the nurse agency

Date: _____

Dear: _____,

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

- CCHHS Badge ID form
- A Receipt of Policies and Procedures
- A CCHHS Computer Sign on Request Form
- A Customer Services Standards Issuance Receipt
- A Commercial Registry CNA Experience Profile and Skills Checklist
- An Employee Profile form
- A Security Card Access Information Form
- Annual Restraint Competency and reading materials

Provident also requires that all agency employees receive an **annual flu shot.** 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

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

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.

Date ____ / ____ / 20__

Firm/Agency, if non-County

User's Signature

Position or Title

C. Primary Location (check one)

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

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 Lisa Burton Print Name _____

Phone or pager 2-4806 Phone or pager _____

Title MD 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

Customer Services Standards
Issuance Receipt

I, _____, TITLE, _____/DEPARTMENT_____

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

*_____/_____

Employee Signature Date

COMMERCIAL REGISTRY CNA EXPERIENCE PROFILE AND SKILLS CHECKLIST

Name: _____ Classification: _____ 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 Certified Nursing Assistant 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
Vital Signs				**Personal Hygiene**			
Temperature: Oral				Complete bed bath			
Mechanical Thermometer							
Rectual				Partial bath			
Axillary				Sitz bath			
Pulses: Radial				Shower			
Apical				**Oral Hygiene**			
Respirators				Brush teeth			
Blood pressure: One extremity				Denture care			
Four extremities				Foot and Nail Care			
Making of Beds:				Elimination			
Unoccupied				Emptying of catheter foley			
Occupied				Care of Texas catheter			
Surgical				Enemas			
Body Positioning:				Soap Sud			
Lateral				Tap Water			
Prone				Fleets			
Supine				Specimen Collection:			
Fowler				Urine			
Sims				Urine clean catch			
Trenelenburg				Stool			

Commercial Registry Certified Nursing Assistant Skills Checklist

NURSING CARE ACTIVITIES (Check appropriate box)	Can Do	Cannot Do	Need Help	NURSING CARE ACTIVITIES (Check appropriate box)	Can Do	Cannot Do	Need Help
Lift and/or transportation of patient				Care of patients in restraints			
Assist out of bed				Sort			
Transfer from bed to wheel chair				Posey vest/jacket			
Transfer from bed to cart				Heather			
Use of therapeutic beds				Wrists/mitts			
Clinitron				Documentation of Restraints			
Air mattress				Principals of Asepsis			
Use of Hogen Lift				Universal precautions			
Use of overhead lifts				Isolation Types			
Care of patients with				Handwashing			
Crutches				Application of Heat/Cold			
Canes				Use of heating pad			
Walkers				Use of K-Pad (cooling mattress)			
Splints				Heat/cold packs			
Nutritional Needs				Career Patient In Emergency			
Intake/Output Recording				CPR			
Feeding of patients				Pediatric CPR			
Assisting of patients at meals				Care of patient in close observation			
NPO				Post-Mortem Care			

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[1] 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[1]	
ACLS (EXPIRATION)	/ /
PALS (EXPIRATION)	/ /

[1]SEE ATTACHED CODE FORMS

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