LPN

UMS currently has agreements to provide contract nurses to over fifty medical facilities in Lafayette and the surrounding areas. These facilities require basic information about the nurses who perform services at their facilities. In an effort to provide better services to both the contract nurses and the facilities, UMS has assembled the information required by the various facilities in the enclosed packet.

If you wish to contract your services to any of our facilities, please fill out the enclosed package and return it to our office. We will in turn forward this information to any facility you choose to work with. Please advise our staff of your available shift times and areas or departments of preference.
Thank you for choosing to contract your services through UMS. If you have any questions, please contact our office.

Information Checklist

The following items are contained in the information package:

1. **Contract Nurse Information**
2. **Payment Instruction Form**
3. **W-9 Tax Form**
4. **Agreement for Contract Nursing**
5. **Hepatitis B Form**
6. **Age Specific Criteria Checklist**
7. **Skills Assessment Checklist**
8. **Skills Checklist (ER, ICU, Med/Surg, etc.)**
9. **Consent for Criminal Background Check**
10. **Confidentiality Statement**
11. **HIPPA Privacy Protection**

If you wish to contract your services through United Medical Staffing, Inc., please submit the following:

1. **Driver's license**
2. **Social Security Card**
3. **Current Nursing License**
4. **Current CPR card**
5. **Other certification you may have**
   ****Ex. CPI, NALS, PALS, ACLS, IV certification (LPN)**
6. **Current TB/PPD verification or Recent Chest X-ray**
7. **Proof of Malpractice Insurance (If applicable)**
8. **Proof of Worker's Compensation (If applicable)**
9. **Proof of Hepatitis B series if applicable**
10. **Name tag with name and title**

All medical facilities require a yearly TB skin test, a current nursing license and a current CPR card. Please fax or bring your new Nursing License to UMS each January. Fax updated credentials to 337-769-9069.

Contract Nurse Information

Instructions: This form is a professional document and must be complete, true, and accurate. This information may, upon request, be furnished to those facilities which receive services from a contract nurse. Please fill in all blanks.

Name: ______________________ ______________________ ______________________
Last **First** **Middle**
Address: ____
City/State: ______________________, ______________ **Zip Code**________
Home phone: ______________________
Cellular phone: ______________________
Pager: ______________________
Alternate phone # : ______________________
Email Address: ______________________
Social Security No.______-________-__________
Date of Birth: ______________________
Referred by: ______________________

Please Check One:
Registered Nurse________
Licensed Practical Nurse________
Certified Nursing Assistant________
Other ______________________
Preferred Shifts ____

Work History -- (Beginning with most recent)
Name of Company____
Address____
City/State/Zip____
Phone No.______________________
From______________ **To**______________
Position______________________
Duties____
____

Name of Company____
Address____
City/State/Zip____
Phone No.______________________
From______________ **To**______________
Position______________________
Duties____
____

Name of Company____
Address____
City/State/Zip____
Phone No.______________________________
From______________ **To**_________________
Position________________________________
Duties____
____

Name of Company____
Address____
City/State/Zip____
Phone No.______________________________
From______________ **To**_________________
Position________________________________
Duties____
____

Education:
School name #1: __________________________ **Yr. grad:** ________
City/State: ________________, ____________ **Degree:**__________

School name #2: __________________________ **Yr. grad:** ________
City/State: ________________, ____________ **Degree:**__________

School name #3: __________________________ **Yr. grad:** ________
City/State: ________________, ____________ **Degree:**__________

Other Licensure:
State: ______________ **Lic.#:** ___________ **Expires:** __________

Nursing License Number__________________ **State**______________
Has your nursing license ever been suspended?_____ **If so, explain why.**____
____

Malpractice Ins. Co. ______________________________________
Policy#: ______________________
Exp. date: _____________________

Worker's Compensation Insurance Co. and Policy No. ________________
Exp. Date______________________

Signature and Title: **Date:**

____________________________ __________________

United Medical Staffing, Inc.
Payment Instruction Form

I, the undersigned, do hereby instruct and direct United Medical Staffing, Inc, (UMS) to pay all sums due to me for services rendered as an independent contractor upon my submission of invoice.

I understand that I am an independent contractor and not an employee of UMS and it is my desire that UMS regard the information signed by me on the daily time slip as accurate. However, I do understand that UMS has total authority to verify any time slips before submitting payments.

I understand that I am self-employed and am responsible for filing and paying my own federal, Social Security and F.I.C.A. taxes. I further understand that UMS is not responsible for my tax liability for fees received while sub-contracting my services through UMS.

I authorize UMS to release my check to the following named persons:

1.____________________________________
2.____________________________________
3.____________________________________
4.____________________________________

I understand and agree that this release will remain valid until I notify UMS in writing, either by mail or personally hand deliver to UMS a written statement canceling this release. I further agree that I will hold UMS harmless for the monies due me if misappropriated by the above named individuals.

I would like my check mailed to me. (Initial if applicable)

1.____________

Signature______________________________

Date__________________________________

Form **W-9**
(Rev. October 2004)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as reported on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ .... ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.) | Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number
| | | – | | – | | | |

or

Employer identification number
| | – | | | | | | |

Part II Certification

Under penalties of perjury, I certify that:

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

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

Sign Here | **Signature of U.S. person ▶** | **Date ▶**

Purpose of Form

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

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

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

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

For federal tax purposes you are considered a person if you are:

- an individual who is a citizen or resident of the United States,
- a partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- any estate (other than a foreign estate) or trust. See Regulation section 301.7701-6(a) for additional information.

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

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

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

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

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

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

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

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

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

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

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

Penalties

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

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

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

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

Specific Instructions

Name

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

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

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

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

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

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

Exempt From Backup Withholding

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

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

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

Exempt payees. Backup withholding is not required on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

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

IF the payment is for . . .	**THEN the payment is exempt for . . .**
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients 1 through 7 [2]

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

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

Part I. Taxpayer Identification Number (TIN)

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

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

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

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

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

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

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

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

Part II. Certification

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

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

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

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

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

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

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

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

What Name and Number To Give the Requester

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

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

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

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

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

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

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, or to Federal and state agencies to enforce Federal nontax criminal laws and to combat terrorism. The authority to disclose information to combat terrorism expired on December 31, 2003. Legislation is pending that would reinstate this authority.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

AGREEMENT TO SOLICIT AND PROVIDE NURSING SERVICES

This Agreement outlines the arrangement between ________________________, hereinafter referred to as IC and UNITED MEDICAL STAFFING, INC., hereinafter referred to as UMS. IC and UMS are the only parties to this agreement.

