the nurse agency

Dear: _____,

Enclosed please find the orientation materials for Provident Hospital of Cook County. This includes:

- A Badge ID form
- A Receipt of Policies and Procedures
- A CCHHS Computer Sign on Request Form
- A Customer Services Standards Issuance Receipt
- A PHCC Employee Profile Sheet
- A Commercial Registry Nurse Data Sheet
- A Commercial Registry Nurse Experience Profile and Skills Checklist
- A Security Care Access Information Form

Please complete and return this entire packet to us as soon as you complete them. **Be sure to sign your name on these forms where indicated**. Please call us if you have any questions.

Sincerely,

All of Us at The Nurse Agency

1900 West Polk Street
Suite 123
Chicago, Illinois 60612

Memorandum

Date: November 18, 2009

To: Human Resources Department of Provident Hospital

Re: **RECEIPT OF POLICES AND PROCEDURES**

I, _____, have been given copies of the following policies of the
Please Print
Cook County Health and Hospitals System. I understand that it is my responsibility to read and abide by these polices and that if I have any questions that I should contact the Director of Human Resources for clarification.

I also understand that refusal to sign this acknowledgement of receipt of the below mentioned policy does not remove my responsibility to adhere to the policies.

- Policy # 00.01.16S – Smoke-Free Campus
- Rule 8 – Conduct and Discipline of Personnel

Signature: _____ Date: _____

Witness: _____ Date: _____

☐ Employee refused to sign.

cc: Department File
Personnel File

CCHHS Computer Sign-On Request Form

Nursing

Network: _____

Cerner: _____

Other:

A. ☐ Add ☐ Change access or personal info ☐ Inactivate ☐ Re-new

B. Last _____ First _____ MI _____ Healthcare Credentials (e.g., RN, LPN, CRNA, CNS)

Cook County ID badge # or last 2 of SSN _____ APN NPI _____ APN Pager _____

State License # _____ APN DEA _____

With my signature, I affirm that I received, read, and will abide by the Information Security Rules of the Behavior.

_____ / _____ / 20____ Date

_____ Firm/Agency, if non-County

_____ User's Signature

_____ Position or Title

C. Primary Location (check one)

☐ ACHN ☐ Core Center ☐ Juv Det ☐ Provident

☐ Cermak ☐ J H Stroger ☐ OFH ☐ Public Health

_____ Medical Department or ACHN Site or Public Health Site

D. Access Duration

____/____/____ -- ____/____/____

Start Date End Date

(End date for temporary users such as students, volunteers, residents & contractors)

☐ County Employee *(No end date)* EMP# Req _____

E. Special Access ☐ Cook County email ☐ Internet ☐ VPN ☐ AcuityPlus ☐ ANSOS

☐ Bridge same access as :_____ ☐ Zeiss same access as :_____

☐ Clairvia ☐ PyxisES ☐ Teletracking same access as :_____

F. Cerner **Check 1** below or request access the same as (existing user) _____

☐ Correctional Medical Tech	☐ Nurse RN InPt Orders JTDC	☐ Nursing Medical Assistant OB
☐ Correctional Medical Tech w/Rad Order	☐ Nurse RN Mgmt/Admn 2	☐ Nursing Medical Assistant Ophthalmology
☐ ED Nurse	☐ Nurse RN Mgmt/Admn Amb	☐ Nursing Medical Assistant PowerNote
☐ Nurse Instructor	☐ Nurse RN Mgmt/Admn InPt	☐ Nursing PCA/CNA Amb
☐ Nurse LPN Amb	☐ Nurse RN Mgmt/Admn InPt Cermak	☐ Nursing PCA/CNA InPt
☐ Nurse LPN InPt	☐ Nurse RN NICU	☐ Nursing Telemetry Tech
☐ Nurse LPN InPt Cermak	☐ Nurse RN Ophthalmology	☐ Nursing Unit Clerk Amb
☐ Nurse LPN InPt OB	☐ Nurse RN Public Health	☐ Nursing Unit Clerk Cermak
☐ Nurse RN Amb	☐ Nurse RN Public Health Supv	☐ Nursing Unit Clerk InPt
☐ Nurse RN Amb Diabetes Team	☐ Nurse RN Specialty Service	☐ SurgiNet OR Manager
☐ Nurse RN Amb OB	☐ Nurse RN Specialty Service PowerNote	☐ SurgiNet OR Nurse 1
☐ Nurse RN InPt OB	☐ Nurse Student APN Anesthetist	☐ Utilization Management
☐ Nurse RN Infusion Center	☐ Nurse Student RN	☐ Utilization Management Supv
☐ Nurse RN InPt Orders	☐ Nurse Student RN/APN	☐ QA/UR
☐ Nurse RN InPt Orders Cermak	☐ Nursing Medical Assistant	

