



## 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. Job Application must be completed in full, including the Primary Applicant Agreement/Professional Conduct Expectations. Job application is valid for one year. Please print or type neatly. You may include your resume, but it will not replace a complete job application.
2. Signed and completed I-9 Form.
3. **Two** written references on letterhead or a performance evaluation with **one** other reference. These are 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                    | ▪ Perioperative Nursing             | ▪ Medical Surgical Nursing: Pediatric |
| ▪ Intermediate Care Nursing: Adult                | ▪ Psychiatric Nursing: Adult & Peds | ▪ Surgical Tech                       |
| ▪ Perinatal Nursing: Neonatal                     | ▪ Perinatal Nursing: Maternal       | ▪ LPN/LVN                             |
| ▪ Critical & Intermediate Care Nursing: Pediatric | ▪ Medical Surgical Nursing: Adult   |                                       |

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

#### **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.
8. Proof of immunity to Rubeola, Rubella and Mumps (**positive titer or 1 official, physician signed MMR**).
9. Proof of immunity to Varicella-(positive titer or Varivax inoculation).
10. Tetanus within 10 years, or signed declination.

#### **Licenses, Professional Certifications, and Resuscitation Credentials**

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

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

*Thank you for your attention to creating an admirable Healthcare Professional file.*

FASTAFF ▪ 800-736-8773 ▪ Fax: 888-508-7854 ▪ [www.fastaff.com](http://www.fastaff.com)  
6501 S. Fiddler's Green Circle, Suite 200 ▪ Greenwood Village, CO 80111

Revised 12/28/07

Checklist

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Application Packet

# JOB APPLICATION

Please Print Clearly and Use Black Ink Only

Date Available for Work \_\_\_\_\_

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

Email Address \_\_\_\_\_

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

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

Address #2 (If you possess a PO Box for your main address, please provide another non-PO Box address) \_\_\_\_\_

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 one of the following choices)

**Direct Mail-** Ref# or Description \_\_\_\_\_

**Website-** \_\_\_ FASTAFF website \_\_\_ U.S. Nursing website

**Web Advertisement-** Please specify which site you saw the ad on: \_\_\_\_\_

**Magazine/Journal-** \_\_\_ RN Magazine \_\_\_ HT Magazine \_\_\_ Nursing Magazine \_\_\_ AORN  
\_\_\_ Nursing Spectrum \_\_\_ Nurse Week \_\_\_ Other (please specify) \_\_\_\_\_

**Newspaper-** City, State of Newspaper \_\_\_\_\_

**FASTAFF Road Recruitment-** City, State you visited FASTAFF \_\_\_\_\_

**Personal Referral -** Name of Referrer \_\_\_\_\_

**Trade Show-** Trade Show Name \_\_\_\_\_

**Other** (please specify) \_\_\_\_\_

Have you spoken to a Recruiter?  Yes Name \_\_\_\_\_  No

**If you have spoken to a Recruiter please be sure to place their name above.**

## EDUCATION

Name and Location of School(s)	Graduated (Date)	Type of Degree
_____	_____	_____
_____	_____	_____
_____	_____	_____

## LICENSURE

*(Please list all including expired)*

State	Professional License #	Expiration Date
AK		
AL		
AR		
AZ		
CA		
CO		
CT		
DC		
DE		
FL		
GA		
HI		
IA		
ID		
IL		
IN		
KS		

State	Professional License #	Expiration Date
KY		
LA		
MA		
MD		
ME		
MI		
MN		
MO		
MS		
MT		
NC		
ND		
NE		
NH		
NJ		
NM		
NV		

State	Professional License #	Expiration Date
NY		
OH		
OK		
OR		
PA		
RI		
SC		
SD		
TN		
TX		
UT		
VA		
VT		
WA		
WI		
WV		
WY		

Which of these licenses is your 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?  Yes  No

If YES, please explain \_\_\_\_\_

## PROFESSIONAL CERTIFICATIONS

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

<b>Type</b>	<b>Expiration Date</b>
-------------	------------------------

_____	_____
_____	_____
_____	_____

## 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
_____	_____	_____
_____	_____	_____
_____	_____	_____

## 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 REGISTERED NURSE.

SPECIALTY	PRIMARY	FLOAT	DATE (mo/yr)
<b>CRITICAL CARE- ADULT</b>			
Bone Marrow Transplant ICU	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Burn ICU	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Cardiac ICU	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Cardiac Catheterization Lab	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Cardiothoracic ICU	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Cardiovascular ICU	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Emergency Department- Level 1	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Emergency Department- Level 2	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Emergency Department- Level 3	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Medical ICU	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Neuro ICU	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Neurosurgical ICU	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Transplant ICU	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Trauma ICU	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Surgical ICU	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
<b>CRITICAL CARE - PEDIATRIC</b>			
Burn ICU - Peds	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Cardiac Catheterization Lab	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Emergency Room - Peds	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Pediatric ICU	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Pediatric - Transplant ICU	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Other:	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
<b>INTERMEDIATE CARE - ADULT</b>			
Cardiac SD/Telemetry Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Endoscopy Lab	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Surgical Step-down Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
<b>INTERMEDIATE CARE - PEDIATRIC</b>			
Pediatric Step-down Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Other:	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
<b>MEDICAL SURGICAL - ADULT</b>			
Admitting/Observation Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Diabetic Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Gastrointestinal Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
General Surgery Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Genitourinary Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Geriatric Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Gynecology Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Hematology Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Hemodialysis Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Home Health	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Hospice Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Med Surg Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Renal Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Neurology Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____
Oncology Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/____/____

SPECIALTY	PRIMARY	FLOAT	DATE (mo/yr)
<b>MEDICAL SURGICAL - ADULT CONT'D</b>			
Orthopedic Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Outpatient Clinic	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Pulmonary Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Radiology Services	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Rehabilitation Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Skilled Nursing Facility	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
<b>MEDICAL SURGICAL - PEDIATRIC</b>			
General Peds Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Oncology Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Home Health	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Hospice Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Rehabilitation Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Other:	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
<b>PERIOPERATIVE</b>			
Pre-op Holding or Monitoring	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Operating Room	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Cardiovascular OR	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Cystoscopy Suite	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
ENT/Ophthalmology OR	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
General Surgery OR	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Neurosurgical OR	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Orthopedic OR	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Transplant OR	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Post Anesthesia Care Unit/ RR	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Same Day Surgery	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
<b>PERINATAL</b>			
Antepartum Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Labor & Delivery	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
High Risk Labor & Delivery	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
LDRP	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Mother Baby Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
NICU, Level 2	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
NICU, Level 3	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Newborn Nursery	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Postpartum Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Other:	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
<b>PSYCHIATRY – ADULT</b>			
General Psychiatric Unit - Adult	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Chemical Dependency Unit-Adult	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Dual Diagnosis Unit - Adult	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Locked Psychiatric Unit - Adult	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Other:	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
<b>PSYCHIATRY - PEDIATRICS</b>			
Adolescent Psychiatric Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Dual Diagnosis Unit - Adolescent	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ Yrs	_____/_____/_____
Pediatric Psychiatric Unit	<input type="checkbox"/> _____ Yrs	<input type="checkbox"/> _____ 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.

<input checked="" type="checkbox"/>	Skill		<input checked="" type="checkbox"/>	Skill
	Arrhythmia Interpretation			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:

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## ADDITIONAL INFORMATION

Have you 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 of "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 essential 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 to two years 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 FASTAFF where I may need to travel to an assignment.

Date available for assignment \_\_\_\_\_

I would like to be considered for positions 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 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: \_\_\_\_\_

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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  CNA  Other \_\_\_\_\_  
Reason for leaving \_\_\_\_\_

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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  CNA  Other \_\_\_\_\_  
Reason for leaving \_\_\_\_\_

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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  CNA  Other \_\_\_\_\_  
Reason for leaving \_\_\_\_\_

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\*Supplemental includes travel, per diem, and local staffing assignments.

# EMPLOYMENT EXPERIENCE CONT'D

Fill out the following information for any job you have been employed at 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  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  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  CNA  Other \_\_\_\_\_

Reason for leaving \_\_\_\_\_

\*Supplemental includes travel, per diem, and local staffing assignments.

# PRIMARY APPLICANT AGREEMENT

The following agreement is for informational purposes. FASTAFF<sup>®</sup> Inc. has the right to decide whether to hire any applicant, and the applicant has the right to choose whether to be placed by FASTAFF. Both will agree to the following:

## FASTAFF'S COMMITMENT

**PLACEMENT.** FASTAFF will attempt to secure placement of the Applicant at an assignment with a facility for the time period indicated on the Assignment Agreement Letter (AAL). This time period may be extended at the completion of the assignment as long as the facility, applicant, and FASTAFF agree on the terms at the time of the extension. The AAL 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.** FASTAFF agrees to pay the applicant according to the pay rate indicated on the AAL, and in accordance with applicable Federal, State, and Local laws. The pay rate may vary according to 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 AAL, which is sent to applicant for final approval.

