



Independent Nursing and Health Care Staffing Services

Dedicated, Established, RN Owned

INS/AHSA - Staff Credential Verification Summary (SCVS) Form

Release#072807272006

*Please complete all that apply to a specific staff person below –
All supporting documentation must be **faxed to 586 771-4205** and kept on file by INS*

Independent Nursing Ph- 586 771-4097 Fax- 586 771 4205	25689 Kelly Rd Roseville Michigan 48066
*** Staff Name:	S.S.# (Last 4 digits):

*** Staff Designation (Nursing, Phys. ,Rad., Ther., Pharm., etc.):
*** Specialty (RN-Tele, RN-ICU, Anesth., MRI, PT, COTA, etc.):

***** Licensure/Certification/Registration**

Primary License/Cert./Reg.#:	State:	Exp. Date:
Secondary License/Cert./Reg.#:	State:	Exp. Date:
Other License/Cert./Reg.#:	State:	Exp. Date:

***** Certifications (please complete all that apply)**

CPR Expiration Date:	Issuing Agency (American Heart, etc.):
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ACLS Exp. Date:	PALS Exp. Date:	NRP Exp. Date:
NALS Exp. Date:	TNCC Exp. Date:	

Other	Exp. Date:
Other	Exp. Date:

***** Professional Education**

Highest Degree Received:

INS Office to Complete

OSHA/JCAHO Competency – Date/s Last Administered (please complete all that apply):

Blood borne Pathogen:		TB Awareness:	
Fire:		Domestic Violence:	
Age Specific Care:		Safety:	
Needle-stick Prevention:		Universal Precautions:	
Moving Patients:		PPE:	
HIV/AIDS Update:		Restraints Education:	
HIPAA:		Other: <i>(Enter here)</i>	

Competency Testing - Please record date administered and initial results (%) –
All Exams must be remediated to 100%

	Score %	Date Taken
Approved Medication Administration Exam:		
Discipline/Unit Specific Competency Exam/s (<i>specify</i>):		
Medical Terms Exam (Medical Office):		

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AHS - Staff Credential Verification Summary (SCVS) Form (cont.)

Staff Name:	S.S.# (Last 4 digits):
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Area Specific Competency Skills Checklists - Please list discipline and last date completed
(must be current to 1 year)

Nursing (RN-ICU, CNA, etc.)	Date Completed	Radiology (Gen., Rad. Ther., etc.)	Date Completed

Therapy (PT, OT, etc.)	Date Completed	Pharmacy	Date Completed	Phys. or Medical Office	Date Completed

***** Medical Information – (Please note: hospital-specific requirements may vary)**

Fax documents to 586 771-4205

Last Physical/Health Assessment Date (must be current to within 1 year):	Fit for Duty (Y/N):
Last PPD Date:	Results:
Last Chest X-ray Date (if applicable):	Results:
TB FIT Test Date:	Size:
MMR Immunization Date:	Results:
Varicella: Titer or History (enter one):	Date:
HEP B Vaccine Received* (Y/N):	HEP B Vaccine Declined (Y/N): (if Y, attach form)
*Anti Hbs Titer Date:	
Drug Screen (9 panel) Date Performed:	Negative (Y/N):

Background Evaluation – All checks performed below must reflect a “clear” record or noted otherwise by SSP

Description	Last Date Performed	Clear? If not, please explain
Professional License/Cert./Reg. Verification:		
Professional Disciplinary Action Search:		
Criminal Background Search- <u>National (7 yrs)</u> :		
Education Verification (Highest level):		
Employment Verification (Last 3 Employers):		
Social Security Number Verification:		
Sexual Offender and Predator Registry Search:		
GSA List-Excluded From Federal Programs:		
OIG List of Excluded Entities/Indiv. Search:		

We, as an approved staffing provider to AHS member facilities, certify that the above information is complete and accurate. All pertinent information related to the above (SCVS) Form is present in this employee's file and the above named employee is fully competent to perform all duties associated with work assignment. In addition, this employee has had at least one (1) year of experience (within the last two (2) years) in the area being assigned.

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SSP Representative (Printed)

SSP Representative (Signature)

Date

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