



REQUIRED DOCUMENTATION CHECKLIST

(ALL COPIES MUST BE CLEAR)

The Documentation Below Must Be In Your File Prior To Any Assignment.

Application Materials (forms provided in this document)

1. Job **Application** must be completed in full. Please print or type neatly. You may include your **resume**, but it will not replace a complete job application.
2. **Clinical Skills Checklist** (Neonatal and OR in addition, if applicable).
3. Signed Job Description.
4. **Two** references and/or written references on letterhead or a performance evaluation with **one** other reference.
5. State Criminal Back Ground Check with in the last 6 months.

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

5. A current physical or physician's statement within previous 12 months.
6. Hepatitis B documentation (vaccination series of three, titer, booster, or signed declination).
7. A TB screen current within 12 months or chest X-ray current within two years.

Licenses, Professional Certifications, and Resuscitation Credentials

8. Clear copies of all current therapist **licenses** and professional certifications.
9. Clear copy of a **current CPR** card. If you have additional resuscitation credentials (**ACLS**, ENPC, NRP, PALS, TNCC).
13. Proof of eligibility to work within the United States (For example: a Social Security Card and a Driver's License, or Passport).

All the above items must be in your *completed* nurse file before your file is faxed to a facility for any assignment.

Please make sure that you include the highlighted items above with your application

Thank you for applying with Rehability Care

14902, Shelborne Road, Westfield, IN 46074
Phone: (317)286-2885 | Fax: (317)536-3097



RN		LPN	
SPL		PT	
PTA		OT	
COTA		OTHER	

Personal Information

Name		Date
Social Security #		Date of Birth
Present Address		
City	State	Zip
Home Phone ()		Other Phone ()
Has your license or certification ever been under investigation?		Yes <input type="checkbox"/> No <input type="checkbox"/>
CPR Expiration	Date of Last Physical Exam	Date of Last TB
Have you been convicted of a felony or a misdemeanor within the last 5 years?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please describe		
Are you eligible to work in the United States?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Drivers License #	State	
Name of person to be notified in case of an emergency		Phone ()

Additional Information

Do you have any physical limitations that preclude you from performing any work for which you are being considered?	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
If yes, what can be done to accommodate your limitation	

Licensure and Certifications

PPD Test	Date Given	Date Read	Induration	Negative	Positive
Step 1				<input type="checkbox"/>	<input type="checkbox"/>
Step 2				<input type="checkbox"/>	<input type="checkbox"/>
Chest X-Ray	Date	Results (Results must be attached)			

Employment Desired

Position	Date available for work	Salary Desired
Are you currently employed? <input type="checkbox"/>	If so, may we contact your present employer? <input type="checkbox"/>	
By whom were you referred to us?		

Education

Name	Location	Graduated (Y/N)	Degree

Personal References

Name	Name
Address	Address
Phone ()	Phone ()

Employment Experience

Employer	Address	
Position	From	To
Supervisor	Phone	
Reason for leaving?	May we contact your supervisor?	YES <input type="checkbox"/> NO <input type="checkbox"/>

Employer	Address	
Position	From	To
Supervisor	Phone	
Reason for leaving?	May we contact your supervisor?	YES <input type="checkbox"/> NO <input type="checkbox"/>

Employer	Address	
Position	From	To
Supervisor	Phone	
Reason for leaving?	May we contact your supervisor?	YES <input type="checkbox"/> NO <input type="checkbox"/>

Experience

Area	Experience in last 3 years	Area	Experience in last 3 years	Area	Experience in last 3 years	Area	Experience in last 3 years
Alcohol Detox		Labor & delivery		Oncology		Psychiatric	
Burns		Medical Floor		Operating Room		Rehabilitation Care	
Cardiac Care		Medications		Orthopedics		Surgical Floor	
Doctor's Office		Neurological		OB/GYN		Urology	
Home Healthcare		Nursery		Pediatrics		Private Duty	
Intensive Care		Nursing Home					

I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on this application shall be grounds for dismissal. I authorize investigation of all statements contained herein and the references listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release all parties from all liability for any damage that may result from furnishing same to you. I understand and agree that, if hired, my employment is for no definite period and may, regardless of the date of payment of my wages and salary be terminated at any time without prior notice. I understand that I am not to transport patients in my automobile, nor am I to drive patients in the patient's automobile without written consent from the Rehability Care Office.

