



**Fax application to: 866-307-5952
or email info@modernindustrialservices.com**

Date: _____

Number of Pages including cover sheet: _____

Please contact _____ and call _____ as soon as possible, if application packet is incomplete or is illegible

To:

Attn: Modern Industrial Services, Inc.

Phone: (800) 834-1720

Recruiter: _____

From: _____

Name: _____

Phone Number: _____

Fax Number: _____

Email-Address: _____

Please submit the application file in the following Check List Order.

- ___ 1. Employment Application and Work History
- ___ 2. Skills Checklist Provide Clear Copies of Personal Identification, RN License, Certifications (BLS, NRP, etc)
- ___ 3. Age Specific Evaluation
- ___ 4. Employee Confidentiality
- ___ 5. HIPPA Form
- ___ 6. Blood Borne Pathogen Inservice
- ___ 7. OSHA Form
- ___ 8. Employment Reference (2)
- ___ 9. Consent to do Background Check
- ___ 10. Medical Test
- ___ 11. Competency Exam
- ___ 12. Authorization to Release Health Info
- ___ 13. Consent to Drug Test
- ___ 14. Hepatitis B Vaccination
- ___ 15. Physician Statement
 - a. Vaccination Record (TB, MMR, Varicella, Hepatitis)
- ___ 16. CA Penal Code



Registered Nurse Employment Application

(Please fill out all spaces even if you attach a resume)

Last NameFirst NameMiddle Name

Address

CityStateZip Code

E-mail Address

Primary PhoneSecondary Phone

Are you a US Citizen?Date of BirthSocial Security Number

Emergency Contact Name *and* Primary Phone

Preferred Shift (circle one): Day Night

Dates Available: Specialty Preference:

Specialty	Dates Worked	Years of Experience	Specialty	Dates Worked	Years of Experience

RN Licensure (attach separate sheet if necessary)

State	License Number	Expiration Date



Nursing School	City/State	Graduation Date	Degree

Certification (Please circle):

Name	Expiration	Name	Expiration
CPR/BLS		PALS	
ACLS		NRP	
CCRN		TNCC	
FHM		EMPC	

Have you ever been convicted of a felony? (if yes, please explain): _____

Will you consent to a criminal background check? Yes No

Are you able to perform the functions of the position you are applying for? Yes No

Some of our clients require a drug screen. Will you submit to one if asked? Yes No

Employment History

Dates Employed: _____ Facility Name: _____

Address _____ City _____ State _____ Zip Code _____

Unit Worked: _____ Full Time/Part Time/Traveler/Per Diem: _____

Immediate Supervisor Name _____ Phone Number _____

Can we contact your Supervisor? Yes No



Shift Worked: _____ Teaching Facility: _____ Charge: _____

Patient Ratio: _____ Reason For Leaving: _____

Dates Employed: _____ Facility Name: _____

Address City State Zip Code

Unit Worked: _____ Full Time/Part Time/Traveler/Per Diem: _____

Immediate Supervisor Name Phone Number

Can we contact your Supervisor? Yes No

Shift Worked: _____ Teaching Facility: _____ Charge: _____

Patient Ratio: _____ Reason For Leaving: _____

Dates Employed: _____ Facility Name: _____

Address City State Zip Code

Unit Worked: _____ Full Time/Part Time/Traveler/Per Diem: _____

Immediate Supervisor Name Phone Number

Can we contact your Supervisor? Yes No

Shift Worked: _____ Teaching Facility: _____ Charge: _____

Patient Ratio: _____ Reason For Leaving: _____

Dates Employed: _____ Facility Name: _____

Address City State Zip Code



Applicant EEO-1 Information Collection Form

Dear Applicant:

Please fill out the Affirmative Action data below. To ensure that Modern Industrial Services, Inc. complies with pertinent hiring practices, Modern Industrial Services, Inc. must keep records about our applicants for employment. This questionnaire will be kept in a confidential file, separate from the application for employment. Failure to provide this information will in no way adversely affect your candidacy for this position. However, we would greatly appreciate your willingness to submit this information for our commitment to equal opportunity.

Please **print** your name and city information. This information is strictly confidential however your information must be legible for reporting purposes.

