FRONTIER HEALTH CARE SERVICES
FHC
Quality Health Care

1642 Brice Road * Reynoldsburg, Ohio *43068

Office: 614-751-8884 * Fax: 614-751-8804 * Toll Free: 1-888-751-8884

REQUIRED DOCUMENTATION CHECKLIST

(All copies must be clear)

The Documentation Below Must Be In Your File Prior To Placement

☐ **Application Materials (forms provided in this document)**

1. Employment Application must be completed in full, including the Primary Applicant Agreement/Professional Conduct Expectations. Employment application is valid for one year. Please print or type neatly. You may include your resume, but it will not replace a completed employment application.
2. Signed and completed I-9 Form.
3. **Two** written references on letterhead or a performance evaluation with **one** other reference. These will be valid for one year.
4. Clinical Skills Checklist(s) and signed Job Description. These are valid for one year. Please be sure you fill out all of the skills checklists and job descriptions that apply to you:

+ Critical Care Nursing: Adult
+ Intermediate Care Nursing: Adult
+ Perinatal Nursing: Neonatal
+ Critical & Intermediate Care Nursing: Pediatric
+ Medical Surgical Nursing: Adult
+ Perinatal Nursing: Maternal
+ Psychiatric Nursing: Adult & Peds
+ Perioperative Nursing
+ Medical Surgical Nursing: Pediatric
+ Dialysis Nursing Care Nursing
+ Post Partum/Nursery Care Nursing

If you do not have the correct skills checklist(s) in your application packet, please contact your Placement Specialist or download it at www.frontierhealthcareservices.com under **Forms & Info.**

☐ **Medical Documentation (you may use the forms attached or provided clear, original copies with a Doctor's signature and an official stamp)**

1. A current physical or physicians statement within previous months.
2. Hepatitis B documentation (vaccination series of three, titer, booster, or signed declination)
3. A TB screen current within 12 months or chest X-ray current within two years.
4. Proof of immunity to Rubelola, Rubella and Mumps (**positive titer or 1 official, physician signed MMR)**.
5. Proof of immunity to Varicella-(positive titer or Varivax inoculation)
6. Tetanus within 10 years, or signed declination.

☐ **License, Professional Certifications, and Resuscitation Credentials**

1. Clear copies of all current nursing licenses and professional certifications.
2. Clear copy of a current American Heart Association Health Care Provider BLS card preferred. If you have additional resuscitation credentials (ACLS, ENPC, NRP, PALS, TNCC) please send copies of both front and back of credentials.
3. Proof of eligibility to work within the United States (For example: a Social Security Card and a Driver's License, or Passport). A completed, I-9 Form must accompany these documents.

JOB APPLICATION

Please print clearly and use black ink only.

Date Available for work: _____

Last Name:_____ Middle Name:_____First Name:_____

Email Address:_____

Current Address:_____

City:_____State:_____Zip:_____

Address #2:_____

City:_____State:_____Zip:_____

Current Phone Number:_(___)_____Permanent Phone Number:_(___)_____

Other Phone Number (Cellular, Pager, Other) Type: _____ (___)_____

Permanent Address: _____

City: _____State:_____Zip:_____

Social Security Number: _____ Birth Date: ____/____/_____ (MM/DD/YY)

Required upon Employment

Can you provide proof of eligibility to work in the United States? ☐ YES ☐ NO

Emergency Contact (Not living with you) _____Phone: _(___)_____

Type of Profession: ☐ RN ☐ LPN/LVN ☐ Certified Surgical Tech/OR Tech ☐ Other (please specify)_____

Shift Preference: ☐ AM ☐ PM ☐ Either

Referred by: (please select on of the following choices)

☐ Direct Mail – Ref# or Description_____

☐ Website- _____ FHC Website_____Other_____

☐ Web Advertisement- Please specify which site you saw the add on:_____

☐ Magazine/Journal-_____RN Magazine_____HT Magazine_____Nursing Magazine_____

☐ Newspaper- City, State of Newspaper_____

☐ FHC Road Recruitment- City, State you visited FHC:_____

☐ Personal Referral-Name of referrer:_____

☐ Other (please specify): _____

Education

Name and Location of School(s)	Graduated (date)	Type of degree

Licensure

(Please list all including expired)

