BLOODBORNE PATHOGENS RISK CLASSIFICATION FORM – AGENCY STAFF	
JOB CATEGORIES AND RISK OF EXPOSURE	
☒Category I:	Your job routinely involves potential for mucous membrane or skin contact with blood, body fluids or tissues. Employees whose duties include anticipated tasks for potential exposure include: physicians, nurses, phlebotomists, environmental services, transportation, mental health specialists, public safety offices, grounds maintenance
☐Category II:	Your job may expose you occasionally or in emergency or unplanned situations to blood, body fluids or tissues. This potential exposure may be required as a condition of employment. Employees whose duties include such potential include: activity therapists, psychologists, social workers, vocational rehabilitation, pharmacy, supply, dietary, librarian, volunteers, chaplains
☐Category III:	Your job does not involve exposure to blood, body fluids or tissue. You do not perform or help in emergency medical care or first aid as part of your job. Tasks that involve handling or implements or utensils, use of public or shared bathroom facilities or telephones and personal contacts such as handshaking are Category III tasks. Employees included in Category III include: secretarial staff, administration, business office, medical records

Date: _____

I have reviewed the categories described and understand that my category of risk as an Agency Nursing staff as indicated above.

_____

Print Name

_____

Signature

_____

Social Security Number

Worldwide Travel Staffing_____

Name of Agency

Emergency Contact Form

Employee Name: _____

Emergency Contact Name: _____

Emergency Contact Relationship to you: _____

Emergency Contact Phone Number: _____

South Carolina Department of Mental Health

Nursing Agency Personnel Acknowledgement– ID Card/Keys

With the inception of kronos, all agency nursing staff will be issued a South Carolina Department of Mental Health (SCDMH) Identification card (ID). The ID card is to be used for clocking in/out and in some cases to gain entrance to the facility. Keys will also be issued for the work area and fire box (Key B).

If I lose/misplace my ID and/or key(s), I am to notify the facility's DON/designee immediately.

I acknowledge that upon my resignation or termination the ID and keys must be returned. If they are not returned, my agency will be charged for each item.

The fee for the replacement of lost or unreturned ID card and/or keys is listed below.

Identification Card:	$25.00
Identification Clip:	$0.50
Key Fee:	$10.00 each
Key B:	No replacement fee

Agency Name: Worldwide Travel Staffing

Staff Signature: _____ Date _____

Agency Representative Kevin Peters Date _____

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
DIRECTIVE STATEMENT

Personal Appearance of Employees

It is the policy of the South Carolina Department of Mental Health that each employee's dress, grooming and personal hygiene should be appropriate to the employee's work situation and her/his profession. Violation of the directives may lead to appropriate disciplinary action.

I have reviewed SCDMH Directive #826-01. I have read, understand, and will adhere to the written procedures.

Print Name: _____ Signature: _____

Facility: _____

Date: _____

#
###

DMH

NURSING ADMINISTRATION

I understand that it is my **responsibility** to notify the Nurse Manager/Director of Nursing/ Chief Nursing Officer/designee **immediately** of any change(s) with my nursing license/certification.

_____ _____

Name/Title Date

South Carolina Department of Mental Health

Acknowledgement and Acceptance of Agency Contract Personnel Position

I understand and acknowledge that as a 13 week agency contract employee, I am required to work 40 hours a week and every other weekend, assigned holidays and am required to float between all DMH-Columbia, SC units/lodges and facilities based on the needs of the organization.

Additionally, by signing this form below, I acknowledge and **accept** the **Primary Facility**

offered to me: _____
(List the Primary Facility Offered by the organization)

Furthermore, by signing this form below, I acknowledge and **accept** the **Primary Shift**

offered to me: _____
(List the Primary Shift Offered by the organization)

Lastly, by signing this form below, I acknowledge and **accept** the **Secondary Shift**

offered to me: _____
(List the Secondary Shift Offered by the organization)

Employee (Print Name): _____ Title: _____

Employee Signature: _____ Date: _____

Agency Name: Worldwide Travel Staffing

Agency Representative (Print Name): Kevin Peters

Agency Representative Signature: Kevin Peters

Date: _____

South Carolina Department of Mental Health

Acknowledgement and Acceptance of DIS Float Agency Personnel Position

I understand that by accepting this floater assignment, I am expected to provide nursing coverage at all of Columbia's DMH facilities based on the needs of the organization. I understand that I am expected to work at least 3 shifts per month.

