TPF Nursing

198 Avenue of the Americas
New York, NY 10011
phone: 212 219-2677
toll free: 800 243-6449
fax: 212 431-2594
www.tpfnursing.com

DATE: _____

TO: _____

FROM: _____

*Please fill out the enclosed application and return it to our office. For initial submission the following documents must be submitted:

1. Work History/Resume (with no gaps of more than three months)
2. Original Nursing License or Certification for Discipline
3. Skills Checklist in Area of Specialty
4. Shift preference
5. Certifications (applicable to Area of Specialty)
6. 2 Professional References (Direct Supervisors - current or within a year)

If you have any questions, please do not hesitate to call us (212) 219-2677.

Thank you for applying with us at TPF Nursing Registry.

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PRE-EMPLOYMENT APPLICATION

Check one: RN LPN HHA PCA CNA OTHER

NAME (LAST, FIRST, MIDDLE) _____ AREA OF SPECIALTY _____

STREET ADDRESS _____ CITY, STATE, ZIP CODE _____

HOME PHONE _____ WORK PHONE _____ PAGER/CELL _____

CELL PHONE CARRIER: _____

(Note: A cell phone number and cell phone carrier enables us to text you in the event of an emergency when other communications may be down.)

DO YOU HAVE AN ANSWERING MACHINE?_____ E-MAIL_____

U.S. CITIZEN? YES_____NO _____

WHAT FOREIGN LANGUAGES DO YOU SPEAK FLUENTLY?_____

REFERRED BY:_____

EDUCATION

	NAME/LOCATION	DEGREES	GRADUATION YR.
HIGH SCHOOL			
SCHOOL OF NURSING			
UNDERGRADUATE			
GRADUATE SCHOOL			
OTHER TRAINING			

EMPLOYMENT EXPERIENCE

ATTACH YOUR RESUME OR COMPLETE THE INFORMATION BELOW. START WITH YOUR PRESENT/LAST JOB.
LIST ONLY THOSE EMPLOYEES WHO ARE HEALTH CARE PROVIDERS.

1. EMPLOYER:_____ SUPERVISOR:_____

   ADDRESS:_____

   POSITION HELD:_____ TYPE OF FACILITY:_____

   PHONE NUMBER:_____ REASON FOR LEAVING:_____

   FROM:_____ TO:_____ JOB DESCRIPTION:_____

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2. EMPLOYER:_____ SUPERVISOR:_____

ADDRESS:_____

POSITION HELD:_____ TYPE OF FACILITY:_____

PHONE NUMBER:_____ REASON FOR LEAVING:_____

FROM:_____ TO:_____ JOB DESCRIPTION:_____

3. EMPLOYER:_____ SUPERVISOR:_____

ADDRESS:_____

POSITION HELD:_____ TYPE OF FACILITY:_____

PHONE NUMBER:_____ REASON FOR LEAVING:_____

FROM:_____ TO:_____ JOB DESCRIPTION:_____

CERTIFICATIONS & SPECIALIZATION

PLEASE LIST YOUR LICENSE NUMBER AS WELL AS ANY OTHER CERTIFICATION'S YOU HAVE:

(1)_____ STATE:_____ EXP. DATE:_____

(2)_____ STATE:_____ EXP. DATE:_____

(3)_____ STATE:_____ EXP. DATE:_____

ADDITIONAL INFORMATION

1. HAVE YOU EVER BEEN **CHARGED WITH A FELONY OR MISDEMEANOR**? NO_____ YES _____

*IF YES, PLEASE EXPLAIN*_____

2. AS A CONDITION OF YOUR EMPLOYMENT, YOU AGREE THAT BACKGROUND CHECKS WILL BE PERFORMED BY EMPLOYER.

_____

NEW YORK STATE LAW PROHIBITS DISCRIMINATION BECAUSE OF DISABILITY.

FEDERAL STATE LAWS PROHIBIT THE DICRIMINATION ON THE BASIS OF RACE, AGE COLOR, RELIGION, SEX, NATIONAL ORIGIN, MARITAL STATUS AND DISABILITY.

I UNDERSTAND THAT ANY FALSE STATEMENT BY ME IN THIS APPLICATION WILL BE CAUSE FOR REJECTION OR DISMISSAL. I AUTHORIZE VERIFICATION OF ALL INFORMATION GIVEN.

PRINT NAME _____ DATE_____

SIGNATURE _____

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Name: _____ Date: _____

Title/Facility_____Email: _____ Phone: _____

The Applicant named below has applied for a position in our agency. Your name has been given as a reference source. In order to provide proper placement for this candidate, we would appreciate your response to the items listed below. All information will be held in strict confidence. We appreciate your cooperation.

Applicant _____ Dates employed From _____ To _____

Position held _____Teaching Facility Yes / NO

No. Beds on Unit_____ Charge Experience Yes / NO

Avg. Patient Caseload _____ Supervisory Experience Yes / NO

Reason For leaving (If applicable) _____

I hereby authorize any personal information to be released to **T.P.F. NURSING REGISTRY, INC.**

Date _____ Signature _____

PLEASE EVALUATE APPLICANT	POOR	GOOD	VERY GOOD	EXCELLENT
Quality of Performance				
Attendance & Dependability				
Cooperation with others				
Job Knowledge/ Competency				
Flexibility & Willingness to learn				
Personal Appearance				
Bedside manner				
Communication Skills				
Willingness & Ability to float				

1. In what capacity have you worked with applicant? _____

   _____

2. Please indicate specialty areas in which applicant has experience _____

   _____

3. Additional comments _____

   _____

4. Is applicant eligible for rehire? _____Yes _____No If No, why not? _____

Signature _____ Position _____ Date _____

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Name: _____ Date: _____

Title/Facility_____Email: _____ Phone: _____

The Applicant named below has applied for a position in our agency. Your name has been given as a reference source. In order to provide proper placement for this candidate, we would appreciate your response to the items listed below. All information will be held in strict confidence. We appreciate your cooperation.

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No. Beds on Unit_____ Charge Experience Yes / NO

Avg. Patient Caseload _____ Supervisory Experience Yes / NO

Reason For leaving (If applicable)_____

I hereby authorize any personal information to be released to **T.P.F. NURSING REGISTRY, INC.**

Date _____ Signature _____

PLEASE EVALUATE APPLICANT	POOR	GOOD	VERY GOOD	EXCELLENT
Quality of Performance				
Attendance & Dependability				
Cooperation with others				
Job Knowledge/ Competency				
Flexibility & Willingness to learn				
Personal Appearance				
Bedside manner				
Communication Skills				
Willingness & Ability to float				

1. In what capacity have you worked with applicant? _____
   _____
2. Please indicate specialty areas in which applicant has experience _____
   _____
3. Additional comments _____
   _____

Is applicant eligible for rehire? _____Yes _____No If No, why not? _____

Signature _____ Position _____ Date _____

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POLICIES, PROCEDURES AND GENERAL INFORMATION

OFFICE HOURS: **198 Avenue of the Americas from 8:00am to 5:00pm, Monday – Friday**

ON-CALL
Staffing Coordinators are on call after business hours. You must call and speak to a TPF Coordinator and Client Representative if you have an emergency or need to cancel or confirm a shift; otherwise, any other questions can be answered during office hours. The On-Call number is ***347-997-0163.***

TIME SHEETS
It is your responsibility to sign-in and out in the nursing office. Be sure to write clearly on the sign in sheet: **(1) Date, (2) Name, (3) Shift, (4) Social Security and (5) Unit.** If you fail to record your time for any reason or if you have any timesheet problems, be sure to notify the office manager before the end of the workweek. If your time sheet is incomplete, you will be paid the following pay period. If you are working at an outpatient clinic, it is your responsibility to fax your own time sheet to TPF before **1:00pm on Mondays**.

PAYROLL CHECKS
Employee's checks can be **mailed, direct deposited, or picked up**. Payday is ***every Thursday.*** Checks will be automatically mailed unless you request that your name be added to the Pick-Up List. To receive direct deposit, please mail in a voided personal check and allow 2-3 payroll processes before it takes effect.

CANCELLATION POLICY
All shifts must be cancelled **at least 2 hours prior to the start of shift**. If a staffing coordinator cannot be reached, you must contact the nursing office at the facility where you are scheduled to work. Also, if you are going to be tardy, you must contact the agency and / or nursing office. Our On-Call number is ***347-997-0163.***

DOCUMENTATION
All employees must have on file current documentation, a completed application & a TPF ID badge in order to begin working. Nurses will receive expiration notices concerning expired documents by email. These updates can be emailed faxed or brought into the office.

