



**Corporate Office**  
6305 Elysian Fields Ave, Suite 400  
New Orleans, LA 70122  
Phone: 504 283-3767 / 800 715-5553  
Fax: 504 283-6004 / 866 283-6004

**APPLICATION FOR EMPLOYMENT**

Please fill out application in its entirety

Date \_\_\_\_\_

Date available \_\_\_\_\_

Classification \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_

Pager # \_\_\_\_\_

Alt Phone # \_\_\_\_\_

E-Mail \_\_\_\_\_

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

Date of Birth \_\_\_\_\_

Citizenship \_\_\_\_\_

Place of Birth \_\_\_\_\_

Education                      Name and Address                      Yr. Graduated                      Type of Degree

Nursing/Tech School \_\_\_\_\_

University/ Other \_\_\_\_\_

**Nursing Applicants only:**

Specialty: 1) \_\_\_\_\_ Years Exp. \_\_\_\_\_

2) \_\_\_\_\_ Years Exp. \_\_\_\_\_

3) \_\_\_\_\_ Years Exp. \_\_\_\_\_

Critical Care Course \_\_\_\_\_ Date \_\_\_\_\_

Related Courses/Certification (i.e. Chemotherapy, EKG, Balloon, Pump, etc) \_\_\_\_\_

**Physical, Respiratory & Occupational Therapists Applicants only:**

Certified \_\_\_\_\_ Registered \_\_\_\_\_

Physical Therapist Applicants **ONLY**: Professional Certification/ Registration No. and Expiration Dates (PT)

\_\_\_\_\_

Respiratory Therapist Applicants **ONLY**: What month and year did you pass Certification/ Registration exams?

\_\_\_\_\_

Occupational Therapist Applicants **ONLY**: Professional Certification/ Registration No. and Expiration Dates (OT)

\_\_\_\_\_

**All applicants:**

1) Professional License No. \_\_\_\_\_ State \_\_\_\_\_ Exp. \_\_\_\_\_

2) Professional License No. \_\_\_\_\_ State \_\_\_\_\_ Exp. \_\_\_\_\_

3) Professional License No. \_\_\_\_\_ State \_\_\_\_\_ Exp. \_\_\_\_\_

<u>Certification</u>	<u>Date Received</u>	<u>Expiration Date</u>
CPR	_____	_____
ACLS	_____	_____
PALS/ NALS	_____	_____
BCLS	_____	_____

Additional specialty courses taken:

<u>Course</u>	<u>Date</u>
_____	_____
_____	_____
_____	_____

List of additional education, skills, experience, or other relevant qualifications below: \_\_\_\_\_

List any professional organizations of which you are a member: \_\_\_\_\_

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**Work History: *most recent job first***

Hospital/ Facility \_\_\_\_\_  
Immediate Supervisor \_\_\_\_\_ Supervisor's Shift \_\_\_\_\_  
Address \_\_\_\_\_ Dept./Unit/ Floor \_\_\_\_\_  
City/ State/ Province/ Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Position held \_\_\_\_\_ Date Employed: From \_\_\_\_\_ To \_\_\_\_\_  
Specialty \_\_\_\_\_ Charge Experience \_\_\_\_\_  
Number of Beds \_\_\_\_\_ Reason for Leaving \_\_\_\_\_  
Type of Nursing (Primary, ect.) \_\_\_\_\_ Was this a travel assignment? Yes \_\_\_\_\_ No \_\_\_\_\_

Hospital/ Facility \_\_\_\_\_  
Immediate Supervisor \_\_\_\_\_ Supervisor's Shift \_\_\_\_\_  
Address \_\_\_\_\_ Dept./Unit/ Floor \_\_\_\_\_  
City/ State/ Province/ Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Position held \_\_\_\_\_ Date Employed: From \_\_\_\_\_ To \_\_\_\_\_  
Specialty \_\_\_\_\_ Charge Experience \_\_\_\_\_  
Number of Beds \_\_\_\_\_ Reason for Leaving \_\_\_\_\_  
Type of Nursing (Primary, ect.) \_\_\_\_\_ Was this a travel assignment? Yes \_\_\_\_\_ No \_\_\_\_\_

Hospital/ Facility \_\_\_\_\_  
Immediate Supervisor \_\_\_\_\_ Supervisor's Shift \_\_\_\_\_  
Address \_\_\_\_\_ Dept./Unit/ Floor \_\_\_\_\_  
City/ State/ Province/ Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Position held \_\_\_\_\_ Date Employed: From \_\_\_\_\_ To \_\_\_\_\_  
Specialty \_\_\_\_\_ Charge Experience \_\_\_\_\_  
Number of Beds \_\_\_\_\_ Reason for Leaving \_\_\_\_\_  
Type of Nursing (Primary, ect.) \_\_\_\_\_ Was this a travel assignment? Yes \_\_\_\_\_ No \_\_\_\_\_

Hospital/ Facility \_\_\_\_\_  
Immediate Supervisor \_\_\_\_\_ Supervisor's Shift \_\_\_\_\_  
Address \_\_\_\_\_ Dept./Unit/ Floor \_\_\_\_\_  
City/ State/ Province/ Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Position held \_\_\_\_\_ Date Employed: From \_\_\_\_\_ To \_\_\_\_\_  
Specialty \_\_\_\_\_ Charge Experience \_\_\_\_\_  
Number of Beds \_\_\_\_\_ Reason for Leaving \_\_\_\_\_  
Type of Nursing (Primary, ect.) \_\_\_\_\_ Was this a travel assignment? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you eligible for rehire at all of your previous employment positions: Yes No

If no, please attach sheet with explanation.