State	Professional License #	Expiration Date	State	Professional License #	Expiration Date	State	Professional License #	Expiration Date
AK			KY			NY		
AL			LA			OH		
AR			MA			OK		
AZ			MD			OR		
CA			ME			PA		
CO			MI			RI		
CT			MN			SC		
DC			MO			SD		
DE			MS			TN		
FL			MT			TX		
GA			NC			UT		
HI			ND			VA		
IA			NE			VT		
ID			NH			WA		
IL			NJ			WI		
IN			NM			WV		
KS			NV			WY		

Which of these licenses id you original state of licensure? _____

Has your license or certification ever been under investigation? ☐ Yes ☐ No

If YES, please explain:_____

Has your license or certification ever been revoked or under suspension? Y☐s N☐
If YES, please explain:_____

Professional Certifications

(Please list all certification. Ex., CCRN, RNC-NICU, OCN, CRRN)

Type	Expiration Date

Resuscitation Credentials

Please indicate your resuscitation credential(s) by placing the expiration date next to the appropriate credential in the below table

Resuscitation Credential	Expiration Date	Resuscitation Credential	Expiration Date
ACLS		NRP	
BLS		PALS	
ENPC		TNCC	

Continuing/Professional Education

Course Name	Date	CEUs Earned

Name:_____ Social Security#:_____

SPECIALTIES AND UNIT EXPERIENCE

Please indicate the amount of experience in years you have worked in the following specialties/units. Primary experience must be within the last 1-2 years. Float experience must be within the last 5 years. ALL EXPERIENCE MUST BE AS A RN.

SPECIALITY	PRIMARY	FLOAT	DATE (mo/yr)
CRITICAL CARE – ADULT			
Bone marrow transplant ICU	❑ _____Yrs	❑ _____Yrs	_____/___
Burn ICU	❑ _____Yrs	❑ ____Yrs	_____/___
Cardiac ICU	❑ _____Yrs	❑ _____Yrs	_____/___
Cardiac Catheterization Lab	❑ _____Yrs	❑ _____Yrs	_____/___
Cardiothoracic ICU	❑ _____Yrs	❑ _____Yrs	_____/___
Cardiovascular ICU	❑ _____Yrs	❑ _____Yrs	_____/___
Emergency Department-Level 1	❑ _____Yrs	❑ _____Yrs	_____/___
Emergency Department-Level 2	❑ _____Yrs	❑ _____Yrs	_____/___
Emergency Department-Level 3	❑ _____Yrs	❑ _____Yrs	_____/___
Medical ICU	❑ _____Yrs	❑ _____Yrs	_____/___
Neuro ICU	❑ _____Yrs	❑ _____Yrs	_____/___
Neurosurgical ICU	❑ _____Yrs	❑ _____Yrs	_____/___
Transplant ICU	❑ _____Yrs	❑ _____Yrs	_____/___
Trauma ICU	❑ _____Yrs	❑ _____Yrs	_____/___
Surgical ICU	❑ _____Yrs	❑ _____Yrs	_____/___

CRITICAL CARE- PEDIATRIC			
Burn- ICU- Peds	❑ _____Yrs	❑ _____Yrs	_____/___
Cardiac Catheterization Lab	❑ _____Yrs	❑ _____Yrs	_____/___
Emergency Room-Peds	❑ _____Yrs	❑ _____Yrs	_____/___
Pediatric ICU	❑ _____Yrs	❑ _____Yrs	_____/___
Pediatric- Transplant ICU	❑ _____Yrs	❑ _____Yrs	_____/___
Other:	❑ _____Yrs	❑ _____Yrs	_____/___
INTERMEDIATE CARE-ADULT			
Cardiac SD/Telemetry Unit	❑ _____Yrs	❑ _____Yrs	_____/___
Endoscopy Lab	❑ _____Yrs	❑ _____Yrs	_____/___
Surgical Step-down Unit	❑ _____Yrs	❑ _____Yrs	_____/___
INTERMEDIATE CARE- PEDIATRIC			
Pediatric Step-down Unit	❑ _____Yrs	❑ _____Yrs	_____/___
Other:	❑ _____Yrs	❑ _____Yrs	_____/___
MEDICAL SURGICAL – ADULT			
Admitting/Observation Unit	❑ _____Yrs	❑ _____Yrs	_____/___
Diabetic Unit	❑ _____Yrs	❑ _____Yrs	_____/___
Gastrointestinal Unit	❑ _____Yrs	❑ _____Yrs	_____/___
General Surgery Unit	❑ _____Yrs	❑ _____Yrs	_____/___
Genitourinary Unit	❑ _____Yrs	❑ _____Yrs	_____/___
Geriatric Unit	❑ _____Yrs	❑ _____Yrs	_____/___
Gynecology Unit	❑ _____Yrs	❑ _____Yrs	_____/___
Hematology Unit	❑ _____Yrs	❑ _____Yrs	_____/___
Hemodialysis Unit	❑ _____Yrs	❑ _____Yrs	_____/___
Home Health	❑ _____Yrs	❑ _____Yrs	_____/___
Hospice Unit	❑ _____Yrs	❑ _____Yrs	_____/___
Med Surg Unit	❑ _____Yrs	❑ _____Yrs	_____/___
Renal Unit	❑ _____Yrs	❑ _____Yrs	_____/___
Neurology Unit	❑ _____Yrs	❑ _____Yrs	_____/___
Oncology Unit	❑ _____Yrs	❑ _____Yrs	_____/___

SPECIALITY	PRIMARY	FLOAT	DATE (mo/yr)
MEDICAL SURGICAL – ADULT CONT'D			
Orthopedic Unit	❑ _____Yrs	❑ _____Yrs	_____/___
Outpatient Clinic	❑ _____Yrs	❑ _____Yrs	_____/___
Pulmonary Unit	❑ _____Yrs	❑ _____Yrs	_____/___
Radiology Services	❑ _____Yrs	❑ _____Yrs	_____/___
Rehabilitation Unit	❑ _____Yrs	❑ _____Yrs	_____/___
Skilled Nursing Facility	❑ _____Yrs	❑ _____Yrs	_____/___
MEDICAL SURGICAL – PEDIATRIC			

General Peds Unit	❑ _____Yrs	❑ _____Yrs	_____/___	
Oncology Unit	❑ _____Yrs	❑ _____Yrs	_____/___	
Home health	❑ _____Yrs	❑ _____Yrs	_____/___	
Hospice Unit	❑ _____Yrs	❑ _____Yrs	_____/___	
Rehabilitation Unit	❑ _____Yrs	❑ _____Yrs	_____/___	
Other:	❑ _____Yrs	❑ _____Yrs	_____/___	
PERIOPERATIVE				
Pre-op Holding or Monitoring	❑ _____Yrs	❑ _____Yrs	_____/___	
Operating Room	❑ _____Yrs	❑ _____Yrs	_____/___	
Cardiovascular OR	❑ _____Yrs	❑ _____Yrs	_____/___	
Cystoscopy Suite	❑ _____Yrs	❑ _____Yrs	_____/___	
ENT/Ophthalmology OR	❑ _____Yrs	❑ _____Yrs	_____/___	
General Surgery OR	❑ _____Yrs	❑ _____Yrs	_____/___	
Neurosurgical OR	❑ _____Yrs	❑ _____Yrs	_____/___	
Orthopedic OR	❑ _____Yrs	❑ _____Yrs	_____/___	
Transplant OR	❑ _____Yrs	❑ _____Yrs	_____/___	
Post Anesthesia Care Unit/RR	❑ _____Yrs	❑ _____Yrs	_____/___	
Same Day Surgery	❑ _____Yrs	❑ _____Yrs	_____/___	
PERINATAL				
Antepartum Unit	❑ _____Yrs	❑ _____Yrs	_____/___	
Labor & Delivery	❑ _____Yrs	❑ _____Yrs	_____/___	
High Risk Labor & Delivery	❑ _____Yrs	❑ _____Yrs	_____/___	
LDRP	❑ _____Yrs	❑ _____Yrs	_____/___	
Mother Baby Unit	❑ _____Yrs	❑ _____Yrs	_____/___	
NICU, Level 2	❑ _____Yrs	❑ _____Yrs	_____/___	
NICU, Level 3	❑ _____Yrs	❑ _____Yrs	_____/___	
Newborn Nursery	❑ _____Yrs	❑ _____Yrs	_____/___	
Postpartum Unit	❑ _____Yrs	❑ _____Yrs	_____/___	
Other:	❑ _____Yrs	❑ _____Yrs	_____/___	
PSYCHIATRY – ADULT				
General Psychiatric Unit – Adult	❑ _____Yrs	❑ _____Yrs	_____/___	
Chemical Dependency Unit – Adult	❑ _____Yrs	❑ _____Yrs	_____/___	
Dual Diagnosis Unit – Adult	❑ _____Yrs	❑ _____Yrs	_____/___	
Locked Psychiatric Unit – Adult	❑ _____Yrs	❑ _____Yrs	_____/___	
Other:	❑ _____Yrs	❑ _____Yrs	_____/___	
PSYCHIATRIC – PEDIATRICS				
Adolescent Psychiatric Unit	❑ _____Yrs	❑ _____Yrs	_____/___	
Dual Diagnosis Unit – Adolescent	❑ _____Yrs	❑ _____Yrs	_____/___	
Pediatric Psychiatric Unit	❑ _____Yrs	❑ _____Yrs	_____/___	

SPECIALTY SKILLS

Please identify with a check √ any of the skills listed below, for which you have completed organized training or unit experience *and* which you have at least six months experience.

√	SKILL	√	SKILL
	Arrhythmia Administration		**Intracranial Pressure Monitoring**
	Chemotherapy Administration		**IV Catheter Insertion**
	Chemotherapy Administration Credentialed		**IV Conscious Sedation**
	Circulating OR Skills		**LVAD**
	CVVN, CAVH, or CRRT		**Mechanical Ventilation**
	ECT		**PICC Line Insertion**
	ECMO		**Peritoneal Dialysis**
	Fetal Monitoring		**Scrub OR Skills**
	Hemodialysis		**Sheath Removal**
	Intra-Aortic Balloon Pump		**Transport Skills**

If you have other specialty skills experience (ex., case management, infection control, other monitoring , other) please list below:

_____

_____

ADDITIONAL INFORMATION

Have you ever been convicted of a felony that would prohibit your employment at a health care facility?
YES ☐ NO ☐

Have you ever been convicted of any law violation? Include any plea "guilty" or "no contest".
(Exclude minor traffic violations) ❑ YES ❑ NO

If yes, give details _____

(A conviction will not necessarily disqualify an applicant for employment.)

Are you currently employed? ❑ YES ❑ NO

If YES, may we contact your employer? ❑ YES ❑ NO

Do you have any physical or mental conditions that would inhibit or restrict your ability to perform the essential functions of your job? ❑ YES ❑ NO

IF YES, would you be requesting any accommodations to aid you in fulfilling the essentials duties of your job? ❑ YES ❑ NO

If YES, what are they? _____

Are you a graduate from a foreign Nursing School (including Canada)? ❑ YES ❑ NO

Do you have one or two year of current experience? ❑ YES ❑ NO
Do you carry your own medical malpractice insurance? ❑ YES ❑ NO
If yes, please list Carrier name and address and policy number. _____

PLEASE CHECK ALL THAT APPLY:

❑ I would like to be considered for positions with Frontier Health Care where I may need to travel to an assignment.

Date available for assignment _____

❑ I would like to be considered for position with U.S. Nursing where a labor dispute may exist.

EMPLOYMENT EXPERIENCE

Fill out the following information for any job you have been employed at least within the past 2 years.
A resume is not acceptable. Start with your present or last job.
MAKE COPIES OF THIS PAGE AS NEEDED.

Your Name: _____ Social Security#: _____ Date: _____

Employment Dates From____/____/____ (MM/DD/YY) To____/____/____ (MM/DD/YY)

Hospital/facility:_____ Agency (if used):_____ ❑ Full Time ❑ Part time

Address:_____ City:_____ State: _____ Zip:_____

Immediate Supervisor:_____ May we contact this employer? ❑ YES ❑ NO

Specialty/Unit: _____ Types of Patients:_____

Number of Beds:_____ Supervisory experience? ❑ YES ❑ NO Was this a supplemental*assignment? ❑YES ❑ NO

Position: ❑ RN ❑ LPN/LVN ❑ STNA/CNA ❑ Other: _____

Reason for leaving:_____

Employment Dates From____/____/____ (MM/DD/YY) To____/____/____ (MM/DD/YY)

Hospital/facility:_____ Agency (if used):_____ ❑ Full Time ❑ Part time

Address:_____ City:_____ State: _____ Zip:_____

Immediate Supervisor:_____ May we contact this employer? ❑ YES ❑ NO

Specialty/Unit: _____ Types of Patients:_____

Number of Beds:_____ Supervisory experience? ❑ YES ❑ NO Was this a supplemental*assignment? ❑YES ❑ NO

Position: ❑ RN ❑ LPN/LVN ❑ STNA/CNA ❑ Other: _____

Reason for leaving:_____

Employment Dates From____/____/____ (MM/DD/YY) To____/____/____ (MM/DD/YY)

Hospital/facility:_____ Agency (if used):_____ ❑ Full Time ❑ Part time

Address:_____ City:_____ State: _____ Zip:_____

Immediate Supervisor:_____ May we contact this employer? ❑ YES ❑ NO

Specialty/Unit: _____ Types of Patients:_____

Number of Beds:_____ Supervisory experience? ❑ YES ❑ NO Was this a supplemental*assignment? ❑YES ❑ NO

Position: ❑ RN ❑ LPN/LVN ❑ STNA/CNA ❑ Other: _____

Reason for leaving:_____

PRIMARY APPLICANT AGREEMENT

The following agreement is for informational purposes. Frontier Health Care Services has the right to decide whether to hire any applicant, and applicant has the right to choose whether to be placed by FHC. Both will agree to the following.

FRONTIER HEALTH CARE SERVICES COMMITMENT

PLACEMENT. FHC will attempt to secure placement of the Applicant at an assignment with a facility for the time period indicated on the agreement. This time period may be extended at the completion of all assignment as long as the facility, applicant, and FHC agree on the terms at the time of the extension. The agreement letter will be sent to the applicant upon verification of placement and requires the Applicant's initials to represent agreement between all parties' expectations.

PAY RATE. FHC agrees to pay the applicant according to the pay rate indicated on the agreement letter, and in accordance with applicable Federal, State, and Local Laws. The pay rate may vary according to the location of assignment and may change if there is an extension of the current assignment or relocation to a new assignment. Any pay rate changes will be addressed with a new agreement letter, which is sent to applicant for final approval.

TRAVEL TO AND FROM TRAVEL ASSIGNMENT. If applicable, FHC will coordinate travel of one round trip through Corporation's travel assignment obligation. If the applicant departs or quits the assignment before the agreed upon completion date, Applicant pay for the return costs home. Applicant also agrees that FHC may deduct these costs from their paycheck. If the Applicant drives to the travel assignment, a mileage policy will apply.

HOUSING. FHC will use its best efforts in placing the Applicant in reasonable housing accommodations while on a travel assignment. Final housing accommodations will be specified on the agreement letter. If applicable and if applicant provides his or her own housing while on a travel assignment, FHC will offer a reimbursement policy if indicated on the agreement letter.

REIMBURSMENTS. All requests for reimbursements are subject to FHC approval and must be submitted to FHC within 90 days of incurring expenditure. Reimbursement forms can be found on our website at www.frontierhealthcaresvc.com or by fax or by mail.

LICENSURE. FHC agrees to assist the Applicant in obtaining proper licensure for travel assignment in other states. However, licensure is the sole responsibility of the Applicant. FHC also agrees to reimburse Applicant for the cost of the permanent licensure incurred for the state in which the Applicant completes the travel assignment obligation and follows all FHC reimbursements requirements, including but not limited to submittal of a copy of the permanent licensure for which Applicant is seeking reimbursement, as well as proof of payment.

BENEFITS. FHC agrees to provide the Applicant with the benefits program. FHC reserves the right to change the benefits at anytime with or without notification.

24/7. FHC's phone lines are open twenty-four (24) hours per day, seven (7) days a week for the Applicant's convenience. FHC reserves the right to change hours of operation at anytime with or without notification.

DEDUCTIONS FROM PAYCHECK. Applicant authorizes FHC to deduct from Applicant's paycheck for any of the following travel assignment reasons: unpaid single supplement housing expenses that were incurred for rooming alone instead of having a roommate, non-authorized housing expenses such as replacing items taken from housing accommodation, telephone and fax charges left unpaid at the time of departure, any other room service charges, damage/destructions to housing, and any other expenses owed to FHC.

DISCLAIMER. FHC reserves the right, and the Applicant acknowledges FHC may at anytime, with without notice, modify this agreement letter. All modifications will be updated to the PAA so Applicants can remain informed as to the expectations of both the company and Applicants. Changes are effective immediately when made to the agreement letter. Continued employment after any posted change, is an acceptance by Applicant of the modification.

APPLICANT'S COMMITMENT

EDUCATION AND TRAINING. Applicant states that he/she has obtained education and training in the healthcare field and is duly licensed and authorized to practice nursing.