I agree, I will not seek or accept employment, either directly or indirectly in any capacity from any client of Rehability care to whom I have been assigned for at least 90 days after the last day of that assignment. I further understand that I cannot be paid until I present a time slip signed by both the client and me to the Rehability Care office.

Name of Applicant _____ Date _____

Signature of Applicant _____ Date _____



PT SKILLS/PROFICIENCY CHECKLIST

1=no experience 2=familiar with 3=experienced in 4=able to teach and supervise

WORK SETTINGS	1	2	3	4	MODALITIES	1	2	3	4
Rehabilitation Hospital					Acupuncture				
General Acute Care					Hot Packs				
Rehabilitation Unit in Hospital					Neuromuscular Reeducation				
Pediatric Rehab. Hospital/Clinic					Myofascial Release Techn.				
Sports Medicine Clinic					Fluidotherapy				
Childrens Hospital					Hydrotherapy				
School System					Whirlpool				
Home Health Care					Hubbard Tank				
Outpatient Clinic					Therapeutic Pool				
Nursing Home					Biofeedback				
Private Practice					TENS				
Psychiatric Hospital					Muscle Stimulation				
Physician Office					Ultrasound				
					Diathermy				
					Cryotherapy				
ORTHOPEDICS									
ROM					Traction (Mechanical)				
Back School					Cervical				
Back Syndromes					Lumbar				
Hip Fractures					Cervical Traction (Manual)				
Total Hip/Total Knee					Massage				
Hand Injury					Wound Dressing/Debridement				
TMJ Dysfunction					Paraffin				
Arthritis Programs					Vasopneumatic Devices				
Mobilization Techniques					Easy Street				
Gait Training					Continuous Passive Motion				
Manipulation Techniques									
Post-surgical mgmt. tendon/muscle release					PEDIATRICS				
					Learning Disabled				
					Spina Bifida				
					Balance Disorders				
NEUROLOGIC					Early Intervention				
Stroke Rehab					NICU Treatment				
Coma Management					Neurodevelopmental Testing				
Head Trauma					DDST				
Spinal Cord Injury					Orthotics				
Functional Splinting					Equipment Assessment				
Adaptive Equipment					Adaptive				
Neuromuscular Rehabilitation					ADL				
					Mental Retardation				
PROSTHETICS/ ORTHOTICS					Cerebral Palsy				
AK Prosthetics									
BK Prosthetics					SPORTS MEDICINE				
UE Prosthetics					Strength/Endurance Training				
Orthoplast					Lido Back				
Resting Splints					Kin Com				
AFO/PLS					Biodex				
Static Splinting					Cybex				
Dynamic Splinting					Orthotron/Kinetron				
Serial/Inhibitory Casting									
SPORTS MEDICINE					OTHER				
Taping/Strapping					Symptom Magnification				
Nautilus					Assessment				
Bracing/Joint Immobilization					Cardiac Rehabilitation				
					Chest Physiotherapy				
					Burn Management				
ADAPTIVE EQUIPMENT					Inservice Education				
Assessment					Geriatrics				
Fabrication					HHA supervision				
Wheelchair					PTA supervision				
Seating									
Ordering									
WORK HARDENING					Applicant Signature				
Job Site Evaluation					Applicant Name				
Functional Capacity Evaluation					Date				
Work Capacity Evaluation									