**Professional References:** *Must be knowledgeable of or have supervised your work performance.*

Relation: \_\_\_\_\_ Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/ State/ Zip: \_\_\_\_\_

Relation: \_\_\_\_\_ Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/ State/ Zip: \_\_\_\_\_

Relation: \_\_\_\_\_ Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/ State/ Zip: \_\_\_\_\_

Referred to Medi-Lend by: \_\_\_\_\_

Have you ever been convicted of a crime? Yes No

If yes, please attach sheet with explanation.

Has your nursing license ever been suspended or under investigation? Yes No

If yes, please attach sheet with explanation.

Have you ever terminated from a travel assignment? Yes No

If yes, please attach sheet with explanation.

Have you ever broken a travel contract? Yes No

If yes, please attach sheet with explanation

In case of an emergency, notify:

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_

I verify that the above information is true and correct. Any falsification will be reported to the appropriate authorities, and will be the basis for termination of employment. I do hereby give on to all whom I have referenced to give a full accounting of my work performance and history. I do authorize the information of my previous, current and, future positions to be included in the agency's Quality Assurance Database and the use in QA activities. I understand that refusal by any party to provide said information may result in denial of offer of employment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# **Medi-Lend Nursing Services, Inc.**

## CORPORATE OFFICE

6305 ELYSIAN FIELDS, STE. 400  
NEW ORLEANS, LA 70122  
PHONE: 504-283-3767 / 800-715-5553  
FAX: 504-283-6004 / 866-283-6004

## **JOB DESCRIPTION**

### **TITLE:**

Licensed Practical Nurse

### **DEFINITION:**

The Medi-Lend Nursing Services, Inc. Licensed Practical Nurse is a highly qualified professional health care provider. The LPN assists the professional nurse in providing nursing care and related assistance in accordance with the approved standards of care.

### **QUALIFICATIONS:**

1. Current annual CPR
2. Current state L.P.N. license
3. Per diem nurses: **A minimum of five (3) years recent post graduate work experience in the area you wish to seek assignment**
4. Contracted nurses: **A minimum of five (5) years recent post-graduate work experience. A minimum of: 1) thirteen (13) weeks duration 2) Thirty-two (32) hours per week**
5. Score at least **93%** on pharmacology and unit specific tests
6. Annual physical including VDRL, TB exam, Measles, Mumps, Rubella, Rubeola, Vercicella Titer, Hep B, HAA
7. Certificate of continuing education in specialty areas
8. Copies of all continuing education classes taken within the past twenty-four (24) months
9. ACLS, CCRN, NALS for related specialties
10. JACH requirements, i.e., fire and safety, etc.
11. Three (3) high quality references, (2) recommendations
12. Graduate of an accredited school of nursing
13. Citizen of the United States or show federally approved identification

## **DUTIES AND RESPONSIBILITIES**

1. To provide nursing care which will meet the needs of the patient, in compliance with the physicians orders and the established standards of nursing practice
2. Document pertinent observations and information related to the patient's clinical condition. Maintain effective communications regarding patient care.
3. Maintain accurate records of nursing observations and care provided. Document patients response to medications and treatments.
4. Provide leadership. Acts as a role model.
5. Participates in team conferences, and serves on Nursing Committee when requested.
6. Assists the physician with procedures and treatments.
7. Performs treatment and administers medications according to physicians orders, and hospital policy.
8. Initiates and/or participates in CPR and Codes when necessary.
9. Maintain order, safety and strict control of narcotics.
10. Assists in planning and initiation of patient education.
11. Attends and supports Inservice Education Programs. Keeps abreast of current trends in nursing. Maintains skills and licensures.
12. Performs related duties as assigned.

I HAVE READ THE ABOVE JOB DESCRIPTION AND PLEDGE PERFORMANCE AS INDICATED.

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MLNS ADMINISTRATION

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APPLICANT

# Medi-Lend Nursing Services, Inc.

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## MEDICAL HISTORY

Please fill out in its entirety.

_____	_____	_____	_____
Name	Gender	Age	
	/ /	/ /	
	DOB	Date	
1.)	Have you had or presently have any of the following: (Please put a check on the line of any applicable item)		
_____	Epilepsy / Seizures	_____	Frequent or Severe
Headaches	_____		
_____	Dizziness or Fainting Spells	_____	Frequent Trouble Sleeping
_____	Depression or Excessive Worry	_____	Recent Gain / Loss in
Weight			
_____	Ulcer of Stomach Trouble	_____	Rupture
Problems	_____		Ear, Nose or, Throat
_____	Eye / Vision Problems	_____	
_____	Asthma or Chronic Sinusitis	_____	Hay Fever
_____	Shortness of Breath	_____	Chronic or Frequent Colds
_____	Tuberculosis	_____	Chronic Cough
_____	Rheumatic Fever	_____	Chicken Pox
_____	Hepatitis	_____	Diphtheria
_____	Jaundice	_____	Veneral Disease
_____	Arthritis or Rheumatism	_____	Lameness
_____	Cramps in Legs	_____	Back Trouble
_____	Heart Trouble	_____	High or Low Blood Pressure
_____	Appendicitis	_____	Thyroid or Goiter Trouble
_____	Kidney Trouble	_____	Severe Tooth or Gum
Trouble			
_____	Gall Bladder Trouble	_____	Gall Stones
_____	Allergies to Medication	_____	Any reaction to Serum Drugs
_____	Diabetes	_____	Other:
_____			

