



Thank you for allowing Millenia Medical Staffing to assist you in your endeavors as a traveling medical professional. We are excited to welcome you to our team! Please complete the following items below so that we can begin the credentialing process.

You will find the enclosed documents that are to be completed and returned.

- Application
- Work History and/or Resume'
- Skills Checklist(s)
- Reference Forms(3)
- Authorization Release

Please provide us with the following documents:

- Copy of active nursing license(s)
- Copy of all valid CPR/Life Support certification cards
- Copy of current photo for ID Badge (*must be original*)
- Copy of drivers license or identification card
- Copy of social security card or birth certificate or passport
- Copy of Signed Physician Statement
- Copy of TB/PPD Test Results *within 1 year* or Chest X-Ray *within 2 years*
- Copy of MMR vaccine or Rubella & Rubeola & Mumps titers
- Copy of Varicella Titer and Hepatitis B Titers
- Copy of Hepatitis B Series, Titter or Declination

Thank you for your prompt return of the above documents. Upon receipt of your information, you will be contacted regarding available assignments.

Sincerely,

Travel Division



APPLICATION

INSTRUCTIONS: Please complete all sections and sign. If a section does not apply, please indicate by answering "N/A". If additional explanations are provided please write "See Attached" and include the documentation.

PERSONAL INFORMATION

Full Name: _____ Maiden (if applicable): _____
Last First Middle Initial

Temporary Address: _____

Home Address: _____

Mailing Address: (check one) _____ Home _____ Temporary _____ SS#: _____

Phone: (____) _____ (____) _____ (____) _____ (____) _____
Home Cell Work Pager

E-Mail: _____ Place of Birth: _____

Date of Birth: _____ Referral Source/Name: _____

Emergency Contact: _____ (____) _____
Name Relationship Phone

Can you, upon employment, submit verification of your legal right to work in the United States? Yes No

EMPLOYMENT INFORMATION

RN YES NO LPN YES NO CST YES NO ST YES NO

Specialty: _____
1st Choice 2nd Choice 3rd Choice

Years Experience: _____
1st Choice 2nd Choice 3rd Choice

Geographical Preference: _____
1st Choice 2nd Choice 3rd Choice

EDUCATION AND TRAINING

*If information is on resume', please write "resume'." If not, please complete information thoroughly.

◆ UNDERGRADUATE: _____
School City State Start End Degree

◆ UNDERGRADUATE: _____
School City State Start End Degree

◆ GRADUATE: _____
School City State Start End Degree

Did you graduate from a foreign school? YES NO When did you pass the U.S Nursing Boards Exams?



CERTIFICATIONS

Certification	Issue Date	Expiration Date	Instructor
<input type="checkbox"/> ACLS	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> BCLS	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> ATLS	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> PALS	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> CCRN	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> NRP	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> CEN	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> TNCC	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> CHEMO	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> FHM	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO

LICENSURE INFORMATION

List all active and inactive licenses. If you have an inactive license, please note why that license is inactive. Attach a separate sheet if necessary.

Name of State	Active or Inactive	Date Issued	Expiration Date	License Number
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

GENERAL HISTORY (Please provide a brief explanation below of all "YES" answers or attach a separate sheet if necessary.)

	YES	NO
1. Have you ever had a state license to practice nursing refused, suspended or revoked?	_____	_____
2. Have you ever voluntarily surrendered or non-renewed a state license to practice nursing?	_____	_____
3. Has membership in any professional association or society ever been revoked or refused?	_____	_____
4. Has a hospital ever suspended, restricted or refused your staff privileges at any time while under peer investigation?	_____	_____
5. Have you suffered from or been treated for a chronic illness or a physical defect for more than 30 days or are you suffering from or being treated for a chronic illness or a physical defect now?	_____	_____
6. Have you ever been or are you currently being treated for mental illness including inpatient, outpatient or counseling? (If YES, provide details of rehabilitation program, including dates of treatment)	_____	_____
7. Have you ever had counseling for mental therapy for more than 30 days or are you receiving counseling now?	_____	_____
8. Have you ever taken psychiatric medications for more than 30 days or are you taking them now?	_____	_____
9. Have you ever been treated for alcoholism or narcotic addiction including inpatient, outpatient or counseling? (If YES, provide details of rehabilitation program, including dates of treatment)	_____	_____
10. Are you currently being treated for alcoholism or narcotic addiction including inpatient, outpatient or counseling? (If YES, provide details of rehabilitation program, including dates of treatment)	_____	_____
11. Have you ever been convicted of a felony?	_____	_____

If you answered yes on any of the above please attach separate sheet with thorough explanation

I hereby authorize the above information is true and accurate to the best of my knowledge

Signature

Date



WORK HISTORY

Millenia Medical Staffing requires all work history, so please list all facilities where you have worked during your career. If **all** information is on your Resume', you may write "Resume'." If not, please complete information.

