ☐ Yes (If yes, the reverse side of this form must be completed.)

I have examined and obtained a current history on the individual named above, and to the best of my knowledge, he/she is in good physical and mental health, is free of any communicable diseases, has no physical limitations and is able to function in his/her professional discipline and specialty on a full-time basis at full capacity without any accommodations.

_____ _____
Signature of Physician Date

_____ _____
Printed name of Physician Date of physical exam

OTHER REQUIREMENTS

The following tests are typical requirements for employment with Nurse Professinals Home Care, L.L.C. and standard in the healthcare industry. Please attach copies of results.

- Positive titer or immune status for Rubella, Rubeola, Varicella and Mumps
- Hepatitis B vaccine, titer or signed declination form
- Hepatitis C titer
- Tetanus/TD Booster

As a condition of employment as an agency nurse, some healthcare facilities may have health requirements in addition to this list.

Nurse Professionals Home Care, L.L.C.

Two Step PPD Policy

The two-step test is not the usual PPD skin test in which you receive an injection of PPD and the test area is observed one time at a specific time frame.

The two-step PPD test is used to detect individuals with past TB infections who now have diminished skin test reactivity. This procedure reduces the likelihood that a boosted reaction is later interpreted as a new injection.

The reason for the two stage PPD test appears to be the "booster phenomenon". It occurs in some people who were infected with TB in the past because the body loses its ability to react to the Tuberculin solution. Thus, when these people are tested many years after the initial infection they may have a negative reaction. However, if they are tested a second time within op to one year of the first test, they may have a positive reaction. This positive reaction is due to a "boosted" ability to react to the Tuberculin solution. To avoid misinterpretation between a boosted response and a new infection, many facilities employ the two step procedure. In this procedure a person is given a baseline PPD test. If the test is (-), a second test is administered 1-3 weeks later (i.e. the second test can be read 7-21 days after the first). If the second test is negative, the person is considered uninfected. If the second test is positive, then the person is considered to have a "boosted" reaction to an infection that occurred in the past.

Beyond that, secondary testing is useful to help offset potential false negative testing results. The sensitivity of the Tuberculin testing in patients presenting with newly diagnosed pulmonary TB can be as low as 80% in immune-compromised or otherwise unhealthy compromised patients. The 20% false negative rate is due to a combination of immune-suppression of delayed hypersensitivity from cytokines as well as factors relating to acute illness and/or poor nutrition. Even once these patients have returned to normal health and nutrition status, such as those in the general population, the sensitivity of Tuberculin testing is still only approximately 95%. This one-in-twenty false negative rate could certainly warrant the use of secondary testing, especially for those working in a healthcare setting.

We have begun to utilize the "4 visit" approach for two step testing (per CDC):

1. Visit 1, Day 1: PPD antigen is applied under the skin
2. Visit 2, Day 3: PPD test is read (within 48-72 hours of placement). If positive, it indicates TB infection and a chest x-ray and further evaluation is necessary.
3. Visit 3, Day 7-21: A second PPD skin test is applied (for those that test one was negative).
4. Visit 4, 48-72 hours after placement: the second test is read. A positive 2nd test indicates TB infection in the distant past. CXR and further evaluation will likely be necessary.

Reference Material 16
Chesapeake Registry Program
Confidentiality of Protected Healthcare Information

An Agency Healthcare Provider's training in the confidentiality of protected healthcare information should include at least the following subject areas:

1. Confidentiality of patient healthcare information is important to the patient, the facility, and the Agency Healthcare Provider. Patient information should only be shared on a "need to know" basis with those healthcare providers involved in the patient's care. Otherwise, Agency Healthcare Providers should never discuss the patients they see or care for in the Participating Institutions.
2. Many laws require providers to maintain the confidentiality of healthcare information, including professional standards of ethics, state laws, and federal laws. New regulations under a federal law called the Health Insurance Portability and Accountability Act (HIPAA) require health care providers to protect the confidentiality of healthcare information and describe patients' rights about their healthcare information.
3. These new HIPAA regulations--called the Privacy Standards--protect healthcare information, whether it is written, electronic, or verbal information.
4. The Privacy Standards require Participating Institutions to have policies and procedures about how a patient's healthcare information is used internally and how that healthcare information is released to others outside the Participating Institution. The Agency Healthcare Provider must follow the Participating Institution's policies about how to handle healthcare information. In general, Agency Healthcare Providers should only use patient healthcare information to assist in the treatment of a patient, and should never release patient healthcare information outside the Participating Institution. If there is a need for the Agency Healthcare Provider to release patient healthcare information outside the Participating Institution, the Agency Healthcare Provider must get advance approval from his or her supervisor at the Participating Institution.
5. Patients' rights under the Privacy Standards, include the right to access their own healthcare information, the right to ask for changes to that information, the right to a list of releases the Participating Institution makes, a right to ask the Participating Institution to change the way it handles a specific patient's information, and a right to communicate in a confidential way. Agency Healthcare Providers should find out to whom they should refer patients if the patients have questions about these rights.
6. The government has the power to impose civil money fines and criminal penalties on Agency Healthcare Providers and Participating Institutions that violate the Privacy Standards. If an Agency Healthcare Provider violates the Participating Institution's policies or procedures regarding the confidentiality of healthcare information, it can constitute grounds for dismissal from a Participating Institution.

Notice of Confidentiality Obligations

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 Institutions at which I am assigned under the Chesapeake Registry Program. 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 procedures of each Participating Institution where I am assigned. My agreement to maintain the confidentiality of Confidential Patient Information shall survive the termination of my employment with said Agency and the conclusion of any assignment at a Participating Institution under the Chesapeake Registry Program.

Agency Name: _____

Signature: _____

Print Name: Date:

Nurse Professionals Home Care, L.L.C.

Skills Checklist

First name: _____

Last name: _____

Social Security number: _____

This profile is for use by nurses with more than one year's experience in their discipline and specialty. It will not be the only determining factor in your acceptance for employment.

