



Assignment Despite Objection

I, _____, a Registered Nurse employed at _____
(Name) (Facility Name)
on _____, _____, _____, hereby object to the assignment as
(Unit) (Shift) (Date)
made to me by _____ at _____ on _____
(Supervisor) (Time) (Date)

In my professional opinion, as a licensed Registered Nurse, the situation described on this form is not adequate to meet the needs of the patients assigned to me at this time. I indicate my acceptance of the assignment despite objection. It is not my intention to refuse the assignment. The purpose of this form is to notify facility supervisory staff that I have been given an assignment I believe is potentially unsafe for patients and/or staff. This form will document this situation.

This assignment is accepted because I have been instructed to do so, despite my objections

My objections to this assignment are (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Short Staffed for Census | <input type="checkbox"/> Charge nurse unable to perform charge nurse duties |
| <input type="checkbox"/> Short staffed for acuity/complexity | <input type="checkbox"/> Inadequate nurse to patient ratios |
| <input type="checkbox"/> Not trained/experienced in area assigned | <input type="checkbox"/> Not provided with adequate assistant(s) |
| <input type="checkbox"/> Not oriented to this unit/case load | <input type="checkbox"/> Forced/Mandatory Overtime |
| <input type="checkbox"/> Floating to multiple units during shift | <input type="checkbox"/> System Failure |
| <input type="checkbox"/> Necessary equipment is not available | <input type="checkbox"/> Missed Breaks/Lunch |
| <input type="checkbox"/> Not trained/experienced to use equipment | <input type="checkbox"/> Other (please explain) |
| <input type="checkbox"/> Transferred/admitted new patient(s) to unit without adequate staff | |

Acuity Factors (check those that apply and indicate number of patients):

- | | |
|--|--|
| <input type="checkbox"/> Ventilator: # of patients _____ | <input type="checkbox"/> Immediate Post-op: # of patients _____ |
| <input type="checkbox"/> Restraints: # of patients _____ | Receiving Blood Products: # of patients _____ |
| <input type="checkbox"/> Total Care: # of patients _____ | Isolation Precaution: # of patients _____ Head |
| <input type="checkbox"/> Unstable new admission: # of patients _____ | Injury/Confused: # of patients _____ Procedure on |
| <input type="checkbox"/> Suicide Precautions: # of patients _____ | unit (chest tube, etc.): # of pts _____ Procedure off unit |
| <input type="checkbox"/> Medicated gtts (insulin, pressors, etc.): # of patients _____ | (CT, etc.): # of patients _____ |
| <input type="checkbox"/> Requires frequent vital signs/assessment: # of patients _____ | <input type="checkbox"/> Other (please explain): _____ # of patients _____ |

Number of Patients _____

Unit Secretary? No ☐ Yes ☐ Charge nurse has patients? No ☐ Yes ☐

Census on Date and Shift of Objection # of patients @ start: _____ Admissions/Transfers: _____ Discharges/Transfers: _____ # of patients @ end: _____ Unit Capacity: _____

Additional Information:

RN Signature

Print Name

Date

Supervisor Signature

Print Name & Title

Date

Complete this form and have it signed by your immediate supervisor or designee. Keep the original for your records and make 3 copies; give one to the supervisor, one to your local MNA unit officer, one to the MNA office (or MNA Labor Representative).

Discussed at PCC Meeting with MNA: Date _____
Follow-up: ☐

☐ MNA Local President: Date _____

☐ Dept. Supervisor: _____