

**CONTINENTAL NURSES**

(888) 894-2900 (phone)

(888) 894-2073 (fax)

**REGISTERED NURSE**

**Profile Verification Sheet**

**ALL BLANKS MUST BE COMPLETED.**

Name \_\_\_\_\_ \*License Number/Expiration Date \_\_\_\_\_

Address \_\_\_\_\_ Date of License Verification \_\_\_\_\_

Emergency Contact Name/Next of Kin and Phone Number \_\_\_\_\_ RN Classification (ICU, M/S, TELE) \_\_\_\_\_

CPR Certification/Expiration Date \_\_\_\_\_ Advanced Certification/Expiration Date \_\_\_\_\_

Nursing Degree/Institution/Date Obtained \_\_\_\_\_

Nursing Education and Work History Verified? \_\_\_ Yes \_\_\_ No

Most recent employer where worked for at least one year/Dates of Employment/Number of Missed Shifts \_\_\_\_\_

**Healthcare Personnel Information:**

	<u>Date Completed:</u>		<u>Date Completed:</u>
Satisfactory TB (annual)	_____	Hepatitis B Declination Form	_____
TB Screening Questionnaire	_____	Varicella: Titre or History (circle one)	_____
Chest X-Ray	_____	Drug Screen (indicate panel)	_____
Physical Exam	_____	Criminal Background Check	_____
Rubella Titre or Immunization	_____	Fingerprinting (date submitted)	_____
Rubeola Titre or Immunization	_____	Fingerprinting (date results received)	_____
MMR Immunization	_____	OIG/Medicare Fraud Search	_____
OSHA TB Fit Test Mask Type	_____	Confidentiality Agreement	_____
Population Served (check all applicable):			
___ Neonatal ___ Infant/Children (0-11) ___ Adolescent (12-18) ___ Adult ___ Geriatric			

**An updated Profile Verification Sheet  
must be provided to Participating Institution prior to assignment.  
Application on file at Continental Nurses.**

**CONTINENTAL NURSES**

Agency Name \_\_\_\_\_ Authorized Agency Representative Signature and Date \_\_\_\_\_

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**CONTINENTAL NURSES**

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Mount Pocono, Pennsylvania 18344

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**LICENSED PRACTICAL NURSE  
Profile Verification Sheet  
ALL BLANKS MUST BE COMPLETED**

Name \_\_\_\_\_ License Number/Expiration Date \_\_\_\_\_

Address \_\_\_\_\_ Date of License Verification \_\_\_\_\_

CPR Certification/Expiration Date \_\_\_\_\_ Date of IV Certification (if applicable) \_\_\_\_\_

Emergency Contact Name/Next of Kin and Phone Number \_\_\_\_\_

Nursing Degree/Institution/Date Obtained \_\_\_\_\_

Nursing Education and Work History Verified? \_\_\_ Yes \_\_\_ No

Most recent employer where worked for at least one year/Dates of Employment/Number of Missed Shifts \_\_\_\_\_

Current Experience with IV Starts? \_\_\_ Yes \_\_\_ No Current Experience with Phlebotomy? \_\_\_ Yes \_\_\_ No

**Healthcare Personnel Information:**

	<u>Date Completed:</u>		<u>Date Completed:</u>
Satisfactory TB (annual)	_____	Hepatitis B Declination Form	_____
TB Screening Questionnaire	_____	Varicella: Titre or History (circle one)	_____
Chest X-Ray	_____	Drug Screen (11 or 12-panel)	_____
Physical Exam	_____	Criminal Background Check	_____
Rubella Titre or Immunization	_____	Fingerprinting (date submitted)	_____
Rubeola Titre or Immunization	_____	Fingerprinting (date results received)	_____
MMR Immunization	_____	OIG/Medicare Fraud Search	_____
OSHA TB Fit Test Mask Type	_____	Confidentiality Agreement	_____

Population Served (check all applicable):

\_\_\_ Neonatal \_\_\_ Infant/Children (0-11) \_\_\_ Adolescent (12-18) \_\_\_ Adult \_\_\_ Geriatric

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Agency Name \_\_\_\_\_

Authorized Agency Representative Signature and Date \_\_\_\_\_

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**OTHER PERSONNEL**

**Profile Verification Sheet**

**ALL BLANKS MUST BE COMPLETED.**

Name \_\_\_\_\_ Certification Number/Expiration Date \_\_\_\_\_

Address \_\_\_\_\_ Date of Certificate Verification \_\_\_\_\_

CPR Certification/Expiration Date \_\_\_\_\_ Classification (OR TECH, RAD TECH) \_\_\_\_\_

Emergency Contact Name/Next of Kin and Phone Number \_\_\_\_\_

Certification Obtained From/Date \_\_\_\_\_

Education and Work History Verified? \_\_\_ Yes \_\_\_ No

Most recent employer where worked for at least one year/Dates of Employment/Number of Missed Shifts \_\_\_\_\_

**Healthcare Personnel Information:**

Date Completed:

Satisfactory TB (annual) \_\_\_\_\_

TB Screening Questionnaire \_\_\_\_\_

Chest X-Ray \_\_\_\_\_

Physical Exam \_\_\_\_\_

Rubella Titre or Immunization \_\_\_\_\_

Rubeola Titre or Immunization \_\_\_\_\_

MMR Immunization \_\_\_\_\_

OSHA TB Fit Test Mask Type \_\_\_\_\_

Population Served (check all applicable):

Date Completed:

