|  |
| --- |
| **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] |

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 |  |  |  |

 |

|  |  |  |
| --- | --- | --- |
| **Please answer the following questions. Provide Explanations if answered yes**1. Are you currently or have been sanctioned from participating in Medicare, Medicaid?

□Yes □NoExplain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Have you been listed on any Medicaid exclusion list or banned from participating in any other Federal or State programs?

□Yes □NoExplain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Have you ever been listed in poor standing with an agency or organization?

□Yes □NoExplain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**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 □NoExplain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Have you ever been convicted of a crime?

□Yes □NoExplain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Are you currently or have been in treatment for the use of illicit drugs or prescribed narcotics?

□Yes □NoExplain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Have you had an experience with a child dying unexpectedly while under your care?

□ Yes □NoExplain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **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 □No2. Have you worked with patients on ventilators? □ Yes □No3. Are you competent in respiratory care such as tracheostomies and airway management? □ Yes □No4. 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 \_\_\_\_\_ |

|  |
| --- |
| **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 \_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **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
 |