Registry Network
Incorporated

Dear Applicant,

Thank you for your interest in becoming an employee of Registry Network, Inc. Enclosed is an application packet and list of documents needed to complete your application. After completing all forms, please return them via US mail, by one of our 877 fax numbers or by using Adobe sign. You will need to call the office that sent you the application to obtain the fax number for that office.

Please complete all the enclosed forms and place a copy of the following documents when returning your application:

1. Current Licenses or Certification.
2. BLS for healthcare provider, ACLS, NRP, NALS, PALS (front & back of all cards).
3. Current Statement of Good Health or Physical Exam.
4. Tuberculosis Screen (PPD/QuantiFERON/T-Spot) within the last year or a Chest X-Ray with in the last four years if you are TB positive.
5. Proof of Rubella, Rubeola, Mumps, and Varicella (Chicken Pox) Titers or signed immunization record showing 2 (two) immunizations, and proof of Respirator Fit Test.
6. Hepatitis B request, decline, proof of immunization, or titer.
7. Influenza request, decline, or proof of immunization.
8. Proof of Tdap immunization or declination.
9. I-9 Documentation that has been notarized unless you are able to come into one of our offices and we can verify the documents ourselves.
10. Voided Check if interested in having Direct Deposit
11. 2 (two) Professional References.
12. 10 or 12 Panel Drug Screen

Registry Network, Inc. has provided temporary medical staffing to government and civilian healthcare facilities for the past Thirty-One years. We are continually seeking qualified healthcare professionals in nursing, respiratory, and radiology specialties to staff acute care hospitals and clinics.

Please call 800-400-1145, if you have questions regarding the application.

We look forward to working with you in the near future.

Sincerely,

Registry Network, Inc.

Form Updated 10/29/2020

Please complete all questions. Include any supplemental information that you feel would be helpful in considering your qualifications.

The Registry Network, Inc. is an equal opportunity employer and abides by all applicable federal and state laws prohibiting discrimination in employment because of race, color, sex, sexual orientation, religion, national origin, age, handicap, medical conditions or marital status.

Registry Network Incorporated

Employment Application

Recruiter: _____

Date: _____

Driver's License: _____

Social Security Number: _____

Personal

Email Address

Last | First | Middle

Present Address: Street | City | State | Zip Code

Home Phone | Cell / Alt Phone

Have you ever been convicted of a felony? ☐ Yes ☐ No

If yes, explain when, where, type of offense and disposition of case.

A conviction will not necessarily disqualify applicant from the job applied for.

U.S Citizen ☐ Yes ☐ No

Position Desired ☐ Travel ☐ Daily Staffing ☐ Both

Shifts Preferred: ☐ A.M. ☐ P.M. ☐ NOC ☐ 8 Hour ☐ 12 Hour

In Case Of Emergency Please Call

Last Name | First | Home Phone | Work Phone

Street | City | State | Zip Code

Relationship

Lic. / Certs.

Please List All Licenses You Have

Type	State	Number	Expires

Please List All Certificates You Have

Type	Expires
Healthcare Provider BLS	
PALS	
NRP	
NALS	
ACLS	

Education

Name and Address of School	Graduate?	Year Graduated	Degree(s)
	☐ No ☐ Yes		
	☐ No ☐ Yes		
	☐ No ☐ Yes		

Travel Emp. History

List All **Travel** Health Care Assignments:

Present Or Most Recent Assignment:	Month / Year
Hospital:	Start:
Address:	End:
Unit Worked:	

Hospital:	Start:
Address:	End:
Unit Worked:	

Hospital:	Start:
Address:	End:
Unit Worked:	

Permanent Employment History

List All **Permanent** Health Care Employment:

Present Or Most Recent Position: May we contact your present employer now for reference? ☐ Y ☐ N	Month / Year
Employer:	Start:
Address:	End:
Phone Number:	Reason For Leaving:
Name And Title Of Supervisor:	
Your Position & Duties:	

Employer:	Start:
Address:	End:
Phone Number:	Reason For Leaving:
Name And Title Of Supervisor:	
Your Position & Duties:	

Employer:	Start:
Address:	End:
Phone Number:	Reason For Leaving:
Name And Title Of Supervisor:	
Your Position & Duties:	

Signature

I hereby certify that the answers given by me to the forgoing questions and statements made are true and correct without consequential omissions of any kind whatsoever, and that I have not knowingly withheld any information regarding my employment together with information they may have regarding me, whether or not it is on their records. I agree that my previous employer shall not be held liable in any respect if any employment offer is not tendered, is withdrawn or my employment is terminated because of false statements, answers or omissions made by me in this questionnaire. I herby release said employers, schools or person from all liability whatsoever for issuing this information. Also, I understand and agree that my position is for not definite period and may, regardless of the date of payment of my wages or salary, be terminated at any time without any previous notice.

