

Winyah Nursing Services, Inc.

Serving Your Staffing Needs

Post Office Box 1390
Andrews, SC 29510
1-888-560-4515 Phone
1-888-864-2920 Fax
www.winyahnursingservices.com

Thank you for your interest in working with Winyah Nursing Services, Inc. We ask that you review the attached information and complete it as soon as possible.

You must submit with a copy of the following information with your application. For your convenience, we can accept your full application by fax, email or postal mail. If you choose to fax your information, we ask you to please lighten all copies of your credentials as much as possible or mail those documents via postal mail.

ACLS Credential

BLS Credential

Social Security Card

Drivers License

Nursing licensure (from ALL states where you currently hold an active status)

Fingerprints (You must provide card and receipt. Contact your local police department to get the scheduled times (this service is offered to the public. Average cost \$5.00)

Photo (Frontal face snapshot only. Submit via postal mail or email to sdouglas@winyahnursingservices.com)

Any additional certifications (i.e. PALS, TNCC, etc.)

Two letters of Professional Reference completed by your immediate supervisor or charge nurse.

*Also, please make sure all documentation is **signed** and **complete**.*

With Sincere Thanks,

The Staff at Winyah Nursing Services, Inc.

Winyah Nursing Services, Inc

SERVING YOUR STAFFING NEEDS

Post Office Box 1390
Andrews, South Carolina 29510
1-888-560-4515 Phone
1-888-864-2920 Fax
www.winyahnursingservices.com

Please print clearly and use black ink only

APPLICATION

Date: _____

How did you hear about Winyah Nursing Services?

- Newspaper
- Referral If so, who? _____
- Magazine
- Letter
- Other
- Web site

Classification

- RN
- LPN
- PT
- OT
- Other _____
(specify)

Employment Desired: Travel Assignment Local Contract Per Diem

First Name: _____ MI: _____ Last Name: _____

Current Address: _____ DOB: _____

City: _____ ST: _____ Zip: _____

Current Phone#: _____ Beeper#: _____ Cell#: _____

e-mail: _____ Social Security: _____

Permanent Address: _____

Education

College Name: _____ City and State: _____

Year Graduated: _____ Degree / Diploma: _____

Recent course / Certification related to your specialty (i.e., IV Therapy, EKG interpretation, Pain Management, Geriatric Care, etc.) Date Completed: _____

Recent Critical Care Course / Date Completed: _____

Licensure / Credentials

Specialty (List most current experience first)

1. _____ Years of Experience: _____ As of (Indicate date): _____

2. _____ Years of Experience: _____ As of (Indicate date): _____

3. _____ Years of Experience: _____ As of (Indicate date): _____

Please indicate which of the following credentials you current hold (Please attach appropriate copies):

CPR Yes No Expiration Date _____ PALS Yes No Expiration Date _____

ACLS Yes No Expiration Date _____ TNCC Yes No Expiration Date _____

BCLS Yes No Expiration Date _____ NALS Yes No Expiration Date _____

Other _____ Expiration Date _____ Other _____ Expiration Date _____

Please indicate any of the following certifications you currently hold (please attach appropriate copies):

CNOR	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Expiration Date _____	OCN	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Expiration Date _____
CEN	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Expiration Date _____	CRRN	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Expiration Date _____
CCRN	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Expiration Date _____	CHEMO	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Expiration Date _____
Other _____			Expiration Date _____	Other _____			Expiration Date _____

Please list any additional skills, education, experience or other relevant qualifications (i.e., foreign language): _____

Professional License / Registry #: _____ State: _____ Expiration Date: _____

Professional License / Registry #: _____ State: _____ Expiration Date: _____

Are you allergic to Latex? Yes No

Have you ever been convicted of a crime or pled guilty or no contest to any criminal charge other than a minor traffic violation? Yes No

If yes, please detail the circumstances, dates, and final outcome: _____

Have you ever been named as a defendant in a professional liability suit? Yes No

If yes, please detail the circumstances, dates, and final outcome: _____

Has your license (in any jurisdiction that you may have been licensed in) ever been investigated, suspended or revoked? Yes No

If yes, please detail the circumstances and the final outcome: _____

Do you have any malpractice or negligence suits pending? Yes No if yes, please detail the suit and it's current status: _____

