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| **Documentation Requirement List**  □ Employment Application  □ Current Professional License [Maryland or Compact State in Good Standing]  □ CPR Certification [ Professional BLS. Original Document. Signed]  □ Social Security Card [Original Document-Not Laminated]  □ Photo Identification [Driver’s License, Passport]  □ Criminal Background Check [Completed with Agency Authorization Number—CJIS **0200090892**]  □ Skills Assessment [Initial and Annual]  □ Face to Face Interview [Initial Only]  □ Hepatitis B Verification or Declination [Initial]  □ Tuberculosis Assessment and Documentation of Negative TB Status [PPD or Chest X-Ray Results]  □ Physical Examination Results [Annual]  □ Employment Verification [**One year** of pediatric experience within the **last 3 years**]  □ Two Professional References [Initial]  □ Medical Malpractice Insurance Certification [Current and Maintained]  □ Pediatric Care Assessment  □ Medication Administration Assessment  □ Infection Control Assessment  □ Respiratory Care Assessment  □ Fire and Life safety  □ Patient Specific Orientation -PSO [Required for any new diagnosis or new patient assignment]  □ Annual In-Service [For educational purposes] |

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| **Compensation:**  LPN-Medicaid clients: $26-$29/Hour  RN: $30 -$32.00/Hour  Private Clients rates are negotiable according to Insurance Re-imbursements |

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| **Employment & Competency History**   |  |  |  |  | | --- | --- | --- | --- | | **Company/Agency Name** | **Dates of Employment** | **Major Responsibilities/Duties** | **Patient**  **Population** | |  | From  \_\_\_\_\_\_\_\_\_\_\_\_\_  To  **\_\_\_\_\_\_\_\_\_\_\_** | □Suctioning Tracheostomy □Ventilators  □Enteral Feedings □Venting □GT □JT Care  □ Wound Care □ Trach Care | □ Pediatrics  **[0-21 years]**  □ Adults | |  | From  \_\_\_\_\_\_\_\_\_\_\_\_\_  To  **\_\_\_\_\_\_\_\_\_\_\_** | □Suctioning Tracheostomy □Ventilators  □Enteral Feedings □Venting □GT □JT Care  □ Wound Care □ Trach Care | □ Pediatrics  **[0-21 years]**  □ Adults | |  | From  \_\_\_\_\_\_\_\_\_\_\_\_\_  To  **\_\_\_\_\_\_\_\_\_\_\_** | □Suctioning Tracheostomy □Ventilators  □Enteral Feedings □Venting □GT □JT Care  □ Wound Care □ Trach Care | □ Pediatrics  **[0-21 years]**  □ Adults | |  | From  \_\_\_\_\_\_\_\_\_\_\_\_\_  To  **\_\_\_\_\_\_\_\_\_\_\_** | □Suctioning Tracheostomy □Ventilators  □Enteral Feedings □Venting □GT □JT Care  □ Wound Care □ Trach Care | □ Pediatrics  **[0-21 years]**  □ Adults | |  | From  \_\_\_\_\_\_\_\_\_\_\_\_\_  To  **\_\_\_\_\_\_\_\_\_\_\_** | □Suctioning Tracheostomy □Ventilators  □Enteral Feedings □Venting □GT □JT Care  □ Wound Care □ Trach Care | □ Pediatrics  **[0-21 years]**  □ Adults |   **References:** Give the names of a minimum of **2 persons** not related to you, whom you have known for at least **one year** and has knowledge of your **professional encounters**.   |  |  |  |  | | --- | --- | --- | --- | |  | Reference #1 | Reference # 2 | Reference #3 | | Name |  |  |  | | Phone Number |  |  |  | | Email |  |  |  | | Relationship | [] Employer [] Colleague [] Classmate [] Client  [] Professor [] Other | [] Employer [] Colleague [] Classmate [] Client  [] Professor [] Other | [] Employer [] Colleague [] Classmate [] Client  [] Professor [] Other | | Years Known |  |  |  | |