CONSENT FOR DRUG / BACKGROUND SCREENING. I understand that the drug/background screening may be required by some of The Registry Network's client facilities and I agree to undergo such screening if required.

Signature of Applicant _____ Date _____

Form Updated 10/29/2020

Registry Network
Incorporated

PROFESSIONAL REFERENCE

The person below has registered with Registry Network, Inc. and has listed you as a present/previous employer. We would appreciate your assistance in verifying employment and evaluating job performance. All information is CONFIDENTIAL. Fax back to **Northern CA** at 877-349-3129 and **Southern CA** at 877-896-0460.

RELEASE OF INFORMATION
(To be completed by Applicant)

Applicant: _____ _____
LAST FIRST MI MAIDEN

Employer: _____ Position Held: _____

Telephone Number: _____ Dates Employed: From____/____
To____/_____

I hereby release from all liability the company or person completing the form, and authorize all information regarding my employment with them. I also release Registry Network, Inc. from all liability for my damages from the disclosure of this information.

_____ _____
Applicant Signature Date

RESPONSE
(To be completed by Employer)

1. Do the employment dates above correspond with your records? ☐ YES ☐ NO

2. Is there anything in the individual's work history that would pose a threat to patient safety?
☐ YES ☐ NO
Comments: _____

3. Would you rehire this employee? ☐ YES ☐ NO

PLEASE EVALUATE EACH OF THE FOLLOWING:

EVALUATION	POOR	AVERAGE	GOOD	EXCELLENT
Attendance				
Punctuality				
Dependability				
Quality of work				
Job knowledge/skills				
Judgment				
Accepts Supervision				
Appearance				
Attitude				

Name of Facility_____ Print Name _____
Signature_____ Title_____ Date_____
Telephone Verification by _____ Date _____
Form Updated 10/29/2020

Registry Network
Incorporated

PROFESSIONAL REFERENCE

The person below has registered with Registry Network, Inc. and has listed you as a present/previous employer. We would appreciate your assistance in verifying employment and evaluating job performance. All information is CONFIDENTIAL. Fax back to us in **Northern CA** at 877-349-3129 and in **Southern CA** at 877-896-0460.

RELEASE OF INFORMATION
(To be completed by Applicant)

Applicant: _____ _____
LAST FIRST MI MAIDEN

Employer: _____ Position Held: _____

Telephone Number: _____ Dates Employed: From____/____
To____/_____

I hereby release from all liability the company or person completing the form, and authorize all information regarding my employment with them. I also release Registry Network, Inc. from all liability for my damages from the disclosure of this information.

_____ _____
Applicant Signature Date

RESPONSE
(To be completed by Employer)

1. Do the employment dates above correspond with your records? ☐ YES ☐ NO
2. Is there anything in the individual's work history that would pose a threat to patient safety?
   ☐ YES ☐ NO
   Comments: _____
3. Would you rehire this employee? ☐ YES ☐ NO

PLEASE EVALUATE EACH OF THE FOLLOWING:

EVALUATION	POOR	AVERAGE	GOOD	EXCELLENT
Attendance				
Punctuality				
Dependability				
Quality of work				
Job knowledge/skills				
Judgment				
Accepts Supervision				
Appearance				
Attitude				

Name of Facility_____ Print Name _____
Signature_____ Title_____ Date_____
Telephone Verification by _____ Date _____
Form Updated 10/29/2020

Registry Network
Incorporated

Release of Records

I hereby give Registry Network permission to receive and release my employment records. This release includes but is not limited to education, experience, credentials, employment references, and medical records. Therefore releasing Registry Network from all liability.

_____ _____

Print Name Date

_____

Signature

Form updated 10/29/2020

Registry Network
Incorporated

BACKGROUND SCREENING RELEASE & AUTHORIZATION FORM

In connection with my application for employment (including contract for services or volunteer services) or tenancy with **Registry Network Inc.,** consumer reports will be requested. These consumer reports (investigative consumer reports in California) may include, as applicable, the following types of information: names and dates of previous employers/landlords, salary, work/tenant experience, education, accidents, licensure, credit (except California), etc. I further understand that such reports may contain public record information such as, but not limited to: my driving record, workers' compensation claims, judgments, evictions, bankruptcy proceedings, criminal records, etc., from federal, state and other agencies which maintain such records.