Hepatitis B Declination Form \_\_\_\_\_

Varicella: Titre or History (circle one) \_\_\_\_\_

Drug Screen (11 or 12-panel) \_\_\_\_\_

Criminal Background Check \_\_\_\_\_

Fingerprinting (date submitted) \_\_\_\_\_

Fingerprinting (date results received) \_\_\_\_\_

OIG/Medicare Fraud Search \_\_\_\_\_

Confidentiality Agreement \_\_\_\_\_

\_\_\_ Neonatal \_\_\_ Infant/Children (0-11) \_\_\_ Adolescent (12-18) \_\_\_ Adult \_\_\_ Geriatric

**An updated Profile Verification Sheet  
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# CONTINENTAL NURSES

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## WORK EXPERIENCE CHECKLIST- RN/LPN

Adult ICU: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience (include month/year)  
Neuro ICU: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Trauma ICU: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
CVICU: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Dialysis Inpt: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Dialysis Outpt: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
ER: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Pediatrics ER: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Tele Med: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Tele Cardiac: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Med/Surg: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Rehab: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Psych: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Burn Unit: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
OR: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
PACU: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Oncology: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
PICU: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
NICU: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Pediatrics: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Psych Peds: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
OB: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Nursery: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
L&D: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Level II Nursery \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Ortho: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Hospice: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
LTC: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Private Duty: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Home Health: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
H/H Infusion: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Intermittent Skilled Visit: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Computer Charting: \_\_\_ yes \_\_\_ no \_\_\_\_\_ dates of experience  
Proper use of restraints: \_\_\_\_\_ \_\_\_ yes \_\_\_ no  
Pain assessment/management: \_\_\_\_\_ \_\_\_ yes \_\_\_ no  
Blood Glucose Monitor Type: \_\_\_\_\_  
OSHA TB Fit Test Mask Type: \_\_\_\_\_

The parenteral administration of electrolytes and fluids: \_\_\_ yes \_\_\_ no

The prevention of contamination and cross-infection as covered in the Universal Precautions annual in-service: \_\_\_ yes \_\_\_ no

The exercise of appropriate safety precautions in the use of electrical and electronic equipment as covered in fire/electrical safety annual in-service: \_\_\_ yes \_\_\_ no

The recognition of need for psychological and social services for patients and their families: \_\_\_ yes \_\_\_ no

**Critical Care:** Nurses assigned to critical care must possess the ability to manage patient care without supervision. This includes, but is not limited to managing patient care in intensive care units, emergency department and specialty units such as high risk obstetric unit. The scope of practice includes, but is not limited to identification of cardiac dysrhythmias, setting up and managing hemodynamic monitoring equipment such as Swan-Ganz catheters, central lines, arterial lines, caring for mechanically ventilated patients, managing the care of patients with specialty equipment such as intra-aortic balloon pumps, epidurals, the use and titration of parenterally administered cardio-tonic drugs, and the use of resuscitation equipment. \_\_\_\_\_ yes \_\_\_\_\_ no

\_\_\_\_\_  
Name (employee signature)

\_\_\_\_\_  
Date

## CONTINENTAL NURSES

\_\_\_\_\_  
Agency Name

\_\_\_\_\_  
Authorized Agency Representative Signature

\_\_\_\_\_  
Date

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**Tuberculosis Screening Questionnaire**

\_\_\_\_\_  
Name Date

Positive TB skin test (PPD) Date: \_\_\_\_\_

Last Chest X-Ray Date: \_\_\_\_\_

Please indicate if you are having any of the following problems for three to four weeks or longer:

- |   |           |          |
|---|-----------|----------|
| 1. Chronic Cough (greater than 3 weeks) | Yes _____ | No _____ |
| 2. Production of Sputum                 | Yes _____ | No _____ |
| 3. Blood-Streaked Sputum                | Yes _____ | No _____ |
| 4. Unexplained Weight Loss              | Yes _____ | No _____ |
| 5. Fever                                | Yes _____ | No _____ |
| 6. Fatigue/Tiredness                    | Yes _____ | No _____ |
| 7. Night Sweats                         | Yes _____ | No _____ |
| 8. Shortness of Breath                  | Yes _____ | No _____ |

NO EVIDENCE OF PULMONARY TUBERCULOSIS OR CONTAGIUM.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agency Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Agency Staff Signature

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**CONTINENTAL NURSES**

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**Attachment 8  
Registry Program  
Background Checks**

The Agency may use either the forms provided by the Department of Health to obtain the background check, or the Agency may contract with HSC to obtain the background investigation. Criminal background checks shall include:

- Criminal conviction search in the state of primary residence and state of original (RN) licensure
- Department of Motor Vehicles search in state of primary residence; and
- Office of Inspector General's List of Excluded Individuals/Entities search ([www.dhhs.gov/proorg/oig/cumsan/index.html](http://www.dhhs.gov/proorg/oig/cumsan/index.html) or any successor website).

Printed search results of the background checks must be maintained on file by the Agency.

**Department of Health Forms**

- Authorization for Release of Information
- Criminal History Screening

**HSC Forms**

- Designation and Authorization for Release and Redisclosure of Information
- Background Investigation Services Request Form

**CONTINENTAL NURSES**  
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**Division of Health Improvement**  
**CAREGIVERS CRIMINAL HISTORY SCREENING PROGRAM**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(NAME) (Must be typed or printed legibly) Social Security # Date of Birth

Pursuant to NSMA 1978, Section 29-10-6(a) (Repl. Pamp. 1990), of the New Mexico Arrest Record Information Act, hereby appoint:

**THE DEPARTMENT OF HEALTH**

As an authorized agent for me for the purpose of inspection (and/or obtaining copies) any New Mexico arrest fingerprint card supported record information maintained by the Department of Public Safety and the Federal Bureau of Investigations, including information concerning felony or misdemeanor arrests.

