




# Work History

# Nationwide Nurses



Please include Last 5 Years Beginning with the Most Recent (This form may be copied if more space is needed)

Place of Employment	Supervisor	Employment Dates		Position Held	Reason for Leaving
		From	To		
Name	First Name			List all that apply for your entire employment	
Street Address	Last Name	Was this a Travel Assignment?			
City	Position	Yes	No		Reference Phone Number
<b>Place of Employment</b>	<b>Supervisor</b>	<b>Employment Dates</b>		<b>Position Held</b>	<b>Reason for Leaving</b>
		From	To		
Name	First Name			List all that apply for your entire employment	
Street Address	Last Name	Was this a Travel Assignment?			
City	Position	Yes	No		Reference Phone Number
<b>Place of Employment</b>	<b>Supervisor</b>	<b>Employment Dates</b>		<b>Position Held</b>	<b>Reason for Leaving</b>
		From	To		
Name	First Name			List all that apply for your entire employment	
Street Address	Last Name	Was this a Travel Assignment?			
City	Position	Yes	No		Reference Phone Number

I certify that the answers to the questions asked in this packet are true and correct to the best of my knowledge. I hereby authorize Nationwide Nurses to investigate statements and responses contained herein. I understand that falsification or misinformation may result in discharge at any time it becomes known by the agency. I understand and agree that neither anything contained in this employment packet nor the granting of any interview creates an employment contract between the agency and myself.

\_\_\_\_\_  
Nurse Full Name (Printed)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
Date

**Clinical Evaluation**



**Previous Employer** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Attention** \_\_\_\_\_

Supervisor Name

Title

\*\*\*\*\*

**APPLICANT  
INFORMATION**

I have made an application for employment with Nationwide Nurses. I hereby authorize you to furnish information concerning my employment record & ability. I release you from any claims that may arise in relation to your response & information provided.

**Name Used While Employed** \_\_\_\_\_

**Positions Held** \_\_\_\_\_ **Clinical Specialty** \_\_\_\_\_

**Dates of Employment From** \_\_\_\_\_ **To** \_\_\_\_\_

**Reason For Leaving** \_\_\_\_\_

\_\_\_\_\_  
Nurse Full Name (Printed)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
SSN

\_\_\_\_\_  
Date

\*\*\*\*\*

**PERFORMANCE  
EVALUATION**

Please evaluate the following skills by checking the appropriate box.

<u>Expectations</u>	<u>Exceeded</u>	<u>Met</u>	<u>Not Met</u>	<u>Comments</u>
Punctuality	_____	_____	_____	_____
Charting Skills	_____	_____	_____	_____
Performance	_____	_____	_____	_____
Adaptability	_____	_____	_____	_____
Initiative	_____	_____	_____	_____
Attitude	_____	_____	_____	_____
Appearance	_____	_____	_____	_____
Cooperation	_____	_____	_____	_____

Is the above Applicant Information correct? Yes \_\_\_ No \_\_\_

If not, what is incorrect? \_\_\_\_\_

Would you rehire this person? Yes \_\_\_ No \_\_\_

Why or why not? \_\_\_\_\_

\_\_\_\_\_  
Completed by (Print Name)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

**Clinical Evaluation**



**Previous Employer** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Attention** \_\_\_\_\_

Supervisor Name

Title

\*\*\*\*\*

**APPLICANT  
INFORMATION**

I have made an application for employment with Nationwide Nurses. I hereby authorize you to furnish information concerning my employment record & ability. I release you from any claims that may arise in relation to your response & information provided.

**Name Used While Employed** \_\_\_\_\_

**Positions Held** \_\_\_\_\_ **Clinical Specialty** \_\_\_\_\_

**Dates of Employment From** \_\_\_\_\_ **To** \_\_\_\_\_

**Reason For Leaving** \_\_\_\_\_

\_\_\_\_\_  
Nurse Full Name (Printed)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
SSN

\_\_\_\_\_  
Date

\*\*\*\*\*

**PERFORMANCE  
EVALUATION**

Please evaluate the following skills by checking the appropriate box.