UMS's principal place of business is located at 109 South College Road, Lafayette, Louisiana 70503. IC's principal place of business is located at:

Street Address:____
City/State/Zip:____

In consideration of the terms hereinafter expressed, IC, the undersigned Independent Contractor, hereby contracts with UMS, to solicit professional nursing services on behalf of IC to be rendered by IC. IC hereby agrees to provide professional nursing services as a LICENSED PRACTICAL NURSE to various medical facilities with whom UMS has agreed to provide supplemental staffing services (hereinafter referred to as FACILITY). IC understands that IC is not guaranteed a position with any FACILITY or with UMS for any period of time and that IC will be asked to provide professional nursing services to FACILITY for periodic staffing projects as the needs of the FACILITY dictate and that this is beyond the control of UMS.

IC understands that in providing the services described in this contract that IC is not employed by UMS within the meaning of Louisiana Revised Statutes 23:1472(12)E or Internal Revenue Service Ruling 61-196, page 715 et seq. IC understands that the monies paid to IC are not wages and that this contract is not a contract of hire. IC agrees to provide professional nursing services to the FACILITY at a negotiated rate to be determined by UMS and IC on a case by case basis and that IC will be paid for those services by UMS on a case by case basis. IC understands that IC is not a member of the regular staff of UMS and that IC is not guaranteed a position with any FACILITY or with UMS. The express intention of the parties is that IC is an Independent Contractor and not an employee, agent, joint venture or partner of UMS. Nothing in this Agreement shall be interpreted or construed as creating or establishing the relationship of employee and employer between IC and UMS or any employee or agent of IC or UMS. Both parties acknowledge that IC is not an employee for state or federal tax purposes. IC understands that IC will perform professional nursing services at his or her sole discretion and control as requested by FACILITY.

IC understands and warrants that IC has a professional status and that IC holds himself out to the public and to UMS as capable of exercising an independent calling requiring specialized skills and that IC ordinarily has full discretion in administering IC's professional services and that IC is not under the direction or control of UMS so as to create an employment relationship with UMS. IC further declares that IC has complied with all federal, state and local business permit and licensing requirements necessary to conduct business.

IC understands that the fees for his or her services will be billed directly to the FACILITY by UMS at a rate different from what IC has negotiated with UMS and that IC may not directly bill the FACILITY to receive monies from the FACILITY. IC understands that IC will be paid at IC's discretion, upon submission of a written invoice to UMS.

IC agrees that if IC provides services directly to the FACILITY during the term of this agreement other than as an independent contractor through UMS, IC will be required to pay UMS $1,000.00 in damages. This will apply only to FACILITIES for whom IC's services have been solicited through UMS.

IC represents to UMS and the FACILITY that he/she is duly licensed as a LICENSED PRACTICAL NURSE in the State of Louisiana and that in providing the referenced professional services, IC will be free from any control or direction by UMS in the performance of professional services under this contract. IC further understands, warrants and represents that the referenced professional services will be provided outside of all of the places of business of UMS for which that service is performed and that IC is customarily engaged in the independently established profession as a LPN. IC understands that IC will be under the direction and control of only the FACILITY in need of the services IC will render. IC declares that IC has obtained professional liability insurance for any and all employees or agents of IC and that IC shall make all applicable premium payments, deductibles, and renewal payments for such policies of IC. IC also declares that IC has obtained

workers' compensation for IC and any and all employees or agents of IC. IC agrees to hold harmless and indemnify UMS for any and all claims arising out of any injury, disability, or death of IC or any employees or agents of IC. IC understands that the insurance contract and other information IC provides to UMS may be disclosed to any FACILITY desiring to utilize IC's professional nursing services. IC understands that UMS shall not obtain or pay for any insurance on behalf of IC.

IC reserves the sole right to control or direct the manner in which services are to be performed. IC shall retain the right to perform similar services for other entities during the term of this Agreement.

IC shall perform the services required by this Agreement at any place or location and at any time as IC deems necessary and appropriate. IC shall be responsible for all costs and expense incidental to the performance of services contracted through UMS, including without limitation, all costs of fees, fines, licenses or taxes required of or imposed against IC and all other IC's costs of doing business. UMS shall not be responsible for any expenses incurred by IC in performing services contracted through UMS.

IC, may at its own expense, hire assistants or substitutes to perform services with or on behalf of IC subject to acceptance of assistants or substitutes by the FACILITY. All such assistants shall be employees and/or subcontractors of IC and not of UMS. IC assumes full responsibility for assistants, including but not limited to all applicable state and federal taxes, unemployment insurance, social security, workers' compensation and other applicable taxes or withholdings.

IC further understands and agrees that as an independent contractor, IC will be responsible for all city, parish, state, federal, FICA, unemployment, professional and other taxes or fees which may accrue or become due as a result of any professional fees earned by IC through professional services rendered by IC pursuant to this contract. IC agrees to hold UMS completely harmless for the payment of the aforesaid taxes or fees and to fully indemnify UMS for any sums including all taxes, fees, costs, attorney fees (expended by UMS) and penalties (incurred by UMS) should IC not pay the aforesaid taxes or fees for any reason and/or any agency seeks to collect from UMS any taxes or fees due by IC. IC understands that IC will be responsible for filing a quarterly tax return and to pay on a quarterly basis all federal and state taxes due as a result of the fees which IC receives and that the taxes are due monthly and the tax returns are due on April 30, July 31, October 31, and January 31 of each year.

The term of this agreement shall be for a period of 1year from the date specified below.

This agreement signed in Lafayette, Lafayette Parish, Louisiana this _____ day of ________________________, 20___.

Accepted By:

UNITED MEDICAL STAFFING, INC.