I.D.
Identification badges can be obtained at the 198 Avenue of the Americas Office during business hours. (Please call before coming in.) All employees must wear badges when working through the agency.

Thank You for registering with us!
We look forward to working with you!

TPF Nursing

PRE-EMPLOYMENT PHYSICAL EXAM

TO BE COMPLETED BY A LICENSED MD,DO, NP,PA,CNM

Applicant _____ **Address** _____ **DOB**_____

TO PHYSICIAN: A health examination is required for the above named person. Please enter details of all requested information. LABORATORY REPORTS MUST BE ATTACHED. Incomplete or illegible information may be rejected

- *Does applicant have any personal health considerations that may impact his/her ability to satisfactorily perform the duties given on a particular assignment (including but not limited to habituation or addiction to depressants, stimulants, narcotics, alcohol or other drugs which could alter his/her behavior?* NO____YES_____ If yes, please describe:_____
- *Is Applicant in good health without restrictions or limitations? Applicant has been assessed and found to be in healthy enough to wear a mask for extended period of time if necessary* NO ____ YES _____

MEDICAL HISTORY:

- Any major illness or health impairment _____
- Hospitalization / Serious injury _____
- Any significant finding in patient's past history? _____
- Any significant finding in patient's family's health history_____
- Allergy_____ Latex/non-medication allergies: NO___ YES___ If yes, please specify:_____
- Medication Currently being taken: _____

PHYSICAL EXAMINATION (notate all spaces, draw-through lines are not acceptable):

Height: _____ Weight: _____ BP: _____ Pulse: _____ Respiration: _____ Temp: _____

Immunizations: **(Please include *lab report with values)***

Examined:	Normal	Abnormal		Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
General Appearance	_____	_____	HEENT	_____	_____	Breasts	_____	_____	Abdomen	_____	_____
Neurological Exam	_____	_____	Heart	_____	_____	Lymph Nodes	_____	_____	GU Exam	_____	_____
Musculoskeletal	_____	_____	Lungs	_____	_____	Pelvic Exam	_____	_____	Rectal Exam	_____	_____
Extremities	_____	_____	Neck	_____	_____	COMMENTS:_____					

- **Two (2) PPD Tests (Mantoux) or one (1) Interferon Gamma Release Assay (e.g. Quantiferon) required:**

If PPD positive, earliest date of + PPD?_____ History of BCG?Y___N___ Date _____ Was Tb prophylaxis taken?N___Y___

PPD Test 1: (w/in 12 months)	**PPD Test 2:** (w/in 3 months)	**Quantiferon (of other IGRA):**
Date placed:_____ Date read: _____	Date placed:_____ Date read: _____	Date: _____
Results: _____ mm ☐ NEG ☐ POS	Results: _____ mm ☐ NEG ☐ POS	Result:_____

What medication? _____ How long? _____ In your opinion what caused + PPD? _____

- **Chest X-Ray** (for + PPD or positive IGRA) Date: _____ Result:_____ *(Chest X-ray must be attached)*
- **Rubella** antibody titer: _____ Date: _____ *(Attach Lab report)* OR vaccine date: _____
- **Rubeola** antibody titer: _____ Date: _____ *(Attach Lab report)* OR 2 doses of live vaccine dates:(1) _____ (2) _____ Exempt if DOB before 1957
- **Mumps** antibody titer: _____ Date: _____ *(Attach Lab report)* OR 2 doses of live vaccine dates: (1) _____ (2) _____
- **Varicella** antibody titer: (required in all cases) _____ Date: _____ *(Attach Lab report)* Vaccination dates: (1) _____ (2) _____
- **Hepatitis B** surface antibody titer: _____ *(Attach Lab report)* Vaccine dates:(1)_____(2)_____(3)_____(or Declination)
- **Tdap vaccine** (within 10 years) Date: _____ Lot #: _____
- **Flu Vaccine** Date: _____ Lot#: _____ Mfr: _____ Expiration: _____

_____ _____

Physician Signature Date

License number: _____

Physician Name printed or stamp: _____ State: _____

Telephone: _____ Address: _____

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HEPATITIS B VACCINATION

I acknowledge that I am at risk of exposure or have been unknowingly exposed to the Hepatitis B Virus as a result of my employment and acknowledge that the Agency will arrange for me to receive the Hepatitis B Vaccine at no cost to myself.

It is my decision to:

☐ **CONSENT:** As a healthcare professional having occupational exposure to blood or other potentially infectious materials, which includes the risk of acquiring Hepatitis B virus (HBV) infection, I have been informed about and offered the opportunity to receive the Hepatitis B vaccine (to be paid for by my current employer). I understand that I must have 3 doses of vaccine to develop immunity. However, as with any medical treatment, there is no guarantee that I will become immune or that I will not experience any adverse side effect from the vaccine. I accept the offer at this time.

☐ **DECLINATION (General):** 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) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination 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, while actively working with TPF Nursing, if I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive it at no charge to me.

☐ **DECLINATION (Specific):** I am declining the opportunity to receive the Hepatitis B vaccination series for the following reason: (please check one)

- ☐ I have previously received the complete Hepatitis B vaccination series.
- ☐ Antibody testing has revealed I am immune to Hepatitis B. (Date Tested:_____)
- ☐ The vaccine is contraindicated for medical reason, describe:

  _____

  _____
- ☐ Other, explain:

  _____

_____ _____
Employee Signature **Employee Name (Please Print)**

_____ _____
Employee Social Security Number **Date**

_____ _____
Clinician Signature **Date**

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HEPATITIS B VACCINATION INFORMATION SHEET

HEPATITIS B: A MAJOR HAZARD

Hepatitis B is an infection of the liver caused by the Hepatitis B virus. The virus is found in blood and other body fluids. Hepatitis B can disable a person for weeks or months and lead to complications. Some people who get infected with the Hepatitis B virus become chronic carriers capable of spreading the disease to others. This group usually has the greatest potential for developing long-term complications, such as chronic active hepititis, chronic persistent hepatitis, cirrhosis, and primary cancer of the liver.

UNDERSTANDING HEPATITIS B: THE COURSE IT TAKES

Hepatitis B is far more contagious than AIDS. There is a greater chance of contracting Hepatitis B from needlesticks (up to 30 times greater), and it can live longer outside the body than the AIDS virus. While both viruses are found in blood, Hepatitis B is more concentrated in blood than AIDS.

Hepatitis B is spread primarily through blood and body fluids that contain blood. In the workplace, the disease can be contracted through needlesticks or other punctures, through open wounds, or breaks in the skin, or through splashes of body fluids to mucous membranes.

Health care workers, especially those who are exposed to blood frequently, are at significantly greater risk of acquiring Hepatitis B than the general population.

CHOOSE TO BE VACCINATED

Recombivax HB is a safe and effective vaccine used to prevent Hepatitis B. Recombivax HB is a non-infectious viral vaccine produced in yeast cells. Recombivax is not manufactured from any blood products. There have been no documented cases of anyone acquiring Hepatitis B from the vaccine.

As with any vaccine or other medications, you could experience some side effects. The most common is a local reaction at the injection site. Recombivax is a series of three injections given in the muscle of the upper arm. Some people have reported soreness, redness and swelling at the site of injection. Some people have also experienced one or more of the following flu-like symptoms: headache, fever, chills, fatigue, achiness, nausea, abdominal cramping and diarrhea.

Women: Because pregnancy risks are unknown, vaccination of pregnant employees should be determined only on the advice of the employee's personal physician. If a pregnant employee chooses to be vaccinated, the child's father must also give consent.

Recombivax HB consists of three dose of vaccine given according to the following schedule:

1st dose: at elected date
2nd dose 1 month later
3rd dose: 6 months after 1st dose

The Centers for Disease Control recommends that anyone who has routine

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PLEDGE OF CONFIDENTIALITY

I, _____ fully understand that clinical and administrative records are treated as confidential materials to be protected for the sake of the patient and for the sake of the services. I understand that:

- ☐ No clinical or clerical personnel is expected to read records except insofar as is or her job requires it.
- ☐ Record content should be treated impersonally and not discussed between staff members except in the most private settings.
- ☐ Information contained in records will not be divulged to any person without proper written authorization of the patient.

_____
Employee Name (*Print Clearly*)

_____
Signature/Title

_____
Witness

_____
Date

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AGREEMENT BETWEEN PARTIES EMPLOYEE/AGENCY

1. I have given the registry a copy of my current New York State license/Certificate, proof of citizenship, proof of malpractice insurance in the amount of one - three million dollars (for RN's and LPN's), two written professional references, current BCLS certification, completed annual Skills Check List and Pharmacology Examination, and have submitted my application and yearly physical report (PPD, MMR, Varicella).