Please mark your level of experience

- A — Theory, no practice
- B — Intermittent experience
- C — One - two years experience
- D — Two plus years experience

A.CARDIOVASCULAR	A	B	C	D
I. Assessment				
a. Auscultation (rate, rhythm)	☐	☐	☐	☐
b. Blood pressure/non-invasive	☐	☐	☐	☐
c. Doppler	☐	☐	☐	☐
d. Heart sounds/murmurs	☐	☐	☐	☐
e. Pulses/circulation checks	☐	☐	☐	☐
2. Equipment & procedures				
a. Telemetry				
(1) Basic 12 lead interpretation	☐	☐	☐	☐
(2) Basic arrhythmia interpretation	☐	☐	☐	☐
(3) Lead placement	☐	☐	☐	☐
b. Pacemaker				
(1) Permanent	☐	☐	☐	☐
(2) Temporary	☐	☐	☐	☐
3. Care of the patient with:				
a. Abdominal aortic bypass	☐	☐	☐	☐
b. Aneurysm	☐	☐	☐	☐
c. Angina	☐	☐	☐	☐
d. Cardiac arrest	☐	☐	☐	☐
e. Cardiomyopathy	☐	☐	☐	☐
f. Carotid endarterectomy	☐	☐	☐	☐
g. Congestive heart failure (CHF)	☐	☐	☐	☐
h. Femoral-popliteal bypass	☐	☐	☐	☐
i. Myocarditis	☐	☐	☐	☐
j. Post acute MI (24-48 hours)	☐	☐	☐	☐
k. Post angioplasty	☐	☐	☐	☐
l. Post cardiac cath	☐	☐	☐	☐
m. Post cardiac surgery	☐	☐	☐	☐
n. Thrombophlebitis	☐	☐	☐	☐
4. Medications				
a. Heparin drip	☐	☐	☐	☐
b. Oral anticoagulants	☐	☐	☐	☐
c. Oral & IVP antihypertensives	☐	☐	☐	☐
d. Oral & topical nitrates	☐	☐	☐	☐

B. PULMONARY	A	B	C	D
I. Assessment				
a. Breath sounds	☐	☐	☐	☐
b. Rate and work of breathing	☐	☐	☐	☐
2. Interpretation of lab results				
a. Blood chemistry	☐	☐	☐	☐
b. Blood gases	☐	☐	☐	☐
3. Equipment & procedures				
a. Airway management devices/suctioning				
(1) Endotracheal tube/suctioning	☐	☐	☐	☐
(2) Nasal airway/suctioning	☐	☐	☐	☐
(3) Oropharyngeal/suctioning	☐	☐	☐	☐
(4) Sputum specimen collection	☐	☐	☐	☐
(5) Tracheostomy/suctioning	☐	☐	☐	☐
b. Assist with intubation	☐	☐	☐	☐
c. Assist with thoracentesis	☐	☐	☐	☐
d. Care of the patient on a ventilator	☐	☐	☐	☐
e. Care of the patient with a chest tube				
(1) Assist with set-up & insertion	☐	☐	☐	☐
(2) Measuring and emptying	☐	☐	☐	☐
(3) Removal	☐	☐	☐	☐
f. Chest physiotherapy	☐	☐	☐	☐
g. Incentive spirometry	☐	☐	☐	☐
h. O_2 therapy & medication delivery systems				
(1) Bag and mask	☐	☐	☐	☐
(2) External CPAP	☐	☐	☐	☐
(3) Face masks	☐	☐	☐	☐
(4) Inhalers	☐	☐	☐	☐
(5) Nasal cannula	☐	☐	☐	☐
(6) Portable O_2 tank	☐	☐	☐	☐
(7) Trach collar	☐	☐	☐	☐
i. Oximetry	☐	☐	☐	☐

First name: Last name:

	A	B	C	D
4. Care of the patient with:				
a. Bronchoscopy	☐	☐	☐	☐
b. COPD	☐	☐	☐	☐
c. Fresh tracheostomy	☐	☐	☐	☐
d. Lobectomy	☐	☐	☐	☐
e. Pneumonectomy	☐	☐	☐	☐
f. Pneumonia	☐	☐	☐	☐
g. Pulmonary embolism	☐	☐	☐	☐
h. Thoracotomy	☐	☐	☐	☐
i. Tuberculosis	☐	☐	☐	☐
C. NEUROLOGICAL				
1. Assessment				
a. Glasgow coma scale	☐	☐	☐	☐
b. Level of consciousness	☐	☐	☐	☐
2. Equipment & procedures				
a. Assist with lumbar puncture	☐	☐	☐	☐
b. Use of hyper/hypothermia blanket	☐	☐	☐	☐
3. Care of the patient with:				
a. Aneurysm precautions	☐	☐	☐	☐
b. Basal skull fracture	☐	☐	☐	☐
c. Closed head injury	☐	☐	☐	☐
d. Coma	☐	☐	☐	☐
e. CVA	☐	☐	☐	☐
f. DTs	☐	☐	☐	☐
g. Encephalitis	☐	☐	☐	☐
h. Externalized VP shunts	☐	☐	☐	☐
i. Meningitis	☐	☐	☐	☐
j. Neuromuscular disease	☐	☐	☐	☐
k. Post craniotomy	☐	☐	☐	☐
l. Seizures	☐	☐	☐	☐
m. Spinal cord injury	☐	☐	☐	☐
4. Administration of anticonvulsants	☐	☐	☐	☐
D. ORTHOPEDICS				
1. Assessment				
a. Circulation checks	☐	☐	☐	☐
b. Gait	☐	☐	☐	☐
c. Range of motion	☐	☐	☐	☐
d. Skin	☐	☐	☐	☐
2. Equipment & procedures				
a. Continuous passive motion devices	☐	☐	☐	☐
b. Support devices				
(1) Cane	☐	☐	☐	☐
(2) Cervical collar	☐	☐	☐	☐
(3) Gait belt	☐	☐	☐	☐
(4) Prosthetic	☐	☐	☐	☐
(5) Sling	☐	☐	☐	☐
(6) Transfer boards	☐	☐	☐	☐
(7) Walker	☐	☐	☐	☐
(8) Wheelchair	☐	☐	☐	☐
c. Traction	☐	☐	☐	☐
3. Care of the patient with:				
a. Amputation	☐	☐	☐	☐
b. Arthroscopic surgery	☐	☐	☐	☐
c. Cast	☐	☐	☐	☐
d. Osteoporosis	☐	☐	☐	☐
e. Pinned fractures	☐	☐	☐	☐
f. Rheumatic/arthritic disease	☐	☐	☐	☐
g. Total hip replacement	☐	☐	☐	☐
h. Total knee replacement	☐	☐	☐	☐
E. GASTROINTESTINAL				
1. Assessment				
a. Abdominal/bowel sounds	☐	☐	☐	☐
b. Fluid balance	☐	☐	☐	☐
c. Nutritional	☐	☐	☐	☐
2. Interpretation of blood chemistry	☐	☐	☐	☐
3. Equipment & procedures				
a. Administration of rube feeding				
(1) Feeding pump	☐	☐	☐	☐
(2) Gravity feeding	☐	☐	☐	☐
(3) Saline lavage	☐	☐	☐	☐
b. Flexible feeding tube				
(i.e., Corpak, Dobhoff)	☐	☐	☐	☐
c. Management of				
(1) Gastrostomy tube	☐	☐	☐	☐
(2) Jejunostomy tube	☐	☐	☐	☐
(3) T-tube	☐	☐	☐	☐
d. Placement of nasogastric tube	☐	☐	☐	☐
e. Salem sump to suction	☐	☐	☐	☐
4. Care of the patient with:				
a. Bowel obstruction	☐	☐	☐	☐
b. Colostomy/ileostomy	☐	☐	☐	☐
c. GI bleeding	☐	☐	☐	☐
d. GI surgery	☐	☐	☐	☐
e. Hepatitis	☐	☐	☐	☐
f. Inflammatory bowel disease	☐	☐	☐	☐
g. Invasive diagnostic testing	☐	☐	☐	☐
h. Liver failure	☐	☐	☐	☐
i. Paralytic ileus	☐	☐	☐	☐
F. RENAL/GENITOURINARY				
1. Assessment				
a. Arterio venous fistula/shunt	☐	☐	☐	☐
b. Fluid balance	☐	☐	☐	☐
2. Interpretation of lab results				
a. BUN & creatinine	☐	☐	☐	☐
b. Electrolytes	☐	☐	☐	☐
3. Equipment & procedures				
a. Insertion & care of straight and Foley catheter				
(1) Female	☐	☐	☐	☐
(2) Male	☐	☐	☐	☐