To the custodian of records in question, I hereby direct you to release such information to the Authorized Agent as described above.

I hereby release the custodian or custodians of such records and the Department of Health and the State of New Mexico, including any of their agents, employees, or representatives in any capacity, from any and all claims of liability or damage of whatever kind or nature, which at any time could result to me, my heirs, assigns, associates, personal representative or representatives of any nature because of compliance by said custodian or custodians with the "Authorization for Release of Information" and my request contained herein for this release or because of any use of these records. This release is binding now and in the future, on my heirs, assigns, associates, personal representative or representatives of any nature.

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

\_\_\_\_\_  
(Date)

**ATTENTION NOTARY: Ensure document is signed in your presence and Name, Social Security Number and Date of Birth information is verified with a valid ID.)**

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

(Seal)

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_

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**Division of Health Improvement**  
**CAREGIVERS CRIMINAL HISTORY SCREENING PROGRAM**  
**Certification of**  
**CRIMINAL HISTORY SCREENING**

\_\_\_\_\_, has / has not completed a criminal history  
Name and title of caregiver/employee  
screening for the following reason:

- Application and Fingerprints submitted on \_\_\_\_\_, no response from CCHSP.  
Date
- Caregiver/employee has been cleared by CCHS, clearance attached.
- Caregiver/employee is not required to have a CCHS clearance, job description attached.
- Caregiver/employee applied for administrative reconsideration on \_\_\_\_\_.  
Date
- Caregiver/employee has received an administrative reconsideration, reconsideration decision attached.
- Caregiver/employee was discovered to have a disqualifying conviction and was terminated on \_\_\_\_\_. CCHSP notice of disqualifying conviction and letter of termination attached. Date

As an authorized agent for \_\_\_\_\_ **CONTINENTAL NURSES**  
Name of Care Provider

I, \_\_\_\_\_, \_\_\_\_\_  
Name (printed) and Title (Printed)

certify that the information stated above is true and correct.

\_\_\_\_\_  
Signature

“This form is to be utilized for documentation in Continental Nurses files.”

**CONTINENTAL NURSES**  
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**Designation and Authorization for Release and Rediscovery of Information**

In connection with my application for employment with \_\_\_\_\_, hereby known as "Hiring Entity", I understand that an investigative consumer report may be requested that will include information as to my character, general reputation, personal characteristics, mode of living, work habits, performance and experience, along with reasons for termination of past employment from previous employers. Further, I understand that information may be requested concerning my motor vehicle registration history and criminal history from various states, private and insurance sources along with other public records available.

I voluntarily and knowingly authorize any present or past employer or supervisor; college or university or other institution of learning; administrator, law enforcement agency, local agency, state agency, Federal agency; private business; military branch or the National Personnel Records Center, personal references; and/or other persons to give records or information they may have concerning my criminal history, motor vehicle history, character, and employment records or any other information requested by Background Investigation Services. I voluntarily and knowingly unconditionally release any named or unnamed informant from all liability resulting from the furnishing of this information. A photocopy of this Designation and Authorization for Release and Rediscovery of Information shall be considered by the recipient to be a signed original, as long as it is transmitted to the recipient by the Hiring Entity or Background Investigation Services and is received within one year of its date.

If I am denied employment, either wholly or partly, because of information contained in this consumer report, a disclosure will be made to me of the name and address of the consumer reporting agency making such report. If the report contains information about me that is a matter of public record, such as arrests, indictments or convictions, I may also be informed of the name and address of any person to whom the information is reported.

I have read the above notice and understand what it means.

\_\_\_\_\_  
 Applicant Name (Print)

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

\_\_\_\_\_  
 Today's Date

**Please complete the following:**

<b>Last Name</b>	<b>First Name</b>	<b>Middle</b>
<b>Home Address - Street</b>	<b>City</b>	<b>State</b>
<b>Zip</b>		
<b>Date of Birth*</b>	<b>Social Security Number</b>	
<b>Driver's License Number</b>	<b>State in which Drivers' License was issued</b>	

**\*This information is not relevant to any hiring decision; however, it may be necessary in the verification process if required by the verification source for identification purposes only.**

\*\*\*\*\*  
*This area to be used when notarization is required.* (Seal)

Subscribed and sworn by me on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
 Notary Public

\_\_\_\_\_  
 My Commission Expires

## BACKGROUND INVESTIGATION SERVICES REQUEST FORM

Please check the appropriate box indicating the type of investigative services you would like performed on your applicant. All investigations are performed based on a completed application and signed release of information. These items must be completed and forwarded to BIS before any investigative services can be rendered on your behalf.