In case of an emergency, notify:

Name _____ Relationship _____

Address _____ Telephone (____) _____

City _____ State _____ Zip _____

The statements made in this application are true to the best of my knowledge. I understand that any falsification will be the basis for disqualification of employment or termination of services. I authorize Winyah Nursing Services, Inc. to verify the information I have provided and to contact past employers and references concerning my ability, character and employment records. I release all such persons from liability for furnishing said information. I authorize Winyah Nursing Services, Inc. and my employer, to release a copy of this employment application and any medical information which may be relevant to my employment to their client facilities. By applying with Winyah Nursing Services, I authorize release of this information to all other affiliates of the company and I acknowledge and agree that they may contact me using facsimile or any other means. Nothing contained in this employment application, or in the granting of an interview, is intended to create an employment contract between Winyah Nursing Services, Inc. and the applicant for either employment or for providing of any benefit. All orders of employment are made conditional upon the applicant's proving employment authorization.

Signature _____

Date _____

Employment History

Are you employed now? Yes No

May we contact your present employer? Yes No

May we contact your previous employer? Yes No

Please complete all information for each hospital. If any of the employers listed below are day agencies, please provide the name of the agency as well as the name of the hospital where you provided per diem care (i.e., list each hospital you worked at separately and include the agency name as well).

Hospital _____
 Address _____
 City/State _____
 Position Held/Specialty _____
 Average Patient Ratio _____
 Number of Beds in Unit _____ in Hospital _____
 Type of Nursing Primary Team

Charge Experience Yes No How often? _____
 Immediate Supervisor _____
 Phone (____) _____
 Date Employed: From _____ To _____
 Reason for Leaving _____
 Was this a Travel Assignment Yes No
 With what agency? _____

Hospital _____
 Address _____
 City/State _____
 Position Held/Specialty _____
 Average Patient Ratio _____
 Number of Beds in Unit _____ in Hospital _____
 Type of Nursing Primary Team

Charge Experience Yes No How often? _____
 Immediate Supervisor _____
 Phone (____) _____
 Date Employed: From _____ To _____
 Reason for Leaving _____
 Was this a Travel Assignment Yes No
 With what agency? _____

Hospital _____
 Address _____
 City/State _____
 Position Held/Specialty _____
 Average Patient Ratio _____
 Number of Beds in Unit _____ in Hospital _____
 Type of Nursing Primary Team

Charge Experience Yes No How often? _____
 Immediate Supervisor _____
 Phone (____) _____
 Date Employed: From _____ To _____
 Reason for Leaving _____
 Was this a Travel Assignment Yes No
 With what agency? _____

Hospital _____
 Address _____
 City/State _____
 Position Held/Specialty _____
 Average Patient Ratio _____
 Number of Beds in Unit _____ in Hospital _____
 Type of Nursing Primary Team

Charge Experience Yes No How often? _____
 Immediate Supervisor _____
 Phone (____) _____
 Date Employed: From _____ To _____
 Reason for Leaving _____
 Was this a Travel Assignment Yes No
 With what agency? _____

Signature _____

Date _____

Employment Eligibility Verification

INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1 - Employee. All employees, citizens and noncitizens, hired after November 6, 1986, must complete Section 1 of this form at the time of hire, which is the actual beginning of employment. The employer is responsible for ensuring that Section 1 is timely and properly completed.

Preparer/Translator Certification. The Preparer/Translator Certification must be completed if Section 1 is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete Section 1 on his/her own. However, the employee must still sign Section 1.

Section 2 - Employer. For the purpose of completing this form, the term "employer" includes those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors.

Employers must complete Section 2 by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, Section 2 must be completed at the time employment begins. **Employers must record:** 1) document title; 2) issuing authority; 3) document number; 4) expiration date, if any; and 5) the date employment begins. Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the I-9. However, employers are still responsible for completing the I-9.

Section 3 - Updating and Reverification. Employers must complete Section 3 when updating and/or reverifying the I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in Section 1. Employers **CANNOT** specify which document(s) they will accept from an employee.

- If an employee's name has changed at the time this form is being updated/ reverified, complete Block A.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.