### For Females Only:

Have you ever had or presently have any of the following:

_____	High Risk Pregnancy
_____	Menstrual Disturbances
_____	Menstrual Disorders
_____	Severe Menstrual Pain

2.) Have you ever been injured? \_\_\_\_\_ If so, explain. \_\_\_\_\_

3.) Have you had any operations in the past three years? \_\_\_\_\_ If so, explain. \_\_\_\_\_

4.) Are you presently taking any medication? \_\_\_\_\_ If so, explain. \_\_\_\_\_

5.) Are you presently under any form of medical treatment? \_\_\_\_\_ If so, explain. \_\_\_\_\_

6.) Approximate the number of days missed from work due to illness within the past three years. \_\_\_\_\_

\_\_\_\_\_ For what type(s) of illness(es)? \_\_\_\_\_

I certify that the information above is true and complete to the best of my knowledge.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

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## PHYSICIAN'S STATEMENT

Name	Sex	Age
Date of Examination	Address	

NORMAL	CLINICAL EVALUATION	ABNORMAL	DESCRIBE ABNORMALITIES
_____	Head / Scalp, Face, Neck	_____	_____
_____	Nose, Sinuses	_____	_____
_____	Mouth, Throat	_____	_____
_____	Ear (general), Drums	_____	_____
_____	Eyes (general)	_____	_____
_____	Lungs, Chests, Breast	_____	_____
_____	Heart	_____	_____
_____	Abdomen and Viscera	_____	_____
_____	Upper Extremities	_____	_____
_____	Lower Extremities	_____	_____
_____	Spine	_____	_____
_____	Skin Lymphatic	_____	_____
_____	Neurologic	_____	_____

### MEASUREMENTS AND OTHER FINDINGS

Weight	Temperature	Build:
Height	Pulse	Slender
Eye Color	Blood Pressure	Medium
Hair Color	Respiration	Heavy
		Obese
Chest X-Ray	date ___/___/___	result _____
TB Skin Test	date ___/___/___	result _____
*Rubella titer	date ___/___/___	result _____
*Measles titer	date ___/___/___	result _____
*Varicella titer	date ___/___/___	result _____
*HAA	date ___/___/___	result _____

\*Required for those working in: Neo-natal, Nursery, Pediatric and Labor & Delivery environments.

**The above named patient has been examined by me and found to be in good physical and mental health, free from any back problems, free from any communicable disease, and able to function as an RN / LPN at full capacity.**

Physician's Signature	Date
Physician's Name	License #
Address	Phone

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## JCAHO REQUIREMENTS

### Hospital Specific

Infection Control

Hospital Safety

- Hazardous waste
- Internal disaster
- External disaster
- Fire safety

Electrical Safety

Body Mechanics

In-service: “ Suspected Adverse Drug Reactions and Interactions”

### Nursing Specific

Electrical Safety for Nurses

Use of Defibrillator, Cardiac Monitors

Suction Machines, IVAC Thermometer

The IMED PUMP, the Dinamap

The Pleur-evac

Oxygen Use in Nursing

- wall O<sub>2</sub>
- tanks
- masks
- cannula
- tents, oxyhoods

I certify that the above stated JCAHO requirements were met through classroom attendance and pamphlet distribution for the period of \_\_\_\_\_, 20\_\_\_\_ through \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Trilby A. Barnes, RNC  
President / CEO  
Medi-Lend Nursing Services, Inc.  
New Orleans, Louisiana

\_\_\_\_\_  
Employee signature

\_\_\_\_\_  
Employee Name (please print)

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### **HEPATITIS B FORM**

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

I hereby certify that Medi-Lend Nursing Services, Inc. has informed me of the following and authorize for Medi-Lend Nursing Services to receive any and all of my medical, physical and lab information.

1. OSHA Guidelines regarding Hepatitis B Vaccinations
2. In-service on Blood-borne Pathogens Exposure control plan, including receipt and review of the following:
  - A. All about Universal Precautions
  - B. All about Infection Control
  - C. All about Hazardous Materials
3. Information on Hepatitis B vaccination and where I can receive the vaccination.

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Signature \_\_\_\_\_

I hereby certify that the below checked statement is true of my status regarding Hepatitis B vaccinations:

\_\_\_\_\_ I understand that I may be at risk of acquiring Hepatitis B Virus (HBV) infections. I have been given the opportunity to receive the Hepatitis B Vaccination but have chosen to decline it at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring HBV infections through occupational exposure to blood or other potentially infectious materials. I also understand that if I may decide to receive the Hepatitis B Vaccination, Medi-Lend Nursing Services, Inc. will refer me to a proper source.