Last Name: _____ **First Name:** _____

Which city and state do you work in? _____

Gender

Female: _____ **Male:** _____

Handicap Status

No: _____ **Yes:** _____

(any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairments or is regarded as having such impairments)

Veteran Status

_____ **Vietnam era veteran:** Person who served on active duty for a period of more than 180 days, any part of which occurred between 8/5/64 and 5/7/74 and has any discharge other than dishonorable.

_____ **Disabled Vietnam Veteran:** 30% or more V.A, certified disability incurred or aggravated in the line of duty before 8/5/64 or after 5/7/74.

_____ **Disabled Veteran (not Vietnam era)** 30% or more V.A, certified disability incurred or aggravated in the line of duty before 8/5/64 or after 5/7/74.

Age: Are you over the age 40 but under the age of 70?

Yes: _____ **No:** _____

EEO Ethnicity Code:

Note that all definitions as listed below were provided by the U.S. Federal Government Equal Employment Opportunity Commission (EEOC)

_____ **Black:** Persons having origins in any of the Black racial groups of Africa.

_____ **White:** Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

_____ **Asian or Pacific Islander:** Persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent or the Pacific Islands. This includes, for example: China, Japan, Korea, India, Pakistan, Nepal, the Philippine Islands, Samoa and Polynesia.

_____ **American Indian or Alaskan Native:** Persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

_____ **Hispanic:** Persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.



Skills Set Check List

Line Therapy	Proficient	Observed	Experience
Administration of Medications through Groshong Catheter			
Application of Extension Tubing to Hickman or Broviac Catheter			
Blood Administration			
Cap Change for Hickman or Broviac Catheter			
Central Line Dressing			
Dressing change to Groshong Catheter Site			
Hickman or Broviac Catheter Irrigation			
Home Antibiotic Therapy			
Home Chemotherapy Administration			
Injection Cap Change to Groshong Catheter			
Intravenous Therapy			
Irrigation of Heparin Lock			
Irrigation of Groshong Catheter			
IV Gamma Globulin Administration			
Medication Administration via Epidural Catheter			
Obtaining Blood Specimens from a Hickman or Broviac Catheter			
PICC Lines			
Port A Cath System			
Refill of Insaid Pump			
Total Parenteral Nutrition and Lipids			
Use of Groshong Catheter			
Withdrawal of Blood Samples from Groshong Catheter			
Eyes, Ears, Throat	Proficient	Observed	Experience
Instillation of Ear Drops			
Instillation of Eye Drops			
Instillation of Nose Drops			
Irrigation of the Ear			
Irrigation of the Eye			
Orthopedic Care			
Application of Arm Sling			



Care of Patient following total hip replacement			
Care of Patient following total knee replacement			
Care of Patient in Traction			
Stump Wrapping			
Use of Arm or Leg Splint			
Irrigation of the Eye			
Special Therapeutic Nursing Care	Proficient	Observed	Experience
Administration of Rectal Suppositories			
Application of Leg Bag			
Application of Polyurethane Dressing for Partial Thickness Wounds			
Application of Transparent Wound Dressings			
Application of Unna Boot			
Arteriovenous Fistula & Shunt Dressing Change			
Assessment of Management of Open Wounds			
Blood Glucose Testing Devices			
Care of Gastrostomy Tube			
Catheter Care			
Catherization			
Catherization for PVR			
Cleansing Enema			
Colostomy irrigation			
Condom Cath. Application			
Continuous Bladder Irrigation			
Dry Sterile Dressing			
Enteral Feedings			
Fleets Enema			
Insertion of Rectal Tube			
Insertion of Gastrostomy Tube			
Insertion of Suprapubic catheter			
Intermittent Bladder Irrigation or Installation			
Manual Removal of Fecal Impaction			
Nasogastric Tube Placement			
Oil Retention Enema			
Oral and Nasopharyngeal Suction			
Ostomy Care			
Patency Assessment of Arteriovenous Fistula			



Seizure Precautions			
Specific Gravity			
Sterile Scrub Sponges			
Suprapubic Catheter Care			
Suctioning of the Tracheotomy Tube			
Suture Removal			
Tracheotomy Care			
Vaginal Irrigation			
Special Therapeutic Nursing Care	Proficient	Observed	Experience
Vaginal pack Removal			
Wet Sterile Dressing			
Wound Irrigation			



Evaluation For Age Specific Performance Expectation

Demonstrates supportive behaviors necessary for age specific care by observation, documentation, chart review and in service education.

Please circle those that apply.