Additionally, by signing this form below, I acknowledge and **accept** the **Primary Facility offered to me**: _____
(List the Primary Facility Offered by the organization)

Furthermore, by signing this form below, I acknowledge and **accept** the **Primary Shift offered to me**: _____
(List the Primary Shift Offered by the organization)

Lastly, by signing this form below, I acknowledge and **accept** the **Secondary Shift offered to me:** _____
(List the Secondary Shift Offered by the organization)

Employee (Print Name): _____ Title: _____

Employee Signature: _____ Date: _____

Agency Name: Worldwide Travel Staffing

Agency Representative (Print Name): Kevin Peters

Agency Representative Signature: Kevin Peters

Date: _____

South Carolina Department of Mental Health

Acknowledgement and Acceptance of Per Diem Agency Personnel Position

I understand and acknowledge that I am required to work a minimum of 24 hours a week and at least one weekend a month, assigned holidays and am required to float between all Columbia, SC units/lodges and facilities based on the needs of the organization.

Additionally, by signing this form below, I acknowledge and **accept** the **Primary Facility offered to me**: _____
(List the Primary Facility Offered by the organization)

Furthermore, by signing this form below, I acknowledge and **accept** the **Primary Shift offered to me**: _____
(List the Primary Shift Offered by the organization)

Lastly, by signing this form below, I acknowledge and **accept** the **Secondary Shift offered to me:** _____
(List the Secondary Shift Offered by the organization)

Employee (Print Name): _____ Title: _____

Employee Signature: _____ Date: _____

Agency Name: Worldwide Travel Staffing

Agency Representative (Print Name): Kevin Peters

Agency Representative Signature: Kevin Peters

Date: _____

CONTRACTOR EMPLOYEE AGREEMENT AND WAIVER

Contractor will require each Contractor assigned employee to execute the following Agreement and Waiver to be kept as part of Contractor records described in 4.0:

"In consideration of my assignment to SCDMH or any of its inpatient or outpatient facilities (SCDMH) as a supplemental nursing personnel contractor for [**insert name of Contractor**], I understand and agree that while assigned to SCDMH, I am solely an employee of [**insert name of Contractor**]. I also agree that for all benefits plan, and all other employment purposes, I am eligible only for such benefits as [**insert name of Contractor**], may offer to me as its employee. I further understand and agree that I am not eligible for or entitled to participate in or make any claim upon any benefit plan, policy, or practice offered by SCDMH, inpatient or outpatient facilities or other components, regardless of the length of my assignment to SCDMH and regardless of whether I am held to be a common-law employee of [**insert name of Contractor**] for any purpose. I also acknowledge that I have been given the opportunity to consult with anyone of my choosing before signing this agreement and waiver. Therefore, with full knowledge and understanding, I hereby expressly waive any claim or right that I may have, now or in the future, to such benefits and agree not to make any claim for such benefits."

Employee Signature: _____Date: _____

Agency Staff Signature: Kevin Peters _____Date: _____

STATE OF SOUTH CAROLINA
SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
INTERNET ACCEPTABLE USE POLICY

Users of Internet services provided by the South Carolina Department of Mental Health hereby agree to be subject to and abide by the following policies.

1. State employees or other state officials will limit use of the network to official state business directly related to their job duties. And will not use the network for private, recreational, non-public purposes including the conduct of any personal commercial activity.

2. Transferring state government commercial traffic, as well as research and educational traffic, is an acceptable use so long as such use is acceptable to all interconnected networks along the entire route from source to destination.

3. The network shall not be used for illegal, unlawful, or immoral purposes or to support or assist such purposes. Examples of this would be the incoming or outgoing transmission of threatening, sexually explicit, or obscene or otherwise illegal materials.

4. The network shall not be used to disrupt network users, services or equipment. Disruptions include, but are not limited to, distribution of unsolicited advertising, propagation of computer "worms" and viruses, using the network to attempt unauthorized entry into any other computer accessible through the network, and sustained high volume network traffic which substantially hinders others in their use of the network.

5. State employees may be subject to limitations on their use of the network as determined by the appropriate supervising authority. HIPAA security act requires that all email communication containing Patient Health Information (PHI) kept confidential and no PHI details in the Email Subject Line.

6. All hosts, including personal computers that are connected to the DMH's internal networks, **must disconnect** from the network before using remote access technologies. **No attempt** will be made to access restricted/proprietary information sources without first securing permission from the owners or holders of those sources. Placement of files, resources or information into a computer directory structure accessible via "anonymous FTP" or a published public TELNET account grants de facto permission for access to all network users.

7. State employees or other officials desiring to download large files will consult with their supervisor and appropriate officials to ascertain any technical considerations concerning the download, including available space, configuration, and storage device consumption.