First name: Last name:

	A	B	C	D
b. Catheter care				
(1) 3-way Foley	☐	☐	☐	☐
(2) Supra-pubic	☐	☐	☐	☐
c. Bladder irrigations				
(1) Continuous	☐	☐	☐	☐
(2) Intermittent	☐	☐	☐	☐
d. Specimen collection				
(1) Routine	☐	☐	☐	☐
(2) 24 hour	☐	☐	☐	☐
4. Care of the patient with:				
a. Hemodialysis	☐	☐	☐	☐
b. Nephrectomy	☐	☐	☐	☐
c. Peritoneal dialysis	☐	☐	☐	☐
d. Renal failure	☐	☐	☐	☐
e. Renal transplant	☐	☐	☐	☐
f. TURP	☐	☐	☐	☐
g. Urinary diversion/				
i. ileal conduit nephrostomy	☐	☐	☐	☐
h. Urinary tract infection	☐	☐	☐	☐
G. ENDOCRINE/METABOLIC				
1. Assessment				
a. S/S diabetic coma	☐	☐	☐	☐
b. S/S insulin reaction	☐	☐	☐	☐
2. Equipment & procedures				
a. Blood glucose monitoring				
(1) Electronic measuring device				
type_____				
(2) Performing finger stick	☐	☐	☐	☐
(3) Visual blood glucose strips	☐	☐	☐	☐
b. Indwelling insulin pump	☐	☐	☐	☐
3. Care of the patient with:				
a. Diabetes mellitus	☐	☐	☐	☐
b. Disorders of adrenal gland (Addison's disease)	☐	☐	☐	☐
c. Disorders of pituitary gland (Diabetes insipidus)	☐	☐	☐	☐
d. Hyperthyroidism (Grave's disease)	☐	☐	☐	☐
e. Hypothyroidism	☐	☐	☐	☐
f. Thyroidectomy	☐	☐	☐	☐
4. Medications (administration and teaching)				
a. Insulin	☐	☐	☐	☐
b. Oral hypoglycemic	☐	☐	☐	☐
c. Steroids	☐	☐	☐	☐
d. Thyroid	☐	☐	☐	☐
H. WOUND MANAGEMENT				
1. Assessment				
a. Skin for impending breakdown	☐	☐	☐	☐
b. Stasis ulcers	☐	☐	☐	☐
c. Surgical wound healing	☐	☐	☐	☐
2. Equipment & procedures				
a. Air fluidized, low airloss beds	☐	☐	☐	☐
b. Sterile dressing changes	☐	☐	☐	☐
c. Wound care/irrigations	☐	☐	☐	☐

	A	B	C	D
3. Care of the patient with:				
a. Burns	☐	☐	☐	☐
b. Pressure sores	☐	☐	☐	☐
c. Staged decubitus ulcers	☐	☐	☐	☐
d. Surgical wounds with drain(s	☐	☐	☐	☐
e. Traumatic wounds	☐	☐	☐	☐
I. ONCOLOGY				
1. Assessment				
a. Nutritional status	☐	☐	☐	☐
b. Pain control	☐	☐	☐	☐
2. Interpretation of lab results				
a. Blood chemistry	☐	☐	☐	☐
b. Blood counts	☐	☐	☐	☐
3. Equipment & procedures:				
a. Reverse isolation	☐	☐	☐	☐
4. Care of the patient with:				
a. Bone marrow transplant.	☐	☐	☐	☐
b. Fresh oncologic surgery	☐	☐	☐	☐
c. Inpatient chemotherapy	☐	☐	☐	☐
d. Inpatient hospice	☐	☐	☐	☐
e. Leukemia	☐	☐	☐	☐
f. Radiation implant	☐	☐	☐	☐
5. Medications: Chemotherapy certification?		☐ Yes	☐ No	
J. INFECTIOUS DISEASES				
1. Interpretation of lab results: blood count				
2. Equipment & procedures				
a. Fever management	☐	☐	☐	☐
b. Isolation	☐	☐	☐	☐
3. Care of the patient with:				
a. AIDS	☐	☐	☐	☐
b. Hepatitis	☐	☐	☐	☐
c. Lyme disease	☐	☐	☐	☐
K. PHLEBOTOMY / IV THERAPY				
1. Equipment & procedures				
a. Administration of blood/blood products				
(1) Albumin	☐	☐	☐	☐
(2) Cryoprecipitate	☐	☐	☐	☐
(3) Packed red blood cells	☐	☐	☐	☐
(4) Plasma	☐	☐	☐	☐
(5) Whole blood	☐	☐	☐	☐
b. Drawing blood from central line	☐	☐	☐	☐
c. Drawing venous blood	☐	☐	☐	☐
d. Starting IVs				
(1) Angiocath	☐	☐	☐	☐
(2) Butterfly	☐	☐	☐	☐
(3) Heparin lock	☐	☐	☐	☐

