GOTHAM PER-DIEM APPLICATION
TO WORK OVER-TIME

Gotham's has simplified Jacobi's enrollment for nurses to work over-time thru agency. All you have to do is the following:

1. Go to our website and fill out initial online application and skills-check list.

Go to: **www.gothamcompanies.com** and click on Apply Now

2. After you have completed the online application, fill out the 9 page documents in its entirety and make copies of the following:

- Resume
- RN State Nursing License
- State ID or Passport
- Social Security Card
- Malpractice (if you don't have, go to NSO.COM)
- **BCLS Card is required**
- ***ACLS Card (only if within your specialty requires)***
- ***PALS Card (only if within your specialty requires)***
- ***NRP Card (only if within your specialty requires)***
- ***Any other certificate(s) within your specialty***

You may fax it to my attention: Edwin at (646) 390-5908. Please make sure copies are clear. Or, you can take clear pictures with your smart-phone of the actual document size, **flash must be on**. Email the snap-shots separately to me at: EWilliford@gothamcompanies.com

After you have sent application and documents, please call or text me at (347) 989-6948 so I can retrieve your profile and get you in the system. You will then be able to start working with us right away!

If you have any questions, please free to contact me anytime!

Edwin
347-989-6948

JOB DESCRIPTION: **Registered Nurse**

Reports to: Designated Nurse Manager at the institution/agency where he/she is assigned.

Job Summary:
A registered professional nurse who is capable of diagnosing and treating human responses to actual or potential problems, health care finding, health teaching, health counseling and provision of care supportive to or restorative of life and well being and executing medical regimens by a licensed or otherwise legally authorized physician.

Performance Criteria:

- Maintains standards of nursing care and implements the policies and procedures established by the agency.
- Performs initial and ongoing assessments and documents the patient's biophysical and psychosocial status; educational needs; and service requests.
- Performs a physical assessment consistent with standards of nursing practice.
- Designs all aspects of a nursing care plan that is consistent with the medical regime to meet the patient's needs and abilities.
- Routinely updates the patient's nursing care plan.
- Accurately evaluates and documents patient's change in status.
- Consistently reports appropriate changes in the patient's condition and need for referrals to the Nursing Supervisor and the physician.
- Effectively prioritizes the implementation of the patient's plan of care to meet the changes in status.
- Accurately documents implementation and revisions of the patient's care plan, vital signs, and education.
- Completes required documentation upon admission and at required intervals.
- Initiates and documents counseling and teaching for the client & his/her family.
- Supervises and coaches the client and his/her family members in giving care.
- Initiates and documents discharge planning.
- Demonstrates the ability to communicate effectively with the client and his/her family members.
- Interprets to the client and family implications of the patient's health status.
- Demonstrates the ability to communicate effectively with other members of the health care team.
- Administers and documents clients prescribed medication competently.
- Demonstrates competence in performing all treatments per MD plan of care.
- Consistently adheres to standard precautions, transmission precautions, aseptic technique and infection control guidelines.
- Consistently implements care in a manner that is maximally safe for the client, his/her family, and self.
- Consistently seeks, accepts and implements suggestions to improve performance.
- Demonstrates respect for the opinion of others
- Consistently assumes and follows through on the responsibility for assignment
- Demonstrates the ability to function effectively under stressful situations.
- Maintains confidentiality of patient assessments and records.
- Utilizes time effectively, maintaining a consistent level of productivity.
- Identifies and uses appropriate resources.
- Initiates appropriate preventive and rehabilitative nursing procedures.
- Demonstrates competencies to provide care to patients of all ages.
- Coordinates patient's services and scheduling of multidisciplinary appointments and therapies.
- Consistently submits time card and patient records completed in an appropriate timely manner.
- Demonstrates sound judgment and clinical knowledge in planning and decision making.
- Completes the continuing education requirements annually.
- Consistently complies with standards for attendance, absence notification and punctuality
- Consistently demonstrates professionalism through appearance, performance and communication.

- Demonstrates sound judgment and clinical knowledge in planning and decision making.
- Completes the continuing education requirements annually.
- Consistently complies with standards for attendance, absence notification and punctuality
- Consistently demonstrates professionalism through appearance, performance and communication.
- Assumes responsibility for reading and comprehending all posted notices, communications and policies /procedures.
- Demonstrates competencies to provide care to patients of all ages.
- Respects the rights, privacy and property of others at all times.
- Assumes responsibility to participate in performance improvement activities as directed.