In addition, investigative consumer reports as defined by the federal Fair Credit Reporting Act, gathered from personal interviews with former employers/landlords and other past or current associates of mine to gather information regarding my work/tenant performance, character, general reputation, personal characteristics and lifestyle may be obtained.

I have the right to make a request to the consumer reporting agency: **2020 Background Screening; 1712 Pioneer Ave Suite 500; Cheyenne WY 82001; Phone: 1-800-391-8013** upon proper identification, to request the nature and substance of all information in its files on me at the time of my request, including the sources of information and the agency, on our behalf, will provide a complete and accurate disclosure of the nature and scope of the investigation covered by any consumer report(s); and the recipients of any reports on me which the agency has previously furnished within the two year period for employment requests, and one year for other purposes preceding my request (California three years). **I hereby consent to your obtaining the above information from the agency.** You may view their privacy policy at their website: https://www.TClogiQ.com/

I hereby authorize procurement of consumer report(s) and investigative consumer report(s), including the release of all criminal records. If hired (or contracted), this authorization shall remain on file and shall serve as ongoing authorization for you to procure consumer reports at any time during my employment (or contract) period.

California, Minnesota and Oklahoma Applicants only: Check box if you request a copy of any consumer report ordered on you.

Notice to California Applicants:

You have the right under Section 1786.22 of the California Civil Code to contact the Agency during reasonable hours (9:00 a.m. to 5:00 p.m. (ETZ) Monday through Friday) to obtain all information in your file for your review.

You may obtain such information as follows: 1) In person at the Agency's offices, which address is listed above. You can have someone accompany you to the Agency's offices. Agency may require this third party to present reasonable identification. You may be required at the time of such visit to sign an authorization for Agency to disclose to or discuss your information with this third party; 2) By certified mail, if you have previously provided identification in a written request that your file be sent to you or to a third party identified by you; 3) By telephone, if you have previously provided proper identification in writing to Agency; and 4) Agency has trained personnel to explain any information in your file to you and if the file contains any information that is coded, such will be explained to you.

Notice to New York Applicants:

For consumers applying for work in New York: I acknowledge receiving a copy of Article 23-A of the New York Correction Law.

_____ (Initials)

I acknowledge that I have been provided a copy of consumer's rights under the Fair Credit Reporting Act.

Please Print Clearly

FIRST NAME	MIDDLE NAME	LAST NAME
SOCIAL SECURITY NUMBER	**DATE OF BIRTH (mm/dd/yyyy)**	**PLEASE CHECK ONE**
		☐MALE ☐ FEMALE

Alias/Maiden/Previous Name(s) Use the back of this form if more space is needed.

FIRST NAME	MIDDLE NAME	LAST NAME	YEARS USED

List all addresses, *including current address*, for the past 7 years. Use the back of this form if more space is needed.

ADDRESS, CITY and STATE	ZIP CODE	COUNTY	DATE FROM	DATE TO

DRIVERS LICENSE NUMBER	STATE ISSUED	EXPIRATION DATE
Best Telephone number to reach you on:		
Email Address:		

APPLICANT SIGNATURE: _____ DATE: _____

Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

Registry Network Incorporated

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.

- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
- a person has taken adverse action against you because of information in your credit report;
- you are the victim of identity theft and place a fraud alert in your file;
- your file contains inaccurate information as a result of fraud;
- you are on public assistance;
- you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.

- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.

- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

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- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.

- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567- 8688.

- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS:	CONTACT:
1. a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates.	a. Consumer Financial Protection Bureau 1700 G Street NW Washington, DC 20552
b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:	b. Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357

2. To the extent not included in item 1 above:	
a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks	a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050
b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act	b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480
c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations	c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106
d. Federal Credit Unions	d. National Credit Union Administration Office of Consumer Protection (OCP) Division of Consumer Compliance and Outreach (DCCO) 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, SE Washington, DC 20590
4. Creditors Subject to Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street S.W. Washington, DC 20423
5. Creditors Subject to Packers and Stockyards Act, 1921	Nearest Packers and Stockyards Administration area supervisor
6. Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, SW, 8th Floor Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission
8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations	
9. Retailers, Finance Companies, and All Other Creditors Not Listed	

Above
100 F St NE
Washington, DC 20549
Farm Credit Administration
1501 Farm Credit Drive
McLean, VA 22102-5090
FTC Regional Office for region in which the creditor operates or
Federal Trade Commission: Consumer Response Center – FCRA
Washington, DC 20580 (877)
382-4357