PLACEMENT ACCEPTANCE. Once Corporation secures placement for Applicant at an assignment, Applicant agrees that his or her acceptance will be binding. All details specific assignments will be included in the entire agreement letter. Applicant is not obligated in any way to accept placement position secured by Corporation until the agreement letter is signed.

EMPLOYEE AT WILL. Applicant acknowledges FHC employs Applicant "at will" and no employment promises have been made for any duration of the time. Specifically, Applicant understands he/she may quit employment at anytime with FHC, with or without notice. Similarly, Applicant understands he/she may be discharged by FHC at anytime, without notice, for lawful reason. Contracts of employment can only be made by a written agreement between Applicant and FHC and required the approval and signature of the President and Chief Executive Officer of FHC or authorized representative. Further, should Facility decide to end Applicant's assignment prior to completion date, FHC may purpose a new assignment as long as Applicant is in good standing with FHC.

NONDISCLOSURE AND LIMITED NONCOMPETE. Applicant agrees not to disclose any FHC trade secrets or any confidential or proprietary information of FHC, FHC employees, Facilities, or patients of Facilities. Applicant further agrees not to complete either as a direct competitor or with a competing company at the Facility assignment where Applicant has been placed by FHC for a term of three months after Applicant's final day of work at facility.

NONSOLICITATION OF CORPORATION EMPLOYEES. Applicant agrees not to solicit FHC employees to work for any competing company while on assignment with a FHC facility, and for a period of three months thereafter.

DRUG SCREENS. Prior to placement and throughout employment with FHC, Applicant consents to a urine, blood or breath sample for the purposes of an alcohol, drug, intoxicant, or substance abuse screening test. Applicant also gives permission for the release of the test results for determining the fitness of employment or continued employment. Applicant will utilize clinics that are approved by FHC.

BACKGROUND CHECKS. Before the Applicant is placed and throughout employment with FHC, FHC may, upon a facility's request, conduct background checks of any kind from any location for any purpose FHC considers reasonable. Applicant also gives permission for release of the results for determining fitness of employment and/or continued employment.

EMPLOYMENT AND MEDICAL INFORMATION RELEASE. I authorize FHC to release any and all confidential employment and medical information contained in my employment file to any medical facility or entity with whom FHC has a staffing agreement, and to any other governmental or regulatory agency at such agency's request. For all other purposes, FHC shall keep my employment and medical records confidential and shall advise any medical facility or other entity to which records have been provided to also keep such records confidential. I hereby release

and hold FHC harmless for any result(s) that may arise with regard the release of this confidential information by FHC.

TRAVEL. Applicant agrees to follow all FHC rules regarding travel. Any travel arrangements will be specified in the agreement letter.

HOUSING. Applicant accepts all FHC rules regarding housing. If applicable, final housing arrangements will be encompassed in the agreement letter. Applicant may elect to share housing, or if available, choose a single supplement. If applicable and if applicant provides his or her own housing while on a travel assignment, FHC will offer a reimbursements policy as indicated on the agreement letter.

REIMBURSEMENTS. Applicant agrees to adhere to all rules and polices regarding reimbursements, including but not limited to submitting expenses within 90days of incurring expense. Further, Applicant acknowledges FHC's rules and regulations regarding reimbursement may be modified at time with or without notice for any reason.

RECORDING OF TIME WORKED. Applicant agrees to abide by FHC's procedure for reporting time worked, including hospital supervisor, approval for shift time worked and missed lunch period. The FHC workweek begin at 7:00am on Sunday and ends at 6:59 AM on the following Sunday. Applicant's time sheet must reach FHC each Monday by 10AM Eastern Standard Time in order to be paid in the current week. Any late submission may be paid the following week.

LUNCH BREAK POLICY. Applicant will clock in and out for a minimum of thirty (30) minutes and up to a maximum of one (1) hour for meal periods, in less otherwise specified by facility policy. If the facility requests Applicant to work their lunch period due to patient care and safety, Applicant agrees to obtain two supervisor signatures of approval from Facility Health Care Professional Managers for each applicable shift.

PERSONAL PROPERTY. U.S. Nursing and/or FHC are not responsible for the theft, loss, destruction, or damage to the personal property of its employers.

TERMINATION. Applicant understands if he/she leaves his/her assignment early for any reason or is terminated by FHC, Applicant must vacate company provided housing within 24 hours and will be responsible for return travel costs. Applicant authorizes FHC to deduct any incurred costs from their paycheck.