First name: _____ Last name: _____

	A	B	C	D
2. Care of the patient with:				
a. Central line/catheter/dressing				
(1) Broviac	☐	☐	☐	☐
(2) Groshong	☐	☐	☐	☐
(3) Hickman	☐	☐	☐	☐
(4) Portacath	☐	☐	☐	☐
(5) Quinton	☐	☐	☐	☐
b. Peripheral line/dressing	☐	☐	☐	☐

	A	B	C	D
L. PAIN MANAGEMENT				
1. Assessment of pain level/tolerance	☐	☐	☐	☐
2. Care of the patient with:				
a. Epidural anesthesia/analgesia	☐	☐	☐	☐
b. IV conscious sedation	☐	☐	☐	☐
c. Narcotic analgesia	☐	☐	☐	☐
d. Patient controlled analgesia (PCA pump)	☐	☐	☐	☐

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

AGE SPECIFIC PRACTICE CRITERIA

A. Newborn / Neonate (birth - 30 days)	D. Preschooler (3 - 5 years)	G. Young adults (18 - 39 years)
B. Infant (30 days - 1 years)	E. School age children (5 - 12 years)	H. Middle adults (39 - 64 years)
C. Toddler (1 - 3 years)	F. Adolescents (12 - 18 years)	I. Older adults (64+)

EXPERIENCE WITH AGE GROUPS:	A	B	C	D	E	F	G	H	I
Able to adapt care to incorporate normal growth and development.	☐	☐	☐	☐	☐	☐	☐	☐	☐
Able to adapt method and terminology of patient instructions to their age, comprehension and maturity level.	☐	☐	☐	☐	☐	☐	☐	☐	☐
Can ensure a safe environment reflecting specific needs of various age groups.	☐	☐	☐	☐	☐	☐	☐	☐	☐

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

☐ Medical ___ year(s) ☐ Oncology ___ year(s) ☐ OB/GYN ___ year(s)

☐ Surgical ___ year(s) ☐ Neurology ___ year(s) ☐ Psychiatry ___ year(s)

☐ Telemetry ___ year(s) ☐ Pediatrics ___ year(s) ☐ Rehabilitation ___ year(s)

☐ Orthopedics ___ year(s) ☐ Other (type) _____ ___ year(s)

Certification: (mo/day/yr)

☐ BCLS Exp. date: ___/___/_____

☐ Computerized charting system: _____ date: ___/___/_____

☐ Medication administration system: _____ date: ___/___/_____

☐ Other (type): _____ Exp. date: ___/___/_____

The information given is true and accurate to the best of my knowledge. I hereby authorize Nurse Professionals Home Care, L.L.C. to release this Skills Checklist to Client facilities of Nurse Professionals Home Care, L.L.C. in relation to consideration of employment as a nurse with those facilities.

_____ ___/___/_____

Signature Date

SUBSTANCE ABUSE POLICY

It is the purpose of Nurse Professionals Home Care, L.L.C. to provide a drug-free environment for our clients and our employees. Nurse Professionals Home Care, L.L.C. has established the following policy for existing and future employees.

PROHIBITED ACTIVITIES

The use, possession, solicitation for, or sale of any illegal drugs, narcotics, alcohol, or prescription medication without a prescription on company or customer premises or while performing an assignment is strictly prohibited.

DRUG TESTING

Nurse Professionals Home Care, L.L.C. may conduct drug testing under the following circumstances:

New Applicant: Applicant will be required to pass a drug screen prior to employment.

Randomly: An unannounced random selection of employees for testing may be conducted as deemed appropriate by Nurse Professionals Home Care, L.L.C.

For Cause: When it is the belief of Nurse Professionals Home Care, L.L.C. and/or facility that a drug Problem exists or behavior is inappropriate, drug testing may be required, to include on site testing

POLICY COMPLIANCE

Applicants who fail to pass a pre-employment drug test will not be eligible for employment with Nurse Professionals Home Care, L.L.C.

Employees of Nurse Professionals Home Care, L.L.C. who test positive, or who admit to substance abuse, will be subject to Nurse Professionals Home Care, L.L.C. disciplinary action up to and including termination of employment with Nurse Professionals Home Care, L.L.C.

Nurse Professionals Home Care, L.L.C. will report any such disciplinary action to the appropriate State Board Licensing jurisdiction for review (for applicants and current employees).

Employees who test positive or admit to substance abuse will be referred to local agencies that provide rehabilitation and counseling services for treatment at their own expense

CONFIDENTIALITY

Applicants and employees should know that as a condition of employment, Nurse Professionals Home Care, L.L.C. and/or parties involved in the testing process may be required to provide documentation

regarding drug testing to clients and that the applicant or employee release Nurse Professionals Home Care, L.L.C. to provide this information if required for placement.

Information regarding an individual's drug testing results will only be released upon the written consent of the employee except as noted in the above paragraph.

Nurse Professionals Home Care, L.L.C. will maintain all employee test records in confidence; however, the testing laboratory will disclose information related to a positive drug test of an individual to individual, Nurse Professionals Home Care, L.L.C. or the decision maker in a lawsuit, grievance, or other proceeding initiated by or on behalf of the individual and arising from a certified positive drug test.