- If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired or if a current employee's work authorization is about to expire (reverification), complete Block B and:
 - examine any document that reflects that the employee is authorized to work in the U.S. (see List A or C).
 - record the document title, document number and expiration date (if any) in Block C, and complete the signature block.

Photocopying and Retaining Form I-9. A blank I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed I-9s for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

For more detailed information, you may refer to the **INS Handbook for Employers, (Form M-274)**. You may obtain the handbook at your local INS office.

Privacy Act Notice. The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of the U.S. Immigration and Naturalization Service, the Department of Labor and the Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Reporting Burden. We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: 1) learning about this form, 5 minutes; 2) completing the form, 5 minutes; and 3) assembling and filing (recordkeeping) the form, 5 minutes, for an average of 15 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to the Immigration and Naturalization Service, HOPDI, 425 I Street, N.W., Room 4034, Washington, DC 20536. OMB No. 1115-0136.

**EMPLOYERS MUST RETAIN COMPLETED FORM I-9
PLEASE DO NOT MAIL COMPLETED FORM I-9 TO INS**

Form I-9 (Rev. 11-21-01)K

Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. **ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last		First	Middle Initial	Maiden Name
Address (Street Name and Number)			Appt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #	
I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.			I attest, under penalty of perjury, that I am (check one of the following): <input type="checkbox"/> A citizen or national of the United States <input type="checkbox"/> A Lawful Permanent Resident (Alien # A _____) <input type="checkbox"/> An alien authorized to work until ___/___/___ (Alien # or Admission #) _____	
Employee's Signature				Date (month/day/year)

Preparer and/or Translator Certification. (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): ___/___/___		___/___/___		___/___/___
Document #: _____		_____		_____
Expiration Date (if any): ___/___/___		_____		_____

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) ___/___/___ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name	Address (Street Name and Number, City, State, Zip Code)	Date (month/day/year)
<i>Womens Nursing Services</i>		
176 AITON AVE. ANDREWS, S.C. 29510		

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name (if applicable)	B. Date of rehire (month/day/year) (if applicable)
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.	
Document Title: _____	Document #: _____
Expiration Date (if any): ___/___/___	

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date (month/day/year)
--	-----------------------

LISTS OF ACCEPTABLE DOCUMENTS

LIST A	LIST B	LIST C
Documents that Establish Both Identity and Employment Eligibility	Documents that Establish Identity	Documents that Establish Employment Eligibility
	OR	
<ol style="list-style-type: none"> 1. U.S. Passport (unexpired or expired) 2. Certificate of U.S. Citizenship (<i>INS Form N-560 or N-561</i>) 3. Certificate of Naturalization (<i>INS Form N-550 or N-570</i>) 4. Unexpired foreign passport, with <i>I-551</i> stamp or attached <i>INS Form I-94</i> indicating unexpired employment authorization 5. Permanent Resident Card or Alien Registration Receipt Card with photograph (<i>INS Form I-151 or I-551</i>) 6. Unexpired Temporary Resident Card (<i>INS Form I-688</i>) 7. Unexpired Employment Authorization Card (<i>INS Form I-688A</i>) 8. Unexpired Reentry Permit (<i>INS Form I-327</i>) 9. Unexpired Refugee Travel Document (<i>INS Form I-571</i>) 10. Unexpired Employment Authorization Document issued by the INS which contains a photograph (<i>INS Form I-688B</i>) 	<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <p style="text-align: center;">For persons under age 18 who are unable to present a document listed above:</p> <ol style="list-style-type: none"> 10. School record or report card 11. Clinic, doctor or hospital record 12. Day-care or nursery school record 	<ol style="list-style-type: none"> 1. U.S. social security card issued by the Social Security Administration (<i>rather than a card stating it is not valid for employment</i>) 2. Certification of Birth Abroad issued by the Department of State (<i>Form FS-545 or Form DS-1350</i>) 3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (<i>INS Form I-197</i>) 6. ID Card for use of Resident Citizen in the United States (<i>INS Form I-179</i>) 7. Unexpired employment authorization document issued by the INS (<i>rather than those listed under List A</i>)

Illustrations of many of these documents appear in Part B of the Handbook for Employers (M-274)



