

# REGISTERED NURSE/ LICENSED PRACTICAL NURSE\* APPLICATION REQUIREMENTS

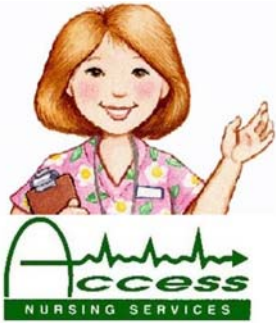
WALK IN APPLICATIONS      BEFORE 12 NOON

16 EAST 40 STREET 3RD FLOOR

BETWEEN MADISON & FIFTH AVENUE

DOCUMENTS MUST BE SUBMITTED PRIOR TO  
ORIENTATION FOR HIRE.

- ORIGINAL LICENSE/ CERTIFICATE
- COMPLETE PHYSICAL (RUBELLA/  
RUBEOLA, VARICELLA)
- DRUG SCREENING - LAB REPORT  
( LESS THAN 30 DAYS OLD)
- \*COLOR BLINDNESS TEST ( NOT  
LPN, NOT HOMECARE)
- 2 PROFESSIONAL REFERENCES
- MALPRACTICE 1MIL– 6 MIL
- UPDATED RESUME
- SOCIAL SECURITY CARD
- PICTURE ID
- 2 STEP NEGATIVE TB SCREENING
- IF TB POSITIVE– CHEST XRAY
- MIINIMUM 1-2 YEARS CRITICAL  
CARE WORK EXPERIENCE IN A  
HOSPITAL
- CPR CERTIFICATION
- HOMECARE NURSE MUST HAVE  
HOMECARE EXPERIENCE



We're glad you are interested in a position with Access Nursing Services of Maryland! We'd love to have you come in to apply.

You can apply in person at our Lutherville office located at 1407 York Road, Suite 306 in the Galleria Atrium Building at the intersection of York Road and Seminary Avenue, just north of 695 (Beltway) exit 26B.

Come **in uniform** any weekday between 9 a.m. and 3 p.m.

You'll need to bring:

- license from the Maryland Board of Nursing
- CPR card – must be current
- physical done within the last 12 months
- PPD done within the last 12 months. If you have your last 2, please bring both with you.
- 2 forms of ID (usually drivers license and social security card.)
- 2 – 3 letters of reference from current or former employers. If you don't have letters, please bring three names, addresses, phone numbers and if possible e-mail addresses and fax numbers so we can check work references quickly.

Helpful items to bring, if you have them:

- Completed CJIS background check if you have it.
- current American Red Cross First Aid Card (for nursing assistants and companions) if you have it

Please visit our website at [www.accessnursing.com](http://www.accessnursing.com) for more information about our company!

Thanks for choosing Access! We look forward to meeting you!

Access Nursing Services  
1407 York Road, Suite 306  
Lutherville, MD 21093  
(410)321-5560



# APPLICATION

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ SOCIAL SECURITY NO. \_\_\_\_\_  
 STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ APT \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
 OVER 18 E-MAIL ADDRESS \_\_\_\_\_ STARTING DATE \_\_\_\_\_ DAYS AVAILABLE (CIRCLE EACH) \_\_\_\_\_ YES NO  
 LICENSE/CERTIFICATE NUMBER \_\_\_\_\_ TYPE \_\_\_\_\_ STATE \_\_\_\_\_ EXPIRES \_\_\_\_\_ NAME ON LICENSE/CERTIFICATE \_\_\_\_\_ M T W T H F S S 7-3 3-11 11-7 12H 8H LIVE-IN \_\_\_\_\_  
 CAR AVAILABLE \_\_\_\_\_ YES  NO   
 DRIVERS LICENSE \_\_\_\_\_ YES  NO   
 CURRENTLY EMPLOYED \_\_\_\_\_ YES  NO   
 WORK FOR A TEMPORARY SERVICE BEFORE \_\_\_\_\_ YES  NO

REFERRAL SOURCES:  
 City News  Comm. News  Mailer  N/sg. Spec.  Internet  Friend  Other: \_\_\_\_\_

**EDUCATION**

NAME	ADDRESS	PHONE	DIPLOMA OR DEGREE	COURSE OF STUDY
HIGH SCHOOL				
NURSING SCHOOL				
COLLEGE OR TECHNICAL SCHOOL				

**EMPLOYMENT HISTORY (5 TO 7 YEARS)**

FROM	TO	EMPLOYER	ADDRESS	SUPERVISOR AND PHONE #	POSITION	WAGE	REASON FOR LEAVING	RESULTS OF CHECK

**FOR OFFICE USE ONLY** Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Please answer the below listed questions and sign and date your application

Have you ever been denied a bond? YES  NO   
 Have you ever been convicted of a crime? YES  NO   
 Have you had any previous involvement as a defendant in a professional malpractice litigation? YES  NO   
 Are you currently involved as a defendant in a professional malpractice litigation? YES  NO

INTERVIEWER'S SIGNATURE: \_\_\_\_\_ TITLE: \_\_\_\_\_  
 PERSONAL APPEARANCE: WELL DRESSED (EXCELL.), GOOD (GOOD), MODEST (AVERAGE), POOR (ILL AT EASE), GAUDY (AWKWD)  
 ATTIRE: WELL DRESSED (EXCELL.), GOOD (GOOD), MODEST (AVERAGE), POOR (ILL AT EASE), GAUDY (AWKWD)  
 MANNER: EXCELL., COURTEOUS (AVERAGE), FAIR (FAIR), POOR (POOR)  
 POISE: EXCELL., GOOD (AVERAGE), ILL AT EASE (ILL AT EASE), AWKWD (AWKWD)  
 VOICE: POOR ENGLISH (EXCELL.), TONE PLEASANT (COURTEOUS), SOFT (AVERAGE), HARSH (FAIR), IMPEDIMENT (POOR)  
 PERSONALITY: EXCELL., VERY LIKABLE (COURTEOUS), PLEASANT (AVERAGE), DULL (DULL)  
 ALERTNESS: ABOVE AVERAGE (EXCELL.), AVERAGE (VERY LIKABLE), SLOW (PLEASANT), DULL (AVERAGE), ROUGH (DULL)  
 ATTITUDE: ENTHUSIASTIC (EXCELL.), LIKES OUR ARRANGEMENT (VERY LIKABLE), NON-COMMITTAL (PLEASANT), DUBIOUS (AVERAGE), ANTAGONISTIC (DULL)

APPLICANT'S SIGNATURE \_\_\_\_\_ Date: \_\_\_\_\_  
 ALTERNATIVE CARE SYSTEMS, INC./ACCESS NURSING SERVICES is an equal opportunity employer. Federal law prohibits discrimination in employment practices because of race, religion, sex, age or national origin. No question in this application is asked for the purpose of limiting or excluding any applicant's consideration for employment because of his or her race, creed, color, national origin, sex, age, disability, marital status, sexual orientation or citizenship status.



## MEDICAL HISTORY QUESTIONNAIRE

The object of this form is to avoid assignment which may be injurious to health.