____
Authorized Agent

____
Independent Contractor

Hepatitis B Vaccine Verification

I understand that due to my occupational exposure to blood and other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine from a physician or other facility of my choice and at my own expense. If I have already received the Hepatitis B vaccine or receive the vaccine in the future, I agree to provide the written documentation to verify the same to UMS if I will continue to contract my services through UMS as an independent contractor.

I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series from a physician or other facility of my choice and at my own expense.

With my <u>**signature**</u> in the appropriate space below, I hereby agree that I decline the Hepatitis B vaccine or have or will provide the written documentation to verify that I have received the Hepatitis B vaccination series.

I decline the Hepatitis B vaccine. ______________________________

I have received the Hepatitis B vaccine. ______________________________

I will provide verification of the Hepatitis B vaccine. ________________

I will take the Hepatitis B vaccine and provide that info to UMS. ________

____

Date ____________________

AGE SPECIFIC CRITERIA CHECKLIST

Please check all applicable areas: **Check all age groups that you have experience working with or N/A if no experience.**

	Neo-Natal			Peds			Adoles-cence			Adult			*Geriatrics*		
	N	Y	N/A	N	Y	N/A	N	Y	N/A	N	Y	N/A	N	Y	N/A
Knowledge of human growth and development															
Ability to assess age specific data:															
Possesses skills/ knowledge to Perform treatments (IE: meds, equipment, etc.)															
Ability to interpret age specific data:															
Ability to interpret age Specific response to treatment															
Ability to involve family or significant other in decision-Making related to plan of care:															

Independent Contractor's Signature: **Date:**

LPN Skills Assessment Checklist

Name: ______________________________ **Date:** ______________

Certifications (List): ______________________________

____

Experience:
(List areas and time spent there) ______________________________

____

Skills List: (Check if you are experienced in the following areas)

Psych Exp.___
PICU/NICU Exp.___
Rec. Room Exp.___
Pediatric Exp.___
Oncology Exp.___
Ortho/Neuro Exp.___
ER Exp.___
Rehab Exp.___
ICU Exp. ___
Labor & Delivery Exp.___
OB/GYN Exp.___
Cardiac Exp.___
Dialysis Exp.___
Nursing Home Exp.___

Assist with Blood Admin.___
Assist with TPN Admin.___
Ostomy Care___
Wound Care___
Decubiti Care___
Foley Care___
Insertion of Foley___
IV Certified___
Admin. Meds via Peg___
PEG Tube Feedings___
Use of Walker/WC___
Knowledge of WNL lab values___
Chest Tube Monitoring___

Dsg. Changes___
Stump Care___
Oxygen Care___
Trach Care___
Read Tele. Strips___
ROM___
Neuro Checks___
Vent Pts.___
Venipuncture___
Assessment of Pts.___
Gait training___
Fetal Monitoring___
Accuchecks___

List any other skills: ______________________________

____

____

Signature______________________________ **Date**______________________

MEDICAL/SURGICAL CLINICAL SKILLS EVALUATION - SELF ASSESSMENT

Date________________________________

Name________________________________

Signature____________________________

Level Of Proficiency

A = Never Performed. You have never performed the stated task and have no experience with this type of skill.

B = Familiar with. You are familiar with the stated task; but you would need more experience and practice to feel comfortable and proficient in this type of skill.

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Please select the column that most accurately describes your proficiency level...

SKILL	A	B	C	D
CARE OF PATIENTS:				
Patient Controlled Analgesia (PCA)				
Colostomy				
Ileostomy				
Aneurysms				
Isolation				
Femoral-popliteal bypass				
Thoracic surgery				
Carotid endarterectomy				
CVA				
Spinal cord injury				
Craniotomy				
DT's				
Overdose				
Burns				
GI bleeding				
AIDS				
ARDS				
Near Drowning				
CARDIOVASCULAR:				
Heart sounds				
Blood Pressure Interpretation				
12-Lead EKG				
Basic arrhythmia interpretation				
Lead placement				
Doppler				
Heart sounds / murmurs				
Pulses / circulation checks				
Pacemaker				

SKILL	A	B	C	D
ASSESSMENT:				
Cardiovascular				
Respiratory				
GI				
GU				
Nutritional status				
Mental status				
Muscoskeletal				
Neurological				
Integumentary				
Pain				
Psychosocial status				
Wound care				
Lab values				
Vital signs				
Effects / side effects medication				
Drug / drug interactions				
Drug / food interactions				
ENDOCRINE:				
Preparation of Insulin				
Administration of Insulin				
Site rotation for injection				
Signs and symptoms of hypo/hyperglycemia				
Urine testing				
Blood testing				
Foot and skin care				
Exercise/activity/rest				
Sick day routine				
Care of patient with Addison's disease				

MEDICAL/SURGICAL SKILLS EVALUATION - SELF ASSESSMENT

SKILL	A	B	C	D	SKILL	A	B	C	D
ENDOCRINE (CONTINUED)					**GI (CONTINUED)**				
Disorders of the pituitary gland					Jackson Pratt				
Grave's disease					Hemovac				
Hypothyroidism					**RENAL/GU:**				
Thyroidectomy					Foley catheter insertion				
PULMONARY					Foley catheter removal				
Apnea monitor					Foley catheter irrigation				
Oralpharyngeal suction					3-Way foley catheter				
Nasotracheal suction					3-Way foley catheter removal				
Tracheostomy Care					Suprapubic tube insertion				
Tracheostomy Suctioning					Suprapubic tube removal				
Airway management					Suprapubic catheter irrigation				
Sputum specimen collection					Nephrostomy tube irrigation				
Chest physiotherapy					Peritoneal dialysis				
Incentive Spirometry					Condom catheter				
Oxygen therapy					Bladder training				
Oximetry					Specimen collection				
Care of the patient on a ventilator					Renal transplant				
Care of the patient with a chest tube					TURP				
Use of inhaler					Urinary diversion / ileal conduit nephrostomy				
Use of Pulmonaide					**NEUROLOGICAL:**				
Postural drainage and percussion					Pain control measures				
Assist with endotracheal intubation					Neuro checks				
Breathing exercises					TENS				
GI:					Assist with lumbar puncture				
NG insertion/removal					Use of hyper/hypothermia blanket				
Nasogastric suction					Aneurysm precautions				
T-tube					Basal skull fracture				
Gastrostomy					Closed head injury				
Jejunostomy					Coma				
Irrigation					CVA				
Administration of tube feeding					DT's				
Salem sump to suction					Encephalitis				
Manual disimpaction					Externalized VP shunts				
Digital rectal exam					Meningitis				
Care of ostomy					Post Craniotomy				