DATE: \_\_\_\_\_ Applicant Name: \_\_\_\_\_

TO: Background Investigation Services Coordinator

FM: \_\_\_\_\_ (Name of Requesting Organization)  
\_\_\_\_\_ (Name of Requesting Authorized Agent)

- Package A: \$ 40.00**  
Local Criminal History Check  
OIG – Medicare/Medicaid Sanctions Query  
Department of Motor Vehicle Records Check  
Social Security Number Verification

### Individual Inquiries

- |                          |   |                          |
|--------------------------|---|--------------------------|
| <input type="checkbox"/> | Social Security Verification                    | \$10.00 each             |
| <input type="checkbox"/> | NM MVD Records Check                            | \$10.00 each             |
| <input type="checkbox"/> | Local Criminal History Check                    | \$12.50 each             |
| <input type="checkbox"/> | Non-Local Criminal History Check                | \$15.50 each + fee       |
| <input type="checkbox"/> | Credit Report                                   | \$12.50 each             |
| <input type="checkbox"/> | Out of State Motor Vehicle Records Check        | \$12.00 each + State fee |
| <input type="checkbox"/> | Reference Checks                                | \$12.50 each             |
| <input type="checkbox"/> | Previous Employer Checks                        | \$12.50 each             |
| <input type="checkbox"/> | Education Verification                          | \$10.00 each             |
| <input type="checkbox"/> | Professional License/Certification Verification | \$10.00 each             |
| <input type="checkbox"/> | OIG – Medicaid/Medicare Sanction Query          | \$10.00 each             |

**Attachment 9  
Audit Form**

**Audit Date:** \_\_\_\_\_

**Agency:** \_\_\_\_\_

**Location:** \_\_\_\_\_

**Auditors:** \_\_\_\_\_

	<b>ON FILE</b>	<b>INCOMPLETE OR OUTDATED</b>	<b>NOT ON FILE</b>	<b>NOT APPLICABLE</b>
<b>Licensure (certification)</b>				
<b>Current CPR</b>				
<b>Current ACLS/PALS/NALS/NRP</b>				
<b>3 years previous work history</b>				
<b>2 years work experience (in area of placement)</b>				
<b>References (minimum of 2):</b>				
Hospital				
Agency				
Other				
Professional				
<b>Hospital Evaluations</b>				
<b>Initial Physical:</b>				
TB Screening:				
TB Screening Questionnaire				
MMR Titre or Immunization				
Varicella Titre or Immunization				
Hepatitis (Heptavax)/Declination				
<b>Drug Screen:</b>				
Initial Hire				
Random Annual				
<b>Criminal Background Check</b>				
<b>Fingerprint</b>				
<b>OIG Cumulative Sanction Report</b>				
<b>Compliance with immigration laws (I-9)</b>				
<b>Profile Verification Sheet</b>				
<b>HSC Work Experience Checklist</b>				
<b>Agency Skills Checklist</b>				
<b>Confidentiality Statement</b>				

**Attachment 10**  
**INITIAL RATE ACCEPTANCE SHEET**  
**June 1, 2004 through May 31, 2005**

The following rates have been accepted by Agency and shall be firm for the entire Agreement period. The Participating Institution and the Agency must agree upon any exceptions in advance and in writing. The rates assume the following:

1. Minimum 13 week assignment;
2. Agency is the employer;
3. Travel and housing cost are inclusive.

The Participating Institution and the Agency should negotiate all other pricing options.

<b>Position</b>	<b>Hourly Rate</b>	<b>On-Call Rate</b>	<b>Charge Rate</b>
RN Non-Specialty	<u>\$49.75</u>	<u>\$6.00</u>	<u>\$2.50</u>
RN Specialty	<u>\$52.50</u>	<u>\$6.00</u>	<u>\$2.50</u>
LPN	<u>\$36.75</u>	<u>\$6.00</u>	N/A
OR Tech	<u>\$37.50</u>	<u>\$6.00</u>	N/A
CVOR Tech	<u>\$38.25</u>	<u>\$6.00</u>	N/A
Rad Tech	<u>\$59.00</u>	<u>\$6.00</u>	N/A
PT	<u>\$53.00</u>	<u>\$6.00</u>	N/A
OT	<u>\$54.00</u>	<u>\$6.00</u>	N/A
SLP	<u>\$54.00</u>	<u>\$6.00</u>	N/A

**Note:** Holiday, Call-Back and Overtime Rates are \$10.00 above the bill rate.

<b>Rate Classifications</b>	
RN Non-Specialty:	Includes M/S, General Telemetry, LTC, Psych, Subacute, Oncology, SNF, Med Rehab, Couplet Care, Ortho, Post Partum, Home Health
RN - Specialty:	Includes ER, OR, ICU, CCU, L&D, General Peds, Progressive Telemetry, Radiology, Level II Nursery, CVICU, CVOR, BMT, NICU, PICU, Dialysis, Cath Lab

**PRICING AND DISCOUNT OPTIONS:** Describe any available discount options or creative pricing options Agency will offer the Participating Institutions (i.e., block discounts, volume discounts, etc.):