Name: \_\_\_\_\_  
(Last) (First)

SS#: \_\_\_\_\_ Title: \_\_\_\_\_ Branch: \_\_\_\_\_

Applying for Job as \_\_\_\_\_ Personal Physician \_\_\_\_\_

<b>Have you ever in the past 5 years...</b>	YES or NO	<b>If YES, Explain</b>
been operated on, been advised to have an operation, been a patient in hospital, sanitarium or institution?		
been seriously injured?		
been refused employment for health reasons OR been forced to give up a job because of health?		
received Workmen's Compensation?		
been rejected for military service for health reasons OR been discharged for health reasons?		
received a pension for disability?		
been refused insurance or driver's license for health reasons?		
Is there any reason you cannot wear a surgical mask for up to twelve (12) hours for infection control purposes?		
Do you need glasses/contacts to read? for distance?		
Have you ever worked with radioactive material?		
Have you ever had seizures or convulsions?		
Do you take medicine regularly?		
Have you ever injured your back?		
Have you ever worn a back brace or knee brace?		
Have you ever had a head injury?		
Do you ever use a hearing aid?		
Have you ever had a rupture, wear a truss?		
Have you ever had radiation therapy?		
Are you now or have you ever used habit forming drugs? (i.e., stimulants, depressants/narcotics)		
Are you now or have you ever had a problem with alcohol?		
<b>Have you ever had:</b>	YES or NO	<b>If YES, Explain</b>
Diabetes		
High Blood Pressure		
Tuberculosis		
Nervous Breakdown		
Heart Trouble		
Varicose Veins		
Arthritis		
Allergies		
<b>In the last 12 months have you...</b>	YES or NO	<b>If YES, Explain</b>
Been diagnosed with tuberculosis		
Taken care of a patient with active TB		
Lived in the same household with someone with active TB		
Had your PPD convert to positive		
Been on anti-tuberculosis medications		
Had a persistent cough with unexplained weight loss		

*The above statements are true to the best of my knowledge. Any misstatement of fact is grounds for release.*

\_\_\_\_\_  
 Date Signature of Applicant

Person to be Notified in Case of an Emergency: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Do not write below this line DATE OF LAST PHYSICAL EXAM

REMARKS:
Date _____ RN/MD SIGNATURE _____

# Employment Eligibility Verification

## INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

**Anti-Discrimination Notice.** It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

**Section 1 - Employee.** All employees, citizens and noncitizens, hired after November 6, 1986, must complete Section 1 of this form at the time of hire, which is the actual beginning of employment. **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

**Preparer/Translator Certification.** The Preparer/Translator Certification must be completed if Section 1 is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete Section 1 on his/her own. However, the employee must still sign Section 1 personally.

**Section 2 - Employer.** For the purpose of completing this form, the term "employer" includes those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors.

Employers must complete Section 2 by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, Section 2 must be completed at the time employment begins. **Employers must record: 1) document title; 2) issuing authority; 3) document number, 4) expiration date, if any; and 5) the date employment begins.** Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the I-9. **However, employers are still responsible for completing the I-9.**

**Section 3 - Updating and Reverification.** Employers must complete Section 3 when updating and/or reverifying the I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in Section 1. Employers **CANNOT** specify which document(s) they will accept from an employee.

- If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired or if a current employee's work authorization is about to expire (reverification), complete Block B and:

- examine any document that reflects that the employee is authorized to work in the U.S. (see List A or C),
- record the document title, document number and expiration date (if any) in Block C, and
- complete the signature block.

**Photocopying and Retaining Form I-9.** A blank I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed I-9s for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

**For more detailed information, you may refer to the Department of Homeland Security (DHS) Handbook for Employers, (Form M-274). You may obtain the handbook at your local U.S. Citizenship and Immigration Services (USCIS) office.**

**Privacy Act Notice.** The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of the U.S. Immigration and Customs Enforcement, Department of Labor and Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

**Reporting Burden.** We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: **1) learning about this form, 5 minutes; 2) completing the form, 5 minutes; and 3) assembling and filing (recordkeeping) the form, 5 minutes, for an average of 15 minutes per response.** If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., Washington, DC 20529. OMB No. 1615-0047

**NOTE:** This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

# Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. **ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Verification.** To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

**I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.**

I attest, under penalty of perjury, that I am (check one of the following):

- A citizen or national of the United States
- A Lawful Permanent Resident (Alien #) A \_\_\_\_\_
- An alien authorized to work until \_\_\_\_\_  
(Alien # or Admission #)

Employee's Signature	Date (month/day/year)
----------------------	-----------------------

**Preparer and/or Translator Certification.** (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	Date (month/day/year)

**Section 2. Employer Review and Verification.** To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____

**CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) \_\_\_\_\_ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name	Address (Street Name and Number, City, State, Zip Code)	Date (month/day/year)

**Section 3. Updating and Reverification.** To be completed and signed by employer.

A. New Name (if applicable)	B. Date of rehire (month/day/year) (if applicable)
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility. Document Title: _____ Document #: _____ Expiration Date (if any): _____	

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.**

Signature of Employer or Authorized Representative	Date (month/day/year)
--	-----------------------

## LISTS OF ACCEPTABLE DOCUMENTS

LIST A	LIST B	LIST C
<b>Documents that Establish Both Identity and Employment Eligibility</b>	<b>Documents that Establish Identity</b>	<b>Documents that Establish Employment Eligibility</b>
<ol style="list-style-type: none"> <li>1. U.S. Passport (unexpired or expired)</li> <li>2. Certificate of U.S. Citizenship (<i>Form N-560 or N-561</i>)</li> <li>3. Certificate of Naturalization (<i>Form N-550 or N-570</i>)</li> <li>4. Unexpired foreign passport, with <i>I-551 stamp</i> or attached <i>Form I-94</i> indicating unexpired employment authorization</li> <li>5. Permanent Resident Card or Alien Registration Receipt Card with photograph (<i>Form I-151 or I-551</i>)</li> <li>6. Unexpired Temporary Resident Card (<i>Form I-688</i>)</li> <li>7. Unexpired Employment Authorization Card (<i>Form I-688A</i>)</li> <li>8. Unexpired Reentry Permit (<i>Form I-327</i>)</li> <li>9. Unexpired Refugee Travel Document (<i>Form I-571</i>)</li> <li>10. Unexpired Employment Authorization Document issued by DHS that contains a photograph (<i>Form I-688B</i>)</li> </ol>	OR	<ol style="list-style-type: none"> <li>1. Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address</li> <li>2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> </ol> <p style="text-align: center; margin: 0;"><b>For persons under age 18 who are unable to present a document listed above:</b></p> <ol style="list-style-type: none"> <li>10. School record or report card</li> <li>11. Clinic, doctor or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>
	AND	<ol style="list-style-type: none"> <li>1. U.S. social security card issued by the Social Security Administration (<i>other than a card stating it is not valid for employment</i>)</li> <li>2. Certification of Birth Abroad issued by the Department of State (<i>Form FS-545 or Form DS-1350</i>)</li> <li>3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (<i>Form I-197</i>)</li> <li>6. ID Card for use of Resident Citizen in the United States (<i>Form I-179</i>)</li> <li>7. Unexpired employment authorization document issued by DHS (<i>other than those listed under List A</i>)</li> </ol>

**Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)**



## MEDICAL HISTORY QUESTIONNAIRE

The object of this form is to avoid assignment which may be injurious to health.

Name: \_\_\_\_\_  
(Last) (First)

SS#: \_\_\_\_\_ Title: \_\_\_\_\_ Branch: \_\_\_\_\_

Applying for Job as \_\_\_\_\_ Personal Physician \_\_\_\_\_

<b>Have you ever in the past 5 years...</b>	<b>YES or NO</b>	<b>If YES, Explain</b>
been operated on, been advised to have an operation, been a patient in hospital, sanitarium or institution?		
been seriously injured?		
been refused employment for health reasons OR been forced to give up a job because of health?		
received Workmen's Compensation?		
been rejected for military service for health reasons OR been discharged for health reasons?		
received a pension for disability?		
been refused insurance or driver's license for health reasons?		
Is there any reason you cannot wear a surgical mask for up to twelve (12) hours for infection control purposes?		
Do you need glasses/contacts to read? for distance?		
Have you ever worked with radioactive material?		
Have you ever had seizures or convulsions?		
Do you take medicine regularly?		
Have you ever injured your back?		
Have you ever worn a back brace or knee brace?		
Have you ever had a head injury?		
Do you ever use a hearing aid?		
Have you ever had a rupture, wear a truss?		
Have you ever had radiation therapy?		
Are you now or have you ever used habit forming drugs? (i.e., stimulants, depressants/narcotics)		
Are you now or have you ever had a problem with alcohol?		
<b>Have you ever had:</b>	<b>YES or NO</b>	<b>If YES, Explain</b>
Diabetes		
High Blood Pressure		
Tuberculosis		
Nervous Breakdown		
Heart Trouble		
Varicose Veins		
Arthritis		
Allergies		
<b>In the last 12 months have you...</b>	<b>YES or NO</b>	<b>If YES, Explain</b>
Been diagnosed with tuberculosis		
Taken care of a patient with active TB		
Lived in the same household with someone with active TB		
Had your PPD convert to positive		
Been on anti-tuberculosis medications		
Had a persistent cough with unexplained weight loss		