OT SKILLS/PROFICIENCY CHECKLIST

	1=no experience	2=familiar with	3=experienced in	4=able to teach and supervise		1	2	3	4
WORK SETTINGS									
Rehabilitation Hospital					Neurodevelopmental therapy				
General Acute Care					Myofascial therapy				
Rehabilitation Unit in Hospital					Joint mobilization				
Pediatric Rehab. Hospital/Clinic					Energy conservation/ work simplification				
Sports Medicine Clinic					Instruct in body mechanics				
Childrens Hospital					Blood pressure monitoring				
School System					Heart rate monitoring				
Home Health Care					Purposeful activities- crafts/leisure				
Outpatient Clinic					Perceptual retraining				
Nursing Home					Cognitive retraining/ compensatory activities				
Private Practice					Desensitization/resensitization				
Psychiatric Hospital					W/C measurements/fitting				
Physician Office					W/C operations				
ASSESSMENT/EVALUATION					Behavior modification techniques				
Client initial assessment					Dysphagia treatment				
Client D/C assessment					Universal Precautions				
Functional evaluations									
ADLs									
Range of motion									
Muscle strength					SPECIALTY AREAS				
Sensation					Spinal Cord Injury				
Cognition					Procedures for post-CVA rehab				
Perception					Orthopedics				
Coordination					Neurological disease				
Driving evaluation					Pediatric experience(0-3yr)				
Swallowing					Pediatric experience (3+yr)				
Vocational Skills					Head trauma				
Leisure skills					HHA supervision				
Mental status					COTA supervision				
Neonatal/developmental assessment					Burn management				
Functional capacity for work					Inservice education				
Oral motor skills					Geriatrics				
Needs for adaptive/home equipment					Total hip/ total knee				
Evaluation for environmental control system					Hand rehab				
PROCEDURE/INSTRUCTION									
Development of care plan					Applicant Signature				
Charting/documentation									
Upper extremity therapeutc exercise					Applicant Name				
Oral motor stimulation									
Neonatal infant stimulation					Date				
Fabrication of splints									
Environmental adaptations									
ADL training									



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www.RehabilityCare.com

JOB DESCRIPTION: PHYSICAL THERAPIST

REQUIREMENTS: The Physical Therapist must meet recognized standards of professional education and qualifications. The Physical Therapist must:

1. Must be a graduate of an educational institution with a degree in Physical Therapy.
2. Must be licensed in the State (as applicable) to practice Physical Therapy.
 - a. Temporary license may be accepted
3. Display evidence of interest in continued education within the profession and is encouraged to be a member of the American Physical Therapy Association.

ESSENTIAL FUNCTIONS:

1. The staff Physical Therapist reports to the Area Administrator of Physical Therapy.
2. He/She may be responsible for supervising/training other personnel such as; Physical Therapy Assistants and/or Physical Therapy Aides.
3. Following receipt of a doctor's referral, the therapist is responsible for evaluating the patient within 24 hours of written referral.
4. After evaluating the patient, the therapist is responsible for planning, administering and supervising the Physical Therapy Assistant in an appropriate treatment plan.
5. The Physical Therapist will communicate with the referring physician and members of the rehabilitation team regarding the patient's total treatment program.
6. The Physical Therapist will maintain an accurate daily record of treatments given to patients.
7. The Physical Therapist will maintain an accurate daily record of treatments administered to patients.
8. The Physical Therapist will provide in-service education to facilities, supportive staff, students and community.
9. The Physical Therapist will perform other duties as assigned by the Area Administrator.
10. The Physical Therapist will follow established policies and procedures of Therapist Express.

TYPICAL PHYSICAL DEMANDS:

Physical Therapist assigned must be able to perform the following physical job functions with or without reasonable accommodation:

1. Lift up to 50 pounds from floor to knuckle occasionally.
2. Lift up to 30 pounds from the knuckle to shoulder occasionally.
3. Lift up to 10 pounds overhead occasionally.
4. Pivot transfer up to 200 pounds continuously.
5. Carry up to 25 pounds, 200 feet frequently.
6. Push/pull 40 pounds, 300 feet frequently.
7. Squat and stoop up to 20 minutes occasionally.
8. Kneel and crawl up to 5 minutes continuously.
9. Fine hand manipulation, bilaterally frequently.
10. Heavy grasp, bilaterally, continuously.
11. Visually acuity corrected to 20/20.
12. Tactile discrimination continuously.
13. Drive up to 2 hours.
14. Comprehensible verbal communication skills continuously.

Employee Printed Name: _____ Date: _____

Employee Signature: _____



Description: Occupational Therapist

Occupational Therapist Job Purpose: Facilitates development and rehabilitation of patients with mental, emotional, and physical disabilities by planning and administering medically prescribed occupational therapy.

Occupational Therapist Job Duties:

- Meets the patient's goals and needs and provides quality care by assessing and interpreting evaluations and test results; determining occupational therapy treatment plans in consultation with physicians or by prescription.
- Helps patient develop or regain physical or mental functioning or adjust to disabilities by implementing programs involving manual arts and crafts, practice in functional, prevocational, vocational, and homemaking skills, activities of daily living, and sensor motor, educational, recreational, and social activities; directing aides, technicians, and assistants.
- Promotes maximum independence by selecting and constructing therapies according to individual's physical capacity, intelligence level, and interest.
- Prepares patient for return to employment by consulting with employers; determining potential employee difficulties; retraining employees; helping employers understand necessary physical and job result accommodations.
- Evaluates results of occupational therapy by observing, noting, and evaluating patient's progress; recommending and implementing adjustments and modifications.
- Completes discharge planning by consulting with physicians, nurses, social workers, and other health care workers; contributing to patient care conferences.
- Assures continuation of therapeutic plan following discharge by designing and instructing patients, families, and caregivers in home exercise programs; recommending and/or providing assistive equipment; recommending outpatient or home health follow-up programs.
- Documents patient care services by charting in patient and department records.
- Maintains patient confidence and protects hospital operations by keeping information confidential.
- Maintains safe and clean working environment by complying with procedures, rules, and regulations.
- Protects patients and employees by adhering to infection-control policies and protocols.
- Ensures operation of equipment by completing preventive maintenance requirements; following manufacturer's instructions; troubleshooting malfunctions; calling for repairs.
- Maintains professional and technical knowledge by attending educational workshops; reviewing professional publications; establishing personal networks; participating in professional societies.
- Develops occupational therapy staff by providing information; developing and conducting in-service training programs.

- Complies with federal, state, and local legal and certification requirements by studying existing and new legislation; anticipating future legislation; enforcing adherence to requirements; advising management on needed actions.
- Contributes to team effort by accomplishing related results as needed.

Skills/Qualifications: Health Promotion and Maintenance, Creating a Safe, Effective Environment, Motivating Others, Legal Compliance, Bedside Manner, Medical Teamwork, Mental Health, Pain Management, Listening, Analyzing Information , Quality Focus

Employee Printed Name: _____

Date:_____

Employee Signature:_____



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Reference Form

Clinician Name: _____ Date of Evaluation: _____

Company: _____ Contact Person: _____

Address: _____ Title: _____

Phone #: _____ Signature: _____

Start Date: _____ End Date: _____ Specialty: _____

of Beds: _____ Unit Description: _____

Eligible for Re-hire: _____ Avg. Patient Caseload: _____

EVALUATION:

Ratings: 4 = Outstanding 3 = Exceeds Expectation 2 = Meets job Requirement 1 = Not Met

Performance	Outstanding	Exceeded Expectation	Meets Job Requirements	Not Met
Job Knowledge				
Work Quality				
Initiative				
Dependability				
Creativity				
Accepts Directions				
Interpersonal Relationship				
Accurate Documentation				
Communicate Effectively				
Attendance				
Punctuality				

Signature of Employee: _____

Employee Name: _____ Date: _____

Reviewed By: _____ Date: _____

Title: _____



EMPLOYEE AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION ON EMPLOYMENT FILE, BACKGROUND CHECK, MEDICAL RECORDS, RANDOM DRUG SCREENING, AND PAYCHECK DEDUCTIONS:

By affixing my signature hereunder, I authorize REHABILITY CARE to release any and all confidential employment, background check and medical information contained in my employment file to any medical facility or entity with whom REHABILITY CARE has a staffing agreement, and to any other governmental or regulatory agency at such agency's request. For all other purposes, shall keep my employment records confidential and shall advise any medical facility or other entity to REHABILITY CARE whom records have been provided to also keep such records confidential. I hereby hold REHABILITY CARE harmless for any result(s) that arise with regards to the release of this confidential

Information by REHABILITY CARE.