Reviewed 8/7/18

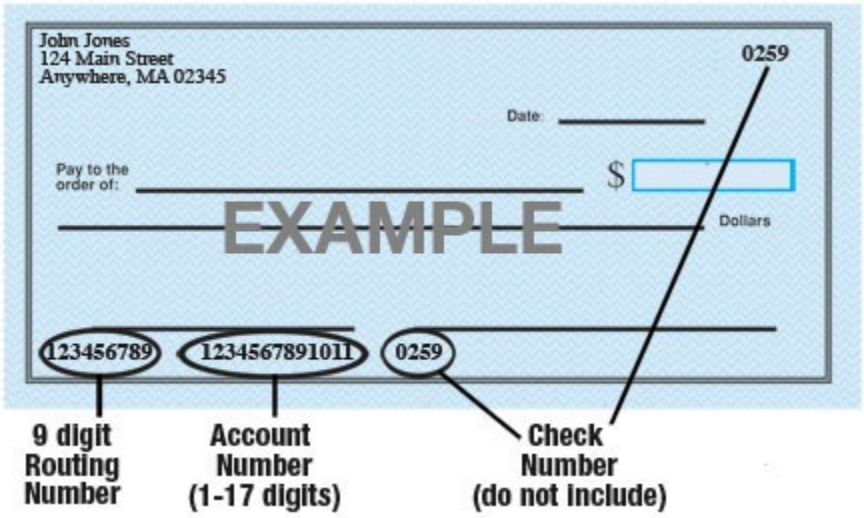
Direct Deposit Authorization Form

Please print and complete ALL the information below.

Name: _____

Address: _____

City, State, Zip: _____



Name of Bank: _____

Account #: _____

9-Digit Routing #: _____

Amount: _____% or ☐ Entire Paycheck

Type of Account: ☐Checking ☐Savings

Please attach a voided check for each bank account to which funds should be deposited. If no check copy is provided and an error occurs by you, your check will first have to be returned by the financial institution before we will reissue the funds.

Registry Network Inc. is hereby authorized to directly deposit my pay to the account listed above. This authorization will remain in effect until I modify or cancel it in writing.

Employee Signature: _____

Date: _____

Form Updated 10/29/2020

Registry Network
Incorporated

CONFIDENTIAL POST-EMPLOYMENT EEOC DATA FORM

NAME (Last, First, Initial) _____

Sex: Female ☐ Male ☐

Date of Birth: ____/_____/_____

US Citizen? Yes ☐ No ☐

☐ Veteran (other than Vietnam era)

☐ Vietnam era Veteran (served on active duty between Aug. 5, 1964 and May 7, 1975)

☐ Handicapped

☐ Disabled Veteran (Vietnam era only)

☐ Disabled Veteran (other than Vietnam era)

RACE OR ETHNIC GROUP (please check only one box)

- ☐ White (Not of Hispanic origin)
- ☐ Black or African American (Not of Hispanic origin)
- ☐ Native Hawaiian or Pacific Islander: All persons having origins in any of the original peoples of the Far East, Southeast, Asia, the Pacific Islands, India or Pakistan.
- ☐ Asian: All persons having origins in any of the original peoples of the Far East, Southeast, Asia, India or Pakistan.
- ☐ Two or more Races:
- ☐ American Indian or Alaskan Native: Persons having origin in the original peoples of North America and who maintain cultural identification through tribal affiliation or community recognition.
- ☐ Hispanic or Latino: All persons of Mexican, Puerto Rican, Cuban, Central or South America, or other Spanish culture or origin.

Date Completed: ____/_____/_____ Signature: _____

Form Updated 10-29-2020

Registry Network
Incorporated

Health Insurance Attestation Form

I, _____, attest that I have Health Insurance that meets the requirements of the Affordable Care Act (ACA) either through private insurance or Covered California. I understand it is my responsibility to inform RNI should my policy change or I no longer have coverage.

Print Name: _____

Signature: _____

Date: _____

Form Updated 10/29/2020

MEAL PERIOD WAIVER
10 & 12 HOUR SHIFT

This will acknowledge that I regularly work a shift in excess of eight (8) hours and wish to waive one of the two meal periods I would otherwise be entitled to receive under state law. In accordance with the requirements of Wage Order 5, this certifies my voluntary waiver of a meal period each day of work. I also understand that Registry Network, Inc. or I may revoke this "Meal Period Waiver" at any time by providing at least one day's advance notice in writing of the decision to do so. This waiver will remain in effect until I exercise, or the Registry Network, Inc. exercises, the option to revoke the waiver.