1 = Almost Never 2 = Some of the time 3 = Nearly Always N/A = Not applicable

Neonate/Infant

Involves the parent/guardian in care/teaching.	1	2	3	N/A
Ensures infant warmth during care/teaching.	1	2	3	N/A
Offers familiar objects to infant.	1	2	3	N/A
Keeps parents in infant's line of vision, within safety specifications.	1	2	3	N/A
Provides a pacifier/distraction prn (as directed).	1	2	3	N/A

Preschooler

Involves child in care whenever possible.	1	2	3	N/A
Allows child to have some control by allowing choices.	1	2	3	N/A
Explains unfamiliar objects.	1	2	3	N/A
Plans care/procedures in advance to decrease child's waiting time.	1	2	3	N/A
Explains procedures using child's terminology.	1	2	3	N/A

School age/Adolescent

Is aware of importance of relationships with peers (may need friends to visit).	1	2	3	N/A
Allows child to have some control/choices when possible.	1	2	3	N/A
Involves the patient in care/teaching.	1	2	3	N/A
Always provides for privacy for adolescent patients.	1	2	3	N/A
Encourage questions during procedures.	1	2	3	N/A

Adult

Involves the patient in planning and providing of care.	1	2	3	N/A
Involves the patient in care/teaching.	1	2	3	N/A
Encourages verbalization of fears.	1	2	3	N/A
Allows patient to maintain control and involves decision making whenever possible.	1	2	3	N/A

Geriatric

Involves the patient in care/teaching.	1	2	3	N/A
Slows pace of care to allow for slower mobility of elderly.	1	2	3	N/A
Monitors for breakdown of skin and need for increase protection.	1	2	3	N/A
Assists with meals as needed (Cuts food into bite size portions, etc.).	1	2	3	N/A
Involves the patient in planning and providing care.	1	2	3	N/A



Employee Confidentiality Statement

As an employee of Modern Industrial Services, Inc. you have both a legal and ethical responsibility to protect the privacy of employees, client nurses and hospitals and propriety information of Modern Industrial Services, Inc. All information that you see here regarding nurses, staff, directly or indirectly, is completely confidential and must not be disclosed or released in any form, except when required in the performance of your duties. If you have access to employee information, you are expected to treat such information in the same confidential manner.

Unauthorized disclosure of medical information is also criminally punishable as a misdemeanor. The mere public acknowledgement of Modern Industrial Services, Inc., of disease, psychiatric disclosure, drug abuse or alcohol abuse may expose the company to both substantial fines and liability to the person.

Any information provided to you by the nurses or hospital is considered confidential and should not be shared with others except when required in the performance of your duties.

I have read the above information and understand that any of this agreement is cause for immediate termination.

Print Name _____ **Date** _____

Signature _____



HIPAA

This notice describes how health information about you may be used and disclosed. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I authorize Modern Industrial Services, Inc. the use and disclosure of my health information. I understand that this will be used by Modern Industrial Services, Inc. and its clients to evaluate my qualifications for employment opportunities as it relates to the healthcare field. This information may also be used for Workers Compensation and similar programs, and/or when necessary to reduce or prevent a serious threat to your health and safety, or health and safety of others. We will only make disclosures to a person or organization able to help prevent the threat.

I further understand that if a person that receives this information is not a healthcare provider, the information disclosed may be re-disclosed and no longer protected by regulations. I understand that I may revoke this authorization at any time by sending a written request to Modern Industrial Services, Inc. except to the degree that action has been taken in reliance on upon this authorization.

This authorization will expire one year from the dated signature below.

Candidate's Signature

Date



Blood Borne Pathogens Inservice

The purpose of this is to ensure of both the patient and the medical service personnel in the workplace. The in-service will include the following:

- Exposure to Blood Bone Pathogens
- Prevention of Needle Stick Injuries
- Needle Capping
- Universal Precautions
- Who is at Risk
- Appraising Protection
- Personal Protection
- Disposal of Biohazards
- New Laws and Federal Acts
- New Technologies

This in-service is provided to all Modern Industrial Services, Inc. healthcare workers and consists of a “Safety Trainer Video” and presentation.

I understand and agree to comply with all safety standards set forth by my employer, Modern Industrial Services, Inc.

I certify by my signature below, that I have been provided with Modern Industrial Services, Inc. Blood Borne Pathogens In-service.