Any employee who is the subject of a drug test conducted under this policy shall upon written request to Nurse Professionals Home Care, L.L.C. have access to any records relating to his/her drug test and any records relating to the results of any relevant certification, review, or revocation of certification proceeding.

REGULATORY COMPLIANCE

Any provisions of this Substance Abuse Policy statement that may be in compliance with any local, state, or federal law will be applied by Nurse Professionals Home Care, L .L.C. so as to be in compliance with any local, state, or federal law.

I have reviewed and understand the contents of the Substance Abuse Policy.

I understand and agree to submit to a urine, blood, or hair specimen for testing under the circumstances and conditions outlined within this Policy. Furthermore, I understand and agree that if I am involved in an accident or other unusual occurrence, which requires medical treatment, the treating physician may order testing which includes a urine, blood or hair specimen.

I hereby hold harmless all parties concerned and involved in the process of administering such drug testing and will not use Nurse Professionals Home Care, L.L.C. or the parties involved for any action taken as a result of said drug testing under this Policy that may prohibit me from securing a job with Nurse Professionals Home Care, L.L.C. or prevent any continued employment with Nurse Professionals Homecare, L.L.C. or with any other company or party.

I understand that as a condition of employment, Nurse Professionals Home Care, L.L.C. and/or the parties involved with the drug testing process may be required to provide documentation regarding drug testing to clients. I release Nurse Professionals Home Care, L.L.C. to provide this information if required for placement.

I hereby attest that I have read and understand the Substance Abuse Policy and that I must be drug and alcohol free as a condition of employment and continued employment with Nurse Professionals Home Care, L.L.C.

Employee Signature Date

Form SSA-89

Form Approved
OMB #0960-0760

Social Security Administration
Authorization for the Social Security Administration (SSA)
To Release
Social Security Number (SSN) Verification

Printed Name _____ Date of Birth _____ SSN _____

I am conducting the following business transaction

_____

[Identify a specific purpose. Example – Seeking a mortgage from the Company – "Identity verification" or "Identity proof or confirmation" is not acceptable.].

with the following company ("the Company"):

Company Name Address

National Background Investigations, Inc PO Box 966 Stevensville, MD 21666 *(Do not change or modify this line.)*

I authorize the Social Security Administration to verify my name and SSN to the Company and/or the Company's Agent, if applicable, for the purpose I identified.

The name and address of the Company's Agent is:

Computer Information Development, LLC 713 W. Duarte Rd., #106, Arcadia, CA 91007 *(Do not change or modify this line.)*

I am the individual to whom the Social Security number was issued or that person's legal guardian. I declare and affirm under the penalty of perjury that the information contained herein is true and correct. I acknowledge that if I make any representation that I know is false to obtain information from Social Security records, I could be found guilty of a misdemeanor and fined up to $5,000.

This consent is valid only for 90 days from the date signed, unless indicated otherwise by the individual named above. If you wish to change this timeframe, fill in the following:

This consent is valid for _____ days from the date signed. _____ (Please initial.)

Signature _____ Date Signed _____

Contact information of individual signing authorization:

Address _____

City/State/ZIP _____

Phone Number _____

Form SSA-89 (8/15/2008)

NOTICE TO NUMBER HOLDER

The Company and/or its Agent have entered into an agreement with SSA that, among other things, includes restrictions on the further use and disclosure of SSA's verification of your SSN. To view a copy of the entire model agreement, visit http://www.ssa.gov/cbsv/docs/modelAgreement11309.pdf.

For Upload Only

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 05/31/2027

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

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

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

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

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

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

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

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

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.) _____
- ☐ 4. An alien authorized to work until (exp. date, if any) _____

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

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

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

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

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

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

Additional Information

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

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

First Day of Employment (mm/dd/yyyy):

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

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

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

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2025

Step 1: Enter Personal Information

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

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

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

MARYLAND
FORM
MW507

Purpose. Complete Form MW507 so that your employer can withhold the correct Maryland income tax from your pay. Consider completing a new Form MW507 each year and when your personal or financial situation changes.

Basic Instructions. Enter on line 1 below, the number of personal exemptions you will claim on your tax return. However, if you wish to claim more exemptions, or if your adjusted gross income will be more than $100,000 if you are filing single or married filing separately ($150,000, if you are filing jointly or as head of household), you must complete the Personal Exemption Worksheet on page 2. Complete the Personal Exemption Worksheet on page 2 to further adjust your Maryland withholding based on itemized deductions, and certain other expenses that exceed your standard deduction and are not being claimed at another job or by your spouse. However, you may claim fewer (or zero) exemptions.

Additional withholding per pay period under agreement with employer. If you are not having enough tax withheld, you may ask your employer to withhold more by entering an additional amount on line 2.

Exemption from withholding. You may be entitled to claim an exemption from the withholding of Maryland income tax if:

a. Last year you did not owe any Maryland Income tax and had a right to a full refund of any tax withheld; AND,
b. This year you do not expect to owe any Maryland income tax and expect to have a right to a full refund of all income tax withheld.

If you are eligible to claim this exemption, complete Line 3 and your employer will not withhold Maryland income tax from your wages.

Students and Seasonal Employees whose annual income will be below the minimum filing requirements should claim exemption from withholding. This provides more income throughout the year and avoids the necessity of filing a Maryland income tax return.

Certification of nonresidence in the State of Maryland. Complete Line 4. This line is to be completed by residents of the District of Columbia, Virginia or West Virginia who are employed in Maryland and who do not maintain a place of abode in Maryland for 183 days or more.

Residents of Pennsylvania who are employed in Maryland and who do not maintain a place of abode in Maryland for 183 days or more, should complete line 5 to exempt themselves from the state portion of the withholding tax. These employees are still liable for withholding tax at the rate in effect for the Maryland county in which they are employed, unless they qualify for an exemption on either line 6 or line 7. Pennsylvania residents of York and Adams counties may claim an exemption from the local withholding tax by completing line 6. Pennsylvania residents living in other local jurisdictions which do not impose an earnings or income tax on Maryland residents may claim an exemption by completing line 7. Employees qualifying for exemption under 6 or 7, should also write "EXEMPT" on line 4.