MEDICAL/SURGICAL CLINICAL SKILLS EVALUATION - SELF ASSESSMENT

SKILL	A	B	C	D
WOUND CARE:				
Wet to dry dressing				
Packing				
Debridement				
Sterile dressing changes				
Burns				
Pressure sores				
Staging decubitus ulcers				
Surgical wounds with drain(s)				
Irrigation				
Occlusive dressing				
INFECTIOUS DISEASES:				
Interpretation of lab results: blood count				
Care of the patient with AIDS				
Care of the patient with Hepatitis				
Fever Management				
Isolation				
Universal Precautions				
Blood Borne Pathogen				
Disposal of Hazardous Waste				
Particulate Respirators				
IV THERAPY:				
Administration of blood				
Packed red blood cells				
Whole blood				
Plasma				
Cryoprecipitate				
Drawing blood from central line				
Drawing venous blood				
Starting IV's				
Peripheral line				
Central line dressing				

SKILL	A	B	C	D
IV THERAPY (CONTINUED)				
Broviac				
Groshong				
Hickman				
Portacath				
Quinton				
Heparin lock				
ONCOLOGY				
Pain control				
Nutritional status				
Reverse isolation				
Bone marrow transplant				
Inpatient chemotherapy				
Inpatient hospice				
Leukemia				
PAIN MANAGEMENT:				
Care of patient with Epidural anesthesia				
IV conscious sedation				
Narcotic analgesia				
Patient controlled analgesia				
Patient teaching				
Family teaching				

SPECIALITY EXPERIENCE:

- ☐ Medical ____ years
- ☐ Surgical ____ years
- ☐ OB/GYN ____ years
- ☐ Orthopedics ____ years
- ☐ Telemetry ____ years
- ☐ Neurology ____ years
- ☐ Oncology ____ years
- ☐ Transplant ____ years
- ☐ Rehabilitation ____ years
- ☐ HIV ____ years
- ☐ Other ____________

I HAVE EXPERIENCE WITH:

- ☐ Computerized charting systems
- ☐ Medication administration system

CRITICAL CARE / ICU/ TELEMETRY CLINICAL SKILLS EVALUATION - SELF ASSESSMENT

Date________________________________

Name________________________________

Signature____________________________

Please select the column that most accurately describes your proficiency level...

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SKILL	A	B	C	D
CARE OF PATIENT WITH:				
Acute MI				
Cardiopulmonary Arrest				
Angina				
Chest trauma				
Stab Wounds				
Closed chest trauma				
CHF				
Cardiogenic shock				
Cardiac Tamponade				
Pre and post open heart surgery				
Pre and post cardiac transplant				
Triple A repair				
Endarterectomy				
Post op vascular surgery				
Valve replacement				
Acute head trauma				
Subarachnoid hemorrhage				
Subdural hematoma				
Drug overdose				
Alcohol overdose				
Seizures/status epilepticus				
Degenerative neurologic disease				
Airway obstruction				
TB				
Asthma				
Respiratory failure				
Chest trauma				
Pulmonary edema				

SKILL	A	B	C	D
CARE OF PATIENT WITH: (CONTINUED)				
ARDS				
Pulmonary embolus				
Lung transplant				
Abdominal trauma				
Gunshot wounds				
Acute liver failure				
Subtotal gastrectomy				
Cancer				
AIDS				
Diabetes				
Burns				
Epidural anesthesia/analgesia				
IV conscious sedation				
Patient controlled analgesia				
Narcotic administration				
CARDIOVASCULAR:				
Abnormal heart sounds/murmurs				
Doppler				
Pulses / circulation checks				
Interpretation of cardiac enzymes				
Interpretation of coagulation studies				
Assist with central line insertion				
Assist with arterial line insertion				
Assist with PA catheter / Swan-Ganz				
Assist with pericardiocentesis				
Cardioversion				
Hemodynamic Monitoring:				
Cardiac output				

CRITICAL CARE/ ICU TELEMETRYCLINICAL SKILLS EVALUATION - SELF ASSESSMENT

SKILL	A	B	C	D
CARDIOVASCULAR (CONTINUED)				
Hemodynamic monitoring (continued)				
CVP monitoring				
MAP				
PA/ Swan-Ganz				
PCW pressure				
Radial a-line				
Intra Aortic balloon pump				
12 lead EKG interpretation				
Arrhythmia interpretation				
Lead-placement				
Rhythm strip assessment				
External Pacemaker				
Permanent pacemaker				
Temporary pacemaker				
Transthoracic pacemaker (epicardial)				
Ventricular assist device				
Pre / post cardiac cath				
Pre / post angioplasty				
CARDIOVASCULAR MEDICATIONS:				
Cardarone				
Atropine				
Bicarbonate				
Digoxin				
Bretylol				
Cardizem				
Dobutamine				
Epinephrine				
Esmolol				
Inocor				
Lidocaine				
Lopressor				
Nipride				
Procainamide				
Retavase				
Streptokinase				

SKILL	A	B	C	D
CARDIOVASCULAR MEDICATION (CONTINUED)				
TPA				
Verapamil				
PULMONARY:				
Breath sounds				
Sputum collection				
Respiratory isolation				
Nasotracheal suctioning				
Endotracheal suctioning				
Obtaining ABG's				
Pleural tubes				
Trach care				
Ventilator settings / complications				
IMV				
SIMV				
PEEP				
Pressure support				
CPAP				
Weaning modes and T-piece weaning				
Bipap mask				
100% NRB				
Use of Ambu bag				
Pulse oximeter				
Oxygen therapy				
ET tube				
Face mask				
Nasal cannula				
Portable oxygen tank				
Trach collar				
Aspiration				
Laryngospasm				
Tension Pneumothorax				
PULMONARY MEDICATIONS:				
Theophylline				
Alupent				
Ventolin				