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| **Please answer the following questions. Provide Explanations if answered yes**   1. Are you currently or have been sanctioned from participating in Medicare, Medicaid?   □Yes □No  Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Have you been listed on any Medicaid exclusion list or banned from participating in any other Federal or State programs?   □Yes □No  Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Have you ever been listed in poor standing with an agency or organization?   □Yes □No  Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Professional License**  Have your professional license current or previous in any State been subject to any adverse actions listed below:   |  |  | | --- | --- | | □ Reprimands  □ Revocations  □ Warnings  □ Probations | □ Suspensions  □ Sanctions  □ Denials  □ Reprimands □ **None of these apply** |   Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Are you currently the subject of any investigations regarding your nursing practice?   □Yes □No  Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Have you ever been convicted of a crime?   □Yes □No  Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Are you currently or have been in treatment for the use of illicit drugs or prescribed narcotics?   □Yes □No  Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Have you had an experience with a child dying unexpectedly while under your care?   □ Yes □No  Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **License Information**  **Category** □ Registered Nurse □ Licensed Practical Nurse □ Certified Nursing Assistant  **State** □ Maryland □ Compact State [Specify] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  License # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Certifications**  CPR Expiration Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PALS [□ NA] Expiration Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Work Experience**  1. Have you worked in the home settings with medically fragile children? □ Yes □No  2. Have you worked with patients on ventilators? □ Yes □No  3. Are you competent in respiratory care such as tracheostomies and airway management? □ Yes □No  4. Have you worked with children who require enteral feeding? □ Yes □No  **Health and Safety**   1. Do you have any physical impairments that would prevent you from lifting? □ Yes □No 2. Have you had the Hepatitis vaccination series? □ Yes □No 3. Have you had an annual physical examination? □ Yes □No 4. Have you ever tested positive for tuberculosis? □ Yes □No 5. Are you aware of needle and sharps safety precautions? □ Yes □No 6. Infection control safety precautions are essential in-home care. Are you aware of the procedures to maintain infection control? □ Yes □No   **Hepatitis-B Vaccination Verification/Declination**  □ I have been vaccinated for Hepatitis-B and completed the series of 3 inoculations  □ I have provided documentation for Hepatitis -B vaccinations  □ I have completed the Hepatitis B series but am unable to find documentation  □ I would like to be vaccinated at no charge to me  □ I decline to be vaccinated for Hepatitis -B [**Please sign here**] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_ |

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| **Tuberculosis Screening**  Have you experienced any of the following symptoms in the past year?   1. Productive cough for more than 3 weeks?...................................... □ Yes □ No 2. Hemoptysis [ coughing up blood]?................................................ □ Yes □ No 3. Unexplained weight loss? ……………….. ………………………□ Yes □ No 4. Fever, chills or night sweats for unknown reasons? ……………...□ Yes □ No 5. Persistent Shortness of breath?....................................................... □ Yes □ No 6. Unexplained fatigue? ……………………………………………. □ Yes □ No 7. Chest Pain? ……………………………………………………… □ Yes □ No 8. Have you had contact with anyone with active tuberculosis disease in the past year? ……. □ Yes □ No 9. Do you have a medical condition, or are you taking any medication that suppresses your immune system?................................................................................................................................... □ Yes □ No   Please provide an explanation for any questions that was answered **“Yes”**  I declare that my answers and statements are correctly recorded, complete and true to the best of my knowledge. I also understand that I am required to provide verifiable documentation [Chest X-ray, PPD] of my health status regarding TB exposure and infection to the agency as required by law.  □I have provided PPD skin Test Results to the agency dated\_\_\_\_\_\_\_\_\_\_\_\_  □I have provided a Chest X-ray result to the agency dated \_\_\_\_\_\_\_\_\_\_\_\_  Healthcare Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_ |

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| **Infection Control Assessment**   1. Hand washing is the most effective method of controlling the spread of germs [] True [] False 2. Gloves should always be worn when handling body fluids [] True [] False 3. Which infection control technique is acceptable when changing a trach tube?    1. Sterile technique    2. Aseptic technique    3. Clean technique 4. What is the difference between **Sterile** technique and **Aseptic** technique?    1. *Sterile Technique* involves the use of sterile gloves, mask and a sterile field for supplies used    2. *Aseptic Technique* involves minimizing the transfer of organisms by not touching sterile areas    3. Both A and B are correct 5. Body fluids should be disposed of in the …    1. Bathroom sink    2. Kitchen sink    3. Bathroom commode and flushed with the lid closed |