\_\_\_\_\_ Medi-Lend Nursing Services, Inc. has informed me of the location(s) where I can receive the Hepatitis B Vaccination series. I agree to have the vaccines and will provide Medi-Lend Nursing Services, Inc. with the dates and locations of each vaccination, which will be documented below.

#### **Date**

#### **Location**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**"ERS" CLIENT ORDER FORM**

PHONE: 504-366-5060

FAX: 504-366-0073

**Medi-Lend Nursing Services, Inc.**

Company Account #: L108

Contact: Erica Legaux

Telephone: 504-283-3767

FAX: 504-283-6004

Applicant \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

**STANDARD REPORTS**

(Use a separate form for each applicant. Refer to ERS Manual for complete report description)

- \_\_\_\_\_ MVR Report State \_\_\_\_\_ Driver's License # \_\_\_\_\_
- \_\_\_\_\_ Worker's Compensation State \_\_\_\_\_
- \_\_\_\_\_ Civil History Report – Circle Type Simple (1) Expanded (2) Due Diligence (3)
- \_\_\_\_\_ Education Verification
- \_\_\_\_\_ Previous Employment
- \_\_\_\_\_ Credit Report
- \_\_\_\_\_ Social Security Search
- \_\_\_\_\_ Federal Court Report – Circle Type Bankruptcy (1) Civil (2) Criminal (3)
- \_\_\_\_\_ Criminal History Report – Circle Type Simple (1) Expanded (2) Due Diligence (3)
- \_\_\_\_\_ Personal References
- \_\_\_\_\_ Professional License Verification Profession \_\_\_\_\_  
State \_\_\_\_\_ License # \_\_\_\_\_

Indicate area(s) to be checked. If unmarked, ERS will use best judgment based on the application information provided.

City State Zip Code

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Fax Reports ( ) Yes ( ) No Call before faxing ( ) Yes ( ) No

Verbals ( ) Yes ( ) No Mail Hardcopy ( ) Yes ( ) No

## PLEASE READ CAREFULLY

### APPLICANT AUTHORIZATION AND CONSENT FOR RELEASE OF INFORMATION

We truly welcome your application with *Medi-Lend Nursing Services*. We are proud that our success is the result of the quality and caliber of our employees. You are applying for a position whose acceptance will place you in a category of recognized professionals. In pursuit of that excellence we require, as a condition of employment, and/or continued employment, that all applicants consent to and authorize a pre-employment verification of the background information submitted on their application or resume.

I, the undersigned applicant, do hereby certify that the information provided by me for the purpose of employment is true and complete to the best of my knowledge. I understand that if I am employed any false statements will be considered as cause for possible dismissal.

This release and authorization acknowledges that *Medi-Lend Nursing Services* may now, or at any time while you are employed, administer a personality profile. This profile includes the following: verification of your education, previous employment history, credit history, criminal history record which may be in the files of any Federal, State, or local criminal justice agency in any state, motor vehicle records, worker's compensation from the Department of Labor and/or the Worker's Compensation Commission. *Medi-Lend Nursing Services* will also contact personal references, require that you provide a urine specimen to be tested for the presence of drugs or alcohol, and receive any and/or other information as deemed necessary to fulfill the job requirements. In conformance with the Americans Disabilities Act, I acknowledge by my signature \_\_\_\_\_ that I have been offered a position, contingent upon a satisfactory background investigation, and therefore, workers compensation information obtained from the Department of Labor and/or the Worker's Compensation Commission is hereby authorized. If blank, the obtaining of worker's compensation information is not authorized. The results of this verification process will be used to determine employment eligibility under *Medi-Lend Nursing Services* employment policies.

I authorize **Employment Research Services**, and any of its agents designated by *Medi-Lend Nursing Services* Personnel, to disclose orally and in writing the results of this verification process and/or interview to the designated authorized representatives of *Medi-Lend Nursing Services*.

I have read and understand this release and consent, and I authorize the background verification. I authorize persons, schools, current and former employers, and other organizations and agencies to provide *Employment Research Services* with all information that may be requested, and I hereby release all of the persons and agencies providing such information from any and all claims and damages connected with their release of any requested information. I agree that any copy of this document is as valid as the original.

I do hereby agree to forever release and discharge *Medi-Lend Nursing Services*, our agent, *Employment Research Services*, and their associated to the full extent permitted by law from any claims, damages, losses, liabilities, costs and expenses, or any other charge or complaint filed with any agency arising from the retrieving and reporting of information. According to the Federal Fair Credit Reporting Act, I am entitled to know if employment was denied based on information obtained by my prospective employer, and to receive, upon written request, a disclosure of the public record information and of the nature and scope of the investigative report.