**BONUSES.** FASTAFF and U.S. Nursing are proud to be Health Care Staffing Services Certified by JCAHO. In order to ensure we are adhering to JCAHO standards, the company reserves the right to withhold all eligible bonus payments from any employee who fails to provide required file documentation including but not limited to renewed license and certifications, I-9 paperwork, physical, skills check list and any other documents required by the client or JACHO.

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

**HOUSING.** FASTAFF 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 AAL. If applicable and if applicant provides his or her own housing while on a travel assignment, FASTAFF will offer a reimbursement policy indicated on the AAL.

**REIMBURSEMENTS.** All requests for reimbursements are subject to FASTAFF approval and must be submitted to FASTAFF within 90 days of incurring expenditure. Reimbursement forms can be found on our website at [www.fastaff.com](http://www.fastaff.com) or by fax or mail.

**LICENSURE.** FASTAFF agrees to assist the Applicant in obtaining proper licensure for travel assignments in other states. However, licensure is the sole responsibility of the Applicant. FASTAFF also agrees to reimburse Applicant for the cost of the permanent licensure incurred for the state in which the Applicant completes a travel assignment obligation and follows all FASTAFF reimbursement 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.** FASTAFF agrees to provide the Applicant with the benefits described in the FASTAFF benefit packet. Applicant is subject to terms and conditions of the benefit program. FASTAFF reserves the right to change the benefits at anytime with or without notification.

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

**DEDUCTIONS FROM PAYCHECK.** Applicant authorizes FASTAFF 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 the housing accommodation, telephone and fax charges left unpaid at time of departure, any other room service charges, damage/destruction to housing, and any other expenses owed to FASTAFF.

DISCLAIMER. FASTAFF reserves the right, and the Applicant acknowledges FASTAFF may at anytime, with or without notice, modify this Primary Applicant Agreement (PAA). 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 PAA, 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 to specific assignments will be included in the AAL. Applicant is not obligated in any way to accept placement position secured by Corporation until the AAL is signed.

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

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

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

DRUG SCREENS. Prior to placement and throughout employment with FASTAFF, 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 FASTAFF.

BACKGROUND CHECKS. Before the Applicant is placed and throughout employment with FASTAFF, FASTAFF may, upon a facility's request, conduct background checks of any kind from any location for any purpose FASTAFF 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 FASTAFF to release any and all confidential employment and medical information contained in my employment file to any medical facility or entity with whom FASTAFF has a staffing agreement, and to any other governmental or regulatory agency at such agency's request. For all other purposes, FASTAFF shall keep my employment and medical records confidential and shall advise any medical facility or other entity to whom records have been provided to also keep such records confidential. I hereby release and hold FASTAFF harmless for any result(s) that may arise with regard to the release of this confidential information by FASTAFF.

TRAVEL. Applicant agrees to follow all FASTAFF rules regarding travel. Any travel arrangements will be specified in the AAL.

HOUSING. Applicant accepts all FASTAFF rules regarding housing. If applicable, final housing arrangements will be encompassed in the AAL. 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, FASTAFF will offer a reimbursement policy as indicated on the AAL.

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

**RECORDING OF TIME WORKED.** Applicant agrees to abide by FASTAFF's procedures for reporting time worked, including hospital supervisor approval for shift time worked and missed lunch periods. The FASTAFF workweek begins at 7:00 AM on Sunday and concludes at 6:59 AM on the following Sunday. Applicant's time sheet must reach FASTAFF each Monday by 10 AM Mountain Standard Time in order to be paid in the current week. Any late submissions 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, unless 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 Healthcare Professional Managers for each applicable shift.

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

**TERMINATION.** Applicant understands if he/she leaves his/her assignment early for any reason or is terminated by FASTAFF, Applicant must vacate company provided housing within 24 hours and will be responsible for return travel costs. Applicant authorizes FASTAFF 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.** FASTAFF and Applicant will maintain the confidentiality and exclusivity of this Agreement.

**AGREEMENT REVIEW.** FASTAFF 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.** FASTAFF is an equal opportunity employer incorporated in the State of Colorado and in good standing with the Colorado Secretary of State. FASTAFF 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.