The above statements reflect the general details considered necessary to describe the principal functions of the job as identified, and shall not be considered as a detailed description of all work requirements that may be inherent in the position.

Qualifications:

- Currently licensed in the State of New York as a Registered Nurse in good standing.
- One (1) year general Medical-Surgical Nursing experience.
- Able to meet health standards of employment.
- Must maintain current BLS Certification.
- Criminal background check required.
- Must successfully complete orientation examinations and competencies

Physical Requirements:

- Maintains physical capabilities to perform all work related duties
- Ability to tolerate varied levels of stress.

Working Conditions:

- Frequently handles sharp instruments and contaminated needles.
- Caring for physically combative patients.
- Potential exposure to hazardous substances (e.g. infections, chemotherapeutic, IV medications).
- Potential exposure to infectious disease.
- Frequent lifting and moving of patients.
- Emotional stress factor inherent with position.

Approved:

Date: 4/09 **Director of Patient Services:** Janet Monaghan RN

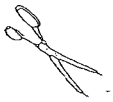
Date: 4/09 **Executive Director/ Administrator:** Margaret Jordan

EMPLOYEE ACKNOWLEDGEMENT
I read and understand the job description above. I know it is my responsibility to follow all aspects of this job description. Further, I know it is my responsibility to ask the supervisor if I have any questions.
Date: **Signature:**

GOTHAM

DIRECT DEPOSIT AUTHORIZATION FORM

1. Read and sign the authorization form below
2. Complete the Direct Deposit Form and attach a voided check on the space provided. The bank account you identify on this form must be in your name and the bank a member of Automated Clearing House (ACH).
3. Return form to Gotham Payroll Department, 75 Maiden Lane, 7th Floor, New York, NY 10038.



DIRECT DEPOSIT AUTHORIZATION

I authorize Gotham Payroll Department to deposit my weekly paycheck directly into my bank account. This authorization will remain in force until I have given written notice to terminate it or until Gotham notify me that this service has been terminated.

At any week, in the event an amount different from what is due to me is erroneously credited in my account, I authorize Gotham Per Diem, Inc. and my bank to make the reversal and/or necessary adjustments.

I understand that it will take three (3) weeks to process direct deposit requests and that direct deposits are effected Fridays and the following Tuesdays.

Signed: _____ SS#: _____

Date: _____

Please complete the form below:

Employee Name:

Employee SS#:

Employee's Bank:

Bank Address:

Bank ABA No:

Account No.: **Account Type:** Checking Savings

ATTACH VOIDED CHECK HERE

REGISTRANT MASTER FILE MAINTENANCE

COMPANY NUMBER |__|__|

ADDITION (__) OR CHANGE (__)

REGISTRANT NO: |__| - |__|__|__|__|__|__|__|__|__|

LAST NAME: |__|__|__|__|__|__|__|__|__|__|__|__|

FIRST NAME: |__|__|__|__|__|__|__|__|__|__|__|__|

ADDRESS: |__|__|__|__|__|__|__|__|__|__|__|__|__|

CITY: |__|__|__|__|__|__|__|__|__|__|__|__|__|

STATE: |__|__|

ZIP CODE: |__|__|__|__|__|

TELEPHONE (1): |__|__|__|--|__|__|__|--|__|__|__|__|

TELEPHONE (2): |__|__|__|--|__|__|__|--|__|__|__|__|

LICENSE#: |__|__|__|__|__|__|__|__|__|

STATUS: |__|__|__|

SPECIAL AREA: |__|__|__|__|__|__|

COMMENTS:

_____

_____

MAIL CHECK |_|

PICK-UP CHECK – BRONX |_|

PICK –UP CHECK – NY |_|

DIRECT DEPOSIT |_|

EMAIL ADDRESS: |__|__|__|__|__|__|__|__|__|__|__|__|

REV/7/08

Form W-4 (2016)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child	G
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ▶	H

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4** — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2016

1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2016, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) ▶ **Date** ▶

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Name:	Phone:
Address:	Social Security Number:

Please indicate if you have had any of these within the past year.

Condition	Were you treated by a doctor? Yes	No	Condition	Were you treated by a doctor? Yes	No
☐ Headaches			☐ Alcohol habituation / addiction		
☐ Vision impairment			☐ Illegal / street drug use		
☐ Hearing difficulties			☐ Drug habituation / addiction		
☐ Speech impairment			☐ Emotional problems		
☐ Fainting / dizzy spells			☐ Nervous breakdown		
☐ Epilepsy / convulsions			☐ Draining wounds		
☐ Wheezing / asthma			☐ Hepatitis		
☐ Frequent colds			☐ Infectious disease		
☐ Chest pain / pressure			☐ Exposure to TB at work or home		
☐ Cardiac (heart) problems			☐ Conversion to a positive PPD		
☐ Hypertension (high blood pressure)			☐ Prior BCG vaccine		
☐ Low blood pressure			☐ Active TB		
☐ Back problems			☐ Positive chest x-ray		
☐ Arthritis / bone problems			☐ Fever		
☐ Stomach ulcer			☐ Night sweats		
☐ Hernia or rupture			☐ Unintentional weight loss		
☐ Diabetes			☐ Fatigue easily		
☐ Renal (Kidney) problems			☐ Loss of appetite		
☐ Allergies			☐ Cough: prolonged, productive, or bloody		

Have you experienced any other serious conditions or illnesses within the past year.

If you answered yes on the questions above, please explain.

Medical problems in the past year	Yes	No	Please Explain
Are you under the care of a physician?			
Have you had any operations?			
Have you been hospitalized?			
Have you had any serious accidents?			
Do you have any health impairment that is a potential risk to patients, families, and or co-workers?			
Do you have any health impairment that would interfere with you performing your duties?			

Signature: _____ Date: _____

RN Signature: _____

CODE OF CONDUCT

Gotham Per Diem, Inc. is committed to conducting its activities in accordance with high ethical standards and all applicable laws, rules and regulations. This Code of Conduct summarizes the key principles that must guide the conduct of all Gotham Per Diem employees and providers.

1. We treat patients/clients and their caregivers, with dignity and respect at all times. We respect patients/clients rights.

2. We strive to provide each Gotham patient/client with the necessary care and services to attain or maintain his or her highest practicable physical, mental and psychosocial well-being, in accordance with his or her assessment and plan of care.

3. We endeavor to comply with all applicable laws, regulations, rules, and Gotham policies.

4. We respect patients/clients privacy and confidentiality, both with regard to records and communications.

5. We do not accept or pay kickbacks, gifts, or offer or accept any payment for referrals.

6. We strive to document all care that we give timely, accurately, and completely.

7. We do not use our position (as individuals or as an organization) to improperly benefit ourselves, our relatives, friends or any business in which we have an interest. Potential conflicts of interest are promptly reported to appropriate management or supervisory personnel.

8. We work with our colleagues, supervisors, Department Heads, Gotham representatives and the Corporate Compliance Officer, to respond to complaints and to correct problems as they arise.

9. We do not tolerate intentional wrongdoing, and we promptly report any suspected wrongdoing to the applicable Gotham representative or to the Corporate Compliance Officer. We understand that there will be no retaliation for making a good-faith report of possible improper behavior.

10. We understand that there can be disciplinary consequences for engaging in noncompliant conduct or for failure to report suspected noncompliant conduct, including termination of employment, termination of contract and prosecution by law enforcement agencies.

Contact Information

Corporate Compliance Officer:
Jim Galvin
Telephone: 1 212 405-2303
Email: jgalvin@gothamcompanies.com

Corporate Compliance E-Mail: corporatecompliance@gothamcompanies.com

CORPORATE COMPLIANCE PROGRAM

COMMITMENT

To create a workplace founded on principles of integrity requires a commitment and participation of each and every individual at all levels. This includes the governing board, corporate management, staff members, and every other individual affiliated with our company and operations.

To ensure that you understand these principles and commit to them:

- Review the corporate compliance document carefully.
- Ask your supervisor if anything is not clear.
- Sign below to show your understanding and commitment.

Together we can maintain a workplace of integrity.

I understand these principles and agree to follow them.