I acknowledge that I have read this waiver, understand it and voluntarily agree to it provisions.

- ❑ I acknowledge that I have read this waiver, understand it and voluntarily waive one of my meal periods.

- ❑ I acknowledge that I have read this waiver, <u>understand it and do not wish to waive one of my 2 meal periods</u>. This means on a 10 or 12 hour shift you wish to take 2 unpaid 30-minute lunch breaks. RNI cannot guarantee the facility will grant you the second meal period, so going to a facility that has 10 or 12 hour shifts may not be an option for you

Employee Signature	Date
Print Name	Department

Registry Network
Incorporated

CONTINUING EDUCATION DOCUMENTATION

Registry Network encourages you to acquire your CEU's throughout your two year license period. RNI and our clients are interested in knowing what you are keeping up with. Please provide us with the names of the courses and the hours given, or simply provide us your CEU award certificate.

EMPLOYEE NAME: _____

OCCUPATION: _____

SPECIALTY: _____

CEU'S ATTENDED DURING: _____

	NAME OF CLASS	NUMBER OF CEU HOURS
1.	_____	
2.	_____	
3.	_____	
4.	_____	
5.	_____	
6.	_____	
7.	_____	
8.	_____	
9.	_____	

_____ _____/_____/_____

EMPLOYEE SIGNATURE DATE

Form Updated 10/29/2020

Registry Network Incorporated

Permanent Tax Residence Declaration

The IRS requires that you pay taxes on housing benefits and travel expense reimbursements, unless you maintain a permanent residence while on a temporary assignment. If you qualify for permanent tax home exemption, we are required to keep your Permanent Tax Home Address on file.

If you do not return the completed form; or if you do not meet the "tax home" criteria, the IRS requires that we treat travel and housing benefits as income and taxes will be withheld accordingly.

Consult your tax advisor regarding tax liability of housing and travel benefits and permanent tax residence.

IRS criteria used to determine your tax home residence is as follows:

- You must meet at least one of the following criteria:
  a) You lived at your permanent tax residence immediately prior to your current assignment, **or**
  b) You have a family member utilizing the residence, or you utilized this residence frequently for purpose of your own lodging.

- There must be a realistic expectation that you will return to & live at your home; **and**
  a) Your tax home must be separate and distinct from your temporary address; and
  b) You pay to maintain your permanent tax residence while you are on assignment (i.e. mortgage, rent, room and board).

- The **Permanent Tax Residence** *must* be:
  a) Habitable living quarters at least 50 miles away from your temporary residence; and
  b) Payments to maintain your permanent tax residence must be real and substantial.

Please be advised, the IRS considers employment away from your home in a single location that exceeds or may exceed one year, to be indefinite, not temporary and therefore housing and travel benefits would be subject to withholding.

Complete this form and return to us as soon as possible.

NAME: _____

Do you qualify for a permanent tax-residence exemption? ___Yes ___No

If, "YES" is selected, please complete the following fields:

_____

STREET ADDRESS

_____

CITY STATE ZIP CODE

I acknowledge by signing this document that the information provided is true and correct. I understand that if I provide an incorrect statement, I may be subject to federal, state, and local taxes; penalties; and interest for which I agree to take full responsibility. I understand that I am responsible for notifying the Company in writing if my permanent tax-residence status should change and I become ineligible for the exemption.

_____ _____

SIGNATURE DATE

Form updated 10/29/2020

Registry Network
Incorporated

Hepatitis B Vaccine Evaluation Consent/Declination Form

Name: _____

To reduce unnecessary immunization of people previously immune (from prior vaccination or by natural infection), please complete the following questions:

1. Have you ever received any vaccine against Hepatitis B? Yes___ No___
   If yes, in what year? _____. How many shots were given? _____

2. Have you ever been told you were exposed to or infected with Hepatitis B?
   Yes ___ No___

3. Although the current vaccine is extremely safe, it is contraindicated for persons allergic to yeast products. Are you allergic to yeast? Yes___ No___

Healthcare workers are at increased risk of Hepatitis B Virus (HBV) infection because of contract with blood and other body fluids. The serious complications and results of HBV infection include liver damage, cirrhosis of the liver, chronic active hepatitis, cancer of the liver, and/or death. There is no specific treatment for HBV infection.