2. While working with Agency, I agree to keep my records updated and signed acknowledgement of TPF Nursing Handbook and Code of Ethics.

3. I understand that I will be reimbursed at an hourly rate, varying based on the type of work.

4. I understand Termination of Employment will be due to unprofessional behavior, such as:
   - Repeated tardiness and repeated unwarranted cancellations
   - Failure to complete assignment
   - Leaving before the end of a shift without explanation
   - Repeatedly not notifying Agency/Employer when calling in sick
   - Repeated failure to report to duty without significant notification (2 hours prior to shift)
   - Unprofessional conduct in regard to patients and hospital personnel
   - "No-Call No Show" - fails to contact Agency/Employer and does not report to work. (Contacting client does not constitute calling in Agency must be notified)

5. I agree that I am an employee of the Agency and will not accept employment in any capacity with Agency's client (hospital, clinic, PD) without the express written consent of the Company. Private duty fee is 15%.

6. I understand that it is my duty to make myself aware of Agency policies and procedures that might affect my practice as a health care provider. If I do not know the proper procedures, I will ask the charge nurse or a supervisor for clarification.

7. I will properly fill out the Agency staff billing voucher each time I work and will wear my Agency I.D. badge.

8. I will inform Agency of a change in schedule 24 hours prior to placement in hospital and will give a record of available hours monthly.

9. I understand that I will be paid weekly with FICA, Federal tax, State tax, City tax, deducted from pay check.

10. I agree to call the office when on call for work and if I decide to take myself off call, I will notify the nursing registry immediately.

11. I agree to provide drug test results if requested.

_____ _____

License Number (If Applicable) Employee Name (*Print Clearly*)

_____ _____

Date Employee Signature

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EMPLOYMENT EMERGENCY NOTIFICATION FORM

Employee _____

Title _____

Date _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name _____Relationship_____

Address _____Apt# _____

_____Zip _____

Telephone (_____)_____
Where person can be reached during the day

.....

Name _____Relationship_____

Address _____Apt# _____

_____Zip _____

Telephone (_____)_____
Where person can be reached during the day

TPF Nursing

DISCLOSURE NOTICE
[IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]
DISCLOSURE REGARDING CONSUMER AND/OR INVESTIGATIVE CONSUMER REPORTS

TPF Nursing Registry, Inc. ("the Company") may obtain information about you for employment purposes and/or contract for services from a third party consumer reporting agency. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your criminal history, social security verification, driving history ("driving records"), verification of your education or employment history, or other background checks.

You have the right, upon written request made within a reasonable time, to request whether a consumer report has been provided about you and to disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history

The third party consumer reporting agency providing the report is:
Applicant Insight, Inc., 5652 Meadowlane Street, New Port Richey, FL, 34652, www.applicantinsight.com, 1-800-771-7703

OR

Sterling Backcheck, 1 State Street, New York, NY 10004, www.sterlingbackcheck.com, 1-800-899-2272

For NY Statewide Criminal Reports ONLY the report is being provided by:
NYS Office of Court Administration, 25 Beaver Street - Room 840, New York, NY 10004, 212-428-2916

The scope of this notice and authorization is all-encompassing, however, allowing the Company to obtain from any outside organization all manners of consumer reports and investigative consumer reports now and throughout the course of your employment and/or contract for services to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

New York and Maine applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Company by contacting the consumer reporting agency identified above directly. You may also contact the Company to request the name, address and telephone number of the nearest unit of the consumer reporting agency designated to handle inquiries, which the Company shall provide within 5 days.

New York applicants or employees only: Upon request, you will be informed whether or not a consumer report was requested by the Company, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.

Oregon applicants or employees only: Information describing your rights under federal and Oregon law regarding consumer identity theft protection, the storage and disposal of your credit information, and remedies available should you suspect or find that the Company has not maintained secured records is available to you upon request.