Credentiaing and Background Investigation

WINYAH NURSING SERVICE (CLIENT #5883) PRE-EMPLOYMENT DISCLOSURE & RELEASE

APPLICANT'S FULL NAME
Any Other Names Used
Social Security No. / / Date of Birth
Current Address
City State Zip
Driver's License State No.
Address:

Name of High School, College, University or Institution of Professional Training where you completed the highest level (or GED - provide state)
Campus Name Campus City Campus State
Name on GED or under which you graduated
Dates of Attendance and/or Graduation

My present employer may be contacted for a job reference. Yes or No
Have you ever been convicted of a crime? Yes or No
Offense County State When

Table with 5 columns: City, State, Dates, From, To. Rows 1-4 for residential history.

Pursuant to the requirements of the Fair Credit Reporting Act, I acknowledge that a credit report, consumer report and/or investigative consumer report may be made in connection with my application for employment with prospective employer...

I authorize, without reservation, any party or agency contacted by PreCheck, Inc. to furnish the information mentioned above. A photocopy of this authorization shall have the same effect as the original.

I understand the information obtained will be used as one basis for employment/contract for services or denial of employment/contract for services. I hereby discharge, release and indemnify the prospective employer, PreCheck, Inc., their agents, servants and employees...

It is expressly understood that the information obtained through the use of this release will not be verified by PreCheck, Inc. The authorization granted herein shall be effective throughout the term of my employment.

I have read and understood the above information, and assert that all information provided by me is true and accurate.

Applicant's Signature Date

Upon your written request within a reasonable period of time, the investigative agency compiling a report will make a complete and accurate disclosure of the nature and scope of the investigation. In addition, if you are denied employment, either wholly or partly because of information contained in a consumer report, a disclosure will be made to you of the name and address of the investigative agency making such a report.

1 The Age Discrimination in Employment Act of 1967 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age. This information is for consumer report purposes only.
2 A "Consumer Report" may consist of employment records, educational verification, licensure verification, driving record, previous address and public records relative to criminal charges.
3 An "Investigative Consumer Report" means a consumer report or portion thereof in which information on a consumer's character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with persons having knowledge.



REQUEST FOR REFERENCE (Confidential):

NAME: _____ Social Security No.: _____ has applied with our company for employment as a _____ and has stated that she/he was employed by you from _____ to _____ in the capacity of _____

We would appreciate you completing the below section and returning this to us at your earliest convenience.

APPLICANT: I hereby approve the release of the below listed information.

X _____
 Applicant's signature

EMPLOYER:

Dates of employment: _____ Date of termination: _____ Position: _____

Reason for termination: _____

PLEASE CHECK THE APPROPRIATE COLUMN INDICATING YOUR RATING OF THIS APPLICANT:

	EXCELLENT	GOOD	AVERAGE	POOR
Technical Ability _____				
Attendance Record _____				
Ability to get along with others _____				
Cooperation _____				
Appearance _____				
Ability to take instructions _____				
Common sense _____				
Effective utilization of time _____				

Any injury on the job? _____ If yes, please state date, nature and lost time _____

Would you re-hire this employee? _____ If no, why? _____

Do you recommend applicant? _____

Facility _____

Signature _____

Title _____

Print Name _____

Date _____

Winyah Nursing Services, Inc

SERVING YOUR STAFFING NEEDS

Post Office Box 1390
Andrews, South Carolina 29510
843-221-4441 Phone
1-888-560-4515
843-221-7133 Fax

BLOODBORNE PATHOGEN FORM

I hereby certify that I have been informed by WINYAH NURSING SERVICES, INC., of the following:

1. OSHA GUIDELINES regarding Bloodborne Pathogen regulation.
2. I have been provided with the information regarding the location at which I can receive the vaccinations.
3. I have been instructed in WINYAH NURSING SERVICES, INC. Bloodborne Pathogens Exposure Control Plan, including receipt and review of:
ALL ABOUT HAZARDOUS MATERIAL. HEPATITIS B
ALL ABOUT UNIVERSAL PRECAUTIONS ABOUT BLOODBORNE PATHOGEN
ALL ABOUT INFECTION CONTROL.
4. OSHA Classification 1 2 3

Further, I hereby state that the following is a true statement of the status regarding the series of three (3) Hepatitis B Vaccinations:

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) Infections. I have been given the opportunity to be vaccinated with Hepatitis B Vaccine. However, I decline Hepatitis B Vaccinations at this time. 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 potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, WINYAH NURSING SERVICES, INC. will refer me to a proper source.