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Agency

Authorized Signature/Date

**Attachment 11 – As of March, 2004**

<b>HOLIDAY PAY POLICY by Facility:</b>	<b>New Year's Day</b>	<b>Memorial Day</b>	<b>July 4th</b>	<b>Labor Day</b>	<b>Thanksgiving Day</b>	<b>Christmas Day</b>	<b>Time Frame</b>
<b>Albuquerque Regional Medical Cntr - LSHS</b>	X	X	X	X	X	X	11:00 p.m. of holiday eve to 11:00 p.m. of holiday.
<b>Carlsbad Medical Center</b>	X	X	X	X	X	X	12:00 a.m. to 11:59 p.m. of holiday.
<b>Cibola General Hospital</b>	X	X	X	X	X	X	7 p.m. the eve of the holiday to 7 a.m. the morning after the holiday, minimum shift of 8 hours
<b>Colfax General Hospital - PHS</b>	X	X	X	X	X	X	Midnight to midnight on the holiday.
<b>Department of Health - DOH</b>	X	X	X	X	X	X	12:01 a.m. to 11:59 p.m. on the holiday,
<b>Eastern New Mexico Medical Center</b>	X	X	X	X	X	X	11:00 p.m. of holiday eve to 11:00 p.m. of holiday.
<b>Espanola Hospital - PHS</b>	X	X	X	X	X	X	Midnight to midnight on the holiday.
<b>Fort Bayard Medical Center</b>	X	X	X	X	X	X	12:01 a.m. to 11:59 p.m. on the holiday,
<b>Gerald Champion Regional Medical Center</b>	X	X	X	X	X	X	Midnight to midnight on the holiday.
<b>Heart Hospital of New Mexico</b>	X	X	X	X	X	X	12:01 a.m. to 11:59 p.m. on the holiday.
<b>Holy Cross Hospital</b>	X	X	X	X	X	X	11:00 p.m. of holiday eve to 11:00 p.m. of holiday.
<b>Kindred Hospital</b>	X	X	X	X	X	X	12:00 a.m. of holiday eve to 12:00 a.m. of holiday.
<b>Las Vegas Medical Center - DOH</b>	X	X	X	X	X	X	12:01 a.m. to 11:59 p.m. on the holiday,
<b>Lea Regional Medical Center</b>	X	X	X	X	X	X	12:00 a.m. of holiday eve to 12:00 a.m. of holiday.
<b>Lincoln County Medical Center - PHS</b>	X	X	X	X	X	X	Midnight to midnight on the holiday.
<b>Los Alamos Medical Center</b>	X	X	X	X	X	X	President's Day, as well. TBD
<b>Lovelace Medical Center - LSHS</b>	X	X	X	X	X	X	11:00 p.m. of holiday eve to 11:00 p.m. of holiday.
<b>Memorial Medical Center</b>	X	X	X	X	X	X	3 <sup>rd</sup> shift on morning of holiday to the 2 <sup>nd</sup> shift the evening of the holiday.
<b>Mountain View Regional Medical Center</b>	X	X	X	X	X	X	12:01 a.m. to 11:59 p.m. on the holiday,
<b>New Mexico Rehabilitation Center - DOH</b>	X	X	X	X	X	X	12:01 a.m. to 11:59 p.m. on the holiday,
<b>Northeast Heights Medical Center - LSHS</b>	X	X	X	X	X	X	11:00 p.m. of holiday eve to 11:00 p.m. of holiday.
<b>Northeastern Regional Hospital</b>	X	X	X	X	X	X	TBD
<b>PHS Zuni Hospital</b>	X	X	X	X	X	X	TBD
<b>Plains Regional Medical Center - PHS</b>	X	X	X	X	X	X	Midnight to midnight on the holiday.
<b>Presbyterian Healthcare Services - PHS</b>	X	X	X	X	X	X	Midnight to midnight on the holiday.
<b>Presbyterian Hospital - PHS</b>	X	X	X	X	X	X	Midnight to midnight on the holiday.
<b>Presbyterian Kaseman Hospital - PHS</b>	X	X	X	X	X	X	Midnight to midnight on the holiday.
<b>Rehabilitation Hospital of New Mex - LSHS</b>	X	X	X	X	X	X	11:00 p.m. of holiday eve to 11:00 p.m. of holiday.
<b>Rehoboth McKinley Christian Health Care</b>	X	X	X	X	X	X	1:00 a.m. to midnight on the holiday.
<b>San Juan Regional Medical Center</b>	X	X	X	X	X	X	11:00 p.m. holiday eve to 11:00 p.m. of holiday.
<b>Sierra Vista Hospital</b>	n/a	n/a	n/a	n/a	n/a	n/a	No holidays recognized.
<b>Socorro General Hospital - PHS</b>	X	X	X	X	X	X	7:00 a.m. to 7:00 p.m./7:00 p.m. to 7:00 a.m.

<b>St. Vincent Hospital</b>	X	X	X	X	X	X	MLK Day and Easter recognized, as well. 12:00 a.m. to 11:59 p.m. on each holiday.
<b>Trigg Memorial Hospital - PHS</b>	X	X	X	X	X	X	Midnight to midnight on the holiday.
<b>Turquoise Lodge - DOH</b>	X	X	X	X	X	X	12:01 a.m. to 11:59 p.m. on the holiday,
<b>Union County General Hospital</b>	X	X	X	X	X	X	7 p.m. the eve of the holiday to 7 a.m. the morning after the holiday.
<b>University Hospital</b>	X	X	X	X	X	X	12:01 a.m. to 11:59 p.m. on the holiday, also New Year's Eve, Day after Thanksgiving, Christmas Eve
<b>West Mesa Medical Center - LSHS</b>	X	X	X	X	X	X	11:00 p.m. of holiday eve to 11:00 p.m. of holiday.

**Attachment 12  
Sample Invoice**

Agency Name  
Address  
Telephone  
Fax

Invoice Date:  
Invoice Number:  
Account Number:

Facility Name  
Address  
ATTN: "Billing Contact"

<u>Employee Name</u>	<u>Classification:</u>	<u>Unit:</u>	<u>Date of Service:</u>	<u>Hours/Shift Worked:</u>	<u>Total Hours:</u>	<u>Hourly Rate:</u>	<u>TOTAL:</u>
Jane Doe	Specialty RN	ICU	2/22/00	0700-1500	8	\$38.00	304.00
						TOTAL:	\$304.00
						*Less any discounts	(000.00)
						TOTAL AMOUNT DUE:	\$304.00

**Attachment 13**  
**Agency Officers/Directors on Board or Committee of Participating Institution**

List the name, title and telephone number of any officer or director who participates on or who is a member of any board or committee of any Participating Institution. If none, state "none."