CRITICAL CARE/ ICU/ TELEMETRY CLINICAL SKILLS EVALUATION - SELF ASSESSMENT

SKILL	A	B	C	D
NEURO:				
Lumbar Puncture				
Glasgow coma scale				
Neuro/cranial assessment				
ICP/ventriculostomy insertion- monitoring				
Application of halo traction				
Stryker frame				
Epidural administration				
Intracranial pressure monitoring				
Nerve stimulators				
Rotating bed				
Pathologic reflexes				
Reflex/motor deficits				
Visual or communication deficits				
NEURO MEDICATIONS:				
Barbiturate induced coma				
Decadron				
Dilantin				
Phenobarbital				
Mannitol				
Valium				
Ativan				
TPA				
GI:				
Bowel Sounds				
Abdominal palpation				
NG insertion/removal/medication instillation				
Pericentesis				
Gastrostomy				
Jejunostomy				
Balloon tamponade				
Interpretation of serum ammonia				
Interpretation of serum amylase				
LFT's				
GI MEDICATIONS:				
AquaMephyton				
H2 blockers				
Ipecac				
Antiemetics				

SKILL	A	B	C	D
RENAL/GU				
Insertion/care/removal of foley catheter				
Continuous bladder irrigation				
Care of suprapubic catheter				
Electrolyte fluid balance				
Hemodialysis				
Peritoneal dialysis				
AV fistula/shunt				
Interpretation of BUN and creatine				
Interpretation of serum electrolytes				
ENDOCRINOLOGY				
Interpret lab results				
Bair hugger warming blanket				
Interpretation of blood glucose				
Interpretation of thyroid studies				
Medication - Insulin drip				
PHLEBOTOMY/IV THERAPY:				
Cryoprecipitate				
Packed red blood cells				
Plasma / albumin				
Whole blood				
Drawing blood from central line				
Drawing venous blood				
Starting IV's				
Care of patient with central line				
Care of patient with Broviac				
Groshong				
Hickman				
Portacath				
Quinton				
Epidural anesthesia/analgesia				
IV conscious sedation				
Patient controlled analgesia				
MISCELLANEOUS:				
Anaphylactic shock				
DIC				
Hypovolemic shock				
Septic shock				
Organ/tissue donation				

EMERGENCY ROOM CLINICAL SKILLS EVALUATION - SELF ASSESSMENT

Date________________________________

Name________________________________

Signature____________________________

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Please select the column that most accurately describes your proficiency level...

SKILL	A	B	C	D	SKILL	A	B	C	D
CARE OF PATIENT WITH:					**CARE OF PATIENT WITH: (CONTINUED)**				
Acute MI					Immobilizer				
Aneurysm					Casts				
Angina					GI bleed				
Cardiac arrest					Abdominal trauma				
CHF					Bowel obstruction				
Myocarditis					Hepatitis				
Aspiration					Hepatic failure				
COPD					Renal failure				
Hemopneumothorax					UTI				
Laryngospasm					Diabetic ketoacidosis				
Pneumonia					Diabetic coma				
Pneumothorax					Hyperthryoidism				
Pulmonary edema					Hypothyroidism				
Pulmonary emboli					Hypothermia				
Tension pneumothorax					Hypothermia				
Skull fracture					Penetrating eye injury				
Closed head injury					Chemical exposure				
CVA					Nose bleed				
DTs					**TRAUMA CARE:**				
Overdose					Anaphylactic shock				
Encephalitis					Cardiogenic shock				
Meningitis					Hypovolemic shock				
Neuromuscular disease					Neurogenic shock				
Seizures					Septic shock				
Asthma					Human bites				
Spinal cord injuries					Animal bites				
Open fractures					Venomous bites				
Closed fractures					First degree burns				

EMERGENCY ROOM SKILLS EVALUATION - SELF ASSESSMENT

SKILL	A	B	C	D
TRAUMA CARE: (CONTINUED)				
Second degree burn				
Third degree burn				
Electrocution				
Gunshot wounds				
Stab wounds				
Hazardous material exposure				
Traumatic amputation				
Poison ingestion				
Assessment and Procedures				
Trauma Center Experience				
Level I				
Level II				
Level III				
Application of MAST suit				
Champion Trauma score				
Poison index				
Glasgow coma scale				
Burn rule of nines				
PEDIATRICS:				
Poison ingestion / overdose				
Near drowning				
Suspected abuse				
Status asthmaticus				
Epilepsy				
WOMEN'S HEALTH:				
Precipitous delivery				
Spontaneous abortion				
Preeclampsia				
Eclampsia				
Premature labor				
DIC				
Rape victims				
PSYCHIATRIC:				
Drug Overdose				
Alcohol Overdose				

SKILL	A	B	C	D
PSYCHIATRIC (CONTINUTED)				
DT's				
Dual diagnosis				
Suicide precautions				
Crisis Intervention				
Restraints				
AMA procedures				
72 hour hold procedures				
CARDIOVASCULAR:				
Auscultation				
Doppler				
Heart sounds / murmurs				
Basic 12 lead interpretation				
Basic arrhythmia interpretation				
Assist with insertion of Arterial line				
CVL				
PA catheter / Swan-Ganz				
Pacemaker				
Cardioversion				
PULMONARY:				
Breath sounds				
Interpretation of arterial blood gases				
Endotracheal tube suctioning				
Nasal airway suctioning				
Oropharyngeal suctioning				
Sputum specimen collection				
Assist with intubation				
Assist with extubation				
Assist with thoracentesis				
Pulse oximetry				
NEUROLOGICAL:				
Glasgow coma scale				
Reflex/motor deficits				
Visual or communication deficits				
Assist with lumbar puncture				
Increased ICP management				

EMERGENCY ROOM CLINICAL SKILLS EVALUATION - SELF ASSESSMENT

SKILL	A	B	C	D
NEUROLOGICAL:				
Intracranial pressure monitoring				
ORTHOPEDICS:				
Circulation checks				
Gait				
Range of motion				
Assist with placement of cast				
Use of support devices (cane, sling, etc.)				
GI:				
Abdominal / bowel sounds				
Fluid balance				
Nutritional status				
Interpretation of blood chemistry				
Placement of nasogastric tubes				
Salem sump to suction				
Saline lavage				
RENAL / GU:				
Assess fluid balance				
Interpretation of BUN and creatinine				
Insertion of straight and indwelling catheter				
Urine specimen collection				
Interpretation of electrolytes				