Cerner **FirstNet** ED: ☐ PROV ☐ ADULT ☐ PEDS ☐ TRAUMA

Share Drive Request (please input path):

G. Request authorized by (Department Chair or Director)

Signed _____ * Signed _____

Print Name _____ Print Name _____

Phone or pager _____ Phone or pager _____

Title Title

Incomplete forms will NOT be processed. Deliver to the Stroger Hosp HIS Help Desk, room 2650 or email the form to cch-helpdesk@cookcountyhhs.org. Call 312-864-HELP, for status after 2 Business days.

Rev. JAN 2018

CCHHS NON-EMPLOYEE BADGING FORM

A separate form must be completed for each contractor requesting a badge. Click on 'Fill & Sign' to enter the required information. All information is required. Physical signatures are required.

Section 1 - This section is completed by Company/Organization/Institution Name (Company)
Complete this section for each employee your company provides to CCHHS. Attach separate sheet(s) for additional Information. Send this form, the job description and any additional documentation via e-mail to the CCHHS Department Head/Manager/Designee responsible for managing the contract with your company.

Contractor Last Name

Contractor First Name

Contractor Company Name

CCHHS Location (Drop Down Menu

Level of Patient Contact (Drop Down Menu)

Contractor Company Job Title

CCHHS Department

Description of work to be done. Attach a job description provided by the Contractor Company.

LEAVE THIS PAGE BLANK

Contractor E-Mail for Correspondence

Contractor Contact Phone Number

Section 2 - CCHHS Access Level Granted - This section MUST be completed by the CCHHS Head/Manager/Designee responsible for managing the contract. Up to seven (7) locations can be selected for access for a badge holder. If less than seven (7) locations, leave additional slots blank. **Once CCHHS Head/Manager/Designee completes and signs this document, return it and all attachments to Company.**

Location 1

Day(s) of Week/Time

Location 2

Day(s) of Week/Time

Location 3

Day(s) of Week/Time

Location 4

Day(s) of Week/Time

Location 5

Day(s) of Week/Time

Location 6

Day(s) of Week/Time

Location 7

Day(s) of Week/Time

CCHHS Head/Manager/Designee Name & Title

Phone #

CCHHS Head/Manager/Designee Department

CCHHS Head/Manager/Designee E-mail

CCHHS Head/Manager/Designee Signature

Date

This section is completed by CCHHS HR

Type of Badging Process Initiated

- ☐ Contractor
- ☐ Other

Type of Badge

- ☐ New
- ☐ Renewal
- ☐ Replacement/ Cashier Receipt

Orientation Attendance Required

- ☐ Yes
- ☐ No

Professional License Type & Number (Or N/A)

PSV Expiration Date

Badge Id #

Badge Holder Extension/Pager/Cell

Badge Expiration Date

HR Approver Name & Title

HR Approver Signature

Date

Section 3 - BADGE HOLDER ACKNOWLEDGMENT - This section is signed when a badge is issued.

I acknowledge the receipt of this security access card and all rules and regulations regarding its use. No access is to be given to unauthorized personnel. I will be held responsible for reporting the loss, theft or misuse of this card. The replacement cost of the card must be paid to the cashier prior to receiving a new card. To receive a new card, a receipt from the cashier with a new Non-Employee Badging form completed and signed by the CCHHS Approver of my work area must be provided to the CCHHS HR department. Any misuse of this card may result in termination of access to all CCHHS facilities.

Badge Holder Signature

Date

HR Approver Name & Title

HR Approver Signature

Date

Customer Services Standards
Issuance Receipt

I, _____, TITLE, _____/DEPARTMENT_____

Received PHCC Customer Services Standards Review and a copy of the Standards Policy.