_____ _____

Signature Date

Leadership	***Human Resources***
Mission statement	Job description
Goals	Credentialing
Scope of care and services	Licensing / Certification
General guidelines	Orientation
Availability/work hours/Float Policy	Time sheet / time card instructions
Advance Directives	Benefits
Health Care Proxy	Federal and State Regulations
Occurrences	Drug free workplace
Complaints	Cultural Diversity and Sensitivity
Emergency Preparedness Plan	Patient Rights, Ethics and Confidentiality
Safety/Fire Safety/MDS / OSHA Compliance	Documentation guidelines
Medical Device Safety Act	Infection Control
Corporate Compliance Plan	
False Claims Act	
Performance Improvement	***Competencies***
Organization's performance improvement goals	Self-Assessment Skills Checklist
Sentinel Events	Age Specific Competencies
National Patient Safety Goals	Clinical Specialty Competency
Reporting Quality Concerns to Joint Commission	

Acknowledgement

- ***I successfully completed the orientation and continuing education topics (listed above) and exams;***
- ***I understand that my competencies will be assessed during at the hospital or facility I am assigned to;***
- ***I understand that I should not accept any assignment that I have not been deemed competent to perform;***
- ***I read and understand my job description;***
- ***I commit to maintaining the principles outlined in the organization's Corporate Compliance Plan and False Claims Act;***
- ***I agree to follow Gotham's policies and procedures;***
- ***I agree to follow the policies and procedures at the hospital or facility I am assigned to;***
- ***I understand my obligations, as an employee of this organization, to abide by the agency's privacy practices/ HIPPA, maintain confidentiality, comply with federal and state laws and report any breaches I discover or witness to the Privacy Officer Designee; I will hold confidential and private all information pertaining to patient's records, client facilities policies and procedures;***
- ***I know it is my responsibility to fully comprehend and implement the guidelines outlined in this module. It is my responsibility to ask the supervisor about anything I do not understand; and***
- ***I received an identification badge. I agree to wear it while on duty. I will return it when I no longer with Gotham.***

Employee Signature: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____

STAFFING ORIENTATION EXAM

Name_____ **Date**_____

	Answer True or False	True	False
1.	You will be oriented to the hospital or facility you are assigned to	_____	_____
2.	You are expected to dress professionally, be well groomed, and limit jewelry at work.	_____	_____
3.	If you cannot work, you must notify Gotham at least 8 hrs. before the start of the shift.	_____	_____
4.	It's OK to yell at the patient when your opinion needs to be heard.	_____	_____
5.	You are required to report patient complaints and injuries to the supervisor and Gotham.	_____	_____
6.	You must call the office immediately if you are injured on the job.	_____	_____
7.	Patients have the right to be treated with dignity and respect.	_____	_____
8.	You must come to work on time. Lateness will not be tolerated.	_____	_____
9.	You must not accept an assignment for a task that you are not deemed competent to do.	_____	_____
10.	All patient information must remain confidential.	_____	_____
11.	You must wear gloves whenever you touch blood, body fluids, and secretions.	_____	_____
12.	Our agency will not tolerate dishonesty, stealing, and or committing any type of fraud.	_____	_____
13.	You are responsible to maintain a safe work environment.	_____	_____
14.	You must wash your hands or use an alcohol based rub before and after patient care.	_____	_____
16.	You must follow the policies of Gotham and the hospital / facility you are assigned to.	_____	_____
17.	You do not have to wash your hands if you were wearing gloves to care for the patient.	_____	_____
18.	When you wash your hands you must turn the faucet off with a paper towel.	_____	_____
19.	You are responsible to notify Gotham if you have a change in phone number or address.	_____	_____
20.	You must follow CDC, OSHA standards, and the National Safety Guidelines every shift.	_____	_____

Scoring

Number of Questions Wrong:	Grade	Participants Grade	Validated by (Name / Date)
1	95		
2	90		
3	85		

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	___-___-___		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy):*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:			Date *(mm/dd/yyyy):*
Last Name *(Family Name)*	First Name *(Given Name)*		
Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP *Employer Completes Next Page* STOP

I _____attest that I work directly at Jacobi Medical Center. Jacobi has my current documents listed below, and they are filed directly at Jacobi's H.R. and OHS Department if needed and requested:

- PHYISCAL
- FLU VACCINATION
- HEP B
- DPT
- BSN OR AAS
- DRUG SCREEN
- MMRV TITERS
- CRIMINAL BACKGROUND CHECK
- REFERENCES

First Name:_____

Last Name:_____

Signature:_____

Date:_____