

Dear Healthcare Professional,

I would like to take this opportunity to introduce and welcome you to Quality Medical Staffing, LLC.

Our company is nurse owned and operated. Staff is available 24 hrs a day, to assist you with any issues. We strive on paying our healthcare professionals the highest pay rates in the industry. With our agency, you are not just an employee, our healthcare professionals are respected and we take the time to know the needs of our team. We offer bonuses, referral incentives, and a flexible work schedule.

If you have any questions or would like additional information, please contact our office at (877) 426-8793.

Sincerely,

Nicholas Marrujo, President/CEO

Quality Medical Staffing

EMPLOYEE CHECKLIST

The items below ***must*** be completed to be considered for employment with Quality Medical Staffing, LLC. As you complete each item, place an [X] in the box to the left of the item.

A photocopy of current ***Driver's License, Social Security Card, Valid Nurse License, CPR Certification and other certifications. (for example pals, acls, etc.)***

A photocopy of your immunization records, including: ***PPD, Measles, Mumps, Rubella, and Hepatitis B. (This is mandatory for employment) PPD must be within the last year.***

Completed and signed application.

A copy of your current resume, including completed reference forms.

A completed "Skills Checklist", specific to your field.

Completed I-9 and W 4

Current Pre employee Drug Screen (If requested)

Signed and Completed Physicians Statement

If you have any questions or need help in completing any of the above items, please contact:

Quality Medical Staffing
824 Union St.
Las Vegas, NM 87701
1-877-426-8793
Fax: (505) 426-8793

**Quality Medical Staffing
Background Authorization Form
Personal Information**

Name: _____ SSN: _____

Previous Name Used: _____

Home Address: _____

How long have you lived at this address: _____

Previous Address: _____

Date of Birth: _____

Driver's License Number: _____

Have you ever been convicted of a crime (misdemeanor or felony) other than a traffic violation, with in the past seven (7) years? A conviction includes a plea, verdict, or finding of guilt regardless of whether sentence is imposed by the court.
YES [] NO []

Where? _____ When? _____

Charge: _____

Sentence: _____

Has your driver's license ever been suspended or revoked? YES [] NO []

*** THIS INFORMATION IS REQUIRED IN ORDER TO CONDUCT AN ACCURATE CRIMINAL BACKGROUND SEARCH.

In connection with my application for employment (including contract for services) with you, I understand that investigative background inquires are to be made on myself including consumer credit, criminal convictions, motor vehicle, education and other reports. These reports will include information as to my character, work habits, performance and experience along with reasons for termination and past employment from previous employers.

I certify that, to the best of my knowledge, all the information provided to Quality Medical Staffing, LLC. hereforth, in this application packet and in any future communication, is true and complete. I understand that any misrepresentation, falsification or willful omission may result in a refusal of employment or dismissal after employment.

I authorize without reservation, any party or agency contacted by this employer to furnish the above mentioned information.

I release Quality Medical Staffing, LLC. and any other person and/or agencies from and damage and/or liable acts that may result from obtaining the above information.

APPLICANT' Signature: _____ Date: _____



Quality Medical Staffing

Application

General Information

First Name	Middle Name	Maiden Name	Last Name	
Address		City	State	Zip
Email Address		How did you hear of Trustaff?		
Home Phone	Cell Phone	Other Contact Number	Best Time to Contact	
Emergency Contact		Relationship	Emergency Contact Phone	

Employment Profile

Please check yes or no for each of the following questions.