Line 4 is **NOT** to be used by residents of other states who are working in Maryland, because such persons are liable for Maryland income tax and withholding from their wages is required.

If you are domiciled in the District of Columbia, Pennsylvania or Virginia and maintain a place of abode in Maryland for 183 days or more, you become a statutory resident of Maryland and you are required to file a resident return with Maryland reporting your total income. You must apply to your domicile state for any tax credit to which you may be entitled under the reciprocal provisions of the law. If you are domiciled in West Virginia, you are not required to pay Maryland income tax on wage or salary income, regardless of the length of time you may have spent in Maryland.

Under the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from Maryland income tax on your wages if (i) your spouse is a member of the armed forces present in Maryland in compliance with military orders; (ii) you are present in Maryland solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under the SCRA enter your state of domicile (legal residence) on Line 8; enter "EXEMPT" in the box to the right on Line 8; and attach a copy of your spousal military identification card to Form MW507. **In addition, you must also complete and attach Form MW507M.**

Duties and responsibilities of employer. Retain this certificate with your records. You are required to submit a copy of this certificate and accompanying attachments to the **Compliance Division, Compliance Programs Section, 7 St. Paul Street, Baltimore, MD 21202**, when received if:

1. You have any reason to believe this certificate is incorrect;
2. The employee claims more than 10 exemptions;
3. The employee claims an exemption from withholding because he/she had no tax liability for the preceding tax year, expects to incur no tax liability this year and the wages are expected to exceed $200 a week;
4. The employee claims an exemption from withholding on the basis of nonresidence; or
5. The employee claims an exemption from withholding under the Military Spouses Residency Relief Act.

Upon receipt of any exemption certificate (Form MW507), the Compliance Division will make a determination and notify you if a change is required.

Once a certificate is revoked by the Comptroller, the employer must send any new certificate from the employee to the Comptroller for approval before implementing the new certificate.

If an employee claims exemption under 3 above, a new exemption certificate must be filed by February 15th of the following year.

Duties and responsibilities of employee. If, on any day during the calendar year, the number of withholding exemptions that the employee is entitled to claim is less than the number of exemptions claimed on the withholding exemption certificate in effect, the employee must file a new withholding exemption certificate with the employer within 10 days after the change occurs.

FORM
MW507 Employee's Maryland Withholding Exemption Certificate

Print full name	Social Security Number
Street Address, City, State, ZIP	County of residence (Nonresidents enter Maryland county (or Baltimore City) where you are employed.

☐ Single ☐ Married (surviving spouse or unmarried Head of Household) Rate ☐ Married, but withhold at Single rate

1. Total number of exemptions you are claiming not to exceed line f in Personal Exemption Worksheet on page 2. . . . . 1. _____
2. Additional withholding per pay period under agreement with employer. . . . . 2. _____
3. I claim exemption from withholding because I do not expect to owe Maryland tax. See instructions above and check boxes that apply.
   ☐ a. Last year I did not owe any Maryland income tax and had a right to a full refund of all income tax withheld and
   ☐ b. This year I do not expect to owe any Maryland income tax and expect to have the right to a full refund of all income tax withheld. (This includes seasonal and student employees whose annual income will be below the minimum filing requirements).
   If both a and b apply, enter year applicable _____ (year effective) Enter "EXEMPT" here . . . . . 3. _____
4. I claim exemption from withholding because I am domiciled in one of the following states. Check state that applies.
   ☐ District of Columbia ☐ Virginia ☐ West Virginia
   I further certify that I do not maintain a place of abode in Maryland as described in the instructions above. Enter "EXEMPT" here. . . . . 4. _____
5. I claim exemption from Maryland **state** withholding because I am domiciled in the Commonwealth of Pennsylvania and I do not maintain a place of abode in Maryland as described in the instructions on Form MW507. Enter "EXEMPT" here. . . . . 5. _____
6. I claim exemption from Maryland **local** tax because I live in a local Pennysylvania jurisdiction within York or Adams counties. Enter "EXEMPT" here and on line 4 of Form MW507. . . . . 6. _____
7. I claim exemption from Maryland **local** tax because I live in a local Pennsylvania jurisdiction that does not impose an earnings or income tax on Maryland residents. Enter "EXEMPT" here and on line 4 of Form MW507. . . . . 7. _____
8. I certify that I am a legal resident of the state of _____ and am not subject to Maryland withholding because I meet the requirements set forth under the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act. Enter "EXEMPT" here. . . . 8. _____

Under the penalty of perjury, I further certify that I am entitled to the number of withholding allowances claimed on line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on whichever line(s) I completed.

Employee's signature	Date
Employer's name and address including ZIP code (For employer use only)	Federal Employer Identification Number

APPLICANT NAME:_____ Date: _____

Please list all facilities (hospitals, nursing homes, and other health care facilities) that you have either worked at or had an assignment at within the last 10 years:

Facility Name (including city, state)	Unit Worked	Dates	Employee or Agency (cirde one)	
			Employed	Agency
			Employed	Agency
			Employed	Agency
			Employed	Agency
			Employed	Agency
			Employed	Agency
			Employed	Agency
			Employed	Agency
			Employed	Agency
			Employed	Agency
			Employed	Agency

I attest that the information provided in this application is complete and accurate, to the best of my knowledge. Providing incomplete or inaccurate information may result in disqualification from employment eligibility and may be a violation of state law(s) that could result in civil penalties. Nurse Professionals, LLC is authorized to obtain information from my current and previous employers, and to release information in support of my application (application, references, background search results, etc.) to the Company's client institutions and to the appropriate governmental or licensing entities. Nurse Professionals, LLC may also share applicant information with its affiliates. I understand that Nurse Professionals, LLC, certain states and / or Client institutions will require criminal background checks, and I consent to such checks. Prior to conducting any background checks that qualify as consumer or investigative consumer reports, I will be provided and will return, separate disclosure and acknowledgment forms as required by Nurse Professionals, LLC.