8. State employees who violate any copyright declarations are acting outside the course and scope of their employment or other authority and the State of South Carolina is relieved of any legal responsibility therefore. State employees will be personally responsible and liable for such infringing activities.

9. Use of network services provided by the South Carolina Department of Mental Health may be subject to monitoring for security and/or other reasons. The Department considers any violation of appropriate use, principles, or guidelines to be a serious offense and reserves the right to copy and examine any files or information resident on Department systems allegedly related to inappropriate use. Users of these services are therefore advised of this potential monitoring and examination and agree to these practices.

10. State employees are subject to discipline for violation of this policy and for any unauthorized use of state property.

I have read and understand the conditions of acceptable use as defined above. _____

(Date)

_____ _____

(Printed Name) **(Signature)**

Submit

DMH COMPUTER SECURITY UPDATE REQUEST

First Name	Init.	Last Name	Credentials i.e.(MD,RN,etc)	XXX-XX- Soc. Sec. Num. **(last 4 of SSN)**	Date

Facility/Center Name	Supervisor's Name	( ) Telephone Number

Type request: New ☒ Change ☐ Delete ☐ User-id: _____ (ID on change/delete only)

Inpatient EMR
AVATAR CWS
☐ Activity Therapist
☐ Adult Transitional Services
☐ BHA
☐ Clinical Counselor
☐ LPN
☐ Nurse Extern
☐ Nurse Practitioner
☐ ODON
☐ Pharmacist
☐ Physician
☐ Psychiatrist
☐ Psychologist
☐ RN
☐ Social Worker
☐ Student Nurse
☐ Unit Clerk
☐ Utilization Management
☐ Other

Patient Information
AVATAR PM
☐ Admissions
☐ Census Responsibilities
☐ Client - Inquiry
☐ Financial Eligibility
☐ Medical Record/ HIS
☐ Nursing
☐ Social Worker
☐ Discharge Readiness
AVATAR CFMS -Banking
☐ Cashier
☐ Administration

CIS – CMHC's Outpatient/EMR
☐ CIS - Data-Entry
☐ CIS - Center Administration
☐ CIS - Staff Prod. View Pay
☐ CIS - Read Only (Clinicians)
☐ CIS - Intake Only
☐ CIS - Scheduler - Read ONLY
☐ CIS - Scheduler
☐ CIS – Comm. Homes / CRCF
CIS - Privileges
☐ CIS - Reverse Privileges
☐ CIS - Continuity of Care
☐ CIS - Web Entry
EMR
☐ EMR Data - Entry
☐ EMR Read - ONLY
☐ EMR Staff Admin.
☐ SCHIEx

Mainframe Patient System
☐ Patient Inquiry
☐ Patient Accounts
☐

NOTES:

Date:	**Security Administrator Signature:**	**Director of Designee Signature:**

Submit Clear

SCDMHFORM
JUNE 88 (REV. JUL. 2017) DP-65

USER AUTHORIZATION FORM

Last 3 digits of SSN:		
First Name	**Middle Initial**	**Last Name**
TITLE:		
Location		**Room Number**
DEPARTMENT:		
Phone Number	**Extension**	**Fax Number**
Does this user need e-mail?		**Check one:** ☐ Yes ☐ No
Does this user need Webaccess to their e-mail?		**Check one:** ☐ Yes ☐ No
Does this user need Pxyis access?		**Check one:** ☐ Yes ☐ No
Supervisor / Manager Signature		**Date**

Submit

RPP Appendix B:

SCDMH Inpatient Services and Long Term Care Services

Respirator Medical Evaluation Questionnaire

Respirators must be used in workplaces in which employees are exposed to hazardous airborne contaminants. When respiratory protection is required employers must have a respirator protection program as specified in OSHA's Respiratory Protection standard (29 CFR 1910.134). Before wearing a respirator, workers must first be medically evaluated using the mandatory medical questionnaire or an equivalent method. To facilitate these

Medical evaluations, this INFOSHEET includes the mandatory medical questionnaire to be used for these evaluations.

Medical Evaluation and Questionnaire Requirements

The requirements of the medical evaluation and for using the questionnaire are provided below:

- The employer must identify a physician or other licensed health care professional (PLHCP) to perform all medical evaluations using the medical questionnaire in Appendix C of the Respiratory Protection standard or a medical examination that obtains the same information. (See Paragraph (e)(2)(i).)
- The medical evaluation must obtain the information requested in Sections 1 and 2, Part A of Appendix B. The questions in Part B of Appendix B may be added at the discretion of the health care professional. (See Paragraph (e)(2)(ii).)
- The employer must ensure that a follow- up medical examination is provided for any employee who gives a positive response to any question among questions 1 through 8 in Part A Section 2, of Appendix B, or whose initial medical examination demonstrates the need for a follow-up medical examination. The employer must provide the employee with an opportunity to discuss the questionnaire and examination results with the PLHCP. (See Paragraph (e)(3)(i).)
- The medical questionnaire and examinations must be administered confidentially during the employee's normal working hours or at a time and place convenient to the employee and in a manner that ensures that he or she understands its content. The employer must not review the employee's responses, and the questionnaire must be provided directly to the PLHCP. (See Paragraph (e)(4)(i).)

