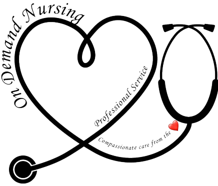

ON DEMAND NURSING, LLC 662-836-4881
"We count on each other" P.O. Box 251
Belzoni, MS 39038
odnursing@gmail.com

Medical Experience

Healthcare Discipline
Advanced Practice RN_________ RN __________

LPN II________ LPN________

CNA_________ other_________

Total Years of Experience________

Education
GraduateSchool___________________City________State____YearGraduated_____ Degree Type____

NursingSchool____________________City________State_____YearGraduated____DegreeType______
Vocational/Technical________________City_________ State___Year Graduated_____Degree Type____

Clinical Experience
Please identify the amount of experience you have in each unit listed below. Greater flexibility with float experience translates into more opportunities for assignment.

Critical care____ Operating Room____
Emergency Room____ Post-Partum_____
Medical Surgical _____ Labor and Delivery____
Stepdown/ICU ______ Geri-Psych______
Dialysis_______ Inpatient Rehab_____

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CONTRACTOR'S STATEMENT OF UNDERSTANDING

1. I understand that RNs will be paid $40-45 dollars and LPN.'s $25-30 dollars/hr. and CNA $15-20 dollars per hours for subcontracting to the client facilities.

2. I understand that I may be pulled to other areas in the facility, at the client facilities discretion, If I refuse I agree to contact the office first at 662-836-4881.
3. I understand that I am not and employee of their hospital. Any changes to my schedule or cancellations must be handled by On Demand Nursing, LLC.
4. I understand that I can contact the on-call person after hours at 662-836-4881.
5. I understand that I must sign in and out to receive payment for any given shift during that. pay period. If I fell to sign in or out, I must wait until a hospital representative is able to confirm that I worked that shift.
6. I understand that if I need to cancel, I must contact On Demand Nursing, LLC within 4 hours prior to the start of my scheduled shift.
7. I understand that If I am a no call/ no show, I may not be able to return to that facility.
8. I understand that dishonest with sign in sheets and falsifying documents is considered forgery and can be viewed as a criminal act.
9. I understand that excessive cancellation, will consider my work status as inactive.
10. I understand On Demand Nursing, LLC is not responsible for providing Worker's Compensation or Professional Liability Insurance for me because of my independent contractor status and that I am Responsible for providing my own Professional Liability Insurance.
11. I understand that I am not an employee of On Demand Nursing, LLC and as an independent contractor I will receive a 1099 from On Demand Nursing, LLC and at the end of the tax year, I am responsible for my own tax reporting.
12. I authorize and understand that my application packet (to include Social Security number and Health Status Information) may be released to client facilities.

_____________________________________ _________________________________

Independent Contract Signature Date

______________________________________ __________________________________

Management Signature Date

ON DEMAND NURSING LLC
STAFFING AGENCY

HEALTHCARE PROVIDER STATEMENT OF HEALTH

PATIENT NAME: ____

The above named patient to my knowledge, has no physical, mental chronic or communicable diseases that would prevent them from being a caregiver in a home of facility setting.

This patient is, to the best of my knowledge, is able to perform all necessary work duties in a home or facility setting.

____ ______________

Print Name/Credentials of Medical Provider Date

Address: ____

____

_____________________________________ _______________

Medical Provider’s Signature Date

P.O. Box 251
Belzoni, MS 39038
(662) 836-4881
Fax: (769) 969-1013

Hepatitis B Vaccination Status

Name____________________ Classification ____________________

The hepatitis B Vaccination will made available to all healthcare personnel after personnel have received the required training, within 10 working days of initial assignment and to all who have occupational exposure, unless the healthcare personnel are exempted from having the Hepatitis B Vaccination series for any of the following reasons:

(check one)

_______Antibody testing indicates me to be immune

_______The vaccine cannot be given for medical reasons

_______I have received the complete Hepatitis B Vaccination series previously

_______I would like the Hepatitis B Vaccination

_______I am currently receiving the Hepatitis Vaccination

______________________ ____________________

Signature Date

Declination Statement

I decline the Hepatitis B Vaccination at this time, I understand that my declining the vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. Understand that due to my occupational exposure to blood and other potentially infectious materials, I may be at a higher risk of acquiring Hepatitis B.

_________________________________ _________________

Signature Date

ON DEMAND NURSING LLC
STAFFING AGENCY

TB SKIN TEST REPORTING FORM

NAME ____
(Please Print)

DATE OF TEST __________________________

DATE READ____
(HAVING TEST READ 48 TO 72 HOURS AFTER IT IS GIVEN)

READ BY: ____

RESULTS: ______________ O MM/NEGITIVE

______________ MM/POSITIVE

IF REDNESS OR SWELLING IS PRESENT YOUR TEST MUST BE READ BY EMPLOYEE HEALTH OR NURSING SUPERVISOR

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