GENERAL

CHOICE OF LAW. This Agreement will be construed in all respects according to the laws of the state of Colorado.

CONFIDENTIALITY OF AGREEMENT. FHC and Applicant will maintain the confidentiality and exclusivity of this Agreement.

AGREEMENT REVIEW. FHC and Applicant agree each party has fully read and reviewed this Agreement. Should any ambiguities arise, the interpretation of the ambiguity will not automatically be construed in favor of the Applicant.

EQUAL OPPORTUNITY EMPLOYER. FHC is an equal opportunity employer incorporated in the State of Ohio and in good standing with the Ohio Secretary of State. FHC does not discriminate in respect to hiring, firing, compensation, and all other terms and conditions of privileges of employment on the basis of race, color, national origin, ancestry, sex, age, pregnancy or related medical conditions, martial status, religious creed, or disability.

NOTICES. Any notices which are required or permitted will be in writing and will be deemed properly delivered to the other party when U.S. Mail, certified, postage prepaid and addressed to the following:

For Corporation:

Frontier Health Care Services
Attn: Records Department
1642 Brice Road
Reynoldsburg, OH 43068

For Applicant:

Applicant name: _____

Applicant address: _____

_____

HEALTH CARE PROFESSIONAL CONDUCT EXPECTATIONS

Your professional conduct and clinical performance on FHC assignments id directly related to our ability to solicit new and interesting job opportunities for you. As such, FHC expects you will adhere to the following Professional Conduct Expectations while on assignment. Failure to meet these expectations could lead to your termination from FHC.

- I will not discuss any elements of my compensation with anyone employed at the host facility.
- I will not discuss any previous assignments worked for FHC with anyone employed at the host facility.
- I will not recruit any Health Care Professionals at the host facility, whether temporary or permanent employees.
- I will communicate with the management, staff and patients of the host facility in a respectful manner at all times.
- I will honor all terms of my agreement letter, including but not limited to beginning and ending assignment dates, housing arrangements if applicable, and travel arrangements if applicable.
- I will honor the policies and procedures of FHC and the host facility.

I certify that I have read, understand and intend to comply with the Primary Applicant Agreement and Professional Conduct Expectations and the facts contained in this application are true and accurate. I understand any misrepresentation or omission of facts is cause for dismissal. I authorize the employer to investigate any and all statements contained herein and request the persons, firms, and/or corporations named above to answer any and all questions relating to this application. I release all parties from all liability, including but not limited to, the employer and any person, firm or corporation who provides information concerning my prior education, employment or character.

Clement Akosile, President

Name of Applicant

Signature of Applicant Date

FRONTIER HEALTH CARE SERVICES

"Visionary Quality Care"

1642 Brice Road * Reynoldsburg, Ohio *43068
Office: 614-751-8884 * Fax: 614-751-8804 * Toll Free: 1-888-751-8884

REQUEST FOR REFERENCE

(Please have your reference form filled out completely before returning to FHC)

I authorize, _____ (Name of Health Care Professional's Manager) from _____ (Facility Name and Address)
to release information about me for the purpose of supplying a reference check.

Signature Date

Social Security Number of Health Care Professional: _____

How would you rate this former employee?

_____ has applied for a nursing position with Frontier Health Care
(Name of Health Care Professional)
Services and has given us your name as a professional reference. We would appreciate it if you would evaluate the applicant's past performance and make any additional comments you feel might assist us in making our decision in hiring this Health Care Professional. Your comment will be kept in strict confidence.

Name and Title of Reference:_____Phone Number:_____

Facility Name:_____Address:_____City,St,Zip:_____

Dates Health Care Professional was employed: From:_____ To: _____

Health Care Professional's title:_____Clinical Area Worked:_____

	Exceeds Expectations	Meets Expectations	Meets Some Expectations	Does Not Meet Expectations
Quality of Work	❑	❑	❑	❑
Productivity	❑	❑	❑	❑
Professionalism	❑	❑	❑	❑
Emotional Stability	❑	❑	❑	❑
Flexibility	❑	❑	❑	❑
Dependability	❑	❑	❑	❑
Enthusiasm	❑	❑	❑	❑
Leadership Ability	❑	❑	❑	❑
Communication Skills	❑	❑	❑	❑
Attendance/Punctuality	❑	❑	❑	❑
Appearance	❑	❑	❑	❑
Customer Service Skills	❑	❑	❑	❑