Can you provide proof of eligibility to work in the United States?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you ever been convicted of a crime that would prevent employment at a health care facility? If yes, please provide a detailed explanation on a separate sheet of paper.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you ever had a license or certification investigated, revoked, or suspended? If yes, please provide a detailed explanation on a separate sheet of paper.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have at least one year of current experience on a hospital floor?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you willing to submit to a criminal background check?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you willing to submit to a drug screen?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have any limitations that would restrict you from performing essential functions in the position for which you are applying? If yes, please provide a detailed explanation on a separate sheet of paper.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are your driving privileges suspended or revoked in any state? If yes, please provide a detailed explanation on a separate sheet of paper.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Can you provide proof of auto insurance for rental car usage?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Education

School / University	Location	Month / Year Graduated	Degree / Diploma Awarded

Expertise / Experience

Unit / Specialty	Years of Experience	Equipment / Procedures



Quality Medical Staffing

Name

Work History *List below all permanent positions (full-time & part-time), local agency, and travel assignments.*

Facility	Location	Dates Employed	Unit	# Beds
Supervisor	Phone	Reason for Leaving	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-Time <input type="checkbox"/> Local Agency <input type="checkbox"/> Travel (company: _____)	

Facility	Location	Dates Employed	Unit	# Beds
Supervisor	Phone	Reason for Leaving	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-Time <input type="checkbox"/> Local Agency <input type="checkbox"/> Travel (company: _____)	

Facility	Location	Dates Employed	Unit	# Beds
Supervisor	Phone	Reason for Leaving	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-Time <input type="checkbox"/> Local Agency <input type="checkbox"/> Travel (company: _____)	

Facility	Location	Dates Employed	Unit	# Beds
Supervisor	Phone	Reason for Leaving	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-Time <input type="checkbox"/> Local Agency <input type="checkbox"/> Travel (company: _____)	

Facility	Location	Dates Employed	Unit	# Beds
Supervisor	Phone	Reason for Leaving	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-Time <input type="checkbox"/> Local Agency <input type="checkbox"/> Travel (company: _____)	

Facility	Location	Dates Employed	Unit	# Beds
Supervisor	Phone	Reason for Leaving	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-Time <input type="checkbox"/> Local Agency <input type="checkbox"/> Travel (company: _____)	

Professional References

Name	Title	Facility	Contact Number



Quality
Medical Staffing

Name

Licensure

State	License Number	Issue Date	Expiration Date

Certifications

Certification	Expiration Date	Certification	Expiration Date
BLS		OCN	
ACLS		Critical Care Course	
PALS		Trauma Course	
NALS / NRP		Other (_____)	
CCRN		Other (_____)	
CEN		Other (_____)	
Chemotherapy		Other (_____)	
CNOR		Other (_____)	

Application Certification

I certify that all statements made in this application are true to the best of my knowledge. I understand that any falsification or misleading information given in my application may result in the termination of my employment with QMS

I understand that nothing contained in this application is intended to create an employment contract, either verbal or written, with QMS or its clients. Furthermore, I understand that in the event of my employment, it is "at will"

_____ Signature

_____ Date

Quality Medical Staffing

VARICELA QUESTIONNAIRE

This questionnaire is a Quality Medical Staffing, LLC. employment requirement to determine your history of Varicella (chicken pox). Chickenpox is an infection disease caused by the Varicella, a virus of the herpes family. The transmission is spread by coughing, sneezing, direct contact and considered and highly contagious.

- It is my belief that I have had Varicella (chickenpox). Yes [] Date _____
No [] _____
- As a child I lived with a sibling who had chickenpox. Yes [] Date _____
No [] _____
- Acyclovir is a medication I have taken for herpes viruses. Yes [] Date _____
No [] _____
- A copy of the results is available and I can provide? Yes [] Date _____
No [] _____

I certify that, to the best of my knowledge, all the information provided to Quality Medical Staffing, LLC. Thereforth, in this application packet and in any future communication, is true and complete. I understand that any misrepresentation, falsification or willful omission may result in a refusal of employment or dismissal after employment.

Print Name: _____

Signature: _____

Date: _____

Quality Medical Staffing

HEPATITIS B DECLINATION STATEMENT

This Statement of Declination of Hepatitis B vaccination must be signed by the employee who does not accept the vaccine.

This statement is not a waiver:

I understand that due to my occupational exposure to body fluids, blood or other potential infectious materials or substance I may be at risk of acquiring Hepatitis B Virus (HBV) infection.

I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to me. However, I decline the vaccination at this time.