_____/_____
Employee Signature Date

PROVIDENT HOSPITAL OF COOK COUNTY

EMPLOYEE PROFILE

NAME	
EMPLOYEE NUMBER	
TELEPHONE NUMBER	
SKILL	
SHIFT	
UNIT	
CHARGE	Y N
EDUCATION (DEGREE)	
CPR DATE (EXPIRATION)	/ /
EVALUATION DATE (LAST)	/ /
LICENSE NUMBER	-
EMERGENCY NAME	
EMERGENCY NUMBER	
PAGER NUMBER (IF APPLICABLE)	
QUALIFICATIONS/CERTIFICATIONS (areas you can work and certifications obtained)	

STANDARD SCHEDULE
(INCLUDE CODE' FOR SHIFT WORKING AND DAYS OFF)

S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S

HIRE DATE	/ /
CAREER LADDER'	
ACLS (EXPIRATION)	/ /
PALS (EXPIRATION)	/ /

'SEE ATTACHED CODE FORMS

PROVIDENT HOSPITAL OF COOK COUNTY COMMERCIAL REGISTRY NURSE DATA SHEET

Please Print:

Date: _____ Registry: _____

Name: _____
(Last) *(First)* *(Middle)*

Address: _____

Telephone: _____

Nursing Preparation: _____ Year Graduated: _____
(AD, Diploma, BSN, MSN, LPN)

Six months or more clinical competence in the following areas:

_____

_____

_____

Signature of Agency Nurse: _____

To be completed by Staffing Office Personnel

1. Original Current RN/LPN Illinois License Number: _____

   Issue Number: _____

   Expiration Date: _____

2. Current CPR Certification _____ 3. LPN Pharmacology Certification _____
   (Exp. Date) *(Yes/No)*

4. Picture I.D. (Agency, Drivers License, State)

5. Other Credentials: _____

6. Copies of the above are attached _____ If no, why not?
   (Yes/No)

_____

_____

The above data and credentials were checked and reviewed by:

_____ _____
Staffing Office Representative Date

COMMERCIAL REGISTRY NURSE EXPERIENCE PROFILE AND SKILLS CHECKLIST

Name _____ RN or LPN _____ DATE _____

To be completed prior to or during orientation at the hospital. Must be received by the Provident Hospital of Cook County staffing office and reviewed by a nursing supervisor during the commercial registry nurse's orientation.

PREVIOUS EMPLOYERS	CLINICAL AREAS WORKED	POSITION HELD	INCLUSIVE DATE

NURSING AREAS	MONTHS OF EXPERIENCE	NURSING AREAS	MONTHS OF EXPERIENCE
Critical Care		Pediatrics ICU	
MICU		Surgery	
SICU		Medicine	
TRAUMA		Out Patient	
NEURO		Psychiatric	
BURNS		Other:	
CORONARY			
TELEMETRY			
Emergency Room			
Operating Room			
Recovery Room			
Ob/Gyne			
Labor & Delivery			
Post Partum			
Newborn Nursery			
Pediatrics			
Neonatal ICU			

Provident Hospital of Cook County
Department of Nursing and Patient Care Services
Commercial Registry Nurse's Skills Checklist

Name_____ Date_____

NURSING CARE ACTIVITIES (Check appropriate box)	Can Do	Cannot Do	Need Help	NURSING CARE ACTIVITIES (Check appropriate box)	Can Do	Cannot Do	Need Help
MEDICATION				***TUBES (continued)***			
Administration				Endotracheal			
Z-Track Technique				Hemovac Suction			
Narcotics				Gastric Tube Feedings			
Hyperalimentation				***PROCEDURES***			
IV Push				Care of T-Tube			
Lipids				Jejunostomy			
IV Piggybacks				Gastrostomy			
Patient Controlled Analgesia				***RESPIRATORY THERAPY***			
IRRIGATION				Ambu Bag to E.T. Tube			
Bladder Continuous Irrigation				Incentive Spirometry			
Ostomy Irrigation				Ventilator Care			
CATHERIZATION				***VITAL SIGNS***			
Insertion Foley Male				Apical Pulses			
Female				Peripheral Pulses			
Removal Foley				Neuro Signs			
TUBES				Blood Pressure			
Insertion Nasogastric				***EQUIPMENT***			
Tracheostomy Care				Stryker Frame			
Suctioning Oral				Hoyer Lift			
Tracheal				Air Mattress			