Reason this Health Care Professional left your facility: ❑ Terminated ❑ Lay-off ❑ Resigned ❑ Temporary

Comments (please continue on back, if necessary) _____

_____

Would you hire this Health Care Professional again? ❑ YES ❑ NO

Signature:_____ FRONTIER HEALTH CARE SERVICES Date:_____

Please return this form to:
Frontier Health Care Services
1642 Brice Road
Reynoldsburg, OH 43068

Or *Fax to:* (614)- 751-8804

"Visionary Quality Care"

1642 Brice Road * Reynoldsburg, Ohio *43068
Office: 614-751-8884 * Fax: 614-751-8804 * Toll Free: 1-888-751-8884

CLINICAL EVALUATION

RN Information

Name:_____Assignment Dates:_____

Would this RN be welcome to work in your facility again? ❑ YES ❑ NO

Facility Information

Facility Name:_____ Location:_____
Unit Name:_____ Unit Specialty:_____ #Unit Beds:_____
Facility Type: ❑ Teaching ❑ Non-Teaching

Clinical Performance/Attributes	Exceeds Standards	Meets Standards	Does Not Meet Standards*
Assesses patients in a timely and individualized manner according to patient need	❑	❑	❑
Works collaboratively with other members of the team to develop an individualized plan of patient care	❑	❑	❑
Performs interventions in a timely, accurate, and safe manner	❑	❑	❑
Documents the patient care process accurately	❑	❑	❑
Demonstrates competency appropriate for assigned patient population including adaptations for age specific care	❑	❑	❑
Communicates respectfully & effectively with patients, families, visitors & all facility staff and physicians	❑	❑	❑
Maintains confidentiality in all aspects of patient care	❑	❑	❑
Adhere to facility polices and procedures	❑	❑	❑
Reports to work on time and as scheduled. Notifies immediate supervisor if unable to work	❑	❑	❑
Exhibits a high level of professionalism	❑	❑	❑
Exhibits flexibility and adaptability	❑	❑	❑

*= Please specify deficiencies in comment section below.

Comments:_____

_____

_____

Print Name/Title:_____

Signature: _____ **Date:** _____

PHYSICIAN'S STATEMENT

(Please Print Clearly)

Full name:_____
(Please Print)

Note: It is the responsibility of the applicant to have their physician fill out the appropriate section of this form.

PHYSICIAN TO COMPLETE THIS SECTION:

TB Skin Test — Date Completed: _____ Results: _____
Chest X-ray(If TB positive) — Date Completed: _____ Results: _____
Rubella Titer ❑ MMR ❑ — Date Completed: _____ Results: _____
Rubeola Titer ❑ MMR ❑ — Date Completed: _____ Results: _____
Mumps Titer ❑ MMR ❑ — Date Completed: _____ Results: _____
Varicella Titer ❑ Varivax ❑ — Date Completed: _____ Results: _____
Hepatitis B Titer ❑ MMR ❑ — Date Completed: _____ Results: _____
Hepatitis B Series ❑ — 1st Date Completed:_____2nd Date:_____3rd Date:_____
Tetanus ❑ — Date Completed:_____

Please submit supporting documentation of immunization records and lab results

I have examined the individual name above, and to the best of my knowledge, he/she is in good physical and mental health, free of any communicable diseases, and is able to function in his/her profession at full capacity. By signing below I certify that above information is valid.

Physician Signature: _____*Date:*_____

*Printed Physician's Name:*_____

Frontier Health Care Services applicant is to complete the following:

HEPATITIS B VACCINATION

(Check and Sign Applicable Statement)

❑ I understand the OSHA guidelines and **DECLINE** the Hepatitis B Vaccination.

Signature: _____ Date:_____

TETANUS VACCINATION DECLINATION

I,_____, RN, understand that I have been requested to supply proof of Tetanus Vaccination or agree to the vaccination prior to placement with Frontier Health Care Services, LLC. However, I decline the Tetanus Vaccination. Further, I understand that my refusal may limit my placement options in that I understand I cannot be placed at a FHC client (hereinafter "Facility") that requires the Tetanus vaccination.

Therefore, in consideration of my employment with Frontier Health Care Services and placement at a Facility, I agree to hold harmless both Facility and FHC, their owners, directors, employees, staff, and agents, form any and all liability arising out of my refusal of the Tetanus Vaccination.

*Signature:*_____*Date:*_____