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Agency

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Authorized Signature/Date

**Attachment 14**  
**Agency Quality Review Program**

1. Briefly describe Agency's Quality Review Program on a separate page.
  - A. Identify the Agency employees responsible for the following areas who will serve as contacts for the Participating Institution. Please attach each person's resume or a description of his/her work history and tenure with Agency.

Administrative Contact: \_\_\_\_\_  
Phone/Fax/E-Mail: \_\_\_\_\_  
(To handle very serious issues)

Nursing/Staffing Contact: \_\_\_\_\_  
Phone/Fax/E-Mail: \_\_\_\_\_  
(To receive all needs and deal with the hospitals day-to-day)

RN Representative: \_\_\_\_\_  
Phone/Fax/E-Mail: \_\_\_\_\_  
(To be available for clinical concerns)

Billing/Invoicing Contact: \_\_\_\_\_  
Phone/Fax/E-Mail: \_\_\_\_\_  
(To handle all invoicing/billing)

- B. Briefly describe Agency's protocol for ensuring that the quality assurance criteria included in this RFP are met. Include a copy of the Quality Assurance Report forms used by Agency.
    - C. Briefly describe Agency's process for submitting Profile Verification Sheets to Participating Institutions five days prior to assignment start date. Also describe how Agency will track expirations of information on Profile Verification Sheets and how Agency will keep track of sending updated Profile Verification Sheets.
    - D. Identify any audit deficiencies noted by any entity for Agency audits performed during the last twelve months. Explain the correction plan.
2. List on a separate page all New Mexico, Arizona, Colorado and Texas facilities that Agency has done business with during the last twelve-month period. Such facilities may be contacted by HSC to provide appropriate validation of Agency staffing protocol. If Agency has not done business in New Mexico, provide a list of references with phone numbers from surrounding states.

**Attachment 14**  
**Quality Review Program**

3. Complete the following checklist verifying that Agency agrees to comply with the RFP quality criteria (see RFP for detail) for the following items:

Yes	No	
___	___	Introduction
___	___	Definitions
___	___	Term
___	___	Healthcare Personnel Requirements
___	___	Payment
___	___	Agency Representations and Warranties; Disclosures
___	___	Internal Quality Review Program
___	___	Orientation
___	___	Assignment Protocol
___	___	Non-Solicitation of Employees
___	___	Termination
___	___	Reports
___	___	Insurance
___	___	Indemnity
___	___	Independent Contractor
___	___	Use of Name
___	___	Confidential Information
___	___	Notice
___	___	Non-Discrimination
___	___	Access to Books and Records
___	___	Governing Law
___	___	Effect of Law
___	___	Assignment
___	___	Limited Agreement
___	___	Amendment
___	___	Waiver
___	___	Authority

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Agency

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Authorized Signature/Date

**Attachment 15  
Initial File Submission**

<b>TO:</b>	_____
<b>FACILITY:</b>	_____
<b>FAX NUMBER:</b>	_____
<b>FROM:</b>	_____
<b>DATE:</b>	_____
<b>TOTAL PAGES FAXED:</b>	_____

AGENCY: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

**APPLICANT PROFILE:**

NAME: \_\_\_\_\_

SPECIALTY (include years of experience): \_\_\_\_\_ CERTIFICATIONS: \_\_\_\_\_

NEW MEXICO LICENSE STATUS: \_\_\_\_\_

NUMBER OF TRAVEL ASSIGNMENTS COMPLETED: \_\_\_\_\_

AVAILABLE TO START: \_\_\_\_\_ SHIFT INTERESTED IN: \_\_\_\_\_

**APPLICANT CONTACT INFORMATION:**

VIA AGENCY: \_\_\_\_ YES \_\_\_\_ NO

VIA APPLICANT: \_\_\_\_ YES \_\_\_\_ NO

Contact name: \_\_\_\_\_

Phone number: \_\_\_\_\_

Phone number: \_\_\_\_\_

\*Best time: \_\_\_\_\_

\*Note: Hospital: please leave clear message with first and last name, facility name, and phone number and best time to call back.

COMMENTS: \_\_\_\_\_

ATTACHED: (1) WORK HISTORY, (2) REFERENCES AND (3) AGENCY SKILLS CHECKLIST

**Attachment 16  
Confidentiality Agreement for Agency Healthcare Providers  
As required by Participating Institutions**

While performing services pursuant to The New Mexico Travel Registry Program Agreement between my employer ("Agency") \_\_\_\_\_ and the Participating Institution ("Institution"), I hereby agree to the following provisions:

Medical Records Confidentiality: I understand that while performing services under this Agreement, I might have access to records relating to the treatment of patients of Participating Institution ("Medical Records"). I hereby agree not to disclose any Medical Records or the contents of any Medical Records except in accordance with the Health Insurance Portability and Accountability Act to anyone other than (i) any employee of Participating Institution who needs to know the contents of the Medical Records in the performance of their employment; and (ii) members of the Participating Institution Medical Staff involved in the direct care of the concerned patient. To the extent that the Medical Records relate in any way to the treatment of alcohol or drug abuse, I acknowledge (i) that I am bound by regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. 2.1 et seq. and (ii) if necessary, I will resist in judicial proceedings any efforts to obtain access to the Medical Records, except as provided in the above-cited regulations. To the extent that the Medical Records contain test results governed by the Human Immunodeficiency Virus Test Act, Participating Institution makes the following disclosure to me regarding such records:

"This information has been disclosed to you from records whose confidentiality is protected by State Law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains or as otherwise permitted by State law. A person who makes an unauthorized disclosure of this information is guilty of a petty misdemeanor and shall be sentenced to imprisonment in the county jail for a definite term not to exceed six months or the payment of a fine of not more than five hundred dollars (\$500.00), or both."