The Hepatitis B vaccine is 80-95% effective in preventing Hepatitis in susceptible people. The vaccine is given intramuscularly in three doses, with the second and third doses given one and six months after the first dose. The most common side effect has been limited to soreness or redness at the injection site. Systemic complaints could include fatigue/weakness, fever, headache, and malaise. The duration of protection is probably more than five years. However, this or the need for boosters is yet to be determined.

_____ **I request that the Hepatitis B vaccine be administered to me.**

I understand that due to my occupation exposure to blood and other potentially infectious materials that I may be at risk of acquiring HBV infection. I also understand that by declining this vaccine, I continue to be at risk of acquiring HBV, a serious disease. I understand I can change my mind and request to receive the vaccine at any time.

_____ **I presently decline the Hepatitis B vaccine.**

Signature: _____ Date: _____

Form Updated 10/29/2020

Registry Network
Incorporated

TB SURVEILLANCE SYMPTOMS REVIEW
FOR +PPD EMPLOYEES

Name: _____ **Date:** _____

1. Have you ever been treated for a + PPD with INH? If yes, when? _____

_____

2. Have you had any known exposure to TB? _____

_____

3. Have you experienced any of the following during the past year?

A) Night sweats	Yes ____	No ____
B) Persistent coughing	Yes ____	No ____
C) Coughing up blood	Yes ____	No ____
D) Excessive weight loss	Yes ____	No ____
E) Excessive fatigue or tiredness	Yes ____	No ____
F) Fever of unknown origin	Yes ____	No ____

Employee's Signature: _____

Revised 10/29/2020

Registry Network
Incorporated

Tetanus, Diphtheria & Pertussis (Tdap)
Proof of Immunization/ Declination

Registry Network, Inc. is pleased to offer all our field employees the Tdap Vaccine through our contracted provider. Please contact our Human Resources Department and they will schedule your appointment and then our Payroll Department will set up the payroll deduction. Please check the appropriate box below, sign, date, and print your name.

Healthcare Providers are at an increased risk of acquiring these serious diseases due to patient contact.

Tdap

- ❑ **I have already received the Tdap vaccine on_____. Please provide us with your immunization record showing proof.**
- ❑ **I elect NOT to receive the Tdap vaccine at this time.**

I understand that by my declining I may have a higher likelihood of acquiring and spreading the Virus.

I understand that it is my responsibility to ensure my good health and the health of my patients.

_____ _____
Employee Signature Date

_____
Printed Name

Form updated 10/29/2020

Registry Network
Incorporated

ACKNOWLEDGMENT OF RECEIPT OF HANDBOOK

If I am a nonexempt employee, I understand that I will be authorized and permitted to take an unpaid, duty-free meal period of no less than 30 minutes whenever I exceed five hours in a work day. The meal period should begin prior to completing my fifth hour of work unless I am scheduled to work six (6) hours or less, and we agree in writing that the meal period may be waived. I understand I am authorized and permitted a second unpaid, duty-free meal period of thirty minutes whenever I work for a period of more than 10 hours in any workday.

If I am a nonexempt employee, I also understand that I am authorized and permitted to take one, ten-minute paid rest break for every four hours worked or major fraction thereof. I further understand that the rest period should be taken as close to the middle of each work period as possible.

I understand that my employer is committed to fulfilling its obligations under the Americans with Disabilities Act and any applicable state or other laws prohibiting discrimination against qualified individuals with disabilities. As part of this commitment, I understand that my employer wishes to make reasonable accommodations for individuals with known physical or mental disabilities, consistent with its legal obligations to do so. My employer also invites all individuals with disabilities to participate in a good faith, interactive process and identify reasonable accommodations that can be made without imposing an undue hardship.

I understand my employer's desire to participate in an interactive process and make reasonable accommodations in order to comply with any applicable legal requirements. I agree to provide any information necessary to achieve this goal if I wish to receive accommodations now or in the future as a result of a physical or mental disability.

I also acknowledge that this *Employee Handbook* supersedes and replaces any other employee handbook or similar document that may have been previously distributed. I further acknowledge that my employment is at-will and is not for a specified period of time and can be terminated at any time for any or no reason, with or without cause or notice.

By my signature below, I acknowledge that I have received a copy of this *Employee Handbook*. I also acknowledge that I have read and understand the contents of the *Employee Handbook*, and I (check one) do ____ do not ____ want to discuss the handbook or any particular policies, benefits or procedures described in it with my Supervisor or another Company official.

Printed Name _____ Date _____

Signature _____ Date _____

Form Updated 10/29/2020