



Doctors Council SEIU

50 Broadway, 11th Floor, Suite 1101
New York, New York 10004
Phone (212) 532-7690 Fax (212) 481-4137
Barry Liebowitz, M.D., President – Frank Proscia, M.D., Executive Director



ASSIGNMENT DESPITE OBJECTION (A.D.O.) NOTIFICATION FORM

I/We (PRINT): _____ (SIGN): _____
(if more than one person is objecting, use the reverse side to write relevant information)

Employer _____ Facility/Hospital _____ Department/Unit _____
Shift _____ Work Phone _____ Home Phone _____

hereby advise the Supervisor, _____, on behalf of myself/ourselves and other employees in the facility/hospital that I/we protest the assignment(s) described below which were made despite this objection on _____ (date), at _____ (time).

In my/our professional opinion, this assignment is unsafe because of (check appropriate items):

- Lack of training or experience in area assigned/being assigned to work in non-credentialed area
- Lack of adequate doctor staffing for acuity (short-staffed)/not following staffing guidelines
- Lack of adequate ancillary staffing (nurses, aides, etc.) for acuity (short-staffed)/not following staffing guidelines
- Excess case/work load
- Inappropriate or lack of acuity system
- Infectious patient(s) not properly identified/isolated
- Patient should be in a critical care unit with appropriate critical care staffing
- Unit is staffed with untrained and/or unqualified personnel
- New patients were transferred or admitted to unit without additional staff
- Inappropriate assignment for skill level
- Requested assistance from manager or supervisor and was denied
- Lack of or not properly working equipment/machinery/supplies
- Involuntarily forced to work beyond my/our scheduled hours
- Other (please specify) _____

Brief description of assignment and problem or a specific poor outcome/may identify by Room # (attach extra sheet if needed):

The assignment described above may be, in the professional opinion of the signer(s), unsafe and may place patients at risk. Since I/we could be disciplined for refusal to accept this assignment and because I/we do not wish to abandon the patient(s), I/we will, under protest, carry out this assignment to the best of my/our ability; knowing the facility/hospital will bear full responsibility for any adverse effects on the patient(s) stemming from this assignment. Because this assignment may be unsafe and inconsistent with quality patient care, I am submitting this ADO Form. Acting as patient advocate(s), the signer(s) request(s) that the facility/hospital take appropriate corrective action to insure that no employee or patient is placed in this situation in the future.

ADDITIONAL INFORMATION

Unit Census _____

Unit Capacity _____

Acuity: High Average Low

Case/work load: High Average Low

Patient Care Staffing Count:

	Regular Full Time	Regular Part Time	Per Diem Sessional/Hourly	Float (Transfer)	Agency/ Traveler
MDs					
Residents/ Interns/Fellows					
PAs					
Nurse Practitioners					
RNs					
LPNs					
CNAs					
Techs					

Was there a unit secretary on duty? Yes No

Number of treatments required for your assignment (for example, seclusion/restraints, meds, I.V.s, dressings) _____

Description of a poor patient outcome or missed treatments: _____

INSTRUCTIONS (please see other side for further important instructions)

- Complete this form as soon as possible upon receiving objectionable assignment but without interrupting your work or the care of the patient(s).
Make three (3) copies for distribution:
- (1) Give a copy to your immediate supervisor.
 - (2) Send a copy to Doctors Council SEIU at above address or fax number (212-481-4137).
 - (3) Keep a copy for your records. Keep this copy for a period of seven (7) years.