I understand that by declining this HBV vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease.

I understand employees can request and receive the Hepatitis B vaccination in the future if they continue to have exposure to body fluids, blood or other potentially infectious materials of substances.

I understand if I remain occupationally at risk and I want to be vaccinated with Hepatitis B vaccine, as an active Quality Medical Staffing employee I can receive the vaccination series at no charge.

My signature also acknowledges that I do not have a known sensitivity to yeast or a previous reaction to the vaccine that is known.

Print Name: _____

Signature: _____

Date: _____

Quality Medical Staffing POLICIES

1. Quality Medical Staffing, LLC. is dedicated to providing quality healthcare professionals. Always be on time and look your very best. Adhere to the dress code and follow all the rules and regulations of the facility.
2. Assignments are offered on a first come, first serve basis. We inform the facility of your availability, shift preferences, and specialty. While the initial hours and days of work are set forth and explained in the interview, these are not guaranteed during your employment and you may be required to work other shifts, hours, or areas as organizational needs required.
3. Salary will be discussed when the position is offered. Your salary is confidential and should be discussed only with your recruiter. Failure to adhere to this policy could result in termination. Employees receive their paychecks weekly on Friday. Federal withholding taxes and FICA are withheld from your check in accordance with Federal laws. State taxes are withheld accordingly. Quality Medical Staffing will observe the same holidays as the hospital where you are assigned. Time and one half is paid for hours worked on holidays and overtime over forty (40) hours per week. Week start on Sunday 6am and end on the following Sunday 6am. Time sheets will be provided for you. *You are responsible for faxing in your time sheet on Monday 5:00 pm. No payroll checks can be issued until time sheets are in the office and therefore, it is suggested that all employees confirm the receipt of faxed time sheets via phone.*
4. Cancellation of a shift must be four (4) hours prior to the beginning of the shift or a penalty of four (4) hours of wages will be paid by employee. If more than 2 shifts are called off during a thirty (30) day period, employee may be subject to termination. Cancellation of one (1) shift or a no show will result in forfeit of hours accumulated towards bonus. Accumulation of hours towards current bonus period will not start until thirty (30) days after day of no show or call in. A no show to a facility without notifying facility of Quality Medical Staffing will be subject to termination.
5. Quality Medical Staffing employee agrees not to work in a facility staffed by Quality Medical Staffing for a period of 60 days during employment, upon termination or resigns employment from Quality Medical Staffing.
6. Licensure must be verified and on file prior to employment.
7. Employees are hired on the basis of character, references, qualifications and their ability to perform their duties competently. Employees are required to have one (1) year experience current experience.
8. Quality Medical Staffing is an equal opportunity employer. Employees are hired and promoted without regard to race, color, creed, national origin, age or gender.
9. Application for employment and all other forms completed, including W-4 and I-9 forms, become a part of your permanent record. Any willful misrepresentation of facts or misstatements made on these records will be grounds for dismissal.
10. Performance evaluations, continuing education credits and certifications will also be maintained at all times in your file. It is your responsibility to notify our office of any changes in your tax status and to supply us with additional certifications that you wish to have added to your file. Failure to adhere to the rules and regulations of this company and the facility where assigned will not be tolerated. Disciplinary action ranging from written warning to suspension without pay and termination will be taken. And disciplinary action will become a permanent part of your file. All accidents or injuries involving a patient or employee must be reported to your supervisor and Quality Medical Staffing immediately. Contact Quality Medical Staffing immediately if a question of liability arises.
11. Terms: Your employment with Quality Medical Staffing is at will and for no definite period. This means that, just as you can terminate your employment with Quality Medical Staffing at any time and for any reasons, with or without notice or cause, Quality Medical Staffing retains similar rights. By signing these guidelines, you understand that no guarantee of continued employment has been made to you.
12. Quality Medical Staffing has a zero tolerance sexual harassment policy. Please contact a Quality Medical Staffing manager or the human resource director of the healthcare facility where you are assigned if you have been sexually harassed or subject to any form of sexually inappropriate behavior.