Medical records information is confidential and REHABILITY CARE will instruct client facilities and/or other entities to treat the provided information confidential as well. I consent to a urine, blood or breath sample for the purposes of an alcohol, drug, intoxicant, or substance abuse screening tests. Furthermore, I consent to the release of the test results for purposes of determining the fitness for employment or continued employment.

I authorize REHABILITY CARE to deduct from my paycheck for any of the following: unpaid single-supplement housing expenses being the cost incurred for rooming by oneself instead of sharing a room with a roommate, non-authorized housing expenses including but not limited to housing items taken from room(s) or other provided housing, telephone and fax charges to room left unpaid at time of departure, any other room service charges such as movie rentals or dry cleaning costs, any damage/destruction done to room or other housing, and any other expenses due and owing to REHABILITY CARE.

My signature hereunder further indicates that I have read the EMPLOYEE AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION ON EMPLOYMENT FILE, BACKGROUND CHECK, MEDICAL RECORDS, RANDOM DRUG SCREENING AND DEDUCTION FROM PAYCHECK POLICY in its entirety and understand its contents.

I understand that my employment is "at will" and may be terminated by me or REHABILITY CARE at any time, with or without prior notice, for any lawful reason or no reason. I further understand no contract is intended by me or REHABILITY CARE and as such my employment is not governed by any contractual relationship with REHABILITY CARE. I certify that the facts contained in this application are true and accurate. I understand that 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.

Signature

Date

REHABILITY CARE 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, marital status, religious creed, or disability.



I hereby authorize the release of any information requested on this form. I also release the person / facility below from all liability in providing any type of reference information.

Applicant Signature _____

Social Security Number _____ Date _____

****Do not write below this line****

Dear _____ Phone _____

_____ has applied for employment with us.
We would appreciate your cooperation in verifying or correcting the enclosed information and answering the following questions. Please return this self addressed letter to us as soon as possible. All information is confidential. Thank you for your assistance.

Employed from _____ to _____

Position(s) held _____

Applicant's reason for leaving _____

Subject to re-hire _____ If no, why not? _____

Facility / Company _____

Signature/Title _____ Date _____

☐ Telephone Reference

Comments: _____

Signature of person taking information _____ Date _____



PREVENTING AND ADDRESSING SEXUAL HARASSMENT AND UNLAWFUL DISCRIMINATION

The Company is committed to working with Client healthcare facilities to provide a work environment that is free of harassment and discrimination. In keeping with this commitment, we do not tolerate any form of sexual harassment or any other form of unlawful discrimination.

Harassment based on race, sex, national origin, disability, sexual orientation; religion or other protected characteristic is a violation of state and federal laws. State and federal laws define sexual harassment to include unwelcome sexual advances, requests for sexual favors, and other verbal, visual, or physical conduct of a sexual nature. Any person who commits such a violation may be subject to personal liability as well as disciplinary actions, up to and including termination.

Sexual harassment of employees by supervisors, co-workers or clients/customers is strictly prohibited. Such conduct is unlawful when:

- ◆ Submission to the conduct is made a term or condition of employment;
- ◆ Submission to or rejection of the conduct is used as the basis for an employment decision affecting an employee; or
- ◆ The conduct has the purpose or effect of unreasonably interfering with an employee's work performance, or creating an intimidating, hostile, or offensive work environment.

Examples of sexual harassment include unwelcome sexual flirtations, advances or propositions; verbal abuse of a sexual nature; subtle pressure or requests for sexual favors; unnecessary touching of an individual; a display in the workplace of sexually suggestive objects or pictures; sexually explicit or offensive jokes; or a physical assault.

If at anytime on your assignment you believe that you are being subjected to discrimination or harassed in any way, please express your assessment of remarks made or actions taken as "harassment," or "discrimination" and the facts of the incident(s) to your direct supervisor, the house supervisor, or, if you prefer, the assignment facility's Human Resources department.

In many situations, individuals are insensitive to the offensiveness of their words or behaviors, but will cease the offensive behavior when its impact is brought to their attention. Try this approach, bearing in mind that what is acceptable in one environment may not be acceptable in another.

While working as a Traveler you may find environments that are less tolerant of “kidding around” and “teasing” than you have been used to, or you may find yourself uncomfortable in an environment that is far more tolerant of “kidding around” or “teasing” than you have worked in before. In this situation, make your discomfort known through the appropriate chain of command at the healthcare facility.

