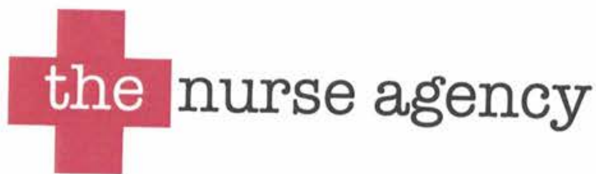

Dear: ______________________________,

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

10829 S. Western Avenue • Suite B • Chicago, IL 60643 • Phone: (773) 779-8200 • Fax: (773) 779-8866
www.thenurseagency.com

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

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Heather E. O'Donnell
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

CCHHS Computer Sign-On Request Form

Nursing

Network: ____________________

Cerner: ____________________

Other:

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

B. Last [ ] First [ ] MI [ ]

Healthcare Credentials (e.g., RN, LPN, CRNA, CNS)

Cook Cty Employee # if none and if no state license or NPI, then last 2 of SSN

State License #

APN Pager ____-____-____

APN NPI

APN DEA

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

____/____/ 20____ Signature Date

Firm/Agency, if non-County

User's Signature

Position or Title

C. Primary Location (check one) (domain)

☐ ACHN ☐ Core Center ☐ Juv Det ☐ Provident

☐ Cermak ☐ J H Stroger ☐ OFH ☐ Public Health

Department (or ACHN site)

D. ____/____/____ -- ____/____/____

Start Date End Date

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

E. ☐ *email* ☐ *Internet* ☐ *ANSOS* ☐ *ORSOS* ☐ *Vista* ☐ *SCC SoftLab*

☐ *Productivity & Benchmarking* ☐ *Time & Attendance ** ☐ *Cerner Test ** ☐ *Citrix Local Access**

*requires additional authorization

# of boxes checked in section E ______

F. Cerner Either request access the same as (existing user) ____________________ or check one below

☐ ED Nurse	☐ Nurse RN Mgmt Admn	☐ Nursing CMT
☐ Nurse APN	☐ Nurse RN Mgmt/Admn 2	☐ Nursing PCA/CNA Amb Reg'try
☐ Nurse APN Anesthetist	☐ Nurse RN Mgmt/Admn Amb	☐ Nursing PCA/CNA InPt Reg'try
☐ Nurse Instructor	☐ Nurse RN Mgmt/Admn InPt	☐ Nursing PCA/CNA Amb
☐ Nurse LPN Amb	☐ Nurse RN Procedural	☐ Nursing PCA/CNA InPt
☐ Nurse LPN Amb Registry	☐ Nurse RN Specialty Service	☐ Nursing Telemetry Tech
☐ Nurse LPN InPt	☐ Nurse Student LPN	☐ Nursing Unit Clerk Amb
☐ Nurse LPN InPt Registry	☐ Nurse Student PCA	☐ Nursing Unit Clerk InPt
☐ Nurse RN Amb	☐ Nurse Student RN	☐ SurgiNet OB Nurse
☐ Nurse RN Amb Registry	☐ Nurse Student RN/APN	☐ SurgiNet OR Nurse
☐ Nurse RN InPt Orders	☐ Nursing Activity Worker-Play Therapist	
☐ Nurse RN InPt Orders Registry	☐ Nursing Clinical Health Advocate	

For Stroger Cerner ED **FirstNet:** ☐ Adult ☐ Peds ☐ Trauma

G. Request **patient records** of ☐ Cermak ☐ Child Adv* ☐ Core Center

☐ Juv Detention* ☐ OFH ☐ Provident ☐ SHCC ☐ SHCC Emp Health*

←- **# boxes checked** in G ______

H. Request authorized by

Signed ____________________ * Signed ____________________

Title ____________________ Title ____________________

Printed Name Printed Name

I. Deliver to either (a) Stroger Hosp HIS Help Desk, room 2650 SHCC, fax 312-864-9364, (b) Provident IS Office, or (c) Oak Forest Hosp IT Help Desk. Call Help Desk, 312-864-HELP, for status. After 48 hours, bring County ID to pickup password in person.

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

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[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

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 ______________ *(Yes/No)* If no, why not?

____

____

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
EQUIPMENT (continued)			
Hypo/Hyperthermia Blanket			
Leather Restraints			
Soft Restraints			
Posey Belt and Jacket			
Glucose Monitoring			
Device (Accu-Check)			
Bed Scale			
Defibrillator			
Cardiac Monitor			
Electric Bed			
Air Fluidized Bed			
SPECIMENS			
Throat Culture			
Urine Midstream			
Clinitest/Acetest			
Wound Cultures			
Hematocrit			
PREPARATIONS FOR PROCEDURES			
Lumbar Puncture			
Thoracentesis			

NURSING CARE ACTIVITIES (Check appropriate box)	Can Do	Cannot Do	Need Help
Pelvic Exam/Pap Smear			
Cutdowns			
C.V.P. Insertions			
Chest Tube Insertion			
IVs			
Insertion			
Heparin Lock			
Venipuncture			
DOCUMENTATION/FLOW SHEETS			
Assessment			
Transcription of Orders			
Patient Response to Tx.			
Nursing Care Plan			
Medication and IV Profiles			
Discharge Planning			
PATIENT EDUCATION			
Pre-Operative Teaching			
Diabetic Teaching			
MISCELLANEOUS			
Peritoneal Dialysis			
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

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