I understand and acknowledge that no guaranteed or fixed employment terms have been offered to me. I understand that if I do not cover any shifts for a period of 90 days I will be terminated from employment and will not be eligible for unemployment compensation. Rehiring will be based on past work record. I authorize Quality Medical Staffing to investigate all statements in my application and to secure any necessary information from all my employers, references and academic institutions. I hereby release all of those employers, references, academic institutions and Quality Medical Staffing from any and all liability arising from their giving or receiving information about my employment history, my academic credentials or qualifications and suitability for employment with Quality Medical Staffing. I authorize Quality Medical Staffing to do a background check for employment. In the event of employment or an offer of employment, I authorize any physician or hospital to release any information which may be necessary to determine my ability to perform the essential functions of the job for which I am hired or being considered. I

hereby agree to submit to any lawful drug, alcohol or other testing that may be required as a condition of employment or continued employment and understand that refusal to submit to such testing during the course of my employment may result in termination. I agree and understand that any offer of employment I may receive is contingent upon my successful completion of Quality Medical Staffing pre-employment screening process including any physical examination that may be required. I have read and I agree to meet Quality Medical Staffing minimum requirements of the position for which I am being hired, as described in the job profile. I will comply with all rules, regulations and policies of Quality Medical Staffing. I understand that nothing in this employment application, or any communications with Quality Medical Staffing employees, executives or representatives is intended to create an employee contract between Quality Medical Staffing and I also understand that Quality Medical Staffing has the right to modify its policies without no such promises are guaranteed by Quality Medical Staffing unless made in writing and signed by an authorized representative of Quality Medical Staffing.
I certify that I have read, understand and agree to the above conditions of employment.

Signature: _____ Date: _____
_____/_____/_____

Quality Medical Staffing

ANNUAL PHYSICAL HEALTH CLEARANCE

The physician statement of Health Clearance is a Quality Medical Staffing requirement to be completed on or by the anniversary date to meet standards for employment. The Health Clearance is intended to be a work related statement of my ability to perform without limitations.

PHYSICIANS INFORMATION: (*Physician is to complete this section*)

Physician _____ Print _____ Name: _____

The medical record will show a conducted history and physical on: _____/_____/_____

To the best of my knowledge the individual named below is in good physical and mental health and is free of any communicable diseases. This individual has no apparent health condition that would create a hazard to self or others and is able to function at full capacity without limitations.

Physicians Signature: _____ Date: _____
_____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

EMPLOYEE INFORMATION:

Print Name: _____

TB / PPD Form

PPD Skin Test (required yearly) Date: _____ Results:

Or Chest X-Ray (required yearly) Date: _____ Results:

Quality Medical Staffing

AUTHORIZATION FOR MEDICAL RELEASE

This medical release and the results will be kept confidential, except, for necessary disclosure to authorized representatives of Quality Medical Staffing and its clients, safety and health personnel regarding possible emergency treatment and others as may be authorized by law. This authorization remains valid until cancelled in writing and received by U.S. registered mail.

I understand that this authorization for medical release is work related and supports my ability to function without limitation. Any medical information released by the physician is solely for benefit of Quality Medical Staffing and its clients.

Therefore, I understand that my medical and physical information and its release, has a reasonable relationship to my work for Quality Medical Staffing and its clients. I do hereby authorize you to release any information from my medical record and medical examination which is relevant to my employment with Quality Medical Staffing.

EMPLOYEE INFORMATION:

Print Name: _____

Signature: _____

Social Security: _____

Date: _____

Quality Medical Staffing Reference Check Form

Applicant: Please fill out the top portion of the form with the name and contact information of a professional reference. This must be someone you have worked with or has information regarding your professional skills and work performance.

_____	_____
Date	Applicants Name Print
	Applicant Signature

I, _____, have applied for employment with Quality Medical Staffing and authorize you (my current/former employer) to release my employment and performance information to Quality Medical Staffing and to any of Quality Medical Staffing clients.