Washington State applicants or employees only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

Last name:_____ First name:_____ Middle name:_____

*Social Security: _____ *Date of Birth:_____

**This information will be used for background screening purposes only and will not be used as hiring criteria.*

Signature: _____ Date:_____

TPF Nursing

ACKNOWLEDGMENT AND AUTHORIZATION

AUTHORIZATION REGARDING CONSUMER AND/OR INVESTIGATIVE CONSUMER REPORTS

I acknowledge receipt of the DISCLOSURE REGARDING CONSUMER AND/OR INVESTIGATIVE CONSUMER REPORTS and certify that I have read and understand this document. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout my employment and/or contract for services, if applicable, to the extent permitted by law. In accordance with this notice, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Applicant Insight, Inc., 5652 Meadowlane Street, New Port Richey, FL, 34652, www.applicantinsight.com, 1-800-771-7703, another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants or employees only: By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.

Minnesota applicants or employees only:
□ please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company.

Oklahoma applicants or employees only:
□ please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company.

California applicants or employees only:
□ Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW.

Last name:_____ First name:_____ Middle name:_____

Other Names/Alias:_____

Include Maiden or Name Changes, No Direct Derivatives Ex: Susan vs. Sue, David vs. Dave

*Social Security: _____ *Date of Birth:_____

**This information will be used for background screening purposes only and will not be used as hiring criteria.*

Driver's License: _____ DL State of Issuance:_____

Phone Number: _____ Email Address:_____

Present Address: _____

City/State/Zip: _____

Signature: _____ Date:_____

ARTICLE 23-A

LICENSURE AND EMPLOYMENT OF PERSONS PREVIOUSLY CONVICTED OF ONE OR MORE CRIMINAL OFFENSES

Section 750. Definitions.
751. Applicability.
752. Unfair discrimination against persons previously convicted of one or more criminal offenses prohibited.
753. Factors to be considered concerning a previous criminal conviction; presumption.
754. Written statement upon denial of license or employment.
755. Enforcement.

S 750. Definitions. For the purposes of this article, the following terms shall have the following meanings:

(1) "Public agency" means the state or any local subdivision thereof, or any state or local department, agency, board or commission.

(2) "Private employer" means any person, company, corporation, labor organization or association which employs ten or more persons.

(3) "Direct relationship" means that the nature of criminal conduct for which the person was convicted has a direct bearing on his fitness or ability to perform one or more of the duties or responsibilities necessarily related to the license or employment sought.

(4) "License" means any certificate, license, permit or grant of permission required by the laws of this state, its political subdivisions or instrumentalities as a condition for the lawful practice of any occupation, employment, trade, vocation, business, or profession. Provided, however, that "license" shall not, for the purposes of this article, include any license or permit to own, possess, carry, or fire any explosive, pistol, handgun, rifle, shotgun, or other firearm.

(5) "Employment" means any occupation, vocation or employment, or any form of vocational or educational training. Provided, however, that "employment" shall not, for the purposes of this article, include membership in any law enforcement agency.

S 751. Applicability. The provisions of this article shall apply to any application by any person who has previously been convicted of one or more criminal offenses, in this state or in any other jurisdiction, to any public agency or private employer for a license or employment, except where a mandatory forfeiture, disability or bar to employment is imposed by law, and has not been removed by an executive pardon, certificate of relief from disabilities or certificate of good conduct.

S 752. Unfair discrimination against persons previously convicted of one or more criminal offenses prohibited. No application for any license or employment, to which the provisions of this article are applicable, shall be denied by reason of the applicant's having been previously convicted of one or more criminal offenses, or by reason of a finding of lack of "good moral character" when such finding is based upon the fact that the applicant has previously been convicted of one or more criminal offenses, unless:

(1) there is a direct relationship between one or more of the previous criminal offenses and the specific license or employment sought; or

(2) the issuance of the license or the granting of the employment would involve an unreasonable risk to property or to the safety or welfare of specific individuals or the general public.

S 753. Factors to be considered concerning a previous criminal conviction; presumption. 1. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall consider the following factors:

(a) The public policy of this state, as expressed in this act, to encourage the licensure and employment of persons previously convicted of one or more criminal offenses.

(b) The specific duties and responsibilities necessarily related to the license or employment sought.

(c) The bearing, if any, the criminal offense or offenses for which the person was previously convicted will have on his fitness or ability to perform one or more such duties or responsibilities.

(d) The time which has elapsed since the occurrence of the criminal offense or offenses.

(e) The age of the person at the time of occurrence of the criminal offense or offenses.

(f) The seriousness of the offense or offenses.

(g) Any information produced by the person, or produced on his behalf, in regard to his rehabilitation and good conduct.

(h) The legitimate interest of the public agency or private employer in protecting property, and the safety and welfare of specific individuals or the general public.