SKILL	A	B	C	D
ENDOCRINOLOGY:				
Signs and symptoms of diabetic coma				
Signs and symptoms of insulin reaction				
Blood glucose monitoring				
MEDICATIONS:				
Adenocard				
Adrenalin				
Lanoxin				
Cardizem				
Dobutamine				
Dopamine				
Esmolol				
Lasix				
Nitroglycerin				
Nitroprusside				
Aminophylline				
Bronkosol				
Epinephrine				
Isuprel				
Steroids				
Terbutaline				
Decadron				
Dilantin				
Mannitol				
Phenobarbital				
Solu-Medrol				
Antiemetics				
Antispasmodic				
Ipecac				
Insulin				
Administration of blood and blood products				
IV THERAPY:				
Central line/catheter/dressing				
Broviac				
Groshong				
PICC				

PEDIATRIC CLINICAL SKILLS EVALUATION - SELF ASSESSMENT

Date________________________________

Name________________________________

Signature____________________________

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Please select the column that most accurately describes your proficiency level...

SKILL	A	B	C	D	SKILL	A	B	C	D
CARE OF THE CHILD WITH:					**CARE OF THE CHILD WITH: (CONTINUED)**				
Bacterial endocarditis					Failure to thrive				
Cardiomyopathy					Intestinal parasites				
Congenital heart defects					Ileostomy				
CHF					Pyloric stenosis				
Myocarditis					Ulcerative colitis				
Pericarditis					Circumcision				
Post cardiac cath					Glomerularnephritis				
Post cardiac surgery					Hemodialysis				
Rheumatic fever					Hypospadias				
Asthma					Ileal conduit ureteral				
RSV					Infantile polycystic disease				
BPD					Kidney transplant				
Cystic fibrosis					Peritoneal dialysis				
LTB					Renal failure				
Pertussis					UTI				
Pneumonia					Wilms tumor				
Tonsillitis					Cushing's syndrome				
TB					Juvenile diabetes				
Battered child syndrome					Thyroid malfunction				
Closed head trauma					Anemia				
Encephalitis					Bone marrow transplant				
Multiple sclerosis					DIC				
Near drowning					Hemophilia				
Osteogenic sarcoma					Hodgkin's disease				
Osteomyelitis					Leukemia				
Spinal Cord injury					Sickle cell anemia				
Anal fissure					AIDS				
Cleft lip/palate					CMV				

PEDIATRIC SKILLS EVALUATION - SELF ASSESSMENT

SKILL	A	B	C	D
CARDIOVASCULAR:				
Interpretation of blood gases				
Interpretation of hemoglobin/hematocrit				
Basic EKG interpretation				
Non-invasive cardiac monitoring				
Heart sounds / murmurs				
Perfusion				
PULMONARY:				
Breath sounds				
Bulb syringe for suctioning				
Nasal suctioning				
Oral suctioning				
Tracheostomy suctioning				
Apnea monitor				
Chest physiotherapy				
Chest tubes				
Oximeter				
Oxygen delivery- face mask				
Hood				
Isolette				
Nasal cannula				
Tent				
Trach collar				
Water seal drainage system				
NEURO/ORTHOPEDICS:				
Assess level consciousness				
Application of splints				
Assist with lumbar puncture				
Cast				
Pinned fractures				
Traction				
GI:				
Abdominal assessment				
Nutritional assessment				
Interpretation of serum electrolytes				
Bottle feeding				

SKILL	A	B	C	D
GI: (CONTINUED)				
Gavage				
Peripheral hyperalimentation				
Gastrostomy				
Jejunal feeding				
NG tubes				
Penrose drains				
Placement of naso/orogastric tube				
RENAL/GU:				
Assessment of fluid balance				
Interpretation of BUN and creatinine				
Urinalysis				
Assist with suprapubic tap				
Catheter insertion				
ENDOCRINOLOGY:				
Interpretation of blood glucose				
Interpretation of thyroid studies				
Blood glucose testing				
HEMATOLOGY / ONCOLOGY:				
Assessment of nutritional status				
Interpretation of lab results				
Reverse isolation				
Chemotherapy				
PHLEBOTOMY / IV THERAPY:				
Cryoprecipitate				
Packed red blood cells				
Whole blood				
Drawing blood from central line				
Drawing venous blood				
Starting IV's				
Central line				
Broviac				
Groshong				
Hickman				
Portacath				
Quinton				

PEDIATRIC CLINICAL SKILLS EVALUATION - SELF ASSESSMENT

SKILL	A	B	C	D
WOUND MANAGEMENT:				
Assess skin for breakdown				
Stasis ulcers				
Surgical wound healing				
Burns				
Pressure sores				
Staging decubitus ulcers				
Sterile dressing				
Traumatic wound care				
Use of air fluidized low airloss beds				
Wound irrigation				
MEDICATIONS:				
Alupent				
Theophylline				
Isuprel				
Ventolin				
Clonopin				
Corticosteroids				
Dilantin				
Phenobarbital				
Tegretol				
Valium				

SKILL	A	B	C	D
MEDICATIONS: (CONTINUED)				
Growth hormone				
Insulin				
Thyroid				
Prednisone				
Chemotherapy				
Immunizations				
MISCELLANEOUS:				
Normal growth and development				
Normal laboratory values				
Recognize signs and symptoms of abuse/neglect				
Anorexia				
Bulimia				
ENT surgery				
Eye surgery				
Ingestion of foreign body				
Ingestion of poison or toxin				
Plastic surgery				
Suicidal threats / actions				

My pediatric experience is primarily in:
☐**Medical** ☐**Surgical** ☐**Orthopedics** ☐**Oncology**
☐**Neurology** ☐**Rehabilitation** ☐**Other**________________

NICU/PICU CLINICAL SKILLS EVALUATION - SELF ASSESSMENT

Date______________________________

Name______________________________

Signature_________________________

Level Of Proficiency

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Please select the column that most accurately describes your proficiency level...