*The above statements are true to the best of my knowledge. Any misstatement of fact is grounds for release.*

\_\_\_\_\_  
 Date Signature of Applicant

Person to be Notified in Case of an Emergency: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Do not write below this line DATE OF LAST PHYSICAL EXAM

REMARKS:
Date _____ RN/MD SIGNATURE _____



## AUTHORIZATION FOR RELEASE OF INFORMATION

By execution of this document, I acknowledge that I have been informed by Access Nursing Services, Inc. that a criminal history check will be performed on my name. I have informed this agency of all name(s) (i.e. maiden, aliases) that I have used in the past. I understand that I have been employed on an emergency basis due to patient care needs, and that my employment and/or training are temporary pending the results of the criminal history check.

I have not been convicted of the following crimes:

- An offense under Section 125, Penal Law (murder)
- An offense under Section 135, Penal Law (kidnapping and false imprisonment)
- An offense under Section 130, Penal Law (indecent with a child)
- An offense under Section 135, Penal Law (agreement to abduct from custody)
- An offense under Section 130, Article 263 Penal Law (solicitation of a child)
- An offense under Section 260, Penal Law (endangerment of a child)
- An offense under Section 150, Penal Law (arson)
- An offense under Section 160, Penal Law (robbery)
- An offense under Section 120, Penal Law (assault)
- An offense under Section 220 and 221, Penal Law (sale, purchase or possession of controlled substances)

I also authorize Access Nursing Services, Inc., to conduct the following verifications

- Social Security number verification
- Employment verification
- Substance abuse testing

I acknowledge that if I am found to have been convicted of any other offense(s), that these offenses may also bar my employment or training.

I understand that all information obtained by this agency regarding my criminal history will remain confidential.

I certify that the information on this form contains no willful misrepresentation and that the information given is true and complete to the best of my knowledge.

Print name \_\_\_\_\_

Signature \_\_\_\_\_

Address \_\_\_\_\_

Social Security # \_\_\_\_\_

Date \_\_\_\_\_



## AUTHORIZATION FOR RELEASE OF INFORMATION

As part of my conditions of employment with Access Nursing Services, Inc., I authorize Access Nursing Services, Inc. or it's agents to conduct the following verifications:

- Criminal Check
- Pre-employment credit report
- Social Security number verification
- Education verification
- Employment verification
- Fingerprinting verification

Print name \_\_\_\_\_

Signature \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Social Security # \_\_\_\_\_

Date \_\_\_\_\_



FAX: NY (212) 682-8025  
FAX: NJ (201) 217-0231  
FAX: MD (410) 321-5565

## PRIOR EMPLOYEE REFERENCE CHECK

Job Title: \_\_\_\_\_  
Branch Loc.: \_\_\_\_\_

I hereby authorize my former employer(s) to release to *Access Nursing* any and all information, including, but not limited to, written documentation regarding my employment and termination with the company mentioned below.

Applicant Name: \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ SS#: \_\_\_\_\_

Date: \_\_\_\_\_ Applicant Signature: \_\_\_\_\_

Other Name Worked Under: \_\_\_\_\_

Company Name: \_\_\_\_\_

**TO BE  
COMPLETED  
BY  
APPLICANT**

Name of Reference: \_\_\_\_\_

Time Employed/Known From \_\_\_\_\_ To \_\_\_\_\_

Please check box:  
 Personal reference  
 Work reference

### TO BE COMPLETED BY EMPLOYER

We have maintained a reputation of excellent service because of our comprehensive personnel selection program which emphasizes thorough skill evaluation, in-depth interviewing and complete reference checks. To maintain these high standards, may we ask you to complete this evaluation of the former employee mentioned above? **We assure you that your answers will be held in strict confidence.**

Are dates correct? \_\_\_\_\_ If no: From \_\_\_\_\_ To \_\_\_\_\_

EMPLOYEE EVALUATION <small>Please Check</small>	EXCELLENT	ABOVE AVERAGE	ACCEPTABLE	UNSATISFACTORY
Attendance/Punctuality				
Ability to get along with others				
Quality of work				
Job knowledge				
Initiative				
Dependability				
Attitude				

Reason for leaving: \_\_\_\_\_

*Thank you for helping us supply the best in temporary help.*

Your Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

Your Title: \_\_\_\_\_ Date: \_\_\_\_\_

Your Company Name/Stamp: \_\_\_\_\_ Would You Re-Hire? Yes  No

Telephone: ( ) \_\_\_\_\_ Verified by \_\_\_\_\_ Date \_\_\_\_\_ Intl. \_\_\_\_\_

Fax: ( ) \_\_\_\_\_

**AFTER COMPLETING THIS FORM**

1. Turn form over and fold on dotted lines as indicated.      2. Staple or tape at bottom.      3. Mail to our office      4. Or Fax: To the correct number above.



FAX: NY (212) 682-8025  
FAX: NJ (201) 217-0231  
FAX: MD (410) 321-5565

## PRIOR EMPLOYEE REFERENCE CHECK

Job Title: \_\_\_\_\_  
Branch Loc.: \_\_\_\_\_

I hereby authorize my former employer(s) to release to *Access Nursing* any and all information, including, but not limited to, written documentation regarding my employment and termination with the company mentioned below.

Applicant Name: \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ SS#: \_\_\_\_\_

Date: \_\_\_\_\_ Applicant Signature: \_\_\_\_\_

Other Name Worked Under: \_\_\_\_\_

Company Name: \_\_\_\_\_

**TO BE  
COMPLETED  
BY  
APPLICANT**

Name of Reference: \_\_\_\_\_

Time Employed/Known From \_\_\_\_\_ To \_\_\_\_\_

Please check box:  
 Personal reference  
 Work reference

### TO BE COMPLETED BY EMPLOYER

We have maintained a reputation of excellent service because of our comprehensive personnel selection program which emphasizes thorough skill evaluation, in-depth interviewing and complete reference checks. To maintain these high standards, may we ask you to complete this evaluation of the former employee mentioned above? **We assure you that your answers will be held in strict confidence.**

Are dates correct? \_\_\_\_\_ If no: From \_\_\_\_\_ To \_\_\_\_\_

EMPLOYEE EVALUATION <small>Please Check</small>	EXCELLENT	ABOVE AVERAGE	ACCEPTABLE	UNSATISFACTORY
Attendance/Punctuality				
Ability to get along with others				
Quality of work				
Job knowledge				
Initiative				
Dependability				
Attitude				

Reason for leaving: \_\_\_\_\_

*Thank you for helping us supply the best in temporary help.*

Your Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

Your Title: \_\_\_\_\_ Date: \_\_\_\_\_

Your Company Name/Stamp: \_\_\_\_\_ Would You Re-Hire? Yes  No

Telephone: ( ) \_\_\_\_\_ Verified by \_\_\_\_\_ Date \_\_\_\_\_ Intl. \_\_\_\_\_

Fax: ( ) \_\_\_\_\_

**AFTER COMPLETING THIS FORM**

1. Turn form over and fold on dotted lines as indicated.      2. Staple or tape at bottom.      3. Mail to our office      4. Or Fax: To the correct number above.

# Self-Assessment Age Specific Criteria

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please check the box that most accurately describes your proficiency level in each category.