If the situation is not resolved to your satisfaction, please report the facts of the incident(s) to the Clinical Liaison who will immediately investigate any complaint and work with the assignment facility to define and initiate appropriate preventive and/or corrective action(s).

No Traveler or corporate staff employee will be retaliated against for making a complaint or bringing inappropriate conduct to the Company’s attention, for preventing unlawful practices, or for participating in an investigation, proceeding, or hearing conducted by any governmental agency.

TRAVELERS:

- 1. Be aware that as a Traveler you will be viewed as a “newcomer,” and may not ever become part of the facility’s social “family.” Be especially conscious of this status in your words and actions, taking care never to say or do anything that could be viewed as “in poor taste” or construed as harassing behavior. Always keep in mind that what is acceptable in one environment may not be acceptable in another, and that often one person’s “kidding around” or “teasing” is another person’s “harassment.”*
- 2. Show respect to everyone by refusing to participate in or tolerate inappropriate behavior.*

I have read, understood and intend to comply with these Professional Conduct Expectations.

Employee Signature

Date

Please Print Name

Date



AGE SPECIFIC JOB REQUIREMENTS

JCAHO mandates that caregivers and other facility employees are competent to provide age appropriate care and services. As a result our Client facilities require that we document your competencies for all age groups for whom you provide care.

The following highlights some of the most important caregiver actions related to the age of the patient. Identify the age groups of your patients.

Neonates

Provide protective environment.

- ◆ Cuddle and hug the baby.
- ◆ Use pacifier and bottle as distractions.
- ◆ Position babies in supine position for sleep.
- ◆ Ensure warmth.
- ◆ Involve parents in decision making process.
- ◆ Provide parents with information about support services available to aid them to meet the needs of their baby post-discharge.

Infants

- ◆ Keep parents in infant's line of vision within safety limits.
- ◆ Give infant a familiar object for comfort.
- ◆ Limit the number of strangers present.
- ◆ Remove equipment used and keep rail up after procedure.
- ◆ Position infant in supine position for sleep.
- ◆ Involve parents in decision-making processes.
- ◆ Do not allow infant to routinely use a bottle as a sleeping aid.
- ◆ Provide parents with information about support services available to help them to meet the needs of their child post-discharge.

Toddlers

- ◆ Explain what you'll do before beginning.
- ◆ Use firm, direct approach.
- ◆ Give one direction at a time.
- ◆ Prepare the child immediately before procedures.
- ◆ Allow choices when possible.
- ◆ Distract the toddler from focusing on pain or procedures.
- ◆ Use play as a means of preparation and explanation of procedures.
- ◆ Allow for religious/cultural beliefs as expressed by parents.
- ◆ Include parents in education of the toddler.
- ◆ Emphasize aspects of procedures that will require cooperation.

- ◆ Provide parents with information about support services available to help them meet the needs of their toddler post-discharge.

Pre-school and school-age patients

- ◆ Explain procedure and equipment using correct terminology.
- ◆ Plan for duration of education and play sessions appropriate to child's tolerance.
- ◆ Educate using games, rewards and praise.
- ◆ Allow child to have as much control over the environment as possible.
- ◆ Explain unfamiliar objects.
- ◆ Involve child whenever possible.
- ◆ Plan procedures in advance to reduce child's waiting time.
- ◆ Allow for expressions of religious/cultural beliefs as expressed by the parents.
- ◆ Include parents in the child's education.
- ◆ Provide parents with information about support services available to help them meet the needs of their child post-discharge.

Adolescents

- ◆ Include reasons in explanation of procedures.
- ◆ Encourage questions regarding the patient's fears.
- ◆ Provide privacy – especially for adolescents.
- ◆ Involve in decision making and planning.
- ◆ Expect resistance from the patient.
- ◆ Allow for religious/cultural beliefs.
- ◆ Include parents in the patient's education as appropriate to the family dynamic and medical condition of the patient.
- ◆ Provide parents and the adolescent with information about support services available to help them meet their needs after the patient's discharge.