_____	_____	_____
Phone Number	Name and Title of Reference	Address, City, St. Zip

_____	_____	_____
Facility	Area Worked	Dates of Employment : from
to		

As a current/former employer, you are most qualified to evaluate the skills and performance of this individual. We would appreciate a prompt and thoughtful response. It will be held in strict confidence. Thank you for your assistance.

Reason this Healthcare Professional left your facility: ___Resigned ___Terminated
___Other Reason

for leaving

Does Not Meet	Exceeds	Meets	Meets Some
Expectations	Expectations	Expectations	Expectations
Clinical Knowledge	_____	_____	_____
Quality of Work	_____	_____	_____
Quality of Documentation	_____	_____	_____
Productivity	_____	_____	_____
Communication Skills	_____	_____	_____
Attendance/Punctuality	_____	_____	_____
Leadership Skills	_____	_____	_____
Customer Services Skills	_____	_____	_____

Would you hire this Healthcare Professional again? _____ Yes _____ No

Comments _____

Reference Provided By
Date

Signature

Please Fax Completed form to: Quality Medical Staffing Fax # (505) 426-8793 Phone # 1-877-426-8793

Quality Medical Staffing Reference Check Form

Applicant: Please fill out the top portion of the form with the name and contact information of a professional reference. This must be someone you have worked with or has information regarding your professional skills and work performance.

Applicants Name Print
Date

Applicant Signature

I, _____, have applied for employment with Quality Medical Staffing and authorize you (my current/former employer) to release my employment and performance information to Quality Medical Staffing and to any of Quality Medical Staffing clients.

Phone Number

Name and Title of Reference

Address, City, St. Zip

Facility
to

Area Worked

Dates of Employment : from

As a current/former employer, you are most qualified to evaluate the skills and performance of this individual. We would appreciate a prompt and thoughtful response. It will be held in strict confidence. Thank you for your assistance.

Reason this Healthcare Professional left your facility: ___Resigned ___Terminated
___Other Reason

for leaving

Does Not Meet	Exceeds	Meets	Meets Some
Expectations	Expectations	Expectations	Expectations
Clinical Knowledge	_____	_____	_____
Quality of Work	_____	_____	_____
Quality of Documentation	_____	_____	_____
Productivity	_____	_____	_____
Communication Skills	_____	_____	_____
Attendance/Punctuality	_____	_____	_____
Leadership Skills	_____	_____	_____
Customer Services Skills	_____	_____	_____

Would you hire this Healthcare Professional again? _____ Yes _____ No

Comments _____

Reference Provided By
Date

Signature

Please Fax Completed form to: Quality Medical Staffing Fax # (505) 426-8793 Phone # 1-877-426-8793

Quality Medical Staffing Payroll Information and Time Sheet Policy

Payroll Options:

- Receive a live payroll check, which will be sent to your address
- Have all of your paycheck automatically deposited into your checking or savings account.
- Receive your check through overnight mail. *There is a \$13.50 charge for all US overnight services.*

All time sheets are due in the office every Monday at 8:00 a.m. Mountain Time. You may fax your timesheets to the payroll department; however it is recommended that you confirm that your timesheet has been received. **Any timesheets that are not received by Monday at 8:00 a.m. will be paid on the following payday.** It is important that you submit your timesheets weekly, as we bill on a weekly basis. **PAYDAY is every Friday.** Quality Medical Staffing, LLC pay period is **Sunday thru Saturday**, paying the following **Friday**.

Time Sheet Instructions
The following is a list of everything that is needed to be completed on your time sheet to be able to be paid accurately and in a timely manner.

- Name
- Facility Worked
- Date
- Unit (Example: ER, ICU, OR,PEDS)
- Time In/Time Out/Total Hours
- Less Meal *(Note: If you do not take a meal break, you must have the shift supervisor initial the less meal space on your timesheet, other wise a .5 break will be deducted from your hours for that shift)
- Mileage/Call Back Hours/OT Hours/On Call Hours/Supervisor Initials
- Your Signature
- Supervisor Signature*(Note You must have your supervisor's signature to be able to have your pay check processed).