Key:

1. No Training or Experience
2. Some Experience or Classroom Training- No Experience
3. Performs Proficiently and Independently

CRITERIA	INFANT/ NEONATE BIRTH TO 1 YEAR			PEDIATRIC 1-11 YEARS			ADOLESCENT 12-17 YEARS			ADULT 18-65 YEARS			GERIATRIC OVER 65 YEARS		
	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
Applies growth and development criteria to nursing care															
Is familiar with normal ranges of vital signs for patients of all ages.															
Is familiar with standards of care for all ages based on psychosocial needs															
Includes patient's family in patient education and discharge planning.															
Completes assessment and develops plan of care that is age appropriate															
Assesses specific nutrition and elimination of patient															
Uses teaching methods that are age appropriate.															
Demonstrates communication skills that are age appropriate.															
Demonstrates safety measures that are age appropriate.															

Employee Signature: \_\_\_\_\_ Title: \_\_\_\_\_



# Form W-4 (2006)

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

**Exemption from withholding.** If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2006 expires February 16, 2007. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** You cannot claim exemption from withholding if (a) your income exceeds \$850 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-

earner/two-job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

**Head of household.** Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See line **E** below.

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax.

**Two earners/two jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

**Nonresident alien.** If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2006. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

**Recent name change?** If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 to initiate a name change and obtain a social security card showing your correct name.

## Personal Allowances Worksheet (Keep for your records.)

**A** Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . **A** \_\_\_\_\_

**B** Enter "1" if:   
 { • You are single and have only one job; or   
 • You are married, have only one job, and your spouse does not work; or   
 • Your wages from a second job or your spouse's wages (or the total of both) are \$1,000 or less. } . . . **B** \_\_\_\_\_

**C** Enter "1" for your **spouse**. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . **C** \_\_\_\_\_

**D** Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . **D** \_\_\_\_\_

**E** Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . . . **E** \_\_\_\_\_

**F** Enter "1" if you have at least \$1,500 of **child or dependent care expenses** for which you plan to claim a credit . . . **F** \_\_\_\_\_

**(Note.** Do not include child support payments. See **Pub. 503**, Child and Dependent Care Expenses, for details.)

**G Child Tax Credit** (including additional child tax credit):

- If your total income will be less than \$55,000 (\$82,000 if married), enter "2" for each eligible child.
- If your total income will be between \$55,000 and \$84,000 (\$82,000 and \$119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have four or more eligible children.

**H** Add lines A through G and enter total here. **(Note.** This may be different from the number of exemptions you claim on your tax return.) ► **H** \_\_\_\_\_

For accuracy, **complete all worksheets that apply.** {

- If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed \$35,000 (\$25,000 if married) see the **Two-Earner/Two-Job Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

Form <b>W-4</b>		<b>Employee's Withholding Allowance Certificate</b>		OMB No. 1545-0074
Department of the Treasury Internal Revenue Service		► <b>Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</b>		<b>2006</b>
1 Type or print your first name and middle initial.		Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <b>Note.</b> If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.		
City or town, state, and ZIP code		4 <b>If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a new card.</b> ► <input type="checkbox"/>		
5 Total number of allowances you are claiming (from line <b>H</b> above <b>or</b> from the applicable worksheet on page 2)		5		
6 Additional amount, if any, you want withheld from each paycheck		6		\$
7 I claim exemption from withholding for 2006, and I certify that I meet <b>both</b> of the following conditions for exemption. • Last year I had a right to a refund of <b>all</b> federal income tax withheld because I had <b>no</b> tax liability <b>and</b> • This year I expect a refund of <b>all</b> federal income tax withheld because I expect to have <b>no</b> tax liability. If you meet both conditions, write "Exempt" here . . . . . ► 7				
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.				
Employee's signature (Form is not valid unless you sign it.) ►		Date ►		
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)		10 Employer identification number (EIN)

**Deductions and Adjustments Worksheet**

**Note.** Use this worksheet *only* if you plan to itemize deductions, claim certain credits, or claim adjustments to income on your 2006 tax return.

- 1 Enter an estimate of your 2006 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2006, you may have to reduce your itemized deductions if your income is over \$150,500 (\$75,250 if married filing separately). See *Worksheet 3* in Pub. 919 for details.) . . . **1** \$ \_\_\_\_\_
- 2 Enter:  $\left\{ \begin{array}{l} \$10,300 \text{ if married filing jointly or qualifying widow(er)} \\ \$ 7,550 \text{ if head of household} \\ \$ 5,150 \text{ if single or married filing separately} \end{array} \right\}$  . . . . . **2** \$ \_\_\_\_\_
- 3 **Subtract** line 2 from line 1. If line 2 is greater than line 1, enter “-0-” . . . . . **3** \$ \_\_\_\_\_
- 4 Enter an estimate of your 2006 adjustments to income, including alimony, deductible IRA contributions, and student loan interest . . . . . **4** \$ \_\_\_\_\_
- 5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 7* in Pub. 919) . . . . . **5** \$ \_\_\_\_\_
- 6 Enter an estimate of your 2006 nonwage income (such as dividends or interest) . . . . . **6** \$ \_\_\_\_\_
- 7 **Subtract** line 6 from line 5. Enter the result, but not less than “-0-” . . . . . **7** \$ \_\_\_\_\_
- 8 **Divide** the amount on line 7 by \$3,300 and enter the result here. Drop any fraction . . . . . **8** \_\_\_\_\_
- 9 Enter the number from the **Personal Allowances Worksheet**, line H, page 1 . . . . . **9** \_\_\_\_\_
- 10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earner/Two-Job Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 . . . . . **10** \_\_\_\_\_

**Two-Earner/Two-Job Worksheet (See *Two earners/two jobs* on page 1.)**

**Note.** Use this worksheet *only* if the instructions under line H on page 1 direct you here.

- 1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) . . . . . **1** \_\_\_\_\_
- 2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here . . . . . **2** \_\_\_\_\_
- 3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter “-0-”) and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet . . . . . **3** \_\_\_\_\_

**Note.** If line 1 is *less than* line 2, enter “-0-” on Form W-4, line 5, page 1. Complete lines 4–9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.

- 4 Enter the number from line 2 of this worksheet . . . . . **4** \_\_\_\_\_
- 5 Enter the number from line 1 of this worksheet . . . . . **5** \_\_\_\_\_
- 6 **Subtract** line 5 from line 4 . . . . . **6** \_\_\_\_\_
- 7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . . **7** \$ \_\_\_\_\_
- 8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . . . . **8** \$ \_\_\_\_\_
- 9 Divide line 8 by the number of pay periods remaining in 2006. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2005. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . **9** \$ \_\_\_\_\_

**Table 1: Two-Earner/Two-Job Worksheet**

Married Filing Jointly				All Others					
If wages from <b>HIGHEST</b> paying job are—	AND, wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>HIGHEST</b> paying job are—	AND, wages from <b>LOWEST</b> paying job are—	Enter on line 2 above	If wages from <b>LOWEST</b> paying job are—	Enter on line 2 above		
\$0 - \$42,000	\$0 - \$4,500	0	\$42,001 and over	32,001 - 38,000	6	\$0 - \$6,000	0		
	4,501 - 9,000	1		38,001 - 46,000	7	6,001 - 12,000	1		
	9,001 - 18,000	2		46,001 - 55,000	8	12,001 - 19,000	2		
	18,001 and over	3		55,001 - 60,000	9	19,001 - 26,000	3		
				60,001 - 65,000	10	26,001 - 35,000	4		
65,001 - 75,000				11	35,001 - 50,000	5			
\$42,001 and over	0	3		75,001 - 95,000	12	50,001 - 65,000	6		
				95,001 - 105,000	13	65,001 - 80,000	7		
				105,001 - 120,000	14	80,001 - 90,000	8		
				120,001 and over	15	90,001 - 120,000	9	120,001 and over	10

**Table 2: Two-Earner/Two-Job Worksheet**

Married Filing Jointly		All Others	
If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above	If wages from <b>HIGHEST</b> paying job are—	Enter on line 7 above
\$0 - \$60,000	\$500	\$0 - \$30,000	\$500
60,001 - 115,000	830	30,001 - 75,000	830
115,001 - 165,000	920	75,001 - 145,000	920
165,001 - 290,000	1,090	145,001 - 330,000	1,090
290,001 and over	1,160	330,001 and over	1,160

**Privacy Act and Paperwork Reduction Act Notice.** We ask for the information on this form to carry out the Internal Revenue laws of the United States. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may also subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, and the District of Columbia for use in administering their tax laws, and using it in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

You are not required to provide the information requested on a form that is subject to



Name: \_\_\_\_\_  
Date: \_\_\_\_\_

## POSTPARTUM SKILLS EVALUATION CHECKLIST

This self evaluation is for assessing your experience in specific clinical areas. This self evaluation will not be a determining factor in accepting your application to become an employee of Access Nursing Services.

**1 = No Experience 2 = Limited Experience 3 = Experienced 4 = Highly Skilled**

MEDS/ IV THERAPY	1	2	3	4	INTRAPARTUM PHASE CONT.	1	2	3	4
Administer PO Medications					<b>External Monitor:</b>				
Administer IM and SQ Medications					Tocotransducer				
Peripheral IV Insertion					Ultrasound				
Administer IV Medications					Status of Membranes				
Mix IV Infusion w/Additives					Fetoscope				
Use of Heparin/Saline Locks					Doppler Ultrasound				
Needle-less Systems					Internal Monitor				
<b>Administer/Monitor IV Infusions</b>					Variability/ Reactivity				
Oxytocin Induction/Augmentation					Decelerations-Early, Late, Variable				
Magnesium SO4 Therapy					Pelvimetry				
Labor Suppressants-Ritordine					Assessment for Deep Reflexes				
Antibiotics					Assessment for Clonus				
Heparin					Assessment for Edema				
Discontinue Peripheral IV's					Insert Straight/ Foley Catheter				
Administer Blood/Blood Products					<b>Bedside Clinical Testing</b>				
Draw Blood for Lab Studies					Urine Dipstick				
Vital Sign Monitoring					Blood Glucose Monitoring				
<b>Pulse Oximetry:</b>					<b>PARENT/ INFANT BOND</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Setup					Foster Parent/Infant Bonding				
Ongoing Monitoring					Assist/ Instruct Breastfeeding				
<b>ANTE/INTRAPARTUM</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	Assist/ Instruct Bottle-feeding				
<b>Care of Patient With:</b>					Discharge Teaching				
Pregnancy-induced HTN									
Pre-eclampsia and Eclampsia					<b>POSTPARTUM PHASE</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Multiple Gestation					Postpartum Assessment				
Placenta Previa					Fundus Consistency/Location				
Abruptio Placenta					Initiate Fundal Massage PRN				
Malpresentations					Lochia				
Premature Labor					Bladder Distention				
Diabetes Mellitus					Insert Straight Cath/Foley Cath				
Cardiac Disease					Provide/Instruct Perineal Care				
Asthma					Episiotomy Care				
Infectious Disease					Apply Ice to Perineum				
Hemorrhage					C-Section Incision Care				
Pyelonephritis					Assess Homan's Sign				
Cystitis					Manage Post Partum Pain				
Sickle Cell Disease					RhoGam Administration				
Rh Incompatibilities					Rubella Vaccine				
Oxytocin Challenge Test					<b>Initiate Post-Anesthesia Care:</b>				
<b>INTRAPARTUM PHASE</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	Spinal				
Contraction Characteristics					Epidural				
Determine Fetal Position					General				
Status of Membranes									
Fetoscope									
Doppler Ultrasound									
Intake and Output									

I certify the above to be true and accurate. Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Name: \_\_\_\_\_  
Date: \_\_\_\_\_

## PEDIATRIC SKILLS EVALUATION CHECKLIST

This self evaluation is for assessing your experience in specific clinical areas. This self evaluation will not be a determining factor in accepting your application to become an employee of Access Nursing Services.

**1 = No Experience 2 = Limited Experience 3 = Experienced 4 = Highly Skilled**

NURSING PROCESS	1	2	3	4	RESPIRATORY PATIENTS	1	2	3	4
Nursing History					Oxygen Therapy				
Physical Assessment					Suctioning Techniques				
Nursing Care Plans					Naso-pharyngeal				
Systems Charting					Oro-pharyngeal				
Discharge Planning					Endotracheal				
Patient/Family Education					Tracheostomy Care				
MED ADMINISTRATION	1	2	3	4	MECHANICAL VENTILATION	1	2	3	4
Oral					Incentive Spirometry				
Intramuscular					Pleurevac				
Subcutaneous					Nebulizer				
Z Track					Insertion of Oral Airway				
Secondary Meds- IV					Ambu Bag				
Heparin Lock					<b>SPECIAL NURSING PROC.</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
IV Bolus					Ostomy Care				
Intravenous Solutions					Decubitus Care				
IV Pumps: Type: _____					Enteral Feedings				
Admin of Blood/ Blood Products					Seizure Precautions				
Blood Warmer					Cast Care				
Hyperalimentation					Restraints				
Chemotherapy					Traction				
Multi-Lumen Central Venous Line					Bucks				
ISOLATION TECHNIQUES	1	2	3	4	PELVIC	1	2	3	4
Reverse					Pin Care				
Respiratory					Nasogastric Tube				
Wound and Skin					Foley Catheter				
Strict					Foley Catheter Insertion- Male				
<b>DIABETIC PATIENTS</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	Foley Catheter Insertion- Female				
Urine Testing					PEG Tube Care				
Fingerstick Monitoring					CBI- Continuous Bladder Irrigat				
Insulin Therapy					<b>SPECIAL DEVICES</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Insulin Pump					Enteral Feeding Pump				
S/S DKA					Hypothermia Blanket				
S/S Diabetic Coma					Portable Oxygen Tank				
SURGICAL PATIENTS	1	2	3	4	ADDITIONAL SKILLS	1	2	3	4
Preoperative Care					IV Insertion- peripheral				
Postoperative Care					PICC Certification				
Sterile Dressings					Other: _____				
JP Drains									
Hemovac Drains									
Packing wound									
Conscious Sedation									
CARDIAC PATIENTS	1	2	3	4					
Apical Pulse									
Recording 12 Lead EKG									
Basic Arrhythmia Interpretation									
PALS									
CPR									

I certify the above to be true and accurate. Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Name: \_\_\_\_\_  
 Date: \_\_\_\_\_

## PEDIATRIC CRITICAL CARE SKILLS EVALUATION CHECKLIST

This self evaluation is for assessing your experience in specific clinical areas. This self evaluation will not be a determining factor in accepting your application to become an employee of Access Nursing Services.

**1 = No Experience 2 = Limited Experience 3 = Experienced 4 = Highly Skilled**

RESPIRATORY	1	2	3	4	CARDIAC	1	2	3	4
Assessment of Breath Sounds					Assessment of Heart Sounds				
Administer O2 (NC, Mask)					Use of Cardiac Monitors				
Assist with Intubation					Identify Lethal Dysrhythmias				
Ventilate with Ambu Bag					Able to perform:				
Suctioning					Cardioversion				
Use of ETT CO2 detectors					Defibrillation				
Assist with Extubation					Member of Code Team				
Bear Cub/HFV Ventilators					Run Code				
Servo/MA-2 Ventilators					Titrate Drugs				
Weaning Patient from Ventilator					Insert and set up-				
Extubation					Arterial Line				
Troubleshoot Ventilator Problems					Central Venous Catheter				
Pulse Oximetry					Care of Open Heart Surg Patient				
Perform Arterial Blood Gases					Emergency Med Administration:				
Assist with Chest Tube Insertion					Atropine				
Assist with Thoracentesis					Bicarbonate				
Assist with Bronchoscopy					Epinephrine				
Assess Respiratory Complications					Management of Drips:				
<b>NURSING PROCESS</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	Bretyllium				
Nursing History					Dopamine				
Physical Assessment					Insulin				
Nursing Care Plans					Lidocaine				
Systems Charting					Amiodarone				
Discharge Planning/Referrals					Obtain Blood Samples ;				
Patient/Family Education					Arterial Blood Gases				
Function as Primary Nurse					Mixed Venous Gases				
<b>ISOLATION TECHNIQUES</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	Placement of 12 Lead for EKG				
Respiratory					<b>INTRAVENOUS THERAPY</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Wound and Skin					PICC Certified				
Strict					IV Access using:				
<b>SURGICAL PATIENTS</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	Angiocath				
Preoperative Care					Butterfly				
Postoperative Care					CVP				
Dressings					TPN				
<b>RENAL</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	Admin of blood/blood products				
Catheterization					Heparin/saline lock				
Irrigation of Foley					Hickman and Broviac catheters				
CAVD/ CVVHD					<b>PROCEDURES</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Peritoneal Dialysis					Neonatal Eye Prophylaxis				
<b>NEUROLOGIC</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	Med Infuser Uses				
Neurologic Assessment					Vitamin K Administration				
Assisting with Lumbar Puncture					NIBP- PICU				
ICP Monitoring					Tube Feeding				
Assembly of Equipment					Umb Artery Line Setup/Insertion				
Care of Patient					Umb Artery Line Blood Sampling				
Hyper/Hypothermia					Glucometer				
Perform Adv. Neuro Assessment					NG Tube Insertion				
Recognition of Complications					Identaband: Issues and Applies				

I certify the above to be true and accurate. Signature: \_\_\_\_\_ Date: \_\_\_\_\_







Name: \_\_\_\_\_

Date: \_\_\_\_\_

## NEONATAL ICU SKILLS EVALUATION CHECKLIST

This self evaluation is for assessing your experience in specific clinical areas. This self evaluation will not be a determining factor in accepting your application to become an employee of Access Nursing Services.

**1 = No Experience 2 = Limited Experience 3 = Experienced 4 = Highly Skilled**

ADMISSION/ASSESSMENT	1	2	3	4	MEDS/ IV THERAPY	1	2	3	4
Maternal History					Eye Prophylaxis				
Gestational Age					Vitamin K				
Apgar Scoring					Immunizations				
Attend High Risk Delivery					Calculation of Neonatal Doses				
Collect Cord Blood Samples					Knowledge of Routine Neonatal Drugs				
Dextrostix					Knowledge of Emerg. Neonatal Drugs				
Urine Output					Administer IM Meds				
Weight Scale/ Bed Scales					Peripheral IV Insertion				
Identifying Infant					Scalp IV Insertion				
Preparation for Transport					PICC Line Insertion				
Interfacility Emergency Transport					Heparin/Saline Locks				
<b>Initial Physical Assessment:</b>					Needleless Systems				
Anomalies					Administer IV Medications				
Resp Status/ Breath Sounds					Mix IV Infusion w/ Additives				
Suction					Discontinue Peripheral IV's				
Assist with Intubation					Administer Blood/Blood Products				
Apical Pulse					Exchange Transfusion				
Blood Pressure					Central Hyperalimentation				
Skin Care/Cord Care					Peripheral Hyperalimentation				
<b>Thermoregulation</b>					<b>Administer/Monitor IV Infusions:</b>				
Use of Isolette (Incubator)					IV Pump				
Use of Radiant Warmer					Syringe Pump				
Temperature					<b>NUTRITION</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>MEDS/ IV THERAPY</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	Calculate Basic Requirement				
Draw Venous Blood					Assessment of Suck/Swallow				
<b>Access/Care:</b>					Assist/Instruct Breastfeeding				
PICC Line					Collection/Storage of Breast Milk				
Midline					Assist/Instruct Bottle-feeding				
Central Line					Gavage Feedings				
Portacath					<b>METABOLIC/INFECTIOUS</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Percutaneous Arterial Line					Interpretation of Lab Results				
Umbilical Artery/ Venous Line					Isolation Techniques				
<b>GENITOURINARY</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>Care of Neonate with:</b>				
Insertion of Foley Cath					Hepatitis Surface Antigen				
Collect Urine Specimen Bag/Cath					HIV Positive Mother				
Urine Bedside Testing (pH, Sp Gr)					DIC				
<b>Care of Neonate With:</b>					Diabetic Mother (IDM)				
Peritoneal Dialysis					Hypo/Hyperglycemia				
Circumcision					Phototherapy for Jaundice				
Urostomy					<b>GASTROINTESTINAL</b>				
Disorders of External Organs					Assess Bowel Sounds				
Malformation of GU Tract/Kidneys					Assess Abdominal Girth				
Acute Renal Failure					Stool Test				
Congenital Hip Dysplasia					Nasogastric Tube Insertion and Care				
<b>SURGICAL PATIENTS</b>					Gastrostomy Tube				
Preoperative Care					Reflux Precautions				
Postoperative Care									
Dressings									

<b>GASTROINTESTINAL CONT.</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>NEUROLOGICAL</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>Care of the Neonate With:</b>					Assess Neurological Status				
Cleft Lip/Cleft Palate					Assess Hearing of Neonate				
Colostomy/Ileostomy					Assess Eyes of Neonate				
Gastroschisis/ Omphalocele					Asses Pain				
GI Bleeding					Assist with Lumbar Puncture				
Bowel Obstruction					<b>Care of the Neonate With:</b>				
Necrotizing Enterocolitis					Sedation				
Inguinal Hernia					Seizures				
Post-Abdominal Surgery					Chemical Addiction/Withdrawal				
Tracheoesophageal Fistula (TEF)					Hydrocephalus				
Feeding Dysfunction					Spina Bifida				
Small for Gestational Age					Meningitis				
Large for Gestational Age					Increased Intracranial Pressure				
					Intracranial Pressure Monitor				
<b>PULMONARY</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	Externalized VP Shunt/Reservoir				
Respiratory Status/Breath Sounds					Brain Death/ Organ Procurement				
Pulse Oximetry					Intracranial Hemorrhage				
Respiratory/Apnea Monitor									
Assist with Intubation/Extubation					<b>CARDIOVASCULAR</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Obtain ABGs (heelstick/arterial line)					Cardiac/ Respiratory Monitor				
Interpretation of ABGs					Assessment of Pulses				
Evaluation of X-Ray Reports					Assessment of Perfusion				
Suctioning (nasal, Oral, Trach)					Assessment of Heart Sounds/Murmurs				
Chest Physiotherapy					Blood Pressure-Doppler				
Assist Chest Tube Insertion/Removal					Blood Pressure- Arterial Line				
<b>Use of Oxygen With:</b>					EKG Interpretation				
Mask and Bag					Defibrillation/Cardioversion				
Hood					Invasive Hemodynamic Monitoring				
Isolette					<b>Care of the Neonate With:</b>				
CPAP to Cannula					Congenital Heart Disease/Defects				
Oxygen to Analyzer					Cardiomyopathy				
Transcutaneous Monitoring					Post Cardiac Surgery				
<b>Care of Neonate With:</b>					Cardiac Transplant				
Apnea					Cardiac Arrest				
Ventilator (CPAP/PEEP/IMV/.Jet Vent)					Shock- Cardiogenic				
Meconium Aspiration					Shock- Hypovolemic				
Bronchopulmonary Dysplasia (BPD)					Shock- Septic				
Respiratory Distress Syndrome (RDS)									
Chest Tubes					<b>MISCELLANEOUS</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
ECMO- Extracorporeal Memb. Oxygenation					Foster Parenting/Infant Bonding				
Persistent Pulmonary Hypertension					Consents- Procedural/Treatment				
Diaphragmatic Hernia					Consents- Immunization				
					Bereavement/ Postmortem Care				

I certify the above to be true and accurate. Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Name: \_\_\_\_\_

Date: \_\_\_\_\_

## MEDICAL SURGICAL SKILLS EVALUATION CHECKLIST

This self evaluation is for assessing your experience in specific clinical areas. This self evaluation will not be a determining factor in accepting your application to become an employee of Access Nursing Services.

**1 = No Experience 2 = Limited Experience 3 = Experienced 4 = Highly Skilled**

NURSING PROCESS	1	2	3	4	GENTOURINARY (GU)	1	2	3	4
Nursing History					Obtain Clean Catch Urine				
Physical Assessment					Suprapubic Cath Care				
Nursing Care Plans					Nephrostomy Tube Care				
Systems Charting					GU/Foley Irrigations				
Discharge Patients					CBI- Cont Bladder Irrigation				
Patient/Family Education					Intake and Output Measurement				
Admit and Orient Patients					Care of Patients With:				
Supervise Unlicensed Personnel					Shunts and Fistulas				
Pulse Oximetry					Renal Failure				
Vital Sign Monitoring					Nephrectomy				
Urine Dipstick					Renal Transplant				
Wound Care/Debridement					Hemodialysis				
Dressing Changes					Peritoneal Dialysis				
Wound Drains (JP/Hemovac)					Hysterectomy				
Positions/Transferring					Prostate Surgery				
Restraints					GASTROINTESTINAL	1	2	3	4
Isolations Techniques					Assess Bowel Sounds				
Advanced Directives					Assess GI Distress/ Bleeding				
Preoperative Care					Insertion/ Monitoring NG Tube				
Postoperative Care					Tube Feedings via Flexible Tubes				
Diabetic Teaching/Care					Gastrostomy Tube Monitor/ Feed				
Post Mortem Care					Colostomy Care				
ORTHOPEDICS	1	2	3	4	Enemas				
Crutch Walking					Care of the Patient With:				
Cast Care					GI Bleed				
Traction					Wound Dehiscence				
Total Joint Replacement					Abdominal Wounds				
CARDIAC	1	2	3	4	Drains				
Apply Cardiac Monitor					NEUROLOGY	1	2	3	4
Basic Arrhythmia Interpretation					Neuro Assessment/ Vital Signs				
Perform 12 Lead EKG					Glasgow Coma Scale				
Assist with Code					Assist with Lumbar Puncture				
Defibrillation/Cardioversion					Seizure Precautions				
Cardiac Arrest/CPR					Care of the Patient With:				
Arterial Lines					Open/Closed Head Injury				
Central Venous Pressure Lines					CVA				
RESPIRATORY	1	2	3	4	Spinal Cord Injury				
Establish/Maintain Airway					Craniotomy				
Use of Supplemental Oxygen:					Delirium Tremens (DT's)				
Nasal Cannula					VASCULAR	1	2	3	4
Venti Masks					Draw Blood for Lab Studies				
Ventilators					Admin of Blood/Blood Products				
Chest Tubes					Hyperalimentation/TPN				
Pleurevac					Central Venous Lines (CVL's)				
Suctioning					CVLS Dressing Change				
Assessment of Lung Sounds					Hickman/Broviac Catheters				
Chest Percussion					Assess for Edema/Fluid Overload				
GENTOURINARY (GU)	1	2	3	4	Peripheral Pulses				
Insert Straight/Foley Cath- Female					Insertion of Peripheral IV Line				
Insert Straight/Foley Cath- Male					Maintain IV Fluids/ IV Pumps				

I certify the above to be true and accurate. Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Name: \_\_\_\_\_  
Date: \_\_\_\_\_

## LABOR AND DELIVERY SKILLS EVALUATION CHECKLIST

This self evaluation is for assessing your experience in specific clinical areas. This self evaluation will not be a determining factor in accepting your application to become an employee of Access Nursing Services.

**1 = No Experience 2 = Limited Experience 3 = Experienced 4 = Highly Skilled**

MEDS/ IV THERAPY	1	2	3	4	INTRAPARTUM PHASE CONT.	1	2	3	4
Administer PO Medications					<b>External Monitor:</b>				
Administer IM and SQ Medications					Tocotransducer				
Peripheral IV Insertion					Ultrasound				
Administer IV Medications					Status of Membranes				
Mix IV Infusion w/Additives					Fetoscope				
Use of Heparin/Saline Locks					Doppler Ultrasound				
Needle-less Systems					Internal Monitor				
<b>Administer/Monitor IV Infusions</b>					Variability/ Reactivity				
Oxytocin Induction/Augmentation					Decelerations-Early, Late, Variable				
Magnesium SO4 Therapy					Pelvimetry				
Labor Suppressants-Ritordine					Assessment for Deep Reflexes				
Antibiotics					Assessment for Clonus				
Heparin					<b>Bedside Clinical Testing:</b>				
Discontinue Peripheral IV's					Urine Dipstick				
Administer Blood/Blood Products					Blood Glucose Monitoring				
Draw Blood for Lab Studies					<b>INTERVENTIONS DURING LABOR</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Vital Sign Monitoring					Physical Comfort Measures				
<b>Pulse Oximetry:</b>					Emotional Support				
Setup					Coach Psycholprophyactic Breathing				
Ongoing Monitoring					Coach Psycholprophyactic Relaxation				
<b>ANTE/INTRAPARTUM</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	Support, Guide, Labor Coach PRN				
<b>Care of Patient With:</b>					Change Woman's Position PRN				
Pregnancy-induced HTN					Perineal Prep				
Pre-eclampsia and Eclampsia					Care After Rupture of Membranes				
Multiple Gestation					Monitor After Rupture of Membranes				
Placenta Previa					<b>Vaginal Exam:</b>				
Abruptio Placenta					Assess Dilation				
Malpresentations					Assess Effacement				
Premature Labor					Assess Station				
Diabetes Mellitus					Assess Presentation				
Cardiac Disease					<b>L &amp; D INTERVENTIONS</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Asthma					Spontaneous Vaginal Delivery				
Infectious Disease					Forceps Vaginal Delivery				
Hemorrhage					Caesarean Section				
Pyelonephritis					Labor Room Delivery				
Cystitis					General Anesthesia Monitoring				
Sickle Cell Disease					Epidural Anesthesia Monitoring				
Rh Incompatibilities					Spinal Anesthesia Monitoring				
Oxytocin Challenge Test					Local Infiltration (Preparation)				
<b>INTRAPARTUM PHASE</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	Suction Infant Post Delivery				
Contraction Characteristics					Examine Newborn Resp Status				
Determine Fetal Position					Adult CPR				
Status of Membranes					Neonatal Resuscitation				
Fetoscope					<b>Identify Infant:</b>				
Doppler Ultrasound					Bracelet				
Intake and Output					Footprints				
Assessment for Edema					Mother's Bands				
Insert Straight/ Foley Catheter					Eye Prophylaxis				





Name: \_\_\_\_\_

Date: \_\_\_\_\_

## EMERGENCY ROOM SKILLS EVALUATION CHECKLIST

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**1 = No Experience 2 = Limited Experience 3 = Experienced 4 = Highly Skilled**

RESPIRATORY	1	2	3	4	INTRAVENOUS THERAPY	1	2	3	4
Assessment of Breath Sounds					Management of Drips:				
Administer O2 (NC, Mask)					Bretyllium				
Assist with Intubation					Dopamine				
Ventilate with Ambu Bag					Insulin				
Suctioning- Oral					Lidocaine				
Suctioning- ET; Trach					Nipride				
Assist with Extubation					Dobutrex				
Troubleshoot Ventilator Problems					Pronestyl				
Pulse Oximetry					Primacor				
Perform Arterial Blood Gases					Nitroglycerin				
Assist with Chest Tube Insertion					TPA				
Assist with Thoracentesis					Streptokinase				
Assist with Bronchoscopy					Amiodarone				
Assist with Cricothyroid Airway					IV Pumps: _____				
Assess Respiratory Complications					Insertion of Peripheral IV				
RENAL/GU	1	2	3	4	PICC Certified				
Care of Patient With:					IV Access/blood specimen using:				
Acute Renal Failure					Butterfly				
Chronic Renal Failure					Central Line				
Hemodialysis					Porta Cath				
Peritoneal Dialysis					PICC				
Septic Shock					Admin of Blood/Blood Products				
Renal Transplant					<b>CARDIAC</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Insertion of Foley Catheter					Assessment of Heart Sounds				
Continuous Bladder Irrigation					Use of Cardiac Monitors				
Suprapubic Catheter					Identify Lethal Dysrhythmias				
NEUROLOGIC	1	2	3	4	Able to perform:				
Care of the Patient with:					Cardioversion				
Head Injury					Defibrillation				
Spinal Cord Injury					Member of Code Team				
Cerebral Aneurysm					Run Code				
Seizures					Titrate Drugs				
Increased ICP Management					Insert and set up-				
Perform Adv. Neuro Assessment					Arterial Line				
Recognition of Complications					Central Venous Catheter				
GENERAL	1	2	3	4	Assist with Open Chest Procedure				
Care of the Patient With:					Emergency Med Administration:				
Chest Injury					Atropine				
Hemo/Pneumo					Bicarbonate				
Burns					Epinephrine				
DT's					Placement of 12 Lead for EKG				
ARDS/COPD					Prepare for PTCA				
Pulmonary Edema					Apply External Pacemaker				
Lung Transplant					<b>NURSING ASSESSMENT</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Acute MI					Triage				
CHF					Fast Track				
Thoracic Surgery					Pediatrics				
Overdose					Crisis Management				

I certify the above to be true and accurate. Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Name: \_\_\_\_\_

Date: \_\_\_\_\_

### CRITICAL CARE/TELEMETRY SKILLS EVALUATION CHECKLIST

This self evaluation is for assessing your experience in specific clinical areas. This self evaluation will not be a determining factor in accepting your application to become an employee of Access Nursing Services.

**1 = No Experience 2 = Limited Experience 3 = Experienced 4 = Highly Skilled**

RESPIRATORY	1	2	3	4	NEURO CONT.	1	2	3	4
Assessment of Breath Sounds					Halo Traction/Cervical Tongs				
Administer O2 (NC, Mask)					Ventriculostomy				
Assist with Intubation					Epidural Med. Administration				
Ventilate with Ambu Bag					Increased ICP Management				
Suctioning					Perform Adv. Neuro Assessment				
Use of ETT CO2 detectors					Recognition of Complications				
Assist with Extubation					Use of Specialty Beds				
Use of Pressure Ventilators					<b>CARDIAC</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
Use of Volume Ventilators					Assessment of Heart Sounds				
Weaning Patient from Ventilator					Use of Cardiac Monitors				
Use of IMV					Identify Lethal Dysrhythmias				
Use of CPAP					Able to perform:				
Use of PEEP					Cardioversion				
Use of Blow By					Defibrillation				
Use of Assist Control					Member of Code Team				
Use of Pressure Support					Run Code				
Use of Hi Freq Jet Ventilation					Titrate Drugs				
Troubleshoot Ventilator Problems					Insert and set up-				
Pulse Oximetry					Arterial Line				
Perform Arterial Blood Gases					Central Venous Catheter				
Assist with Chest Tube Insertion					Assist with Open Chest Procedure				
Assist with Thoracentesis					Care of Heart Transplant Patient				
Assist with Bronchoscopy					Care Open Heart Surgery Patient				
Assist with Cricothyroid Airway					Care of Patient with:				
Assess Respiratory Complications					Angina				
Care of the Patient With:					CHF				
Chest Injury					Femoral Popliteal Bypass				
Hemo/Pneumo					Abdominal Aortic Aneurysm				
Tracheostomy					Acute MI				
ECM					Permanent Pacemaker				
ARDS					External Pacemaker				
Pulmonary Edema					Transthoracic Pacemaker				
Lung Transplant					Transvenous Pacemaker				
COPD					Emergency Med Administration:				
<b>RENAL</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	Atropine				
Care of Patient With:					Bicarbonate				
Acute Renal Failure					Epinephrine				
Chronic Renal Failure					Management of Drips:				
Hemodialysis					Bretyllium				
Peritoneal Dialysis					Dopamine				
Septic Shock					Insulin				
Renal Transplant					Lidocaine				
<b>NEUROLOGIC</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	Amiodarone				
Care of the Patient with:					Obtain Blood Samples ;				
Head Injury					Arterial Blood Gases				
Spinal Cord Injury					Mixed Venous Gases				
Cerebral Aneurysm					Placement of 12 Lead for EKG				
Seizures					Prepare for PTCA				

I certify the above to be true and accurate. Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Name: \_\_\_\_\_

Date: \_\_\_\_\_

## PSYCHIATRIC SKILLS EVALUATION CHECKLIST

This self evaluation is for assessing your experience in specific clinical areas. This self evaluation will not be a determining factor in accepting your application to become an employee of Access Nursing Services.

**1 = No Experience 2 = Limited Experience 3 = Experienced 4 = Highly Skilled**

NURSING PROCESS	1	2	3	4	PSYCHOTROPIC MEDS	1	2	3	4
Nursing History					Buprenex IM/SL				
Physical Assessment					Clonidine				
Nursing Care Plans					Clonipin				
Systems Charting					Librium				
Discharge Planning					Methadone				
Patient/Family Education					Respirdol				
MED ADMINISTRATION	1	2	3	4	Haldol				
Oral					Anti-Psychotics				
Intramuscular					Anti-Depressants				
Subcutaneous					<b>SPECIAL NURSING PROC.</b>	1	2	3	4
Z Track					Ostomy Care				
Secondary Meds- IV					Decubitus Care				
Heparin Lock					Enteral Feedings				
IV Bolus					Seizure Precautions				
Intravenous Solutions					Cast Care				
IV Pumps:					Restraints				
Type: _____					Traction				
Admin of Blood/ Blood Products					Bucks				
Blood Warmer					Pelvic				
Hyperalimentionation					Pin Care				
Chemotherapy					Nasogastric Tube				
Multi-Lumen Central Venous Line					Foley Catheter				
ISOLATION TECHNIQUES	1	2	3	4	Foley Catheter Insertion-. Male				
Reverse					Foley Catheter Insertion- Female				
Respiratory					PEG Tube Care				
Wound and Skin					CBI- Continuous Bladder Irrigat				
Strict					J Tube				
DIABETIC PATIENTS	1	2	3	4	Cantor Tube				
Urine Testing					<b>SPECIAL DEVICES</b>	1	2	3	4
Fingerstick Monitoring					Clinitron Bed				
Insulin Therapy					Enteral Feeding Pump				
Insulin Pump					Hypothermia Blanket				
S/S DKA					Portable Oxygen Tank				
S/S Diabetic Coma					Gomco Suction				
SURGICAL PATIENTS	1	2	3	4	Hypothermia Blanket				
Preoperative Care					CPM- Cont. Passive Motion				
Postoperative Care					<b>INSERTION TECHNIQUES</b>	1	2	3	4
Sterile Dressings					IV Insertion- peripheral				
JP Drains					PICC Certification				
Hemovac Drains					Other: _____				
Packing wound					<b>MENTAL HEALTH SKILLS</b>	1	2	3	4
Conscious Sedation					Family Intervention				
CARDIAC PATIENTS	1	2	3	4	Crisis Intervention				
Apical Pulse					Group Therapy				
Recording 12 Lead EKG					Behavior Therapy				
Basic Arrhythmia Interpretation					Occupational Therapy				
Defibrillator Testing					Milieu Management				
CPR					Co-Facilitate Group				

I certify the above to be true and accurate. Signature: \_\_\_\_\_ Date: \_\_\_\_\_