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

**For Corporation:**

FASTAFF®  
Attn: Records Department  
6501 S. Fiddlers Green Circle, Suite 200  
Greenwood Village, CO 80111

**For Applicant:**

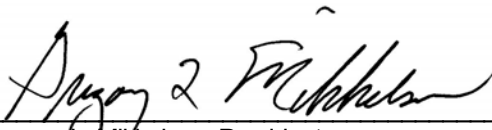
Applicant name: \_\_\_\_\_  
Applicant address: \_\_\_\_\_  
\_\_\_\_\_

# HEALTHCARE PROFESSIONAL CONDUCT EXPECTATIONS

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

- 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 FASTAFF with anyone employed at the host facility.
- I will not recruit any Healthcare 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 FASTAFF 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.

  
\_\_\_\_\_  
Gregory L. Mikkelsen, President

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date



# REQUEST FOR REFERENCE

(Please have your reference fill out form completely before returning to FASTAFF)

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

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

Social Security Number of Healthcare Professional: \_\_\_\_\_

## How would you rate this former employee?

\_\_\_\_\_ has applied for a nursing position with FASTAFF Nursing 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 Healthcare Professional. Your comments will be kept in strict confidence.

Name and Title of Reference: \_\_\_\_\_ Phone Number \_\_\_\_\_

Facility Name: \_\_\_\_\_ Address: \_\_\_\_\_ City, St Zip: \_\_\_\_\_

Dates Healthcare Professional was employed: From \_\_\_\_\_ To \_\_\_\_\_

Healthcare Professional's Title \_\_\_\_\_ Clinical Area Worked \_\_\_\_\_

	Exceeds Expectations	Meets Expectations	Meets Some Expectations	Does Not Meet Expectations
Quality of Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professionalism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flexibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dependability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enthusiasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leadership Ability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attendance/Punctuality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Customer Service Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Reason this Healthcare Professional left your facility:  Terminated  Lay-off  
 Resigned  Temporary

Comments (please continue on back, if necessary) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Would you hire this Healthcare Professional again?  Yes  No

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

Please return this form to:  
FASTAFF  
6501 S. Fiddler's Green Circle, Suite 200  
Greenwood Village, CO 80111

Or fax to: 888-508-7854



# 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, thorough and individualized manner according to patient need .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Works collaboratively with other members of the team to develop an individualized plan of patient care .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Performs interventions in a timely, accurate and safe manner .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Documents the patient care process accurately .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Demonstrates competency appropriate for assigned patient population including adaptations for age specific care .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicates respectfully & effectively with patients, families, visitors & all facility staff and physicians .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintains confidentiality in all aspects of patient care .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adheres to facility policies and procedures .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reports to work on time and as scheduled. Notifies immediate supervisor if unable to work .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exhibits a high level of professionalism .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exhibits flexibility and adaptability .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

\* = Please specify deficiencies in comment section below.

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Print: Name/Title \_\_\_\_\_

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

**Please fax back to 888-873-7812**



## 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

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

\* = Please specify deficiencies in comment section below.

**Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Print: Name/Title** \_\_\_\_\_

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

**Please fax back to 888-873-7812**

# 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 test positive)		Date Completed _____	Results _____
Rubella Titer <input type="checkbox"/>	MMR <input type="checkbox"/>	Date Completed _____	Results _____
Rubeola Titer <input type="checkbox"/>	MMR <input type="checkbox"/>	Date Completed _____	Results _____
Mumps Titer <input type="checkbox"/>	MMR <input type="checkbox"/>	Date Completed _____	Results _____
Varicella Titer <input type="checkbox"/>	Varivax <input type="checkbox"/>	Date Completed _____	Results _____
Hepatitis B Titer <input type="checkbox"/>	Booster <input type="checkbox"/>	Date Completed _____	Results _____
Hepatitis B Series <input type="checkbox"/>		1 <sup>st</sup> Date Completed _____	2 <sup>nd</sup> Date _____
Tetanus <input type="checkbox"/>			3 <sup>rd</sup> Date _____
		Date Completed _____	

**Please submit supporting documentation of immunization records and lab results.**

I have examined the individual named 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 the above information is valid.

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

Printed Physician's Name \_\_\_\_\_

## FASTAFF applicant 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 FASTAFF, Inc. 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 FASTAFF client (hereinafter "Facility") that requires the Tetanus vaccination.

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

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