SKILL	A	B	C	D	SKILL	A	B	C	D
CARE OF PATIENTS:					**CARE OF PATIENTS:**				
Premature Infant					Low Apgar Scores				
Post-mature Infant					Low Birth Weight				
Birth Injuries					Small for Gestational Age				
Soft Tissue Injury					Large for Gestational Age				
Head Trauma					Apnea of Prematurity				
Intracranial hemorrhage					Seizures				
Perinatal Hypoxic-Ischemic Brain injury					Sepsis				
Fractures					Meconium Aspiration				
Paralysis					Persistent Patent Ductus Arteriosis				
Dermatologic Problems					Persistent Pulmonary Hypertension				
Candidiasis					Retinopathy of Prematurity				
Erythema Toxicum Neonatorum					Narcotic-Addicted Infant				
Bullous Impetigo					Fetal Alcohol Syndrome				
Cancer					Spina Bifida				
Anemia					Hydrocephalus				
Hyperbilirubinemia					Skeletal Defects				
Hypocalcemia					Acquired Infections From Mother				
Hyperglycemia					AIDS				
Hypoglycemia					Chickenpox				
Hemolytic Disease					Chlamydia				
Hemorrhagic Disease					Gonococcal Disease				
Phenylketonuria (PKU)					Hepatitis B				
Hepatic Phototherapy					Herpes				
Galactosemia					Listeriosis				
Congential Hypothyroidism					Lyme Disease				
Down's Syndrome					Rubella				
RDS					Syphilis				
Bronchopulmonary Dysplasia (BPD)					Toxoplasmosis				

NICU/PICU CLINICAL SKILLS EVALUATION - SELF ASSESSMENT

SKILL	A	B	C	D
ASSESSMENT:				
Cardiovascular				
Respiratory				
GI				
GU				
Musculoskeletal				
Neurological				
Neurological Reflexes				
Integumentary				
Lab Values				
Vital Signs				
E/SE Medication				
Drug/Drug Interactions				
CARDIOVASCULAR:				
Heart Sounds				
BP Interpretation				
EKG				
Cardiac Catheterization				
Shunt				
ENDOCRINE:				
Preparation of Insulin				
Administration of Insulin				
Urine Testing				
Blood Testing				
PULMONARY:				
Apnea Monitor				
Oralpharyngeal Suctioning				
Nasotracheal Suctioning				
Tracheostomy Tube Cannula Change				
Trach Cleaning				
Trach Suctioning				
Stoma Care				
Oxygen/Oxygen Equipment				
Postural Drainage & Percussion				
Chest Tubes				
Pulmonary Toilet (CPT)				

SKILL	A	B	C	D
PULMONARY (cont...):				
Use of Pulmonaide				
Use of Inhalers				
Use of Aerosolized Medication				
Hemovac				
Ventilators				
IMV/SIMV				
PEEP				
CPAP				
CPR				
Establish Airway				
ET Intubation/Extubation				
GI:				
NG Insertion/Removal				
Nasogastric Suction				
T-Tube				
Gastrostomy				
Jejunostomy				
Irrigation				
Checking Tube Placement				
Feeding Preparation				
Feeding Administration				
Manual Disimpaction				
Digital Rectal Exam				
Ostomy Irrigation				
Periostomal Skin Care				
Application of Appliance				
Care of Ostomy Eq./Supplies				
Jackson Pratt				
Hemovac				
RENAL/GU:				
Foley Catheter Insertion				
Foley Catheter Removal				
Foley Catheter Irrigation				
3-Way Foley Catheter Removal				
3-Way Foley Catheter Irrigation				

NICU/PICU CLINICAL SKILLS EVALUATION - SELF ASSESSMENT

SKILL	A	B	C	D
RENAL/GU (Cont.):				
Suprapubic Tube Insertion				
Suprapubic Tube Removal				
Suprapubic Catheter Irrigation				
Nephrostomy Tube Irrigation				
Peritoneal Dialysis				
Condom Catheter				
Bladder Training				
NEUROLOGICAL:				
Assess Neurological Status				
Intracranial pressure monitoring				
Externalized VP shunt/reservoirs				
Spinal Cord Injury				
Status Epilepticus				
INJECTIONS/WITHDRAWAL:				
IM Injection				
SQ Injection				
ID Injection				
Venipuncture				
INFECTION CONTROL:				
Universal Precautions				
TB Precautions				
Blood Borne Pathogens				
Disposal of Hazardous Waste				
Particulate Respirations				
Venipuncture				
MEDICATION:				
Dobutrex (Dobutamine)				
Intropin (Dopamine)				
Adrenalin (Epinephrine)				
Nitroprusside (Nipride)				
Tridil (Nitroglycerine)				
Sodium bicarbonate				
Anticonvulsant				
Chemotherapy				
Administration of blood / blood products				
Immunizations				

SKILL	A	B	C	D
SAFETY MEASURES:				
Aspiration Precautions				
Remove Environmental Barriers				
Oxygen Precautions				
Evacuation Plans				
Bleeding Precautions				
Seizure Precautions				
PHLEBOTOMY/IV THERAPY:				
Care of child or neonate with Central Line				
Broviac				
Groshong				
Hickman				
Portacath				
Quinton				
PICC				
Umbilical artery line				
Umbilical venous line				
Percutaneous arterial line				
Percutaneous venous line				
MISCELLANEOUS:				
Apgar Scoring				
Gestational age				
Ballard				
Dubowitz				
Bereavement / postmortem care				
Preparation for transport / transfer				
Screen for hearing loss				
Blunt trauma				
Craniofacial reconstruction				
Gun shot / open chest				
Kawasaki disease				
Near drowning				
Penetrating trauma				
Ingestion / overdose				

MY PRIMARY EXPERIENCE IS IN:

☐ Pediatric Intensive Care ☐ Pediatric Stepdown ☐ General Pediatrics

☐ Level I Nursery/NICU ☐ Level II Nursery/NICU ☐ Level III Nur/NICU

POSTPARTUM/ NURSERY CLINICAL SKILLS EVALUATION - SELF ASSESSMENT

Date________________________________

Name________________________________

Signature____________________________

Level Of Proficiency

A = Never Performed. You have never performed the stated task and have no experience with this type of skill.

B = Familiar with. You are familiar with the stated task; but you would need more experience and practice to feel comfortable and proficient in this type of skill.