Adults

- ◆ Include reasons in explanation of procedures.
- ◆ Encourage questions regarding the patient's fears.
- ◆ Provide privacy.
- ◆ Involve in decision making and planning.
- ◆ Allow for religious/cultural beliefs.
- ◆ Bring significant others into the patient's education.
- ◆ Provide for mobility of the patient.
- ◆ Provide information to patient and members of the patient's support network about available services to help meet the patient's and their needs post-discharge.

Geriatrics

- ◆ Include reasons in explanation of procedures.
- ◆ Encourage questions regarding patient's fears.
- ◆ Provide privacy.
- ◆ Speak distinctly.
- ◆ Focus light directly on objects.
- ◆ Slow the pace of explanations and presentations.

- ◆ Ensure warmth.
- ◆ Involve in decision making and planning.
- ◆ Provide for mobility of patient.
- ◆ Change patient positions slowly due to decreased circulatory force.
- ◆ Involve patient or designated individual in decisions involving treatment plan.
- ◆ Consider ability to chew, taste, see, hear, and think and remember in seeking patient's cooperation and in patient teaching.
- ◆ Provide information about support services to help caretakers and other family members meet the patient's and their needs post-discharge.

I have read, understood and intend to comply with these professional conduct expectations.

Nurse Associate Signature

Date

Please Print Name

Date



Physicians Statement

The section below is to be completed by employee.

Medical Release Authorization:

I _____ do hereby authorize _____ to release any information
(Applicant Name) (Physicians Name)
 acquired during my medical examination to Rehability Care. Furthermore I authorize Rehability Care to release any information on this statement, relevant to employment, to any of its client facilities. I understand this must be completed before I can begin work with Rehability Care.

 Employee Signature

 Date

The section below is to be completed by physician or staff.

Height: _____ **Weight:** _____ **Pupils:** Equal ____ Unequal ____

Blood Pressure: _____ **Heart Rate:** _____ **Pulse:** _____

MEDICAL:	NORMAL	ABNORMAL	COMMENTS
Appearance	_____	_____	_____
Eyes/ears/nose/throat	_____	_____	_____
Hearing	_____	_____	_____
Lymph nodes	_____	_____	_____
Heart	_____	_____	_____
Lungs	_____	_____	_____
Abdomen	_____	_____	_____
Genitalia (males only)	_____	_____	_____
Skin	_____	_____	_____
MUSCULOSKELETAL:	_____	_____	_____
Neck	_____	_____	_____
Back	_____	_____	_____
Shoulder/Arm	_____	_____	_____
Elbow/forearm	_____	_____	_____
Wrist/hand/fingers	_____	_____	_____
Hip/thigh	_____	_____	_____
Knee	_____	_____	_____
Leg/ankle	_____	_____	_____

I have examined this patient and determined that this person is in good physical health, free of communicable diseases and is able to function and perform all job duties without any physical limitations in his/her profession at full capacity.

 Physician's Signature

 Physicians Medical ID Number

 Physician Phone

 Address

 City

 State

 Zip

Date of exam: _____ Time of exam: _____



Hepatitis B Vaccination Fact Sheet

The Vaccine:

Engerix-B (Hepatitis B Vaccine-Recombinant) is a noninfectious, Recombinant DNA hepatitis B vaccine. Over several studies, at least 90% of the individuals immunized have been seroprotected. Duration of protection by the vaccine has not been fully defined and is still being studied; however, in one study 76% of the immunized individuals had titers high enough to be considered immune for 10 years after vaccination.

Persons with immune deficiency problems should obtain a written release from their physician prior to receiving the vaccine. Persons with known allergies to yeast may require a different form of the vaccine known as "Hepatitis B Virus Vaccine (Plasma-derived).

Benefits to Recipients:

The hepatitis B vaccine provides protection against acquiring the hepatitis B virus. It is especially recommended to those individuals who have occupational exposure to blood of other potentially infectious materials. Although most people who acquire hepatitis recover fully, about 10% become chronic carriers of the disease and 1-2% die of fulminant hepatitis. There also has been an association between hepatitis B virus and the development of liver cancer and/or cirrhosis of the liver. Thus the vaccine and the vaccination offer a method of protection, free of charge to the Access Therapies employee, from acquiring hepatitis B at work or elsewhere.

Possible Adverse Reactions:

Engerix-B (Hepatitis B Vaccine-Recombinant) is generally well tolerated. No substances of human origin are used in its manufacture. Adverse reactions, if any, to the vaccines are generally mild, infrequent, and transient. As with any vaccine, however, it is possible that expanded commercial use of the vaccine could reveal rare adverse reactions not observed in clinical studies.

The most frequently reported adverse reactions include: injection site soreness, fatigue, weakness, induration, erythema, swelling, fever, headache, and dizziness. Adverse reactions of a more serious nature have been reported, but with a frequency of less than 1% of the immunized population. If there are any further questions regarding adverse reactions of the vaccine, ask your supervisor.

Contraindications:

Not to be used in persons with a known allergy/hypersensitivity to yeast and/or other components of the vaccine. The vaccine should be administered with caution to any person known to have thrombocytopenia or bleeding disorder. These persons should have the vaccination administered via the subcutaneous versus the intramuscular route.

Dosing Schedules:

Three doses of the hepatitis B vaccine are required to confer immunization against infection. "Engerix-B" is administered on a selected date, then again at one-month and at six-months from the date of the first injection.

Pregnancy, Fertility and Lactation:

Since animal reproduction studies have not been carried out on "Engerix-B", the vaccine should be given to pregnant women only when clearly indicated. It is also not known whether the vaccine can cause any harm to the fetus when administered to a pregnant woman. It is not known if the vaccine affects fertility. Finally, it is not known if the vaccine is excreted in human breast milk. Because many drugs are excreted in human breast milk, caution should be used when considering administering the vaccine to a nursing mother.



HEPATITIS B VIRUS VACCINE CONSENT/DECLINATION

Please sign and date EITHER the verification OR declination.
DO NOT SIGN BOTH.

BLOODBORNE PATHOGENS

I HAVE BEEN INFORMED OF THE SYMPTOMS AND MODES OF TRANSMISSION OF BLOODBORNE PATHOGENS INCLUDING HEPATITIS B VIRUS (HBV). I KNOW ABOUT THE AGENCY'S INFECTION CONTROL PROGRAM AND UNDERSTAND THE PROCEDURE TO FOLLOW IF AN EXPOSURE INCIDENT OCCURS.

HEPATITIS B VACCINE VERIFICATION

I fully understand that my occupation may lead to exposure of blood or other potentially infectious materials. I may be at risk of acquiring Hepatitis B infection. I was vaccinated for Hepatitis B (HBV) in the past (ALL 3 vaccines) and the date of my last vaccination was _____. I will provide all records of previous of Hepatitis B vaccinations.

Signature

Date

Printed Name

HEPATITIS B VACCINE DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I choose to be vaccinated for Hepatitis B, I will pursue the vaccination series

Signature

Date

Printed Name



Tuberculosis Screening Questionnaire / TB (PPD) Skin Test

The section below is to be completed by employee.

Employee Name: _____ Date: _____ Discipline: _____

Have you ever had a positive TB Skin Test (PPD) Result: Yes _____ No _____

If Yes; date of last chest X-Ray: _____

Screening Questionnaire: Please indicate if you have had any of the following problems for three weeks or longer:

	Yes	No	Comments
Chronic Cough (greater than 3 weeks):			
Production of Sputum:			
Blood Streaked Sputum:			
Unexplained Weight Loss:			
Fever:			
Fatigue/Tiredness:			
Night Sweats:			
Shortness of Breath:			

Employee Signature Date

The section below is to be completed by persons authorized to administer and read Mantoux Skin Tests.

Testing Location: _____ Date Placed: _____

Site: Right _____ Left: _____ Lot #: _____ Exp Date: _____

Signature (administered by): _____ RN ___ MD ___ Other ___

Date Read (within 48-72 hours of date placed): _____ Induration: _____mm

TB Skin Test / PPD (Mantoux) Result: Negative _____ Positive _____

Signature (administered by): _____ RN ___ MD ___ Other ___

The section below is to be completed by Rehability Care

Date Received: _____ Reviewed By: _____