Montana Nurses Association
20 Old Montana State Hwy
Clancy, MT 59634 (406) 442-6710
www.mtnurses.org

ASSIGNMENT DESPITE OBJECTION (ADO)

******You must notify your immediate supervisor of your concern when it arises. If the situation is not resolved, please complete this form*****

I, ________________________________ a Registered Nurse employed at Billings Clinic
(RN name)

in ______________ during ________________________ , on ________________________ hereby object to the assignment as:
(Department / Unit) *(shift)* *(Date of Occurrence)*

I am a: ☐ Staff RN ☐ Charge Nurse ☐ Float/Resource pool RN

Made to me by: ____ at ______________ on ______________________.
(Supervisor/Person in charge: Name/Title) *(time)* *(date)*

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

☐ **Charge nurse unable to perform CN duties,** secondary to increased patient care assignment	☐ **Patient care equipment missing or unusable**	☐ **This assignment poses a threat to my health or safety**
☐ **Inadequate RN to patient ratios** for patient acuity based on my clinical judgment	☐ **Necessary equipment is not available** e.g.: supplies, IVs medications availability	☐ **This assignment poses a serious threat to the health or safety of a patient under my direct care**
☐ **Insufficient support staff**, requires me to assume additional duties	☐ **Not trained or experienced** in area assigned	☐ **Multiple reassignments (floats) Indicate #:** ___________
☐ **Not provided with needed 1:1 sitter(s)**	☐ **(Other):**	

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

ACTIONS TAKEN BY NURSE*:

* Notified charge nurse of situation/needs? ☐YES / ☐ NO (N/A if RN's assigned role is CN)
* Notified Clinical Coordinator and/or manager: ☐ YES / ☐ NO (name/date/time)
* Notified Staffing office if additional resources needed? ☐YES / ☐ NO (name/date/time)

Patients assigned to me this shift: Shift start: _______Admits: ___________Discharges: _________Shift End:_______
Standard RN-to-patient ratio on this unit: ____

Briefly describe the problem(s), including any pertinent information about staffing, census, acuity, admits/transfers/discharges; use reverse side if additional space is needed:

____
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____
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__________________________ __________________________ __________________
(RN SIGNATURE) ***(PRINT NAME)*** ***(DATE)***

**You must notify the CN or immediate supervisor of your concern when it arises. If the situation is not resolved, it is then appropriate to complete this form. Incomplete forms cannot be accepted. Once entire form is complete, make two copies. Give one to your supervisor, send one to your MNA representative; keep the original for your records.*

MNA & Hospital Leadership Follow-up: ☐ Discussed at Conference committee; date: ________
☐ Response/follow-up with RN by supervisor; date: ___________ ☐ Response/follow-up with RN by MNA; date: ___________ ☐ FURTHER ACTION NEEDED (explain: ____)
ACTION Plan for situation ☐ 60 day follow up
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