Candidate’s Name (Please Print)

Date

Candidate’s Signature

Modern Industrial Services, Inc. Representative-Instructor



OSHA Standards & Competency Assessment

In compliance with JCAHO and OSHA requirements, I acknowledge that I have successfully completed the competency assessment form as well as the following:

- Age Specific Job Requirements
- Blood Borne Pathogens/Infectious Disease
- Electrical Safety
- Ergonomics for Healthcare Workers
- Fire Safety
- Handling of Hazardous Materials
- Hand washing
- Needle Capping
- Patient Bill of Rights
- Patient Confidentiality
- Tuberculosis
- Violence in the Workplace

Candidate's Name (Please Print)

Date

Candidate's Signature

Modern Industrial Services, Inc. Representative



Employment Reference Form

I authorize _____ from _____ to release
 (Healthcare Manager Name/Title)

information about me that relates to this reference check.

Signature

Date

Applicant Name

Position Held

Dates of Employment

Current/Former Employer

Address

City

State

Zip Code

Supervisor Name and Title

Phone Number

Date Employer:

The Person above is seeking employment with Modern Industrial Services, Inc. and has listed you as a prior employer. We would greatly appreciate your help in verifying employment and evaluating job performance. All information provided to us is confidential.

Personal Evaluation	Above Average Performance	Average Performance	Below Average Performance	Very Poor
Clinical Competency				
Productivity				
Quality of Work				
Professionalism				
Communication				
Attitude				
Flexibility				
Appearance				
Punctuality/Attendance				

Is the employee eligible for rehire? Yes No

Comments:

Employer's Signature

Date



Employment Reference Form

I authorize _____ from _____ to release
 (Healthcare Manager Name/Title)

information about me that relates to this reference check.

Signature

Date

Applicant Name

Position Held

Dates of Employment

Current/Former Employer

Address

City

State

Zip Code

Supervisor Name and Title

Phone Number

Date Employer:

The Person above is seeking employment with Modern Industrial Services, Inc. and has listed you as a prior employer. We would greatly appreciate your help in verifying employment and evaluating job performance. All information provided to us is confidential.

Personal Evaluation	Above Average Performance	Average Performance	Below Average Performance	Very Poor
Clinical Competency				
Productivity				
Quality of Work				
Professionalism				
Communication				
Attitude				
Flexibility				
Appearance				
Punctuality/Attendance				

Is the employee eligible for rehire? Yes No

Comments:

Employer's Signature

Date



Background Consent Form Request, Authorization, Consent & Release for Investigative Background Information.

I understand that in processing my application, Modern Industrial Services, Inc. may procure an investigative background report on me. Information for this report may be obtained through personal interview(s), a review of information held by law enforcement or governmental agencies, present or former employer(s), school(s), financial institution(s), or other persons having personal knowledge about me.

I further understand that Modern Industrial Services, Inc. will use the services of an investigative agency, as an agent to procure this report.

These above mention reports may include but are not limited to information as to my character, general reputation, and personal characteristics, motor vehicle records, criminal records, current and former employers, military records, educations records, professional and personal references. I request, authorize and consent to the release and disclosure of any and all information including but not limited to the above to, Modern Industrial Services, Inc. and an investigative agency.

This authorization in original or copy form shall be valid for one year from the date indicated next to my signature. According to the Fair Credit Reporting Act, Modern Industrial Services, Inc. will notify me if employment is denied because of information obtained from a Consumer Reporting Agency. Additionally, I understand that upon written request to the investigative agency within a reasonable amount of time after the date indicated below, I will be given a full and accurate disclosure as to the nature and substance of all information provided to Modern Industrial Services, Inc. I further understand that when requesting a copy of the report, proper identification will be required and I should direct my request to Modern Industrial Services, Inc.

This consumer authorization serves as the required, stand alone, consumer notification that a report may be requested and used for the purpose of evaluating me for employment promotion, reassignment, or retention as an employee.

I understand that any decision to hire me is contingent upon the results of an investigator report. I further understand that misrepresentation or omission of information will be sufficient cause, in and of itself, for rejection or dismissal whenever discovered.

Please provide me with a copy of my background investigation report: Yes No

Print Full Name _____
Print Other Names Used or under which you have been employed _____
Date of Birth _____ Social Security Number _____
Driver's License Number _____ State of License _____

Please provide three years of previous addresses.

Present Address _____ to _____ from _____
Address _____
City, State, Zip Code _____

Former Address _____ to _____ from _____
Address _____
City, State, Zip Code _____

Former Address _____ to _____ from _____
Address _____
City, State, Zip Code _____

Former Address _____ to _____ from _____
Address _____
City, State, Zip Code _____



Competency test for Licensed Nurses

First Name: _____ Email: _____
Last Name: _____ Telephone: _____

A. Coordinated Care

1. The advanced directive in a patient chart is dated June 10, 1998. The patient's son gives the nurse a new power of attorney for Healthcare dated 2001 that is different from the June 10, 1998 advance directive. A nurse should:
 - a. follow neither until clarified by the nurse manager.
 - b. follow the 1998 version.
 - c. follow the 1998 version because the physician's "code" order is based on it.
 - d. follow the 2001 version.
2. The legal age for expressing one's wishes through an advanced directive is:
 - a. 23 years.
 - b. 44 years.
 - c. retirement age.
 - d. 18 years
3. In acute care setting, who might expect the patient to be an advocate for her/him?
 - a. licensed nurse.
 - b. physical therapist.
 - c. all members of the interdisciplinary team caring for the patient.
 - d. social work.
4. The effect of managed care in the healthcare systems has been to:
 - a. decrease length of stay in hospitals.
 - b. support the increased use of new technology.
 - c. focus care strategies on outcomes of care provision.
 - d. all of the above.
5. Your patient with schizophrenia would most likely be treated by which consultant?
 - a. psychiatrist
 - b. psychologist
 - c. physiatrist
 - d. doctor

B. Safety & Infection Control

1. Acute hyphema is associated with what type of injury?
 - a. eye
 - b. orthopedic
 - c. prostrate tumor
 - d. animal bite



2. The nurse discovers a waste basket fire in the room of a sleeping patient. What action should be taken?
 - a. Report the fire.
 - b. Remove the patient.
 - c. Check the patient for breathing and circulation.
 - d. Extinguish the fire.

3. The nurse in an emergency situation tries to determine whether a client has an airway obstruction. Which of the following should the nurse assess.
 - a. ability to speak.
 - b. ability to hear
 - c. oxygen saturation.
 - d. adventitious breath sounds.

4. All of the following are causes of vaginal bleeding except.
 - a. placenta previa
 - b. eclampsia
 - c. uterine rupture
 - d. abruption placentae

5. The nurse is preparing to administer IV Vancomycin to the client. Which of the following nursing actions should be taken first.
 - a. performing a physical assessment prior to administration.
 - b. ensuring the client is not allergic to the medication.
 - c. reviewing peaks and troughs for the past few days.
 - d. obtaining the most recent lab values regarding renal function.

C. Health Promotion and Maintenance

1. When observing elders with swallowing disorders, which of the following signs and symptoms would indicate to the nurse that the client may have aspirated?
 - a. a complaint of food caught in the back of the throat.
 - b. fever of unknown origin.
 - c. request for something to eat or drink.
 - d. lack of functional cough.

2. When caring for a dying elder, the nurse should recognize which of the following behaviors as regression?
 - a. acceptance.
 - b. denial and projection.
 - c. abstract thinking.
 - d. full use of speech.

3. When a client has oral cancer, which of the following medical treatments should the nurse expect to have the greatest negative impact on the body image?
 - a. radiation.
 - b. chemotherapy.
 - c. biopsy and staging.
 - d. radical neck dissection.



4. A client has been taking Lasix to prevent congestive heart failure. What other intervention can the nurse discuss with the client concerning dietary modifications?
- maintain low sodium intake.
 - increase calcium intake.
 - increase fiber intake.
 - maintain low potassium intake.
5. While caring for a client with an HIV related illness, the nurse should use what type of precautionary measures?
- standard precautions.
 - gloves and gowns.
 - gloves, gowns, and mask.
 - no precautions.