I have received the series of three (3) vaccinations at the following facility(s) and on the following dates.

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

I have been informed by WINYAH NURSING SERVICES, INC., of the facility at which I can receive the Hepatitis B Vaccinations Series and I will report to WINYAH NURSING SERVICES, INC. in a timely manner, the name of the facility(s) and dates of each vaccination which will be documented on this form as follows:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Signature _____ SS# _____ Date: _____

I hereby authorize WINYAH NURSING SERVICES, INC. to release any and all of my medical/lab/physical information:

Name _____ Occupations: _____
Signature _____ Date: _____
Witness _____ Date: _____

ANNUAL HEALTH ASSESSMENT

WINYAH NURSING SERVICES, INC.

Employee Name: _____ Date: _____

Address: _____ City/State/Zip: _____

Position: _____ Age: _____ Birthdate: _____ Sex: M F Marital Status: S M W D

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING:

- | | | | | |
|----------------------------------|---|--|--|------------------------------------|
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Kidneys | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Back (spine) | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Seizures | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Lungs | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> Stomach | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Chest pains | _____ | <input type="checkbox"/> Asthma | _____ |

Other: _____

If any of the above is checked, please explain: _____

Other serious illnesses which might effect your ability to perform the essential functions of the position offered (please explain).

State details of prior injuries or operations which might affect your ability to perform the essential functions of the position offered.

I, THE UNDERSIGNED, CERTIFY THE ABOVE ANSWERS ARE TRUE, AND GIVE THE EXAMINING PHYSICIAN PERMISSION TO SUBMIT A REPORT TO THE FACILITY.

Signed _____ Date _____

TO BE COMPLETED BY EMPLOYEE'S PHYSICIAN

Wt. _____ Hgt. _____ BMI _____ Today's blood pressure _____ / _____

PPD: Date Given: _____ Tuberc# _____ EXP. _____ SITE: Left Right forearm

Date read: _____ Results: _____ mm I. NEG POS

Varicella history/titer: _____ Mumps: _____ Rubella: _____ Measles: _____
 (Proof of titer must be provided)

TB Fit Test Mask type: _____

I have examined _____ (employee name) and I have found no condition that appears to prevent him/her from performing the duties of the position applied for with the exception or the possible exception of the following:

Further, I have found no indication of any condition which might represent a possible hazard to the health of patient or other employees in the institution.

Physician name: _____ Physician signature: _____

Address: _____ Phone: _____ Date: _____

**WINYAH NURSING SERVICES, INC.
WORK EXPERIENCE CHECKLIST -- RN/LPN**

Adults ICU:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Neuro ICU:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
CVICU:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Dialysis:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
ER:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Tele Med:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Tele Cardiac:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Med/Surg:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Rehab:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Psych:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Burn unit:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
OR:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Oncology:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
PICU:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
NICU:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Pediatrics:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Psych Peds:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
OB:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Nursery:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
L&D:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Level II Nursery:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Ventilators:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Ortho:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Hospice:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
LTC:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Private Duty:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Home Health:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
H/H Infusion:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Intermittent skilled visit:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Computer charting:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Balloon pumps:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Epidurals:	<input type="checkbox"/> yes	<input type="checkbox"/> no	_____ Months/Years or experience
Basic recognition of EKG arrhythmias:	<input type="checkbox"/> yes	<input type="checkbox"/> no	
Use of emergency equipment:	<input type="checkbox"/> yes	<input type="checkbox"/> no	
Blood glucose monitor type:			

For nurses assigned to special care units, proficiency in intensive or cardiac care and competency in:

The recognition, interpretation, and recording of signs and symptoms in critically ill patients: yes no

The parenteral administration of electrolytes and fluids: yes no

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

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

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

Employee Name: _____ Employee signature: _____

Date _____

Winyah Nursing Services, Inc.