Non-Discrimination: In performing services under the this Agreement, I understand that I and the Participating Institution will make services available for the sick of the area served without regard to race, color, religion, national origin, age, sex, sexual preference, ancestry, or handicap, and will not discriminate in any manner whatsoever.

Compliance with Institution Policies and Applicable Law: In discharging duties under this Agreement between Institution and my employer, I agree to comply with any Rules and Regulations, Institution policies and procedures, standards and requirements of the Joint Commission on the Accreditation of Health Care Organizations, Medicare, Medicaid, and other licensing and accrediting agencies, and all applicable federal and state statutes and regulations.

Limitation on Liability: While performing services under this Agreement, I understand that Institution will not be liable to any Agency Healthcare Provider, nor to any person making claim on behalf of such Agency Healthcare Provider, for any injury, death or damage to the person or property of such Agency Healthcare Provider, arising from any cause whatsoever during the provider's scheduled assignment at Institution when Agency Healthcare Provider is participating in an assignment in connection with the Agreement executed between Institution and the Agency Healthcare Provider's employer; unless injury, death or damage to the person or property is caused by the negligent acts of Institution, its directors, or employees.

Exposure to Blood or Body Fluids: While performing services at Institution, I understand that it will be my responsibility to report any exposures to blood or body fluids to a representative of Institution as well as to my Agency employer's designated representative, and to follow the exposure control plan which has been developed and adopted by Institution, to be applied in conjunction with the exposure control plan which has been developed and adopted by my Agency employer.

Illness or Injury: I understand that it is my responsibility to become familiar with and to comply with the particular policies of my Agency employer related to illness or injury while on the Institution's premises, including reporting of illness or injury and procedures to be followed. If I am unfamiliar with any policies or procedures in regard to illness or injury, I agree to ask my Agency employer for clarification as soon as possible.

Supervision: While performing services under this Agreement, I understand that I will be working under the supervision of Institution personnel. In addition, I understand that I am not to initiate any patient care activities for which I do not feel qualified and/or do not have recent experience in performing, and agree to discuss as may be necessary with personnel assigned to supervise my performance.

By: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Agency Employee

Witnessed by: \_\_\_\_\_ Date: \_\_\_\_\_

Agency: \_\_\_\_\_ Dates of Service: \_\_\_\_\_

Agency Healthcare Provider Information

The following information is requested to assist the Institution in case the need should ever arise to locate you. This information will be held in strict confidence.

Name: \_\_\_\_\_ Maiden Name (if applicable): \_\_\_\_\_

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

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

Phone number: \_\_\_\_\_

Past Address: \_\_\_\_\_

Professional License Number (s)/State (s): \_\_\_\_\_

Please list below the names, addresses, and telephone numbers of your two closest living relatives with whom you do **not** live:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

## **Attachment 17**

### **Business Associate Agreement**

This Business Associate Agreement ("Agreement") is dated as of the \_\_\_\_ day of \_\_\_\_\_, 2004 and is by and between the Participating Institution \_\_\_\_\_ (the "Covered Entity") and the Agency \_\_\_\_\_ (the "Business Associate").

1. Purpose. Covered Entity is a "Covered Entity" and Business Associate is a "Business Associate" as such terms are defined in the HIPAA Privacy Regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996. Pursuant to this Agreement and/or one or more contracts between the parties (the "Contract(s)"), Business Associate shall be provided, create or receive Protected Health Information from or on behalf of the Covered Entity ("PHI"). Business Associate and Covered Entity desire to enter into this Agreement to ensure the protection and proper use of the PHI.

2. Disclosure to Business Associate. From time to time and pursuant to the Contract(s), the Covered Entity will disclose PHI to the Business Associate as it relates to the provision of supplemental staffing.

3. Use and Disclosure of Protected Health Information. Business Associate shall not use or disclose PHI and shall ensure that its directors, officers, employees, contractors and agents do not use or disclose PHI received from the Covered Entity in any manner that would constitute a violation of the HIPAA Privacy Regulations or the HIPAA Security Regulations 45 CFR §§ 160 and 164 (referred to in this Agreement as "HIPAA"). Covered Entity and the Business Associate agree that the Business Associate may only use or disclose PHI as follows: (a) for the purpose described in Section 2 of this Agreement; (b) for the Business Associate's proper management and administration; or (c) as legally required, which shall specifically include but not be limited to the purposes of treatment, payment and healthcare operations as defined under HIPAA. Except for such use, the Business Associate agrees to hold all PHI strictly confidential. Capitalized terms not otherwise defined in this Agreement shall have the meanings as defined in HIPAA. To the extent the Business Associate discloses PHI to a third party, the Business Associate must obtain, prior to making any such disclosure (a) reasonable assurances from the third party that such PHI will be held confidential as provided in this Agreement and only disclosed as required by law or for the purposes for which it was disclosed to such third party, provided that such reasonable assurances shall require that Business Associate enter into a written agreement pursuant to which such third party agrees to be bound by all of the same restrictions and conditions that apply to the Business Associate pursuant to this Agreement; and (b) an agreement from such third party to immediately notify the Business Associate of any breaches of the third party's confidentiality obligations with respect to the PHI.