NURSING CARE ACTIVITIES (Check appropriate box)	Can Do	Cannot Do	Need Help	NURSING CARE ACTIVITIES (Check appropriate box)	Can Do	Cannot Do	Need Help
EQUIPMENT (continued)				Pelvic Exam/Pap Smear			
Hypo/Hyperthermia Blanket				Cutdowns			
Leather Restraints				C.V.P. Insertions			
Soft Restraints				Chest Tube Insertion			
Posey Belt and Jacket				***IVs***			
Glucose Monitoring				Insertion			
Device (Accu-Check)				Heparin Lock			
Bed Scale				Venipuncture			
Defibrillator				***DOCUMENTATION/FLOW SHEETS***			
Cardiac Monitor				Assessment			
Electric Bed				Transcription of Orders			
Air Fluidized Bed				Patient Response to Tx.			
SPECIMENS				Nursing Care Plan			
Throat Culture				Medication and IV Profiles			
Urine Midstream				Discharge Planning			
Clinitest/Acetest				***PATIENT EDUCATION***			
Wound Cultures				Pre-Operative Teaching			
Hematocrit				Diabetic Teaching			
PREPARATIONS FOR PROCEDURES				***MISCELLANEOUS***			
Lumbar Puncture				Peritoneal Dialysis			
Thoracentesis				Post-Mortem Care			

SPECIALTY BASED CHECKLIST - ONLY CHECK OFF YOUR AREA							
CRITICAL CARE	Can Do	Cannot Do	Need Help	***OB/GYNE***	Can Do	Cannot Do	Need Help
Arterial Line				Check Fetal Heart Rate			
Swan Ganz				Check Breasts			
I.A.B.P.				Check Perineum			
Pacemaker Permanent				Check Episiotomy or Laceration			
Pacemaker Temporary				Vaginal Exam			
Assist Cardiac Arrest				Check Lochia			
Assist Intubation				Normal Vaginal Delivery			
MONITOR DRUGS				Emergency Delivery			
Nipride				C-Section Delivery			
Dobutamine				Fetal Monitoring			
Dopamine				Nonstress-Stress Testing			
NTG				Aminocenthesis			
Pavalon				Apgar Scoring			
MSO4				Newborn Stabilization			
Versed				Fetal Monitor			
Lidocaine				Ultra Sound			
Pronestyl				Infant intensive Care			
Phenobarbital				***MONITOR DRUGS***			
Mannitol				Pitocin			
				Augmentation			
				Induction			
				MgSO4			

John H. Stroger, Jr. Hospital of Cook County

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

SECURITY CARD ACCESS INFORMATION FORM

PLEASE PRINT – USE BLACK INK

NAME	LAST	FIRST	MI

DEPARTMENT	EXTENSION/PAGER

HOSPITAL I.D. NO.	TITLE / CLASSIFICATION
DO NOT FILL IN	

CARD NO.

ACCESS LEVELS (LOCATION)	DAYS	TIME RESTRICTIONS
	/	/
	/	/
	/	/
	/	/

I ACKNOWLEDGE THE RECEIPT OT THIS SECURITY ACCESS CARD AND ACKNOWLEDGE ALL RULES AND REGULATIONS REGARDING ITS USE. NO ACCESS IS TO BE GIVEN TO UNAUTHORIZED PERSONNEL. I WILL BE HELD RESPONSIBLE FOR REPORTING THE LOSS, THEFT OR MISUSE OF THIS CARD. THE REPLACEMENT COST OF THE CARD IS TO BE PAID TO THE CASHIER PRIOR TO RECEIVING A NEW CARD. A NEW FORM MUST BE COMPLETED AND SIGNED BY THE DEPARTMENT HEAD / DESIGNEE OF MY WORK AREA AND A REPORT MADE WITH THE HOSPITAL POLICE. MISUSE OF THIS CARD WILL BE IN ACCORDANCE WITH THE COUNTY BOARD'S RULES AND REGULATIONS GOVERNING EMPLOYEE CONDUCT.

Employee Signature / Date

Department Head / Date

REVISED 11/2011