2. In making a determination pursuant to section seven hundred fifty-two of this chapter, the public agency or private employer shall also give consideration to a certificate of relief from disabilities or a certificate of good conduct issued to the applicant, which certificate shall create a presumption of rehabilitation in regard to the offense or offenses specified therein.

S 754. Written statement upon denial of license or employment. At the request of any person previously convicted of one or more criminal offenses who has been denied a license or employment, a public agency or private employer shall provide, within thirty days of a request, a written statement setting forth the reasons for such denial.

S **755. Enforcement.** 1. In relation to actions by public agencies, the provisions of this article shall be enforceable by a proceeding brought pursuant to article seventy-eight of the civil practice law and rules.

2. In relation to actions by private employers, the provisions of this article shall be enforceable by the division of human rights pursuant to the powers and procedures set forth in article fifteen of the executive law, and, concurrently, by the New York city commission on human rights.

TPF Nursing

EMPLOYEE ACKNOWLEDGMENT OF TPF HANDBOOK

I have received an electronic copy of the TPF HANDBOOK and acknowledge my obligation to read and understand its contents. I understand and agree that the Code of Ethics in Employee Handbook is intended to provide an overview of the company's personnel policies, code of ethics and common policies and procedures but does not necessarily represent all nursing registry policies. TPF may at times add, change or rescind any policy or practice at its sole discretion, without notice.

I further agree that the Company's policies and practices do not create an express or implied contract or covenant of any type between TPF and me, and that employment and compensation are for no fixed term but when working as an employee of TPF Nursing it is your obligation to be aware of TPF's Code of Ethics and Policy and Procedure.

This handbook is provided to me for information and immediate reference. I have read it carefully and completely.

Please acknowledge receipt of this handbook by signing and returning this page to TPF.

Employee Name (Print) _____Date_____

Employee Signature _____

NYC HEALTH + HOSPITALS

INFLUENZA VACCINE PARTICIPATION RECORD

Information about the person to Receive Vaccine (Please Print)			Date of VIS: 08/07/15
LAST	**FIRST**	**MIDDLE INITIAL**	**DATE OF BIRTH:**
DEPARTMENT:	**TITLE:**		**TKID#:**

Please check one:

H+H Employee _____ Affiliate _____ Agency/Temps _____ Student _____ Volunteer _____ Contractor _____ Other _____

Risk Assessment:

1. Are you allergic to eggs or egg products? ☐ Yes ☐ No
2. Have you ever had a serious reaction to the Flu Vaccine? ☐ Yes ☐ No
3. Have you ever had Guillain-Barre Syndrome? ☐ Yes ☐ No

"I have read or have had explained to me the information in the Vaccine Information Statement(s) (VIS), the Important Information Statement(s) about the vaccine(s). I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine and ask that the vaccine be given to me."

STAFF SIGNATURE: _____ **DATE:** _____ **TIME:** _____ **am/pm**

Name of Vaccine Given:	**Flu Vaccine 0.5 ml**	Sticker #:	
Date Vaccine Administered:		Site of Injection: ☐ Left Deltoid/ IM	☐ Right Deltoid/IM
Vaccine Manufacturer:		Vaccine Lot Number:	Exp. Date:

Vaccinator:

Print Name: _____ Title: _____ Signature _____

VACCINE DECLINATION FROM NYC HEALTH + HOSPITALS

____ **ALREADY VACCINATED –** I have already received this season influenza vaccine from an external source and I have provided medical documentation to the Occupation Health Office (OHS).

OR

I REFUSE TO RECEIVE THE VACCINE BASED ON THE FOLLOWING REASON(S):

1. ____ Fear of needles
2. ____ Believes vaccine won't work.
3. ____ Non-Allergic reaction to flu shot.
4. ____ The vaccine will give me Flu.
5. ____ Severe allergic reaction to eggs or other vaccine component
6. ____ History of Guillain-Barre' Syndrome
7. ____ Other _____

I understand that NYS Public Health regulation requires all unvaccinated healthcare workers to wear a mask in all NYC Health + Hospitals identified areas when Influenza remains prevalent as per OP-20-59/ OP-20-57. Masks will be worn for the duration of Flu season.
In the future I can change my mind and request to be vaccinated.

STAFF SIGNATURE: _____ **DATE:** _____ **TIME:** _____ **am/pm**