



Dear: _____,

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

- A Receipt of Policies and Procedures
- A CCHHS Computer Sign on Request Form
- A Pharmacy Department Pyxis ID/Password Assignment Info 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

Cook County Health & Hospitals System

Todd H. Stroger • President
Cook County Board of Commissioners

Warren L. Batts • Chairman
Cook County Health & Hospitals System

Jorge Ramirez • Vice-Chairman
Cook County Health & Hospitals System

William T. Foley • CEO
Cook County Health & Hospitals System



1900 West Polk Street
Suite 123
Chicago, Illinois 60612

Health & Hospitals System Board Members

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Andrea L. Zopp

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

PROVIDENT HOSPITAL OF COOK COUNTY

PHARMACY DEPARTMENT

Pyxis MEDICATION Rx System 3000
ID/Password Assignment Information

Statement

I, understand that my ID, in combination with the confidential Bio- ID log in will be my electronic signature for all of my transactions on the MEDSTATION Rx system for both controlled substance and patient care record keeping purposes. A time stamp and date will also be affixed to my transaction. These records will be maintained and archived as per the policies of this Hospital and will be available for inspection by the Drug Enforcement Administration (DEA) as is currently the case with my handwritten records for controlled substances.

I also understand that, to maintain the integrity of my electronic signature, I will be using my Bio-ID sign in and logging off after each use.

Signature _____ Date _____

Print Name & Position _____ User _____

Department _____ Unit _____

Authorized Levels of Access Station: A B C D E F G H I J K

Console (RX Only): A B C D E (See later in this Appendix for definitions)

Authorized Areas for Access _____

Authorized by:
Supervisor _____ Date _____

Entered into Pyxis _____ Date _____

Confidential

MEDICATION Rx System 3000 User Information				
Name	Position	Department	ID*	Temp Password

* Leave blank to be assigned by the Pharmacy Department

Subject: CUSTOMER SERVICE STANDARDS

Policy No. 08-01-51

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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																					
EDUCATION (DEGREE)																					
CPR DATE (EXPIRATION)																					
EVALUATION DATE (LAST)																					
LICENSE NUMBER																					
EMERGENCY NAME																					
EMERGENCY NUMBER																					
PAGER NUMBER (IF APPLICABLE)																					
QUALIFICATIONS/CERTIFICATIONS <small>(areas you can work and certifications obtained)</small>																					
STANDARD SCHEDULE <small>(INCLUDE CODE FOR SHIFT WORKING AND DAYS OFF)</small>																					
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)																					

¹SEE 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 _____
(Exp. Date)

3. LPN Pharmacology Certification _____
(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			
Hyperalimantation				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				Aminocentesis			
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



SECURITY CARD ACCESS INFORMATION FORM

PLEASE PRINT - USE BLACK INK

NAME	LAST	FIRST	MI
------	------	-------	----

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

CARD NO.

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

I ACKNOWLEDGE THE RECEIPT OF 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