SERVING YOUR STAFFING NEEDS

Post Office Box 1390
Andrews, South Carolina 29510
843-221-4441 Phone
1-888-560-4515 Phone
843-221-7133 Fax

PROCEDURE FOR ON THE JOB INJURY WORKMANS COMPENSATION

THESE PROCEDURES MUST BE FOLLOWED WHEN DEALING
WITH ON THE JOB INJURIES (WORKMANS COMPENSATION).

- A. Inquiries that happen during the weekday on day shift hours (this is Monday-Friday, 8:00AM to 5:00PM).
1. Nurses must report the incident to Winyah Nursing Services, Inc. immediately, or they may ask someone to call for them with the pertinent information.
 2. The nurse needs to report all information dealing with the accident, including names(s) of anyone that may have witnessed the incident (see page 3)
 3. The nurse, if needed, may be asked to report to the Workers Compensation Company for assessment or follow up.
 4. If any Hospital/Doctor's office has required procedures we ask that it is reported to Winyah Nursing Services, Inc. immediately and a copy of the "First Injury Report" faxed to use with any other helpful information.
- Injuries happen after hours (5:00PM to 8:00AM or Weekends)
1. Nurse should report to the nearest facility for proper treatment.
 2. Nurse needs to report incident to Winyah Nursing Services, Inc. immediately or following AM (this includes the weekends).
 3. Nurse needs to have all information concerning incident and procedure taken. Same as above, any witness(s) and way to reach them. (see page 3).
 4. Any follow-ups needed will have to be done on one on one basis...most follow ups will be done at the discretion of the Worker's Compensation Company. So, please make sure that we have all information concerning the incident reported.

All incidents are to be reported within 24 hours. There should always be a "first injury Report" filled out at time of accident. The nurse should fax a copy of any reports made to Winyah Nursing Services, Inc. immediately. It is the nurses responsibility to make sure the incident is reported, not the hospitals. These procedures will help in minimizing the problem of you being billed and the hassle that comes with it.

We appreciate you helping us with these important procedures.

INFORMATION NEEDED FOR
ON THE JOB INJURIES

CLAIMANT'S INFORMATION

1. Employer information
2. Name
3. Address
4. Telephone number
5. Social security number
6. Sex
7. Marital status
8. Date of birth
9. Department
10. Occupation
11. Date of hire
12. Employment status (temp)

ACCIDENT/INJURY INFORMATION

1. Date and Time of accident
2. On employer's premises
3. Accident address and county
4. Date employer notified
5. Description of accident
6. Description of injury
7. Witness name and address

Above is general information we will need to file a claim with the Company that handles our Workman's Comp. Any other information that you feel may be essential to this claim would be greatly appreciated.

Acknowledgment for Responsibility To Report Work-Related Medical Injuries

- I acknowledge that I am responsible to obey all safety rules and precautions and to exercise caution in all work activities while on assignment.
- I acknowledge that in conformance with Winyah Nursing Services, Inc. Worker's Compensation policy if I sustain a work related injury, I must notify my assignment supervisor and Manager or QA director immediately. In the event I am unable to do so, I will designate another individual to notify Winyah Nursing Services, Inc. on my behalf.
- I acknowledge that I must immediately complete a "First Report of Injury" form which I may obtain from my Manager or QA Director. Even if no medical care is rendered at the time of injury, I will file a "First Report of Injury" form.
- I acknowledge that if I am treated for a job related injury and/or receive medication during the course of treatment, Winyah Nursing Services, Inc. may not receive bills directly from the care provider. I must present all bills that I receive to my Manager or QA Director as soon as I receive them.
- I acknowledge and agree that during the course of treatment and/or absence for a work related injury or illness, I may be required to undergo drug and alcohol testing and that the results of such testing may impact upon my claim.

Acknowledged, understood and agreed.

Signature

Date

Form W-4 (2009)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2009 expires February 18, 2010. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the Personal Allowances Worksheet below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/multiple job situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or

dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

Nonresident alien. If you are a nonresident alien, see the instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2009. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent.	A	_____
B	Enter "1" if: <ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	B	_____
C	Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	_____
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	_____
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	_____
F	Enter "1" if you have at least \$1,800 of child or dependent care expenses for which you plan to claim a credit (Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	_____
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children. 	G	_____
H	Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.)	H	_____

For accuracy, complete all worksheets that apply.

