

RENAL

Insertion of Catheter - Male and Female
Catheter Care
Suprapubic Tube Insert/Care
Nephostomy Tube
Obtain Urine Culture/Specimen

1	2	3	4	LENGTH OF EXPERIENCE

Care of Patient:

- With Renal Transplant
- On Hemodialysis / Specify Equipment
- On Peritoneal Dialysis
- With Nephrectomy
- Prostate Surgery
- In Acute Renal Failure

NEUROLOGICAL

Neurological Assessment/Vital Signs
Seizure Precautions
Monitoring Intracranial Pressure
D.T's

Care of Patient with:

- Fresh Head Injury (Open and Closed)
- CVA (Stroke)
- Spinal Cord Injury / Surgery
- Craniotomy
- Back Sugery
- Halo Traction / Vest
- Alzheimer / Dementia
- Neuro Muscular Disease

ORTHOPEDIC

Crutch Walking
Traction
Cast Cre
Foot Surgery
Fractured Bone
Care of Multiple Trauma Patient
Total Joint Replacement
Care of Patient with Amputation

RESPIRATORY

Respiratory Assessment
Assisting with Intubation
Oropharyngeal Suctioning
Endotracheal Suctioning

SPECIAL EQUIPMENT

Intra-Aortic Balloon Pump
Heart-Lung Machine
Arthroscopy/Laparoscopy
Blood Retrieval Equipment
Endoscopy/Proctoscopy
Others / Specify

1	2	3	4	LENGTH OF EXPERIENCE

ASSIGNMENTS WILLING AND QUALIFIED TO PERFORM:

Hospital Nursing Home Industrial Dr. Office Home Health Correctional Facility

LICENSE AND CERTIFICATION INFORMATION:

State/License # _____ Expiration Date: _____

State/License # _____ Expiration Date: _____

State/License # _____ Expiration Date: _____

CPR Yes No Expiration Date: _____

EMT Yes No A ___ I ___ P ___ Expiration Date: _____

ACLS Yes No Expiration Date: _____

PALS Yes No Expiration Date: _____

CCRN Yes No

CEN Yes No

IV Certified Yes No

Chemo Certified Yes No

Hemodialysis Certified Yes No Specify Equipment Used: _____

Trauma Nurse Specialist Yes No

Other Yes No Specify: _____

Helicopter _____ Fixed Wing Aircraft _____ Mobile Intensive Care _____

LENGTH OF EXPERIENCE IN:

Burn Unit: _____ Emergency Room: _____ Geriatrics: _____ Intensive Care: _____

Labor & Delivery: _____ Medical Unit: _____ Neonatal ICU: _____ Newborn Nursery: _____

Nursing Home: _____ OB/GYN: _____ Oncology: _____ OR: _____

Ortho Unit: _____ Pediatrics: _____ Pediatric ICU: _____ Post Partum: _____

Psychiatric Unit: _____ Recovery: _____ Respiratory: _____ Surgical: _____

Telemetry: _____ Urology/Renal: _____ Neuro: _____ Clinic / Specialty: _____

CIRCULATING/OPERATING ROOM NURSE

Orthopedic Neuro Plastic ENT

Heart/Vascular General OB/GYN

RECOVERY ROOM NURSE: _____ **PRE-ANESTHESIA:** _____

Has your license ever been under investigation? Yes No

If yes, explain: _____

SHIFT PREFERENCE: 1st choice _____ 2nd choice: _____

The statements made in this application are true to the best of my knowledge. I understand that any falsification will be the basis for disqualification of employment or termination of services.

SIGNATURE: _____ DATE: _____