Excerpt from Appendix C of 29 CFR 1910.134:

OSHA Respirator Medical Evaluation Questionnaire

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee: Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Once filled out, this form must be given to the PLHCP. This form should **not** be submitted to OSHA.

Part A Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date:
2. Your name:
3. Your age (to nearest year):
4. Sex (circle one): Male/Female
5. Your height: ft. in.
6. Your weight: lbs.
7. Your job title:
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code):
9. The best time to phone you at this number:
10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No
11. Have you worn a N 95respirator (circle one): Yes/No If "yes," what type(s):

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

	YES	NO
1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month?	☐	☐
2. Have you *ever had* any of the following conditions?	☐	☐
a. Seizures	☐	☐
b. Diabetes (sugar disease)	☐	☐
c. Allergic reactions that interfere with your breathing	☐	☐
d. Claustrophobia (fear of closed-in places)	☐	☐
e. Trouble smelling odors	☐	☐
3. Have you *ever had* any of the following pulmonary or lung problems?	☐	☐
a. Asbestosis	☐	☐
b. Asthma	☐	☐

	YES	NO
c. Chronic bronchitis	☐	☐
d. Emphysema	☐	☐
e. Pneumonia	☐	☐
f. Tuberculosis	☐	☐
g. Silicosis	☐	☐
h. Pneumothorax (collapsed lung)	☐	☐
i. Lung cancer	☐	☐
j. Broken ribs	☐	☐
k. Any chest injuries or surgeries	☐	☐
l. Any other lung problem that you've been told about	☐	☐
4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?	☐	☐
a. Shortness of breath	☐	☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐	☐
c. Shortness of breath when walking with other people at an ordinary pace on level ground	☐	☐
d. Have to stop for breath when walking at your own pace on level ground	☐	☐
e. Shortness of breath when washing or dressing yourself	☐	☐
f. Shortness of breath that interferes with your job	☐	☐
g. Coughing that produces phlegm (thick sputum)	☐	☐
h. Coughing that wakes you early in the morning	☐	☐
i. Coughing that occurs mostly when you are lying down	☐	☐
j. Coughing up blood in the last month	☐	☐
k. Wheezing	☐	☐
l. Wheezing that interferes with your job	☐	☐
m. Chest pain when you breathe deeply	☐	☐
n. Any other symptoms that you think may be related to lung problems	☐	☐
5. Have you *ever had* any of the following cardiovascular or heart problems?		
a. Heart attack	☐	☐
b. Stroke	☐	☐
c. Angina	☐	☐
d. Heart failure	☐	☐

	YES	NO
e. Swelling in your legs or feet (not caused by walking)	☐	☐
f. Heart arrhythmia (heart beating irregularly)	☐	☐
g. High blood pressure	☐	☐
h. Any other heart problem that you've been told about	☐	☐
6. Have you *ever had* any of the following cardiovascular or heart symptoms?	☐	☐
a. Frequent pain or tightness in your chest	☐	☐
b. Pain or tightness in your chest during physical activity	☐	☐
c. Pain or tightness in your chest that interferes with your job	☐	☐
d. In the past two years, have you noticed your heart skipping or missing a beat	☐	☐
e. Heartburn or indigestion that is not related to eating	☐	☐
f. Any other symptoms that you think may be related to heart or circulation problems	☐	☐
7. Do you *currently* take medication for any of the following problems?	☐	☐
a. Breathing or lung problems	☐	☐
b. Heart trouble	☐	☐
c. Blood pressure	☐	☐
d. Seizures	☐	☐
8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check the following space and go to question 9.)	☐	☐
a. Eye irritation	☐	☐
b. Skin allergies or rashes	☐	☐
c. Anxiety	☐	☐
d. General weakness or fatigue	☐	☐
e. Any other problem that interferes with your use of a respirator	☐	☐
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	☐	☐

For Reviewer ONLY:

10. Employee Approved to wear N-95	☐	☐

Reviewer::_____ Date: _____

Medical Reviewer (LPP): _____ Date: _____