Montana Nurses Association

20 Old Montana State Highway ~ Montana City, MT 59634 ~ 406-442-6710
406-442-1841 (fax) ~ www.mtnurses.org

Assignment Despite Objection Local 16

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):

____ Short Staffed for Census
____ Short staffed for acuity/complexity
____ Not trained/experienced in area assigned
____ Not oriented to this unit/case load
____ Floating to multiple units during shift
____ Necessary equipment is not available
____ Not trained/experienced to use equipment
____Transferred/admitted new patient(s) to unit without adequate staff
____ House Supervisor unable to perform House Sup duties
____ Inadequate nurse to patient ratios
____ Not provided with adequate assistant(s)
____ Forced/Mandatory Overtime
____ System Failure
____ Missed Breaks/Lunch
____ Other (please explain)

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

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

Unit Secretary? No ⬭ Yes ⬭ Charge/HS has patients? No ⬭ Yes ⬭ Number of Patients_____

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).

Follow-up: ⬭ Discussed at PCC Meeting with MNA: Date _____ ⬭ MNA Local President: Date _____

⬭ Dept. Supervisor: