

NAME: _____ RN Therapist Other _____

At Home Quality Care

PERSONAL

Name _____ Preferred Name _____ Social Security # _____

Date of Birth _____ Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Alternate Phone Number _____ Work Phone Number _____

What other home care/nursing services are you registered with? _____ Transportation _____

Do you have a valid Driver's License? Yes No How did you learn about us? _____

Classification	SCHOOL	NAME AND CITY	YEARS ATTENDED	GRADUATED	DEGREE AWARDED
RN				<input type="checkbox"/> YES <input type="checkbox"/> NO	
LPN				<input type="checkbox"/> YES <input type="checkbox"/> NO	
BSN				<input type="checkbox"/> YES <input type="checkbox"/> NO	
MSN				<input type="checkbox"/> YES <input type="checkbox"/> NO	
Other				<input type="checkbox"/> YES <input type="checkbox"/> NO	

NURSING EDUCATION (please list all)

PROFESSIONAL REFERENCES (List the names of two Licensed Nurses; exclude relatives)

Name	Address	Telephone Number

WORK HISTORY

1. Name _____ Phone _____ Address _____ Job Title _____ Salary _____ Your work name if different _____ Dates Worked: From _____ To _____ Hrs/Wk _____ Supervisor _____ Shift _____ Duties _____ Reason for leaving _____	3. Name _____ Phone _____ Address _____ Job Title _____ Salary _____ Your work name if different _____ Dates Worked: From _____ To _____ Hrs/Wk _____ Supervisor _____ Shift _____ Duties _____ Reason for leaving _____
2. Name _____ Phone _____ Address _____ Job Title _____ Salary _____ Your work name if different _____ Dates Worked: From _____ To _____ Hrs/Wk _____ Supervisor _____ Shift _____ Duties _____ Reason for leaving _____	4. Name _____ Phone _____ Address _____ Job Title _____ Salary _____ Your work name if different _____ Dates Worked: From _____ To _____ Hrs/Wk _____ Supervisor _____ Shift _____ Duties _____ Reason for leaving _____

Please explain any gaps in employment _____

First day available for work _____ Number of hours desired per week _____

At Home Quality Care

Please read and sign below.

ACKNOWLEDGEMENT (Please read carefully and sign.)

I hereby authorize and request each former employer and person, firm or corporation given as reference to answer all questions that may be asked and give all information that may be sought concerning me or my work habits, character, or skills. I also understand that in connection with my application for employment with the Company, At Home Quality Care, Inc. may conduct a criminal background investigation and that my employment with the Company, may be contingent on the results of such investigation. I agree, in consideration of your employing me, that I will not seek or accept employment, either directly or indirectly in any capacity from any client of At Home Quality Care, Inc. to whom I have been assigned, for at least 90 working days after the last day of that assignment. I further understand that I cannot be paid until I present a time slip signed by both the client and myself to the At Home Quality Care, Inc. office. I am willing to submit to a physical examination, including the analysis for the detection of the use of unlawful drugs or substances in accordance with applicable laws.

I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.

Applicant Signature

Date

All persons shall have the opportunity to be considered for employment without regard to their race, color, religion, national origin or ancestry, age, disability, sex, marital status, liability for service in the armed forces of the United States, citizenship, or any other characteristic protected by law.

AT HOME QUALITY CARE

RN COMPETENCY ASSESSMENT and SKILLS CHECKLIST

Nurse's Name: _____

Date: _____

Self-Assessment

AHQC Documentation

Unable to Perform	Need Training	Need Refresher	Able to Perform		Date Completed	Method	Initials
				Clinical Performance			
				Infusion Pumps: Includes pump operations, troubleshooting, pt/cg teaching and cleaning.			
				AIM PLUS			
				Body Guard 323			
				CADD PCA			
				CADD Prizm			
				CURLIN			
				DELTEC 3000			
				Eclipse			
				Gravity Infusion/Dial-a-Flow			
				Sigma			
				Syringe Pump (BARD 300 XL, Graseby, Excelsior)			
				Line Maintenance and Therapy			
				Central Line Dressing Change			
				Implanted Ports			
				Lab Procedures/Draw Volumes/Tube Types/Handling			
				Peripheral IV Start/Restart			
				PICC			
				Subcutaneous Device			
				TPN/Lipids			
				Tunneled Catheter			
				Venipuncture for Lab Draws			
Method Key	(O) Observation	(Dis) Discussion	(RD) Return Demo				

I have completed the above self-assessment and skills checklist review and attest that the information is accurate.

Nurse's Signature: _____, RN

Date: _____

Social Security Number _____

I acknowledge that _____, RN has completed the above self-assessment and skills checklist review.

Proctor's Signature: _____, RN

Date: _____

Identify Initials with signature:

1. _____ 2. _____ 3. _____