4. Safeguards Against Misuse of Information. The Business Associate agrees that it will implement appropriate safeguards to prevent the unauthorized use or disclosure of PHI other than pursuant to the terms and conditions of this Agreement.

5. Reporting of Disclosures of PHI. The Business Associate shall report to the Covered Entity any use or disclosure of PHI not provided for in this Agreement or in violation of this Agreement by the Business Associate, its officers, directors, employees, contractors or agents or by a third party to which the Business Associate disclosed PHI pursuant to this Agreement.

6. Access to Information. Within five business days of a request by the Covered Entity for access to PHI about an individual, the Business Associate shall make PHI available to the Covered Entity in the medium and format in which such PHI is maintained by Business Associate for as long as such PHI is maintained. In the event any individual requests access to PHI directly from the Business Associate, the Business Associate shall within two business days forward such request to the Covered Entity. Any denials of access to the PHI requested shall be the responsibility of the Covered Entity.

7. Availability of PHI for Amendment. Within 10 business days of receipt of a request from the Covered Entity for the amendment of an individual's PHI, the Business Associate shall provide such information to the Covered Entity for amendment and incorporate any such amendments in the PHI as required by 45 CFR §164.526.

8. Accounting for Disclosures. Within 10 business days of notice by the Covered Entity to the Business Associate that it has received a request for an accounting of disclosures of PHI regarding an individual during the six years prior to the date on which the accounting was requested, the Business Associate shall make available to the Covered Entity such information as is in the Business Associate's possession and is required for the Covered Entity to make the accounting required by 45 CFR §164.528. Business Associate is not required to account for disclosures made prior to April 14, 2003. At a minimum, the Business Associate shall provide the Covered Entity with the following information: (a) the date of the disclosure; (b) the name of the entity or person who received the PHI, and if known, the address of such entity or person; (c) a brief description of the PHI disclosed; and (d) a brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure. In the event the request for an accounting is delivered directly to the Business Associate, the Business Associate shall, within two business days, forward such request to the Covered Entity. It shall be the Covered Entity's responsibility to prepare and deliver any such accounting requested. The Business Associate hereby agrees to implement an appropriate record keeping process to enable it to comply with the requirements of this Section.

9. Availability of Books and Records. The Business Associate hereby agrees to make its internal practices, books and records relating to the use and disclosure of PHI received from the Covered Entity, or created or received by the Business Associate on behalf of the Covered Entity available to the Covered Entity and to the Secretary for purposes of determining the Covered Entity's and the Business Associate's compliance with HIPAA.

10. Amendment. Upon the enactment of any law or regulation affecting the use and/or disclosure of PHI, or the publication of any court decision relating to any such law, or the publication of any interpretive policy, opinion or guidance of any governmental agency charged with the enforcement of any such law or regulation, the Covered Entity may, by written notice to the Business Associate, amend this Agreement to comply with such law or regulation by providing 30 days' written notice to the Business Associate. Such amendment shall be binding upon the Covered Entity and the Business Associate at the end of the 30-day period and shall not require the consent of the Business Associate unless (a) the Business Associate provides the Covered Entity with notice of objection within the 30-day period; (b) the change has a material adverse economic effect upon the Business Associate as reasonably determined by the Business Associate; and (c) the Business Associate delivers written notice to the Covered Entity during such 30-day period terminating the Contract(s).

11. Breach. Notwithstanding the rights of the parties pursuant to other provisions of the Contract(s) or this Agreement, if the Business Associate breaches its obligations under this Agreement, the Covered Entity may, at its option (a) exercise any of its rights of access and inspection under this Agreement; (b) require the Business Associate to submit to a plan of monitoring and reporting, as the Covered Entity may determine necessary to maintain compliance with this Agreement and such plan shall be made part of this Agreement; (c) terminate this Agreement and the Contract(s) after expiration of a 20 day opportunity to cure; or (d) if termination of this Agreement or the Contract(s) is not feasible report Business Associate's breach or violation to the Secretary of the Department of Health and Human Services. The Covered Entity's remedies under this Section shall be cumulative, and the exercise of any remedy shall not preclude the exercise of any other.

12. Procedure Upon Termination. Business Associate's obligations under this Agreement will terminate only upon the termination of all the Contract(s), provided that upon termination of this Agreement, the Business Associate shall return or destroy all PHI that it maintains in any form and shall retain no copies of such information or, if the parties agree that return or destruction is not feasible, the Business Associate shall continue to extend the protections of this Agreement to such information and limit further use of the information to those purposes that make the return or destruction of the information not feasible. The provisions of this Agreement shall survive termination of the Contract(s).

13. Notices. Any notice required to be given pursuant to the terms of this Agreement shall be in writing and shall be hand-delivered or sent by first-class mail to the party to receive such notice at the addresses listed immediately after each party's signature. Either party to this Agreement may change the address to which notice is to be submitted by notice delivered pursuant to this paragraph 13.

14. Interpretation. This Agreement is intended to comply with HIPAA. If there is any ambiguity in this Agreement, it will be resolved to permit compliance with HIPAA. In the event that any provisions in any other agreements between the parties provides for additional restrictions on the use or disclosure of PHI, those more restrictive provisions will control.

15. Effective Date. The terms and conditions of this Agreement will be effective upon execution of the New Mexico Travel Registry Program Agreement for those Participating Institutions that recognize the Agency as a Business Associate.

Covered Entity

Business Associate

By \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

By \_\_\_\_\_

Name \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No: \_\_\_\_\_