



# Assignment Despite Objection Form

1. Hospital/Facility \_\_\_\_\_ Date \_\_\_\_\_ Shift/Unit \_\_\_\_\_

2. Name \_\_\_\_\_ RN \_\_\_\_ LVN \_\_\_\_ CNA \_\_\_\_ Other \_\_\_\_\_

3. Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E Mail \_\_\_\_\_

4. **Concern (To guarantee patient confidentiality, do not use patient names or other identifiers):**

- ☐ Admission/Transfer Issues
- ☐ Patient acuity concerns
- ☐ Reduction in support staff (CNAs, clerks, transport, EVS, RT, techs, other \_\_\_\_\_)
- ☐ Required by manager to work beyond my scheduled hours or area/mandatory overtime.
- ☐ Patient coverage during breaks/meals
- ☐ Missed: Meal period ☐ Breaks ☐ Worked O/T ☐
- ☐ Equipment/supplies
- ☐ Training for assignment
- ☐ Administration of meds/procedure issues
- ☐ Response to call lights
- ☐ Time to chart/document
- ☐ Time to provide patient family education.

Unit Census \_\_\_\_\_ Capacity \_\_\_\_\_ Acuity: High \_\_\_\_\_ Average \_\_\_\_\_ Low \_\_\_\_\_

7. Staffing Numbers: RNs \_\_\_\_ LVNs \_\_\_\_ CNAs \_\_\_\_

8. Was incident report filed? ☐ Yes

Was HIPAA patient privacy observed? ☐ Yes Other \_\_\_\_\_

9. Treatments: Check which apply to assignment.

## IVS

- ☐ Inserts
- ☐ D/C's
- ☐ IVPB/IVP
- ☐ Titrating gtts
- ☐ Epidurals/PCA

## Medications

- ☐ Pain
- ☐ PRN
- ☐ PO/Injections
- ☐ Multiple/Frequent
- ☐ Finger stick Glucose/Coverage

## Frequency

- ☐ Blood draws/Lab/ABG
- ☐ Blood administration
- ☐ Pre-op/procedure prep
- ☐ Post-op/procedures
- ☐ Amb/OOB w/assist
- ☐ Assist w/meals
- ☐ Transport
- ☐ Admissions/Discharges
- ☐ Hemodynamic Monitor
- ☐ Pharmacy/Lab trips
- ☐ Restraints

☐ Isolation Patients \_\_\_\_\_

☐ Wound/Drain care

☐ Dressing changes

☐ Procedures/Sedation

## Respiratory Treatments

- ☐ Breathing Treatments
- ☐ Intubation/Code Blue
- ☐ Ventilator Care/Support
- ☐ Total Care/Turning
- ☐ Education
- ☐ Ortho Care/Spinal Precaution
- ☐ Respiratory Distress/Suctioning

10. Requested assistance from manager or supervisor? ☐ Yes

Supervisor/Manager name: \_\_\_\_\_

What was his/her response? \_\_\_\_\_

**COMMENTS/OTHER:** (Provide additional information here documenting your concerns checked above. Write on an additional sheet as needed.)

**Resolution:**

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**Additional Comments:**

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**Note: Fax Number and Address**

1. Keep your originals. Document calls to supervisor for assistance and their response.
2. **Deliver a copy of this form to your supervisor, manager or director.**
3. **FAX all forms to SEIU Nevada Local 1107 at 702-386-4883**

Or mail to: SEIU Nevada Local 1107

2250 S. Rancho Dr. #165, Las Vegas, NV 89102

**IMPORTANT - To guarantee patient confidentiality, do not use patient names or other identifiers.**

***Complete this form as soon as possible upon receiving objectionable assignment but without interrupting your work or the care of the patient(s).***