D. Psychological Integrity

1. A student nurse is caring for a 75 year old client who is very confused. The student's communication tools should include:
- written directions for bathing.
 - speaking very loudly.
 - gentle touch while guiding ADL (activities of daily living).
 - flat facial expression.
2. Mary is a client on the acute care unit. The nurse notices as she talks with Mary that Mary is unable to make and maintain eye contact. She puts her head down and looks at the floor. The nurse's assessment of Mary is:
- nonverbal communication.
 - mental status.
 - nursing diagnosis.
 - social skill.
3. The nurse is caring for a client who is dying of terminal cancer. While assessing the client for signs of impending death, the nurse should observe the client for:
- elevated blood pressure.
 - Cheyne-Stokes respiration.
 - elevated pulse rate.
 - decreased temperature.
4. The nurse has informed the family of a terminally ill comatose client about the loss of various senses during imminent death. The nurse determines that the family understands the instructions when one of the family member says that it is believed that the last sense to leave the body is the sense of:
- taste.
 - touch
 - smell.
 - hearing.



5. The nurse assesses for which of the following mental disorders in a child who has experienced abused?
- schizophrenia.
 - bipolar disorder.
 - paranoia.
 - post-traumatic stress disorder.

E. Basic Care & Comfort

1. The nurse should have the client use appropriate safety measures with care by:
- placing the cane on the affected side.
 - placing the cane on the opposite affected side.
 - does not matter which side the cane is on.
 - choice of cane placement should be the choice of the client.
2. A client with major head trauma is receiving bolus enteral feeding. The most important nursing order for this patient is:
- measure intake and output.
 - check albumin level.
 - monitor glucose levels.
 - increase enteral feeding.
3. Physical examination of the patient regarding mobility should begin with.
- gait.
 - oriented to time, place, and person.
 - Romberg test.
 - Tandem walk test.
4. Pain is primarily a:
- protective mechanism as well as a complex for biopsychosocial phenomenon.
 - an emotional response as a part of aging.
 - a single disorder with a single component of neuropathic symptoms.
 - an emotional response to a decrease intensity.
5. Pressure ulcers usually occur:
- when patients are left in one position in bed for extended periods of time.
 - when the patient is “thin” (weight).
 - when the patient is “heavy” (weight).
 - always in both “thin” and “heavy” patients.

Thank you for taking the licensed Nurse competency test. Our staffing coordinator will contact you if necessary.

Sincerely,

Modern Industrial Services, Inc.
Management



Health Information Authorization

I _____ authorize the use or disclosure of my health information as described below.

1. Person(s) or class of persons authorized to use or disclose the information:
(Note: e.g., Name of Provider, lab, etc. that will disclose the information)

Please List:

2. Description of information that may be used or disclosed:
(Note: e.g., all information related to a specific test or type of evaluation)

Please List:

3. This authorization expires _____ [Please insert a date or describe the termination of an event or activity related to the individual or to the purpose of the authorization. This date relates to the termination of the right for the provider to disclose the information and not to Modern Industrial Services, Inc. right to use this information, which, once the information is disclosed, does not terminate].

4. Person(s) or class of persons authorized to receive the information: Modern Industrial Services, Inc.

5. I understand that I may revoke this authorization at any time by sending a written request to the party identified in paragraph 1, except to the extent that action has been taken in reliance on this authorization.

6. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

7. The information will be used or disclosed for the following purposes:
For use by Modern Industrial Services, Inc. and its clients in evaluating my qualifications for employment opportunities and related activities.

Signature of Candidate or Representative and Date: _____

Print Candidate's Name _____

\



Consent for Drug/Alcohol Screen Testing

If you are offered and accept employment with Modern Industrial Services, Inc., in the interest of safety for all concerned, you will be required to take a urine test for drug and/or alcohol use. I, _____, have been fully informed of the reason for this urine test for drug and/or alcohol. I understand what I am being tested for, the procedure involved, and do hereby freely give my consent. In addition, I understand that the results of this test will be forwarded to my potential employer and become part of my record. If this test is positive, and for this reason I am not hired, I understand that I will be given the opportunity to explain the results of this test.

I hereby authorize these test results to be released to Modern Industrial Services, Inc.

Print Name: _____

Signature: _____

Date: _____



Hepatitis B Vaccination

OSHA requires all health care workers to be offered the hepatitis B vaccination by their employer.

1. If you decline to have the hepatitis B Vaccine; please indicate this by signing and dating A.
2. If you have completed the Vaccination series, please indicate this by signing and dating B.
3. If you are in the process of receiving the series, please indicate this by signing and dating C.
4. Please indicate if you require a dose of the Vaccine.

I understand that I will be provided appropriate training at my assigned work place and will adhere to the policies and procedures of the facility to which I am assigned.

I understand that due to my occupational exposure to blood and/or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine at no cost to me, while on active assignment with Modern Industrial Services, Inc.

DECLINATION

A. I decline the Hepatitis B Vaccine series. 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 infectious materials and I want to be vaccinated with Hepatitis B vaccine. I can receive the vaccination series at no charge to me while on assignment with Modern Industrial Services, Inc. I accept the responsibility to inform Modern Industrial Services, Inc. of this decision at the time.

Candidate's signature _____ Date _____

COMPETE SERIES

B. I understand the OSHA guidelines and decline because I have completed the Hepatitis B Vaccination.

Candidate's signature _____ Date _____

VACCINATIONS IN PROGRESS

C. I understand the OSHA guidelines and need # _____ or booster in the series. I will make arrangements to complete the series or booster, or if on assignment. I will make arrangements with Modern Industrial Services, Inc. to receive this dose of the Vaccine series. I will provide the documentation of the series/booster to Modern Industrial Services, Inc. and provide appropriate updates.

Candidate's signature _____ Date _____



Physician's Statement and Vaccination Record

Patient's Full Name _____ Date _____

It is the responsibility of the applicant to have their physician complete and sign this section.

Physician to Complete this Section

___ **MMR** Booster 1) _____ 2) _____

1 MMR required prior to Birthdate of 1957, 2 MMR required after Birthdate of 1957 OR Mumps Titre

Date: _____ Results: _____

Rubella Titre Date: _____ Results: _____

Rubeola Titre Date: _____ Results: _____

___ **TB** PPD Skin Test (required yearly) Date: _____

Results: _____

OR Chest X-Ray (required if TB-Positive) Date: _____ Results: _____

Varicella (chicken pox)

Varicella Titre Date: _____ Results: _____

OR: Varivax Date: _____ Results: _____

OR Immunity by History of Disease Date: _____ Results: _____

Hepatitis B

Vaccine #1 Date: _____ #2 Date _____ #3 Date _____

Booster Date _____

OR Hepatitis B Titre Date: _____ Results: _____

OR Hepatitis B Declination (Sign Below) Date: _____

Please submit supporting documentation of immunization records and all 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 communicable diseases and is able to function in his/her profession in full capacity. By signing below I certify that the above documentation is valid.

Physician's Signature _____ Date _____

Printed Name _____

Lic # _____



Hepatitis B Vaccination

OSHA requires all health care workers to be offered the hepatitis B vaccination by their employer.

1. If you decline to have the hepatitis B Vaccine; please indicate this by signing and dating A.
2. If you have completed the Vaccination series, please indicate this by signing and dating B.
3. If you are in the process of receiving the series, please indicate this by signing and dating C.
4. Please indicate if you require a dose of the Vaccine.

I understand that I will be provided appropriate training at my assigned work place and will adhere to the policies and procedures of the facility to which I am assigned.

I understand that due to my occupational exposure to blood and/or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine at no cost to me, while on active assignment with Modern Industrial Services, Inc.

DECLINATION

A. I decline the Hepatitis B Vaccine series. 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 infectious materials and I want to be vaccinated with Hepatitis B vaccine. I can receive the vaccination series at no charge to me while on assignment with Modern Industrial Services, Inc. I accept the responsibility to inform Modern Industrial Services, Inc. of this decision at the time.

Candidate's signature _____ Date _____

COMPETE SERIES

B. I understand the OSHA guidelines and decline because I have completed the Hepatitis B Vaccination. I will provide documentation to Modern Industrial Services, Inc.

Candidate's signature _____ Date _____

VACCINATIONS IN PROGRESS

C. I understand the OSHA guidelines and need # _____ or booster in the series. I will make arrangements to complete the series or booster, or if on assignment. I will make arrangements with Modern Industrial Services, Inc. to receive this dose of the Vaccine series. I will provide the documentation of the series/booster to Modern Industrial Services, Inc. and provide appropriate updates.

Candidate's signature _____ Date _____



Travel Form

To help us better prepare your travel arrangements, please complete this form and fax it back along with your contract. Travel dates will vary depending on specialty and orientation dates. Details will follow.

First Name: _____ Last Name: _____

*Name must be as it appears on your driver's license.

Preferred Departure City: _____

Alternate Departure City: _____

Preferred Departure Time: _____

Please provide your best contact number and any email address or fax number where we can send your itinerary.

Phone: _____

Fax: _____

Email: _____

Additional Requests?