Signature _____ Date_____

Reference Material 6
Work Experience Checklist – RN & LPN (Rev. 6/13/12)

HOSPITAL UNIT	UNIT EXPERIENCE DURING LAST 12 MOS: APPROX. # SHIFTS	OR APPROX. WEEKS (FULL-TIME)	OR APPROX. MONTHS (FULL-TIME)	Experience in Career as an RN (month/year to month/year)	Per Diem	Core Staff
BMT				/ to /	☐	☐
Burn				/ to /	☐	☐
Cath Lab				/ to /	☐	☐
Dialysis				/ to /	☐	☐
Endoscopy/GI Lab				/ to /	☐	☐
ER				/ to /	☐	☐
ER-Pediatrics				/ to /	☐	☐
ICU				/ to /	☐	☐
ICU-CV (CVICU)				/ to /	☐	☐
ICU-Neuro				/ to /	☐	☐
ICU-Pediatric (PICU)				/ to /	☐	☐
ICU-Trauma				/ to /	☐	☐
L&D				/ to /	☐	☐
LTC				/ to /	☐	☐
MED SURG				/ to /	☐	☐
NICU-Level 2				/ to /	☐	☐
NICU-Level 3				/ to /	☐	☐
Nursery				/ to /	☐	☐
Nursery-Level 2				/ to /	☐	☐
OB				/ to /	☐	☐
Oncology				/ to /	☐	☐
OR				/ to /	☐	☐
OR-CV (CVOR)				/ to /	☐	☐
ORTHO				/ to /	☐	☐
PACU				/ to /	☐	☐
Pediatrics				/ to /	☐	☐
PSYCH-Adult				/ to /	☐	☐
PSYCH-Geriatric				/ to /	☐	☐
PSYCH-Pediatrics				/ to /	☐	☐
Radiology				/ to /	☐	☐
REHAB-Medical				/ to /	☐	☐
Renal/Transplant				/ to /	☐	☐
TELE				/ to /	☐	☐
TELE-Progressive				/ to /	☐	☐
Other:				/ to /	☐	☐
TOTAL	*	**	***	*Not to exceed: *365; **52; ***12*		

THIS FORM MUST BE COMPLETED ANNUALLY!

SYSTEMS & PROCEDURES EXPERIENCE:

Yes ☐ No ☐ Balloon Pump. **If yes: Balloon Pump Certified - Yes ☐/No ☐**
Yes ☐ No ☐ Interpretation of Cardiac Dysrhythmias
Yes ☐ No ☐ Blood Glucose Monitor. **If yes: Type - _____ (Be specific: Accu-chek, etc)**
Yes ☐ No ☐ IV Insertion
Yes ☐ No ☐ Moderate Sedation experience. **If yes: _____years/_____ months of experience**
Yes ☐ No ☐ Epidurals
Yes ☐ No ☐ Fetal Monitoring
Yes ☐ No ☐ Computerized Documentation. **If yes: System Used - _____ (Be specific: Cerner, Meditech, etc)**
Yes ☐ No ☐ Parenteral administration of electrolytes and fluids
Yes ☐ No ☐ Phlebotomy
Yes ☐ No ☐ Recognition of the need for psychological and social services for patients and their families

Employee Name (printed) **Employee Signature/"VIA TELEPHONE" (updates only)** **Date / ☐Update** / /

Agency **Reviewed by (Signature & Credentials [i.e., RN])** **Date**

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HEPATITIS B DECLINE FORM

ACKNOWLEDGMENT:

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring a Hepatitis B virus (HBV) infection. I have been informed of the symptoms and modes of transmission of blood-borne pathogens, including HBV. I know about the facility's infection control procedures that I will be assigned to and understand the procedure to follow if an exposure incident occurs.

I understand the Hepatitis B vaccine is available, at no cost, through the local health department, to nurses and staff whose jobs involve the risk of directly contacting blood or other potentially infectious material. I understand that the vaccination is a 3-step process, and I will be responsible for returning for the last 2 injections.

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring an HBV infection. I have been given the opportunity to be vaccinated through the local health department with Hepatitis B vaccine at little or no cost to me; however, I decline a 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 the Hepatitis B vaccine, I can receive the vaccination series through the local health department at no charge to me.

Employee Signature: _____ Date: _____

Print Name: _____

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Acknowledgment of HIPAA

I acknowledge the confidentiality of patient healthcare information, Confidential Patient Information that I may receive or have access to while providing patient care services at participating hospitals and facilities at which I am assigned under Nurse Professionals Home Care and 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 procedures 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 Nurser Professionals Home Care and Staffing and the conclusion of any assignment at a participating hospital or facility assigned by Nurse Professionals Home Care and Staffing.

I am also aware of the update to HIPAA as of January 25, 2013, and the new rule that became effective on March 26, 2013, in which a modification was completed and under the HITECH (Health Information Technology for Economics and Clinical Health Act) to strengthen protection for individuals' health information. It also serves to strengthen privacy and security protection for individuals' health information. This new regulation prohibits the sale of protected health information and the use of it for marketing and fund-raising purposes. A new standard is also applied to how to determine what qualifies as a breach of unsecured PHI by a health plan or business associate. Under the new law, a breach will be presumed to have occurred unless the health plan or business associate demonstrates that there is a low probability that the PHI has been compromised. For each potential breach, a new rule requires formal risk assessment. If the breach is found to have occurred, the offending health plan is required to notify each affected individual with 60 days of the discovery of the breach.

Employee Signature: _____ Date: _____

Print Name: _____

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REQUIREMENTS FOR NURSES:

ALL REGISTERED AND LICENSED PRACTICAL NURSES CONTRACTED THROUGH NURSE PROFESSIONALS HOME CARE POSSESS THE FOLLOWING CRITERIA:

- *GRADUATION FROM AN ACCREDITED UNIVERSITY OR SCHOOL OF NURSING*
- *CURRENT R.N. OR L.P.N. LICENSE IN THE STATE OF MARYLAND*
- *CURRENT CPR OR BCLS CARD (POSSESSION OF ACLS IF APPLICABLE TO POSITION)*
- *STATEMENT OF LAST PHYSICAL (PERFORMED WITHIN THE LAST 12 MONTHS)*
- *COPY OF LAST TB PPD TEST OR CHEST X-RAY (MUST HAVE BEEN PERFORMED WITHIN THE LAST 12 MONTHS*
- *PROOF OF TETANUS BOOSTER WITHIN THE LAST 10 YEARS)*
- *COPY OF HEPATITIS B SERIES COMPLETION OR SIGNED DECLINATION*
- *COPY OF MMR, VARICELLA, AND HEPATITIS B TITERS*
- *COMPLETION OF THE CLINICAL SKILLS CHECKLIST*
- *SUCCESSFUL COMPLETION OF A BACKGROUND INVESTIGATION*
- *SUCCESSFUL COMPLETION OF A PRE-EMPLOYMENT SUBSTANCE ABUSE TEST*
- *COMPLETION OF THE I-9, W-2 AND MARYLAND MW507 FORMS*
- *CURRENT 2 YEARS OF EXPERIENCE IN PROFESSIONAL SPECIALTY AREA*
- *PROFESSIONAL REFERENCES FROM PRIOR EMPLOYERS*
- *HIPAA COMPLIANCE STATEMENT*
- *COPY OF DRIVER'S LICENSE*
- *COPY OF SOCIAL SECURITY CARD*
- *COMPLETION OF THE MEDICATION ADMINISTRATION TEST*

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National Background Investigations, Inc.
Customized Background Screening Solutions...Simplified

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining on "consumer reports" and/or "investigative consumer reports" by Nurse Professionals Home Care at any time after the receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance to furnish any and all background information requested by National Background Investigation, Inc., P.O. Box 966, Stevensville, MD 21666, 800-798-0079, another outside organization acting on behalf of Nurse Professionals Home Care itself. I agree that facsimile (fax), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by National Background Investigations, Inc., by contacting the consumer reporting agency identified above directly.

Maine, Massachusetts, Minnesota, New Jersey and Oklahoma applicants or employees only: Please initial if you would like to receive a copy of a consumer report if one is obtained by National Background Investigations, Inc. _____

California applicants or employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please initial here if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by National Background Investigations, Inc., whenever you have the right to receive such a copy under California law. _____

SIGNATURE OF ACKNOWLEDGMENT AND AUTHORIZATION

By my signature below, I certify that the information provided on the attached forms is true and correct to the best of my knowledge.

Please print name (last, first, middle): _____

Signature: _____ Date: _____

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APPLICANT DISCLOSURE

Nurse Professionals Home Care may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports many contain information regarding your credit history, criminal history, social security verification, motor vehicle records "driving records", verification of your education or employment history, workers compensation injuries, or other background checks. Please be advised that the nature and scope of this notice and authorization is all-encompassing to include National Background Investigations, Inc., P.O. Box 966, Stevensville, MD 21666, 800-798-0079 or another outside organization. By signing this notice and authorization, you are allowing Nurse Professionals Home Care to obtain from any outside organization all manners of consumer reports and investigative reports now and throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer reports.

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TO BE COMPLETED BY APPLICANT (all information will be used for background screening purposes only)		
Last Name	First Name	Middle Name
Other Known Names Or Other Names Used		
Other First Name	Other Last Name	
Current Address		
City	State	Zip
From (mm/yy)	To (mm/yy)	
Primary Telephone Number	Email	
Date of Birth (mm/dd/yyyy)		
Social Security No.		
Driver's License No.		State
Previous Address of Residence (past seven years)		
1. Address		
City	State	Zip
From (mm/yy)	To (mm/yy)	
2. Address		
City	State	Zip
From (mm/yy)	To (mm/yy)	
3. Address		
City	State	Zip

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From (mm/yy)	To (mm/yy)	

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PROFESSIONAL REFERENCE REQUEST:

Consent by Employee (Name): _____

Facility Name: _____

Facility Address: _____

Manager/Supervisor/Director of Nursing: _____

The Facility listed above has my consent to release any information to Nurse Professionals Home Care regarding prior employment. I also authorize Nurse Professionals Home Care to disclose this information to any client facilities or home care placements.

Employee Signature: _____ Social Security Number: _____

EMPLOYER SECTION: The individual named above has applied for employment with Nurse Professionals Home Care. To implement our thorough screening process, we ask that you provide the information requested below. Your response will be held in the strictest confidence.

Quality of Work:

Superior _____ Exceeds Standards _____ Meets Standards _____ Does Not Meet Standards _____

Reliability (Attendance):

Superior _____ Exceeds Standards _____ Meets Standards _____ Does Not Meet Standards _____

Teamwork:

Superior _____ Exceeds Standards _____ Meets Standards _____ Does Not Meet Standards _____

Accurate Documentation:

Superior _____ Exceeds Standards _____ Meets Standards _____ Does Not Meet Standards _____

Communication Skills:

Superior _____ Exceeds Standards _____ Meets Standards _____ Does Not Meet Standards _____

Adaptability to Change:

Superior _____ Exceeds Standards _____ Meets Standards _____ Does Not Meet Standards _____

Clinical Skills:

Superior _____ Exceeds Standards _____ Meets Standards _____ Does Not Meet Standards _____

Dates of Employment: _____

Is this past employee eligible for rehire? Yes _____ No _____

Name of Evaluator: _____ Date: _____

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Accurate Documentation:

Superior _____ Exceeds Standards _____ Meets Standards _____ Does Not Meet Standards _____

Communication Skills:

Superior _____ Exceeds Standards _____ Meets Standards _____ Does Not Meet Standards _____

Adaptability to Change:

Superior _____ Exceeds Standards _____ Meets Standards _____ Does Not Meet Standards _____

Clinical Skills:

Superior _____ Exceeds Standards _____ Meets Standards _____ Does Not Meet Standards _____

Dates of Employment: _____

Is this past employee eligible for rehire? Yes _____ No _____

Name of Evaluator: _____ Date: _____

Chesapeake Registry Program
Work History/Employment Verification Form

Agency Healthcare Provider's name	
Date of work history verification	
Place of employment	
Location of employment (City & State)	
Role or position worked	
Unit(s) or area(s) worked	
Average hours worked per week	
Dates of employment	/ TO /

Person providing information from previous employer:

Name:

Title or Department:

If verification by phone, this form should be signed and dated below by the Agency Representative obtaining the work history/employment verification.

_____

Signature of Agency Representative taking reference Date