<u>Expectations</u>	<u>Exceeded</u>	<u>Met</u>	<u>Not Met</u>	<u>Comments</u>
Punctuality	_____	_____	_____	_____
Charting Skills	_____	_____	_____	_____
Performance	_____	_____	_____	_____
Adaptability	_____	_____	_____	_____
Initiative	_____	_____	_____	_____
Attitude	_____	_____	_____	_____
Appearance	_____	_____	_____	_____
Cooperation	_____	_____	_____	_____

Is the above Applicant Information correct? Yes \_\_\_ No \_\_\_

If not, what is incorrect? \_\_\_\_\_

Would you rehire this person? Yes \_\_\_ No \_\_\_

Why or why not? \_\_\_\_\_

\_\_\_\_\_  
Completed by (Print Name)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

**Clinical Evaluation**



**Previous Employer** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Attention** \_\_\_\_\_

Supervisor Name

Title

\*\*\*\*\*

**APPLICANT  
INFORMATION**

I have made an application for employment with Nationwide Nurses. I hereby authorize you to furnish information concerning my employment record & ability. I release you from any claims that may arise in relation to your response & information provided.

**Name Used While Employed** \_\_\_\_\_

**Positions Held** \_\_\_\_\_ **Clinical Specialty** \_\_\_\_\_

**Dates of Employment From** \_\_\_\_\_ **To** \_\_\_\_\_

**Reason For Leaving** \_\_\_\_\_

\_\_\_\_\_  
Nurse Full Name (Printed)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
SSN

\_\_\_\_\_  
Date

\*\*\*\*\*

**PERFORMANCE  
EVALUATION**

Please evaluate the following skills by checking the appropriate box.

<u>Expectations</u>	<u>Exceeded</u>	<u>Met</u>	<u>Not Met</u>	<u>Comments</u>
Punctuality	_____	_____	_____	_____
Charting Skills	_____	_____	_____	_____
Performance	_____	_____	_____	_____
Adaptability	_____	_____	_____	_____
Initiative	_____	_____	_____	_____
Attitude	_____	_____	_____	_____
Appearance	_____	_____	_____	_____
Cooperation	_____	_____	_____	_____

Is the above Applicant Information correct? Yes \_\_\_ No \_\_\_

If not, what is incorrect? \_\_\_\_\_

Would you rehire this person? Yes \_\_\_ No \_\_\_

Why or why not? \_\_\_\_\_

\_\_\_\_\_  
Completed by (Print Name)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date



## Clinical Experience



**Nurse Full Name** \_\_\_\_\_  
 (Please print)

**Specialty** \_\_\_\_\_

**Number of years of actual work experience in a hospital setting:**

Please complete thoroughly with dates and/or years of experience in each area. If no experience in a particular area, enter "0".

\*\*\*\*\*

<b>UNIT</b>	<b>Actual Number</b>	<b>Most Recent Year</b>
<b><u>General Nursing</u></b>	<b><u>of Years</u></b>	
Clinic	_____	_____
Med/Surg	_____	_____
Neuro	_____	_____
Oncology	_____	_____
Ortho	_____	_____
Post Op	_____	_____
Psych	_____	_____
Rehab	_____	_____
Telemetry	_____	_____

\*\*\*\*\*

<b><u>Obstetrical Nursing</u></b>		
L & D	_____	_____
Mother/Baby	_____	_____
Nursery	_____	_____
Post Partum	_____	_____

\*\*\*\*\*

<b><u>Pediatric Nursing</u></b>		
Med/Surg	_____	_____
NICU	_____	_____
PICU	_____	_____

\*\*\*\*\*

<b><u>Specialty Nursing</u></b>		
Burn Unit	_____	_____
Cath Lab	_____	_____
CCU/CVICU	_____	_____
Dialysis	_____	_____
ER	_____	_____
ICU	_____	_____
OR	_____	_____
SICU	_____	_____
Transplants	_____	_____

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**I am current in the following Certifications:** (Please provide readable copies of each certification held)

<b>TYPE</b>	<b>Exp. Date (mo./yr.)</b>	<b>TYPE</b>	<b>Exp. Date (mo./yr.)</b>
_____ BCLS	_____	_____ ACLS	_____
_____ PALS	_____	_____ NRP	_____

# Self-Assessment of Med/Surg Nursing Skills



**Nurse Full Name:** \_\_\_\_\_

Please check the skills below according to your performance factor.  
Please circle the number that best describes your proficiency level.

Level of experience:

- 1 = No experience**
- 2 = Intermittent experience**
- 3 = One year experience**
- 4 = Two years consistent**
- 5 = Able to teach and supervise**

### Patient Assessment Skills

Auscultation & Identification of Heart & Lung Sounds	1	2	3	4	5
Auscultation & Identification of Bowel Sounds	1	2	3	4	5
Identification of Abnormal Heart & Lung Sounds	1	2	3	4	5
Using an Oto-Ophthalmoscope to Evaluate Retina, Eardrum	1	2	3	4	5
Assessing Papillary Response as Part of Neurological Assessment	1	2	3	4	5
Assessing & Describing Levels of Consciousness	1	2	3	4	5
Using Appropriate Interview Techniques	1	2	3	4	5
Assessing Skin Breakdown Potential	1	2	3	4	5
Assessing for Fall Risk	1	2	3	4	5

### Care Plan Formulation

Use a Goal Directed Care Plan	1	2	3	4	5
Use a Care Pathway	1	2	3	4	5
Work with a Multidisciplinary Team to Plan Care/Discharge	1	2	3	4	5
Write Nursing Notes Using the Focus-Note Approach	1	2	3	4	5

### Medication Administration

Administer Oral & Topical Route Medications	1	2	3	4	5
Administer Medications Via Injection	1	2	3	4	5
Give IV Push & Piggyback Medications	1	2	3	4	5
Administer Medications Through Gastric Tubes	1	2	3	4	5
Administer Medications via Button Infusers & Ports	1	2	3	4	5
Recognize Adverse Reactions to Medications	1	2	3	4	5

### Intravenous Therapy & Specialty Medication

Give Chemotherapy Medications	1	2	3	4	5
Calculate IV Drug Drip Rates for Cardiac Medications	1	2	3	4	5
Assess For & Manage Complications, Adverse Reactions	1	2	3	4	5

### **Intravenous Therapy & Specialty Medication (cont.)**

Care of Patient with an Acute Allergic Reaction	1	2	3	4	5
Convert IV Lines to Heparin Locks	1	2	3	4	5
Do Heparin Drips	1	2	3	4	5
Collaborate with Pharmacy/Lab on Measuring Drug Levels	1	2	3	4	5
Modify IV Administration for the Latex Allergy Patient	1	2	3	4	5
Start IV's with Butterfly, Cannula & Safety IV Needles	1	2	3	4	5
Hang Blood Products & Monitor Blood Infusions	1	2	3	4	5
Assist with Central Line Insertion	1	2	3	4	5
Discontinue Central Lines	1	2	3	4	5
Use IV Pumps & PCA Pumps	1	2	3	4	5

### **Specimen Collection**

Collect Urine for UA, Culture & Sensitivity	1	2	3	4	5
Collect Stool for Blood, Ova & Parasites	1	2	3	4	5
Collect Anaerobic & Aerobic Specimens for Culture	1	2	3	4	5
Collect 5 and 24 Hour Urine Specimens	1	2	3	4	5
Conduct Capillary Blood Sugar Test	1	2	3	4	5

### **Cardiac Patient Care**

Can Apply Telemetry Leads for Lead II Monitoring	1	2	3	4	5
Can Recognize Death Producing Cardiac Rhythms	1	2	3	4	5
Knows ACLS Algorithms for Various Arrest Patterns	1	2	3	4	5
Can Use a Defibrillator and/or AED	1	2	3	4	5
Can Insert Oral & Nasal Airways	1	2	3	4	5
Can Use a Bag/Valve/Mask Set-up	1	2	3	4	5
Can Put a Laryngoscope Together, Assist with Intubations	1	2	3	4	5
Able to Use a Portable Oxygen Tank	1	2	3	4	5
Assist with Temporary Pacemaker Insertion	1	2	3	4	5
Care for a Cardiac Cath Patient Pre- & Post-Op	1	2	3	4	5
Care for a CABG Patient Pre- & Post-Op	1	2	3	4	5
Understand Principles of Cardiac Rehabilitation	1	2	3	4	5

### **Medical/Surgical Patient Care**

Can do Oral & Nasopharyngeal Suctioning	1	2	3	4	5
Prepares & Applies Warm & Cold Packs	1	2	3	4	5
Dressings:					
Sterile	1	2	3	4	5
Clean	1	2	3	4	5
Wet-to-Dry	1	2	3	4	5
Compression	1	2	3	4	5
Can Apply Knee Immobilizers & Hip Abductors	1	2	3	4	5
Can Apply Slings, Bandages & Binders	1	2	3	4	5
Use a Doppler to Assess Peripheral Pulses	1	2	3	4	5
Monitor CPM Machines Function	1	2	3	4	5
Insert, Manage & Remove Foley Catheters	1	2	3	4	5

**Medical/Surgical Patient Care (cont.)**

Assist with Thoracentesis, Paracentesis & Lumbar Puncture	1	2	3	4	5
Insert, Manage & Remove Nasogastric & Feeding Tubes	1	2	3	4	5
Use Sequential Pressure Devices	1	2	3	4	5
Use Wound Suction Devices & Machines	1	2	3	4	5
Do Continuous Bladder Irrigation	1	2	3	4	5
Monitor Intracranial Pressure	1	2	3	4	5
Set Up & Manage Chest Tubes	1	2	3	4	5
Set Up & Direct Care of Patient in Isolation	1	2	3	4	5
Manage an Epidural Catheter for Pain Control	1	2	3	4	5
Take Care of a Trach	1	2	3	4	5
Manage the Patient in Skeletal or Buck's Traction	1	2	3	4	5
Give Colostomy Care, Manage Appliances	1	2	3	4	5
Manage Mechanical Ventilators, Apnea Monitors	1	2	3	4	5

**Age Specific Practice Criteria**

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

- A. Newborn/Neonate (Birth – 30 Days)
- B. Infant (30 Days – 1 Year)
- C. Toddler (1 – 3 Years)
- D. Preschooler (3 – 5 Years)
- E. School-Age Children (5 – 12 Years)
- F. Adolescents (12 – 18 Years)
- G. Young Adults (18 – 39 Years)
- H. Middle Adults (39 – 64 Years)
- I. Older Adults (64+ Years)

**Experience with Age Groups**

	A.	B.	C.	D.	E.	F.	G.	H.	I.
Able to adapt care to incorporate normal growth & development.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to adapt method & terminology of patient instructions to their age, comprehension & maturity level.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can ensure a safe environment reflecting specific needs of various age groups.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

By this signature, I certify that this information is true and correct to the best of my knowledge. I will be held responsible for any discrepancies.

\_\_\_\_\_  
Nurse Full Name (Signature)

\_\_\_\_\_  
Date

**Request Under The Freedom Of Information Act**



Date \_\_\_\_\_

To \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Do Not Write Above This Line. For Office Use Only.**

**Complete The Information Below:**

Pursuant to the Freedom of Information Act, I request disclosure of any information on me that may be maintained in your files, and to the extent the disclosure is required by law. Please forward the information to the address below.

**Nationwide Nurses  
P. O. Box 7  
Marble Falls, AR 72648  
Toll Free Fax: 1-866-365-8548**

Printed Name \_\_\_\_\_  
First Middle Initial Last

Signature \_\_\_\_\_  
Date

Permanent Address \_\_\_\_\_

Maiden Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

Drivers License \_\_\_\_\_

Current Address \_\_\_\_\_

**Traveler Questionnaire**



**Nurse Full Name** \_\_\_\_\_ **Date** \_\_\_\_\_

Is this your first travel assignment? Yes \_\_\_\_\_ No \_\_\_\_\_

If No, number of travel assignments taken previously \_\_\_\_\_

**My geographical preferences are:**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**I plan on traveling for** \_\_\_\_\_ **period of time.**

**My main reason for traveling is:** (Rank order 1-7)

- \_\_\_\_\_ Advance my career      \_\_\_\_\_ Better compensation      \_\_\_\_\_ Better benefits
- \_\_\_\_\_ New experiences      \_\_\_\_\_ New locations      \_\_\_\_\_ Change of lifestyle
- \_\_\_\_\_ Meet new friends

**When I am not working, I enjoy:** (Rank order 1-7)

- \_\_\_\_\_ Educational advancements      \_\_\_\_\_ Sports      \_\_\_\_\_ Shopping
- \_\_\_\_\_ Museums & Historical sites      \_\_\_\_\_ Entertainment      \_\_\_\_\_ Recreation
- \_\_\_\_\_ Other \_\_\_\_\_ (please write in specifics)

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**I would like to make \$** \_\_\_\_\_ **in compensation.**

**The most important considerations to me in taking a travel assignment are:**

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Thank you for taking the time to complete this questionnaire. **Nationwide Nurses** will utilize this information to supply you with travel opportunities that meet your criteria. We are looking forward to sending you on the ultimate travel experience.

## Interview Guidelines



This is to assist you in your telephone interview with the clinic/hospital. Remember, the clinic/hospital has a copy of your work history, skills checklist and applicable credentials, but you must sell yourself to this clinic/hospital, convincing them that you are the best travel nurse for the position.

Facility Name \_\_\_\_\_ Location \_\_\_\_\_

Nurse Manager \_\_\_\_\_ Unit/Floor \_\_\_\_\_

### UNIT

1. Number of beds: \_\_\_\_\_ Types of patients: \_\_\_\_\_
2. Nurse/ patient ratio on: Days \_\_\_\_\_ Evenings \_\_\_\_\_ Nights \_\_\_\_\_
3. Special equipment that is used: \_\_\_\_\_
4. Type of charting/documentation: \_\_\_\_\_
5. Special procedure/medication system that is used: \_\_\_\_\_
6. Uniform required? Yes \_\_\_\_\_ No \_\_\_\_\_ Provided by: Nurse \_\_\_\_\_ Facility \_\_\_\_\_
7. Number of unlicensed staff available: \_\_\_\_\_
8. Patient Care Model: Team Nursing \_\_\_\_\_ Primary Nursing \_\_\_\_\_
9. Have Travelers been utilized previously in your unit? Yes \_\_\_\_\_ No \_\_\_\_\_
10. If so, how often: \_\_\_\_\_

### SCHEDULE

1. Available date to start work: \_\_\_\_\_ Length of assignment: \_\_\_\_\_
2. Shifts to be worked: \_\_\_\_\_ Are weekend shifts required? Yes \_\_\_\_\_ No \_\_\_\_\_
3. If so, how often? \_\_\_\_\_
4. Will nurse be in a "charge position" at any time? \_\_\_\_\_
5. Is overtime available? Yes \_\_\_\_\_ No \_\_\_\_\_ How much? \_\_\_\_\_
6. Policy on working Holidays: \_\_\_\_\_

### FLOATING

1. I am aware floating is required to similar floors/units. How often? \_\_\_\_\_
2. To which floors/units: \_\_\_\_\_
3. Will travelers float first, or in rotation with permanent staff? \_\_\_\_\_
4. Could I float to more than one unit per shift? Yes \_\_\_\_\_ No \_\_\_\_\_

### FIRST DAY INFORMATION

1. What is the length of the orientation (hospital vs. unit specific)? \_\_\_\_\_
2. Date of next class: \_\_\_\_\_
3. Who will be my preceptor/resource person? \_\_\_\_\_
4. What tests will be required? \_\_\_\_\_
5. Are there study guides available? Yes \_\_\_\_\_ No \_\_\_\_\_
6. Where do I report? \_\_\_\_\_ What time should I report? \_\_\_\_\_
7. Whom do I ask for? \_\_\_\_\_
8. Should I wear a uniform the first day? Yes \_\_\_\_\_ No \_\_\_\_\_
9. Where is parking? \_\_\_\_\_
10. Is free parking available? Yes \_\_\_\_\_ No \_\_\_\_\_ If not, what is the cost? \_\_\_\_\_

Comments \_\_\_\_\_

HAVE YOU ANSWERED ALL THE ABOVE QUESTIONS? IF YOU WANT THE POSITION, **ASK FOR IT!!**



<b>Physician's Statement</b>


**Patient's Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Social Security Number** \_\_\_\_\_

\*\*\*\*\*

I have examined the above individual and found him/her to be in good physical & mental health, sufficient to perform the duties of the nursing profession at full capacity.

**Healthcare Provider Signature:** \_\_\_\_\_

**Date of Physical:** \_\_\_\_\_ **State & License#:** \_\_\_\_\_

\*\*\*\*\*

**To be completed ONLY if completed at time of physical.**

DRUG SCREEN	NEGATIVE	POSITIVE	NOT TESTED
Cocaine (COC)	↙	↙	↙
Marijuana (THC)	↙	↙	↙
Opiates/Morphine (OPI/MOR)	↙	↙	↙
Amphetamines (AMP)	↙	↙	↙
Methamphetamine (mAMP)	↙	↙	↙
Phencyclidine (PCP)	↙	↙	↙
Benzodiazepine (BZO)	↙	↙	↙
Barbiturates (BAR)	↙	↙	↙
Methadone (MTD)	↙	↙	↙
Tricyclic Antidepressants (TCA)	↙	↙	↙
Oxycodone (OXY)	↙	↙	↙
Propoxyphene (PPX)	↙	↙	↙
Methylenedioxymethamphetamine (MDMA)	↙	↙	↙
Alcohol (ALC)	↙	↙	↙

\*\*\*\*\*

Urine sample **WAS** / **WAS NOT** witnessed. *(Please circle one)*

I certify that the above testing results are true and accurate to the best of my knowledge.

**Healthcare Provider Signature:** \_\_\_\_\_



## Nurse Handbook

This agreement made \_\_\_\_\_ is between RK ENTERPRISES, LLC, dba **Nationwide Nurses**, (hereinafter referred to as "**NWN**"), and \_\_\_\_\_, a pending or existing employee of **NWN** (hereinafter referred to as **Nurse**).

WHEREAS, **NWN** is a Arkansas-based Company engaged in the business of recruiting and supplying temporary medical personnel within the health care field, and WHEREAS, the **NURSE** possesses current training and experience of one (1) year in a hospital setting; and

WHEREAS, **NWN** provides equal employment opportunity to all **NURSES**, employees and applicants for employment regardless of race, color, religious creed, national origin, sex, age, sexual orientation, ancestry or physical or mental disability according to applicable state and federal law; and

WHEREAS, **NWN** will provide representation of the **NURSE** in order to place them on assignment with interested **NWN'S** customers (hereinafter "**CLIENT**"), and the **NURSE** desires to be placed on assignment; and

WHEREAS, **NWN** has given **NURSE** access to **NWN'S CLIENTS** and other confidential information; which amounts to significant placement efforts and monetary cost to make placement of **NURSE**;

THEREFORE, in consideration of the covenants and mutual promises contained and for other good and valuable consideration, **NWN** and **NURSE** agree as follows:

1. The **NURSE** desires to find a temporary assignment or permanent placement. **NWN** will use all efforts and financial resources available to find a suitable assignment. **NURSE** understands that he/she is not obligated to accept any assignments. Furthermore, once **NWN** has submitted **NURSE'S** profile to **CLIENT**, should **NURSE** choose to accept an offer made by **CLIENT**, acceptance must be through **NWN**. It is mutually understood that a **CLIENT'S** offer and the **NURSE'S** verbal acceptance of an assignment are binding. Specifics associated with the assignment will be written and then confirmed by the signature of **NURSE** through the **Travel Nurse Contract**. initial \_\_\_\_\_
2. The **NURSE** is to let **NWN** know if **NURSE** has requested other travel companies to submit **NURSE'S** profile to **CLIENTS**. **NWN** will make every effort to prevent profile submission duplication to the **CLIENTS**. **The Nurse cannot take employment with another company with the same Client after NWN has submitted the profile to that Facility.** The **NURSE** cannot work for another travel, per-diem, or local company while on assignment for **NWN**. initial \_\_\_\_\_
3. The **NURSE** agrees employment by **NWN** is at will, temporary, and **CLIENT** may terminate at any time, with or without notice, unless otherwise stated in this agreement. Upon early termination due to no fault of **NURSE**, **NWN** will use reasonable efforts to find a new assignment for the **NURSE**. In the event of early termination due to poor job performance, **NWN** will assist **NURSE** in obtaining return transportation at **NURSE'S** expense. initial \_\_\_\_\_
4. The **NURSE** may accept employment by the **CLIENT**. **NWN** must receive notice of **CLIENT'S** and **NURSE'S** intent. Once **CLIENT** and **NURSE** have given notice, the remainder of the 13 week assignment must be completed, or the contract may be bought out at \$10.00 per hour for every remaining hour left on the 13-week contact assignment. This allows **NWN** to recruit a replacement. initial \_\_\_\_\_

\_\_\_\_\_

5. The **NURSE** may accept employment by another travel or per-diem company at the end of any 13-week assignment, but **NURSE** cannot work for another company in the last facility where assigned by **NWN** for a period of 90 days after resignation. initial \_\_\_\_\_
  
6. The **NURSE** will not at any time divulge confidential and proprietary information about **NWN** or **CLIENT** and **CLIENT'S** patients unless written consent of **NWN**, and where appropriate, **CLIENT**, is given. initial \_\_\_\_\_
  
7. The **NURSE** will act in accordance with the highest ethical and professional standards and agrees to comply with all the **CLIENT'S** policies and procedures. initial \_\_\_\_\_
  
8. The **NURSE** understands and agrees the **CLIENT** may require varying shifts and varying hours at the sole discretion of the **CLIENT**. It is likewise understood and agreed that **CLIENT** may require **NURSE** to float or transfer to another area, floor or affiliated location where **NURSE'S** expertise is appropriate. **NURSE** agrees that he/she will be available to **CLIENT** at least two (2) days a week for on-call status, in addition to regularly scheduled shifts. initial \_\_\_\_\_
  
9. The **NURSE** will provide **NWN** all employment, educational, licensure and medical information as well as any other appropriate information required to be on file prior to the commencement of any assignment. Any known false information submitted is grounds for immediate termination. All physicals, immunizations and other medical information required will be at the **NURSE'S** expense. Continuing education and nursing licensure is reimbursable with receipt while on assignment with **NWN**. initial \_\_\_\_\_
  
10. The **NURSE** and **NWN** will remain in contact during the contracted period and both parties will continue to provide each other information regarding the **NURSE'S** experience during the assignment. **NURSE** must communicate any problems or difficulties **immediately, with proper documentation**. **NWN** is available via telephone 24 hours a day, 7 days a week. **NWN** must have a working contact telephone number at all times and **NURSE** must return **NWN** and **CLIENT** phone calls ASAP. initial \_\_\_\_\_
  
11. Each facility conforms to different paid holidays. **NWN** will pay **NURSE** holiday pay at the rate of time and one-half the regular rate, as outlined in **Travel Nurse Contract**, which is issued with each assignment. Remember, in a holiday week, overtime will not be accumulated until the **NURSE** has worked 40 hours, in addition to the holiday pay. The **NURSE** must work the scheduled shifts immediately preceding and following the holiday in order to be paid holiday pay. Regular pay will be paid to the **NURSE** that is normally scheduled to work the holiday, but cannot due to facility or unit closure. initial \_\_\_\_\_
  
12. The **NURSE** will submit weekly time slips via facsimile by Monday, 12 Noon Central Time, each week. Time slips must be complete and signed by facility supervisor. This policy must be adhered to, in order to allow our Accounting Department sufficient time to complete each week's payroll requirements. Any **NURSE** that does not follow the above requirement agrees that payment for that week's work shall be made the following week, once time slips are submitted. initial \_\_\_\_\_
  
13. Absenteeism or illness without written documentation from a physician verifying the reason shift was missed, will result in **NURSE'S** housing allowances, weekly bonuses and car allowances being pro-rated. All amounts will be deducted from weekly pay. **NWN** will be diligent to this policy and must have written documentation for any absence. The true cost must be reflected in these situations. Three (3) unexcused absences per contract are grounds for termination. No Call, No Show is grounds for immediate termination. initial \_\_\_\_\_

14. The **NURSE** must contact **NWN** when a **CLIENT** cancels shifts. The total hours of the contract are guaranteed by **CLIENT** when lost hours are due to the **CLIENT'S** actions. **CLIENT** will make up lost hours to **NURSE** prior to end of assignment. The **NURSE** may not ask to be placed on on-call status before working all regularly scheduled shifts for the week. initial \_\_\_\_\_
15. If **NWN** cancels contract with **CLIENT** due to a breach, **NWN** cannot guarantee pay to **NURSE** for hours not worked due to this breach. **NWN** will make every reasonable effort to reassign **NURSE** to another **CLIENT**. initial \_\_\_\_\_
16. If **NURSE** terminates an assignment prior to completion without the agreement of **NWN** or is terminated by the **CLIENT** with appropriate cause, **NURSE** must repay additional monetary liability **NWN** incurred, if any, as well as repay a prorated amount of any moneys advanced by **NWN**, including advance travel that is considered an advance predicated on contract completion. Any costs non-recoverable by **NWN** and all hours not worked as fulfillment of assignment contract will be charged back to the **NURSE** at the rate of \$10.00 per hour for each hour missed. In addition, **NURSE** may be held liable due to the circumstances of canceled contract. initial \_\_\_\_\_
17. **NWN** always strives to provide **NURSE** with comfortable and appropriate housing. Inspection by a representative of the **CLIENT** or another party is not always possible. In such an occurrence where housing is not suitable, **NWN** will use every reasonable effort to secure housing that meets **NWN** Standards. **NURSE** will assist in these efforts. If the **NURSE** travels with someone other than another **NURSE** currently on assignment with **NWN**, **NURSE** agrees to pay the following:
- Utilities: **NURSE** pays 25% for up to three (3) additional people. **NURSE** pays 30% if four (4) or more additional people.
  - Additional Bedrooms: **NURSE** pays the difference between Private Accommodations and the number of bedrooms secured.
  - Furniture: **NURSE** pays cost of furniture for each additional bedroom.
- When **CLIENT** provides housing, **CLIENT** will establish the requirements. **NWN** agrees to communicate the **CLIENT** requirements with **NURSE**. When **NURSE** agrees to accept the Per Diem Allowance program, **NWN** will not be responsible for obtaining housing accommodations but will, in every instance, assist **NURSE** in all arrangements. **NWN** will payroll deduct housing costs for **NURSE** out of this Per Diem allowance. initial \_\_\_\_\_
18. The **NURSE** is responsible for the upkeep of the housing accommodations and all the furnished items within. **NURSE** shall return the housing and furnishings provided in good, clean condition, allowing for normal use. It is specifically understood and agreed that the **NURSE** shall be financially responsible for any damages, cleaning costs or repairs that are required by the landlord for the period **NURSE** occupied the premises. Furthermore, move-in may occur 48 hours prior to contracted start date (for inspections and contract preparation), and upon move-out, the **NURSE** has 48 hours after the contracted end date to conduct the walk-through with housing manager and vacate the premises. initial \_\_\_\_\_
19. The **NURSE** is solely responsible for any pet deposit at any housing complex. In addition, **NURSE** shall be financially responsible for any damages incurred as a result of any pet(s). **NURSE** agrees that all pet arrangements will be with Landlord/Manager or housing owners. If for any reason **NWN** pays any charges on behalf of **NURSE**, **NURSE** agrees **NWN** will deduct the cost of such damages from **NURSE'S** pay. initial \_\_\_\_\_
20. The **NURSE** will follow all requirements of the housing complex prior to, during, and after occupation as set forth herein. Additionally, **NWN** will provide all information to **NURSE** so they may contact housing