C = Experienced in. You have performed this task several times; you feel moderately comfortable functioning independently, but you would require a resource person to be nearby.

Please select the column that most accurately describes your proficiency level...

D = Expert. You have a performed this task frequently; you feel comfortable and proficient in this skill; you would not require supervision or practice.

SKILL	A	B	C	D		SKILL	A	B	C	D
INTERVENTIONS/ASSESSMENT:						**CARE OF THE PATIENT WITH:**				
Bladder distention						Asthma				
Breast engorgement						Cardiac disease				
DVT						Diabetes				
Episiotomy						Substance abuse				
Fluid balance						Infectious disease				
Fundal height						Multiple births				
Lochia amount						Tubal ligation				
Vital signs						Preeclampsia				
Perineal hematoma						**MEDICATIONS:**				
Hemorrhoids						Antibiotics				
Interpretation of lab results						Oxytocin infusion				
Contraceptive counseling						Rhogam administration				
Insertion of catheter (foley or straight)						Administration of blood/blood products				
Post C-section care						Drawing blood from central line				
Post anesthesia care:						Drawing venous blood				
Epidural						Starting IV's				
General						Care of the patient with central line				
Local						Care of the patient with peripheral line				
Spinal						Assessment of pain level and tolerance				
Teach and assist with:						Care of patient with epidural				
Breastfeeding / parent education						IV conscious sedation				
Latch-on procedures						PCA				
Positioning										
Use of electric breast pump										
Use of manual breast pump										
Formula preparation and feeding										
Infant care restraint										
Infant caretaking skills										

POSTPARTUM/ NURSERY CLINICAL SKILLS EVALUATION - SELF ASSESSMENT

SKILL	A	B	C	D
NORMAL NEONATAL CARE				
Ballard scale				
Circumference				
Dubowitz scale				
Length				
Neonatal jaundice				
Reflexes				
Vital signs				
Weight				
Administer injections to neonate				
Assist with circumcision				
Assess post op circumcision				
Teach circumcision care to patients				

SKILL	A	B	C	D
NORMAL NEONATAL CARE (CONTINUED)				
Bathe infant				
Culture suspect infectious neonate				
Incubator/Isolettes				
Infant identification				
Monitor bladder and bowel patterns				
Neonate cardiopulmonary resuscitation				
Phototherapy				
Thermal-neutral environment to prevent stress				

Consent for Criminal Background Check

I hereby authorize AccuScreen Systems through Larry Bruce Childers and/or Darin N. Morgan, authorized agent under Title 40 R.S. 1300.51 to perform a criminal background check and/or a State Police records check. I hereby hold harmless AccuScreen Systems, Larry Bruce Childers, and Darin N. Morgan from any cause of action that may arise from inaccurate information contained in State Police records. I also understand any adverse information contained within the files of State police and release to the authorized agency will be provided to me upon written request within ten (10) business days of receiving notice that a record exists. FAX this form to:(225) 383-6445 or (225) 343-9237

Signature: ____________________________ **Date:** ________________

To ensure an accurate and timely search, PLEASE PRINT clearly and complete this form entirely.

PRINT Complete Name: ________________________________

Date of Birth: __________ **Race:** _________ **Sex:** _______

SSN: ___________________ **Driver's Lic.#:** _______________ **State Issued:**_____

Street Address: ____

City, State, Zip: ____

If you have lived in any state other than Louisiana in the LAST 7 YEARS ONLY, complete the following:

City, State, Zip____
Country/Parish_____________________ Mo./Yr.____________________
All last names YOU used while living here_________________________
____

City, State, Zip____
Country/Parish_____________________ Mo./Yr.____________________
All last names YOU used while living here_________________________
____

City, State, Zip____
Country/Parish_____________________ Mo./Yr.____________________
All last names YOU used while living here_________________________
____

Professional License or Education Verification

Prof. Lic./ Degree Earned_____________________ License Number_______________
State/ institution Issuing License/ Degree_______________ Date Issued___________

Additional Comments:____

Confidentiality Statement

You have the right to confidentiality – that means that the information given by you will not be released without your written consent, except to facilities in which you have or will work. We do not discriminate in the delivery of services. This means you will not be treated differently from others because of your race, color, sex, age, disability, religious beliefs, nation origin or political beliefs.

This form gives UMS permission to release to any contracted facility the Independent Contractors credentials, including, but not limited to: background checks, health screenings, certifications and/or licenses, etc.

This agreement signed this _____ day of _______________ 20__.

Accepted By:
UNITED MEDICAL STAFFING, INC.

______________________ ______________________

Authorized Agent Independent Contractor

HIPPA PRIVACY PROTECTION

In accordance with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act, 45 (forty-five) CFR parts 160 and 164 (the "Privacy Regulations"), **United Medical Staffing, Inc.**, and ______________________ **Independent Contractor** understand and agree to abide by the Facility privacy policies and to not use or further disclose and patient's personal health information except as expressly permitted by this Agreement or as otherwise authorized in writing by the patient through a consent or authorization meeting the requirements of the Privacy Regulations.

United Medical Staffing, Inc. and Independent Contractor may only use a patient's personal health information for the sole purpose of treatment, and/or health care operations and may not release any information to unauthorized parties. **United Medical Staffing, Inc.** and **Independent Contractor** agree to implement appropriate safeguards to prevent the unauthorized use and disclosure of any patient's personal health information received by Facility under this Agreement. In addition, **United Medical Staffing, Inc.** and **Independent Contractor** shall make available to the Facility the protected health information for amendment pruposes, should changes to the information be necessary or to provide an accounting of disclosures of the protected health information.
If an unauthorized disclosure of personal health information occurs, **United Medical Staffing, Inc.** and/or **Independent Contractor** shall immediately contact Facility to inform them of the disclosure and any remedial action taken to prevent further disclosures.
United Medical Staffing, Inc. and **Independent Contractor** understand that any unauthorized disclosure of a patient's personal health information is grounds for immediate termination of this Agreement and/or a staffing assignment.

____
INDEPENDENT CONTRACTOR'S Signature

____
UNITED MEDICAL STAFFING, INC.

____
DATE

IV Therapy Certification

I ______________________ verify that I have completed and passed the IV Therapy course at ______________________.

____
Contract Nurse Signature

____
Date