APPLICANT:

\_\_\_\_\_  
Name Printed: Last (Maiden), First

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Drivers License Number                      State

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Client Number

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RECOMMENDATION SHEET

Name \_\_\_\_\_

Please print or type

Position held and unit worked \_\_\_\_\_

How long? \_\_\_\_\_

Would you allow this person to come back? \_\_\_\_\_

Knowledge of grief management \_\_\_\_\_

Knowledge of Critical Care assessment \_\_\_\_\_

Knowledge of unit equipment and monitors \_\_\_\_\_

IV Therapy skills \_\_\_\_\_

Ability to work with staff and physicians \_\_\_\_\_

Ability to work independently and efficiently \_\_\_\_\_

Helpful to co-workers \_\_\_\_\_

Leadership ability \_\_\_\_\_

Neatness \_\_\_\_\_

Timeliness \_\_\_\_\_

Attitude \_\_\_\_\_

Excessive ill calls \_\_\_\_\_

Professionalism \_\_\_\_\_

Charge experience \_\_\_\_\_

Operative experience \_\_\_\_\_

Supervisory experience \_\_\_\_\_

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

## **A Medi-Lend Nurse**

The following policies are discussed with each nurse prior to commencement employment.

A Medi-Lend Nurse must meet all standards below

- a. Graduate of an accredited school of nursing
- b. Current professional license for the state of employment
- c. A minimum of 2 years clinical experience in the last 2 years in the area in which one expects to work
- d. Current CPR card
- e. Excellent health
- f. Satisfactory reference from last two employers
- g. Citizen of the USA or show federally approved identification

Identification badge must be worn at all times

Nursing care assignments shall commensurate with qualifications

Nursing documentation reflects the policies and procedures of the Nursing Service/Unit/Department

Use the proper chain of command to refer all problems and/or questions while on duty

Nurses are instructed to report to the nursing office to sign in unless otherwise specified

Follow the dress code of client hospital (NO CLOGS!!)

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### **REFERENCE CHECK**

Applicant's name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Position applied for \_\_\_\_\_

Name of previous employer \_\_\_\_\_

Address \_\_\_\_\_

City, State \_\_\_\_\_ Zip code \_\_\_\_\_ Phone # \_\_\_\_\_

I give my permission to the above employer to furnish information on my performance while in their employment to Medi-Lend Nursing Services, Inc.

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

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### **TO BE COMPLETED BY EMPLOYER** (Please mail to the above address or fax to 866-283-6004 Attn: Erica)

Dates of employment From \_\_\_\_\_ To \_\_\_\_\_

Position held \_\_\_\_\_

Did the above applicant resign from this position? \_\_\_\_\_ If so, was proper notice given? \_\_\_\_\_

Is the applicant eligible for rehire? \_\_\_\_\_ If not, why? \_\_\_\_\_

Was the above applicant terminated from this position? \_\_\_\_\_ If so, what was the reason for termination? \_\_\_\_\_

#### Characteristics

	EXCELLENT	GOOD	FAIR	POOR
Appearance	_____	_____	_____	_____
Attitude	_____	_____	_____	_____
Dependability	_____	_____	_____	_____
Initiative	_____	_____	_____	_____
Quality of work	_____	_____	_____	_____
Quantity of work	_____	_____	_____	_____
Skill level	_____	_____	_____	_____

Additional Comments \_\_\_\_\_

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE READ CAREFULLY**

I certify that all of the above information is true to the best of knowledge. I understand that false or misleading information or omissions in this application shall result in ineligibility for employment and/or immediate dismissal. I authorize Medi-Lend Nursing Services, Inc., its agents, and employees to investigate all statements made in this application. Medi-Lend Nursing Services, Inc. also has the authority to contact former employers, educational institutions, licensing agencies, and any other institutions, persons or agencies. I hereby authorize Medi-Lend Nursing Services, Inc., its agents, and employees, and said herein before-identified organizations and persons to release any and all records, documents, and information pertaining to such inquiries. I further hereby release all of said parties from any liability or responsibility in connection therewith. I agree that my references and/or a copy of my application and other personal information may be disclosed to an authorized representative from a client hospital or institution of Medi-Lend Nursing Services, Inc. as required by JCAHO.

Title VII of the Civil Rights Act of 1964 prohibits discrimination in employment because of race, color, religion, sex or national origin. Federal law prohibits discrimination on the basis of age with respect to certain individuals. Medi-Lend Nursing Services, Inc. is an equal opportunity employer.

I have read, understand, and willingly agree to the above statements and provisions.

APPLICANT:

\_\_\_\_\_  
Name Printed: Last (Maiden), First

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Drivers License Number                      State

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Client Number



# Medical Surgical Skills Check List

A = Able to perform without any supervision  
 B = Perform infrequently (would require some supervision)  
 C = No Experience

	A	B	C
<b>Care of Patient With:</b>			
cancer (all phases)			
diabetes (all stages)			
peritoneal dialysis			
liver disease			
endocrine disease			
cardiovascular disease			
renal disease			
gastrointestinal disease			
respiratory disease			
vascular disease			
Hemodialysis			
thyroid crisis			
GI bleeds			
ENT disease/surgery			
D.T.'s			
overdose			
suicidal tendencies			
burns - major			
burns - minor			
skin breakdown			
skin disorders			
paraplegia			
quadraplegia			
thoracis surgery			
pre/post cardiac angiogram			
craniotomy			
carotid endarterectomy			
GI surgery			
abdominal surgery			
vascular surgery			
renal surgery			

	A	B	C
plastic surgery			
GYN surgery			
mastectomy			
redium implants			
spinal surgeries			
pulmonary surgery			
tracheotomy			
bronchoscopy			
colonoscopy			
assist with liver biopsy			
assist with bone biopsy			
assist with spinal tap			
amputation			
ileostomy-ileal loop			
fistula			
Dehisence			
Assessment of abdomen			
Assessment of bowel sounds			
Assessment of lung sounds			
<b>Chest Tubes:</b>			
Maintenance			
assist with insertion			
assist with removal			
<b>Assisting with intubation/extubation of E.T. tubes</b>			
<b>Chest physical therapy</b>			
<b>Changing and care of trach tube</b>			
<b>O2 Therapy:</b>			
Face mask			
Nasal cannula			

## MEDICAL SURGICAL SKILLS CHECKLIST

	A	B	C
<b>Suctioning (oro-naso-pharynx)</b>			
<b>Tracheostomy:</b>			
cuffed			
uncuffed			
<b>Drawing blood:</b>			
venous			
arterial			
<b>Insertion of IV into lower extremities</b>			
<b>Assist with IV cut-down</b>			
<b>IV medications</b>			
mixing			
Intralipids/hyperalimentation			
<b>Administration &amp; monitoring of blood &amp; blood products</b>			
<b>Infusion pumps:</b>			
IVAC			
IMED			
IVAC syringe			
<b>IV Therapy:</b>			
Insertion			
Maintenance			
Hickman catheters			
Heparin lock			
caring for IV infiltration			
discontinuing IV therapy			
CVP line maintenance			
CVP line dressing change			
Assisting with insertion of CVP line			
assisting with removal of CVP line			
Angiocaths			
Interactions			
<b>Equipment and techniques:</b>			
diabetic insulin pump			
diabetic glucose monitoring device			
ostomy care			
pleurovacs			
hemovac			
wound irrigations			
NG tube			

	A	B	C
foley cathetar			
3-way catheter			
suprapubic catheter			
nephrostomy			
colostomy irrigation			
ultrasonic doppler			
CPR			
K-wires			
cast care			
spika casts			
body casts			
halo traction			
Bucks traction			
skeletal traction			
crutch walking-teaching			
Hoyer lift			
<b>Administration of medication:</b>			
IV push			
IV drip			
IM			
PO			
rectal			
sub-Q			
sublingual			
topical			
Z-track			
<b>Isolation techniques:</b>			
enteric			
needle stick precautions			
reverse			
respiratory			
strict			
universal blood and secretions precautions			
Wound and skin			
<b>Charge nurse experience</b>			
<b>Charting with the legal aspects of law</b>			
<b>Team leader experience</b>			

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# Pediatric Skills Checklist

A = Able to perform without any supervision  
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	A	B	C
Chest physiotherapy			
Assessment of breath sounds			
Pediatric head to toe assessment			
Working knowledge of pediatric normal lab values			
Working knowledge of pediatric ABG's			
Suctioning (oro-naso-pharynx)			
Pulse Oximeter			
Insertion and maintainance of IV's			
IV meds mixing and administration			
Adminstration & monitoring of blood & blood products			
Infusion pumps			
Triple lumen catheter			
TPN and intralipids			
<b>Administration of medication:</b>			
IM			
IV drip			
IV push			
PO			
rectal			
subq			
topical			
Calculating pediatric dosage			
<b>O2 Therapy:</b>			
nasal cannula			
croup tent			
O2 analyzer			
vaporizer			
ventilation with ambu bag			
<b>Chest tubes:</b>			

	A	B	C
assist with insertion			
assist with removal			
maintenance of			
Child/ Infant CPR			
Tonsillectomy			
Cleft lip/ palate			
Pre/post op teaching			
Diabetic teaching			
Care of dying infant/ child			
Hemovac			
Pleuravac			
NG Tube			
Feeding Tube			
<b>Specimen collection:</b>			
application of collection bag			
diaper aspiration			
Intake & Output			
stool			
urine			
<b>Care of Patient with:</b>			
Aids			
abuse			
anemia			
broncho-pulmonary dysplasia			
croup			
cystic fibrosis			
dehydration			
emphysema/asthma			
epiglottitis			





## Psychiatric Nursing Skills Checklist

A = Able to perform without any supervision  
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 C = No Experience

	0	1	2
<b>CARE OF PATIENTS WITH:</b>			
assaultive behavior			
chemical dependency			
desire to fraternize with staff			
ECT			
eating disorders			
hallucinations			
manic disorder-acute phase			
needs for limit setting			
rapid tranquilization			
restriction to isolation or seclusion			
seizure disorder			
severe anxiety			
Schizophrenia			
suicidal tendencies			
<b>Care of patient with secondary medical problems</b>			
cardiac and/or pulmonary arrest			
cardiac complications			
CHF			
foley catheter/catheter care			
Diabetes			
IV therapy-starts and maintainance			
tube feedings			
pulmonary edema			
Oro-Naso-Pharynx suctioning			
O2 therapy			
ostomy care			
tracheostomy care			
<b>GENERAL</b>			
Admission of psychiatric patient			
Active participation in multi-disciplinary treatment planning			
Active participation in Milieu Therapy			
Behavioristic Charting			

	0	1	2
Conducts or co-conducts group therapy sessions			
Continual reassessment of patient; updating care plan			
Initial nursing intake intervie, assessment and care plan			
Therapeutic communication skills			
<b>iV THERAPY</b>			
administration & monitoring of blood & blood products			
heparin locks			
hyperalimtaion-maintainance & precautions			
use of infusion pumps			
veni-puncture			
<b>Restraints</b>			
ambulatory cuffs			
full restraints			
waist restraints			
Administering medications:			
IM			
IM - Z - techniques			
IV			
PO			
rectal			
sub-Q			
Working knowledge of effective behavior modification techniques			
Assessing needs of elderly psychiatric patient			
Managing the patient with assaultive behavior			
Use of open and closed seclusion			
Active participation in family counselling			
Care of child psych patient			
Care of adolescent psych patient			
Care of adult psych patient			
Care of the rape victim			
Care of the borderline patient			
Discharge planning for patients			
Experience as team leader			

## PSYCHIATRIC NURSING SKILLS CHECKLIST

	A	B	C
Participated as leader of assault team			
Working knowledge of medical model for psych nursing			
Working knowledge of effective crises intervention techniques.			
Administration & monitoring of the following medications:			
psychotropics			
anti-depressants			
MAO-inhibitors			
hypnotic/sedatives			
anti-convulsants			
cardiac medications			
diuretics			
Charge nurse experience			
Team leader experience			
Charting within the legal aspects of law			

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# Labor & Delivery Skills Checklist

A = Able to perform without any supervision  
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 C = No Experience

	A	B	C
<b>Medication Administration:</b>			
Interactions, Incompatibilities, Side effects			
Admin IN. SC Meds (narcotics, analgesics, anticonvulsants, insulin)			
Monitor IV Drips			
Oxytocin Induction, Augmentation			
Magnesium Sulfate Therapy & (other anticonvs. for pre-eclampsia/ eclampsia)			
Labor Supressants (e.g., Ritrodrene)			
Antibiotics			
Heparin			
<b>Intervention During Delivery:</b>			
Spontaneous Vaginal Delivery			
Forceps Vaginal Delivery			
Provide Care & Monitor after rupture of membranes (spontaneous/ artificial)			
Caesarean Section			
Labor Room Delivery			
Obstetric Anesthesia- monitor those requiring special surveillance			
General Anesthesia			
Regional Anesthesia			
Epidural			
Spinal			
Local Infiltration			
<b>Intervention During Labor:</b>			
Provide physical comfort measures			
Provide emotional support			
Support, Guide Labor Coach, P.R.N.			
Change Woman's Position, as needed			
Do a Perineal Prep			
Coach in Psychoprophylactic Breathing and Relaxing Technique			
<b>Obstetric Techniques &amp; Procedures:</b>			
Stress Test (oxytocin challenge test)			
Conduct Fetal Activity Determinants			

	A	B	C
Adult (umbilical artery catheter)			
Infant (assist intubation & umbilical artery cath. Ins., mix resuscitation drugs, admin IM narcan)			
Assess & Document Progress of Labor			
Contraction Characteristics			
Changes in Woman's Behavior, Appearance			
Status of Membranes			
Assess & Document Fetal Status			
Determine Fetal Position			
Auscultate FHR (fetal heart rate) Using:			
Fetoscope			
Doptone (Doppler Ultrasound)			
Monitor Uterine Activity & FHR Patterns using a Fetal Monitor			
External Monitor (tocotransducer, ultrasound, phono or abdominal ECG transducer)			
Internal Monitor (including connecting the leads and calibrating machine)			
<b>OB Techniques &amp; Procedures Cont'd</b>			
Identify FHR Patterns			
Variability Reactivity			
Decelerations – early, late, variable			
Tachycardia - Bradycardia			
Assess & Document Maternal Status:			
Vital Signs (BP, P) According to stage of labor & patient stability			
Deviations from the norm (edema, deep reflexes, clonus)			
Intake & Output including testing urine for Glucose, Protein, Specific Gravity, Ketones			
Escort Patient to assist with:			
Pelvimetry			
Ultrasound Scan			
<b>Postpartum Assessment:</b>			
Fundus Consistency			
Lochia			
Bladder Distension			
Episiotomy			
Incision (for caesarean delivery)			

Perform Cardiopulmonary Resuscitation			
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Vital Signs			
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### Labor & Delivery Skills Checklist

	A	B	C
<b>Provide Intrapartum Care to Women With:</b>			
Pregnancy – Induced Hypertension			
Preeclampsia			
Eclampsia (seizures)			
Placenta Previa			
Abruption Placenta			
Multiple Gestation			
Malpresentations			
Premature Labor			
Diabetes Mellitus			
Cardiac Disease			
Asthma			
Infectious Diseases			
Hemorrhage			
Pyelonephritis			
Cystitis			
Sickle Cell Disease			
Rh Incompatibilities			
<b>Immediate Care of Infant Post Birth:</b>			
Assign Apgar Scores			
Physically Examine Newborn (anomalies, respiratory status)			
Suction Infant			
Weigh Infant			
Identify Infant using Bracelet, Footprints & Mother's Bands			
Eye Prophylaxis			
Collect Cord Blood Samples			
Transfer to Newborn Nursery			

	A	B	C
<b>IV Therapy:</b>			
Start IV Lines			
Regulate IV's			
Mix IV infusion using additives			
Discontinue Peripheral IV's			
Use IV infusion pumps			
Use Heparin Locks			
Institute/ Monitor Blood & Blood Products			
Draw Blood for Lab Studies			
<b>Postpartum Intervention:</b>			
Initiate Fundal Massage, if needed			
Provide Perineal Care			
Apply Ice to Perineum			
Foster Parent-Infant Bonding			
Initiate Post-Anesthesia Recovery Precautions			
Epidural			
General			
Spinal			
<b>Aseptic Technique Relative to L &amp; D:</b>			
Set up a Delivery Table			
Set up a Caesarean Section Table			
Circulate for Caesarean Section			
Scrub for a Caesarean Section			
Circulate, Scrub for Postpartum Tubal Lig.			
Assist w/ an AROM (artificial rupture of membranes) Procedure			
Assist w/ Placement of Fetal Scalp Electrodes for Internal Monitoring			
Assist w/ Placement of an Intrauterine Pressure Catheter for Internal Monitoring			
Assist w/ Fetal Scalp Blood Sample Procedure			
Insert a Straight or Foley Catheter			
Perform a Vaginal Exam and Assess Effacement, Dilation, Station & Presentation			

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# Newborn Nursery Skills Checklist

A = Able to perform without any supervision  
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	A	B	C
Maintenance of Normal Temperature			
Obtaining Axillary Temperature			
Assessing Apical Pulse			
Use of Emergency Equipment for Infants			
Infant CPR			
Administration & Monitoring of Emergency Drugs			
Oxygen Hood			
Assessing Respiratory Rate			
O2 Administration/Management			
Suctioning			
Apnea Monitor			
Cardiac Monitor			
Oral Feeding			
Apgar Scoring			
<b>Admission of newborn into Nursery:</b>			
Intake & Output			
Color			
Activity			
Heart/Lung Assessment			
Gestational Age Assessment			
PKU			
Weighing and Measuring			
Circumcision Set-up/Observation/Documentation			
Preparation for Physical Exam by Physician			
Pulse Oximeters			
Isolation/Observation Nurseries			

	A	B	C
Bathing			
Cord Care			
<b>Care of Infant With:</b>			
Bililight			
Drug Withdrawal			
Prematurity			
Tetralogy of Fallot			
Down Syndrome			
Hydrocephalus			
Cleft Lip/Palate			
Phototherapy			
IV Starts and Maintenance			
Assisting with Umbilical Catheter Insertions			
Mother/Baby Care			
<b>Patient Teaching (mother, father, etc.):</b>			
Skin/Cord Care			
Warning Signs (ie-change in elimination or feeding pattern, fever)			
Bathing			
Phototherapy			
Apnea Monitoring			
Infant CPR			
Charting Within the Legal Aspects of the Law			
Charge Nurse Experience			
Team Leader Experience			

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## Postpartum Skills Checklist

A = Able to perform without any supervision  
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	A	B	C
<b>Post Partum Assessment</b>			
Vital Signs			
Breasts			
Fundus			
Abdominal Incision			
Perineum			
Vaginal Bleeding			
Homan's Sign			
Bladder Distention			
Maternal Adjustment			
Assessing I & O			
Providing Ice/ Heat Lamp Treatment			
IV Therapy - Starts and Maintenance			
<b>Assisting Patient with (including teaching)</b>			
Breast Feeding Infant			
Bottle Feeding Infant			
Bathing Infant			

	A	B	C
Cord Care			
Changing Diapers			
Dressing and Wrapping Infant			
Post Circumcision Care			
Teaching Patient About Her Own Skin Care			
Working Knowledge of Breast Engorgement			
Prevention Methods			
Caring for Patient Giving Infant up for Adoption			
Caring for Patient with Critically Ill Infant			
Caring for the Grieving Post-Partum Patient			
Mother/ Baby Care			
Charge Nurse Experience			
Team Leader Experience			
Charting Within the Legal Aspects of Law			
Knowledge of Infectious Disease			
Precautions			

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# Telemetry Skills Checklist

A = Able to perform without any supervision  
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	A	B	C
Receive patient <b>from</b> critical care			
Transfer of patient <b>to</b> critical care			
Assessment of heart sounds			
Assessment of lung sounds			
Assist with insertion of central line			
Maintenance of central line			
Post Cardiac Cath monitoring for bleeding/ circulation			
Care of Post-OP heart patients			
Chest incision care			
Set up and maintenance of chest tubes			
Pulmonary toiletry			
Administration of nebulizers			
Care of patient with tracheostomy			
Placement and maintenance of electrodes for cardiac telemetry			
Trouble shooting cardiac telemetry			
Interpretation of cardiac rhythm strip			
Care of patients with permanent pacemaker			
Care of patients with internal defib devis			
Use of Defibrillator			

	A	B	C
<b>Administrative by IV Injection and/or Infusion of:</b>			
Lidocaine			
Pronestyl			
NTG			
Isuprel			
Atropine			
Verapamil			
Renal dose Dopamine			
Sodium Bicarb			
Interpretation of arrhythmias			
Assist with cardioversion			
Assessment of arterial blood gas			
Assessment of electrolytes			
12 lead EKG			
Charge Nurse experience			
Charting within legal aspects of law			
Team leader experience			
Universal precautions			

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