complex manager upon arrival and before departure. **NWN** strongly suggests the **NURSE** use the **Move In/Move Out** checklist provided by **NWN**, with manager's signature in place, to verify conditions of all housing accommodations. If **NURSE** does not conduct a walk-through before and at the end of lease, any charges made by housing complex are understood as fact and cannot be argued. As previously stated, **NURSE** shall be responsible independently or via paycheck deduction for all charges incurred. initial \_\_\_\_\_

21. **NWN** carries Workers Compensation Insurance on all employees. **NURSE** understands that he or she is being hired by an Arkansas company in the State of Arkansas. **NURSE** may work in the State of Arkansas or **NURSE** may be assigned a temporary position in another state. Any paperwork filled out by any nurse or any medical personnel or any other person concerning any claims, must be sent directly to **NWN** and no other person or entity. In the event an injury should arise on the job, **NURSE must** report to the immediate supervisor within 24 hours and an incident report must be filled out, signed by **CLIENT** and a copy must be provided to **NWN**. **NURSE** must submit to a drug screen test at **NURSE'S** expense if injured on the job. **NURSE** may be subject to a statutory penalty for late reporting. **NURSE** must agree to adhere to the following **SAFETY RULES**: Wear appropriate shoes and dress; no use of alcohol or drugs while on the job; adhere to **CLIENT'S** general policy & procedures; only operate equipment for which you are qualified to operate and authorized by supervisor; report all unsafe conditions or equipment; make corrections to unsafe conditions only if authorized by supervisor; adhere to proper Body Mechanics to lift patients; always wash hands, using proper hand washing techniques; follow proper hypodermic needle disposal techniques; adhere to fall precautions per facility's policy & procedures; and adhere to Universal Precautions. initial \_\_\_\_\_

All other information concerning the specifics of the **NURSE'S** assignment and **NWN'S** and **NURSE'S** responsibilities are listed in the **Travel Nurse Contract**. This agreement shall be construed in all respects according to the laws of the State of Arkansas. When **NWN** offers a position to a **NURSE** and **NURSE** accepts position from **NWN**, both are acknowledging and indicating agreement with the above-stated terms and the Terms of the **Travel Nurse Contract** issued with each assignment.

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Nurse Full Name (Printed) (Signature)

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Nationwide Nurses Representative Date

## Traveler Conduct Expectations



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

1. I will not discuss any elements of my compensation with anyone employed at the host facility.
2. I will not discuss any previous assignments worked for Nationwide Nurses with anyone employed at the host facility.
3. I will not recruit any Healthcare Professional that is employed by the host facility.
4. I will communicate with the management, staff and patients of the host facility in a respectful manner at all times.
5. I will not work for another travel or local per diem company full time or part time while I am working on assignment for NWN.
6. I will honor all terms of my Nurse Placement Contract Handbook, including, but not limited to, the beginning and ending assignment dates, the hours to be worked, the housing arrangements, if applicable, and travel arrangements, if applicable.
7. I will honor the policies and procedures of Nationwide Nurses and the host facility.

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

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Nurse Full Name (Printed)

(Signature)

Date

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Nationwide Nurses Representative

Date