1199 SEIU • United Healthcare Workers East • Maryland/DC Division RN Area

Assignment Despite Objection Form

Under the law of this state and in accordance with the Maryland Nurse Practice Act or as a registered nurse, I am responsible and accountable to my patients/clients. Therefore, this is to confirm that I have notified you that in my professional judgment, today's assignment is unsafe and places my patients/clients at risk. As a result, the Hospital/Facility and you share responsibility for any adverse effects on patient care. I will, under protest, attempt to carry out the assignment to the best of my professional ability. I have no authority or ability to adjust the number of staff assigned to my shift.

Name:_____ **Date:**_____

Facility:_____

Unit:_____

MY ASSIGNMENT IS:
__primary nurse/team member
__charge nurse/lead nurse
__other: _____

Number of Patients Assigned:_____
Acuity of Patient(s) I was Assigned *(circle one):*: **HIGH AVERAGE LOW**

My Objection(s) is Based Upon the Following: (check all that are appropriate)

__ not trained or experienced in the area
__ not given adequate staff for acuity level
__ pt 1:1 – not given staffing levels to meet
__ staffed with unqualified registry personnel
__ transferred/admitted new patient(s) to unit without adequate staff
__ not oriented to the unit
__ staffed with excess registry personnel
__ not provided with a unit clerk
__ not provided with appropriate ancillary support
__ given an assignment which poses a serious threat to my health and safety

Was Life and/or Safety of Patients Adversely Impacted or Potentially Impacted? ___ Yes ___ No

Was Incident Sheet Completed? ___ Yes ___ No
Meal Period Missed? ___ Yes ___ No
Break Missed? ___ Yes ___ No
Overtime Incurred? ___ Yes ___ No

Staffing Mix on Date of Objection:

	REGULAR	FLOAT	AGENCY	REASSIGNED STAFF FROM ANOTHER UNIT
REGISTERED NURSE				
LPN				
TECHNICIAN				
NURSING AIDE				
UNIT SECRETARY				

Beginning Census:_____ **End of Shift Census:**_____ **Unit Capacity:**_____ **# of Admissions:** _____

Brief Description: *(Use reverse side if necessary)*_____

_____

_____

In Order to Obtain Additional Staffing or Assistance, List the Names of your contacts below:

Unit Manager/Clinical Coordinator_____ **Date/Time**_____
Nursing Supervisor/Clinical Director_____ **Date/Time**_____
Physician/Resident_____ **Date/Time**_____
Administrator_____ **Date/Time**_____

THIS FORM BELONGS TO THE UNION. PLEASE RETURN IT TO A CHAPTER OFFICER IN YOUR FACILITY ASAP OR FAX IT TO (410)992-5330. COPIES WILL BE SENT TO NURSING ADMINISTRATION, RISK MANAGEMENT & MEDICAL DIRECTORS.