- If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.
- If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$25,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.
- If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="font-size: small; margin: 0;">▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-0074 <div style="font-size: 2em; font-weight: bold; margin: 5px 0;">2009</div>
1 Type or print your first name and middle initial. Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <small>Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.</small>
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 _____
6 Additional amount, if any, you want withheld from each paycheck		6 \$ _____
7 I claim exemption from withholding for 2009, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here		<div style="border: 1px solid black; padding: 2px; font-size: 8px;"> </div>
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature <small>(Form is not valid unless you sign it.)</small>		Date
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)
		10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions, claim certain credits, adjustments to income, or an additional standard deduction.

1 Enter an estimate of your 2009 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2009, you may have to reduce your itemized deductions if your income is over \$166,800 (\$83,400 if married filing separately). See Worksheet 2 in Pub. 919 for details.) 1 \$ _____

2 Enter: $\left\{ \begin{array}{l} \$11,400 \text{ if married filing jointly or qualifying widow(er)} \\ \$ 8,350 \text{ if head of household} \\ \$ 5,700 \text{ if single or married filing separately} \end{array} \right\}$ 2 \$ _____

3 Subtract line 2 from line 1. If zero or less, enter "-0-" 3 \$ _____

4 Enter an estimate of your 2009 adjustments to income and any additional standard deduction. (Pub. 919) 4 \$ _____

5 Add lines 3 and 4 and enter the total. (Include any amount for credits from Worksheet 8 in Pub. 919.) 5 \$ _____

6 Enter an estimate of your 2009 nonwage income (such as dividends or interest) 6 \$ _____

7 Subtract line 6 from line 5. If zero or less, enter "-0-" 7 \$ _____

8 Divide the amount on line 7 by \$3,500 and enter the result here. Drop any fraction 8 _____

9 Enter the number from the Personal Allowances Worksheet, line H, page 1 9 _____

10 Add lines 8 and 9 and enter the total here. If you plan to use the Two-Earners/Multiple Jobs Worksheet, also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1 10 _____

Two-Earners/Multiple Jobs Worksheet (See Two earners or multiple jobs on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet) 1 _____

2 Find the number in Table 1 below that applies to the **LOWEST** paying job and enter it here. However, if you are married filing jointly and wages from the highest paying job are \$50,000 or less, do not enter more than "3." 2 _____

3 If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. Do not use the rest of this worksheet 3 _____

Note. If line 1 is less than line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4-9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet 4 _____

5 Enter the number from line 1 of this worksheet 5 _____

6 Subtract line 5 from line 4 6 _____

7 Find the amount in Table 2 below that applies to the **HIGHEST** paying job and enter it here 7 \$ _____

8 Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed 8 \$ _____

9 Divide line 8 by the number of pay periods remaining in 2009. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2009. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 \$ _____

Table 1

Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above
\$0 - \$4,500	0	\$0 - \$6,000	0
4,501 - 9,000	1	6,001 - 12,000	1
9,001 - 18,000	2	12,001 - 18,000	2
18,001 - 22,000	3	18,001 - 28,000	3
22,001 - 26,000	4	28,001 - 35,000	4
26,001 - 32,000	5	35,001 - 50,000	5
32,001 - 38,000	6	50,001 - 65,000	6
38,001 - 46,000	7	65,001 - 80,000	7
46,001 - 55,000	8	80,001 - 90,000	8
55,001 - 60,000	9	90,001 - 120,000	9
60,001 - 65,000	10	120,001 and over	10
65,001 - 75,000	11		
75,001 - 95,000	12		
95,001 - 105,000	13		
105,001 - 120,000	14		
120,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$83,000	\$550	\$0 - \$35,000	\$550
83,001 - 120,000	910	35,001 - 90,000	910
120,001 - 185,000	1,020	90,001 - 185,000	1,020
185,001 - 330,000	1,200	185,001 - 370,000	1,200
330,001 and over	1,280	370,001 and over	1,280

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. The Internal Revenue Code requires this information under sections 3402(b)(2)(A) and 8109 and their regulations. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may also subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws, and using it in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.