No exceptions will be made. *Payroll checks will not be processed if timesheet policy is not followed.*

Signature _____ Date _____

Quality Medical Staffing HIPPA

What does HIPPA stand for?

- Health Insurance Portability Act of 1996 a federal law designed to protect patient's privacy rights regarding personal and health information.

What is considered personal and health information?

- Name
- Address
- Phone Number
- Birth date
- Social Security
- Medical Identification Number

Who is responsible for protecting client's privacy rights?

- Doctor's
- Nurse's
- Receptionists
- Everyone

What are patients rights regarding HIPPA?

Under privacy regulations patients have designated rights to their personal health information, in which doing so requests need to be made in writing by clients. Facility's, agencies then have a specific time frame to respond to this request.

Access to records

- Patients always have the right to request their medical records
- Facilities have 30 days to respond to this request

Restriction to the use and disclosure of information

- Patients can request that their health information be restricted
- Facilities are bound by this request, and the client has the right to terminate this at any time

Incidental Disclosures:

HIPPA does allow for some disclosures for example a client signing in for his appointment; precautions are taken to insure other disclosures do not occur. Some examples are as followed:

- Computer screens positioned to prevent public from viewing
- Computer access requiring a password
- Use of cover sheets to protect confidential information

Confidentiality and HIPPA:

In order to ensure that HIPPA is being used in all aspects of healthcare, we must always remember that what information a client gives is always kept confidential.

Ways to maintain confidentiality:

- When discussing client information make sure the setting is in a private area directed away from other people.
- Never discuss client care with others that care does not pertain to.
- Do not allow unrelated healthcare officials access to clients records

What happens when HIPPA is not enforced?

- Criminal and Civil penalties can be severe which can range from \$100,000 or imprisonments for up to 5years for gaining access to health information under false pretenses

Quality Medical Staffing

HIPPA/OSHA

I _____ understand and acknowledge that as an employee of Quality Medical Staffing I must maintain privacy of my clients and keep information pertaining to my clients confidential. All patient information shall be kept confidential and respected in accordance with the Health Insurance Portability Act of 1996 (HIPPA). I will consult Quality Medical Staffing in the event that I have any questions regarding the scope of privacy policies as described above. I understand that private information pertaining to patient care can only be released when legally required by law. I understand that failure to maintain confidentiality can lead to disciplinary actions, termination, and civil penalties.

Employee printed name:

Date:

Employee signature:

Date:

RN/LPN Job Description

Educational Requirements

Must have graduated from an accredited school of nursing and have a current state license. Must have a minimum of one year experience as an RN or LPN.

Duties and Responsibilities

1. Utilize the nursing process, follow Hospital, Nursing Home, Correctional, etc. policies in order to plan coordinate, implement, and evaluate nursing care of the patient.
2. Document nursing care in a clear, concise manner which reflects the patients status.
3. Initiates and implements an individual nursing care plan for each assigned patient.
4. Delegates task as appropriate to the work setting.
5. Assist staff members as necessary in providing total patient care.
6. Accurately administer and documents all medications given in accordance with physicians orders.
7. Responds to patients emergencies in a safe and appropriately and promptly.
8. Insures that physicians orders are carried out appropriately and promptly.
9. Assesses patients care needs form the beginning of the shift until completion of the shift.
10. Deliveries care to patients that requires the judgment and skills of a registered nurse or licensed practical nurse.
11. Report immediately and accurately all incidents involving medication error and/or patient care error. (This includes documenting incidents appropriately)
12. Promptly recognize and reports any outward changes in a patients condition.
13. Initiates patient education, with family involvement that is pertinent to a patients needs.

- 14. Acts as a resource person and provides emotional support to patient and family.
- 15. Conducts self in a professional manner at all times.
- 16. Delivers nursing care to patients with the scope of practice.

I _____ have read and understand the above job description and agree to comply with it.

Signature

Date