Facility Name		Teaching or Non Teaching		City	State
Start	End	Class	Specialty Unit	# Beds in Unit	# Beds in Facility
Nurse: Patient Ratio		Average Daily Census		Reason for Leaving	
Shift	Supervisor		Phone	Travel Assignment?	

Facility Name		Teaching or Non Teaching		City	State
Start	End	Class	Specialty Unit	# Beds in Unit	# Beds in Facility
Nurse: Patient Ratio		Average Daily Census		Reason for Leaving	
Shift	Supervisor		Phone	Travel Assignment?	

Facility Name		Teaching or Non Teaching		City	State
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Start	End	Class	Specialty Unit	# Beds in Unit	# Beds in Facility
Nurse: Patient Ratio		Average Daily Census		Reason for Leaving	
Shift	Supervisor		Phone	Travel Assignment?	

I hereby authorize the above information is true and accurate to the best of my knowledge

Signature

Date

CRITICAL CARE SKILLS CHECKLIST



KEY

Please place an X in the column best describing your expertise level.

- 1 No Experience.
- 2 Limited Experience; Performs Intermittently.
- 3 Moderate Experience; Needs Resource for Backup.
- 4 Experienced; Performs Independently.

CV/CIRCULATORY	1	2	3	4
Aortic Ballon Pump care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
arterial line/Swan Ganz set up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
obtain blood sample from line	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
remove arterial line	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
assess heart sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
assist in:				
arterial line insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swan Ganz insertion with or without fluroscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
assist with pacemaker insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
pacemaker care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
paceport Swan Ganz	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
recognize pacemaker malfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
temporary/single/double lumen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
assist with pericardiocentesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
blood pressure monitoring/automatic machine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
care of patients with:				
acute aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
acute MI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CHF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
deep vein thrombosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
post TPA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
pulmonary edema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
shock:				
cardiogenic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hypervolemic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
septic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
transplant/cardiac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dysrhythmia recognition and intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
external pacemaker maintenance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
normal anatomy of heart:				
left side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
right side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
normal physiology of CV system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
post angiogram care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
post open heart care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
removal of arterial/venous sheaths	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CV/CIRCULATORY - continued	1	2	3	4
resuscitation:				
perform defibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
perform/set up emergency cardioversion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
prep and administer meds team member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SVO2 monitoring interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
troubleshooting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
set up, run, interpret 12 lead EKG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swan Ganz hemodynamic knowledge of RA/PAP/PCWP/CO/SVR/PVR/CI monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
troubleshooting waveforms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
use of cardiac monitor proper lead placement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
use of doppler	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL SYSTEM				
assessing sensory-motor function extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
assist with lumbar puncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
care of patients with:				
aphasia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CVA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
closed head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
craniotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
multiple trauma patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
overdose patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
spinal cord injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cervical traction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cranial nerve assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crutchfield tongs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
halo traction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LOC assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
monitoring of ICP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
appropriate interventions for changes in pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
pre/post neuro surgical care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
seizure precautions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**NEUROLOGICAL SYSTEM** - continued

1 2 3 4

use of Glasgow coma scale

visual acuity measurement

**PULMONARY**

administer oxygen

Ambu bag techniques

assess lung sounds

assist in intubation/extubation:

nasopharyngeal airway

oropharyngeal airway

care of patients with:

AIDS

acute respiratory distress

asthma

COPD

collapsed lung

DIC

hemothorax

pneumonia

pulmonary embolism

TB

transplant/pulmonary

chest physiotherapy

complications of

chest tube insertion (assist in)

ECMO: care

monitoring

incentive spirometer

Nebulizer

normal physiology of pulmonary

vascular system

obtain arterial blood gas

result interpretation

Pavulonized patient

pulse oximetry

suctioning

use of emergency equipment

thoracentesis

tracheostomy:

assist with emergency trach

changing of trach or tube

dressing changes

skin care

trach tray set up

use of apnea monitor

Ventilator Management:

patient assessment

troubleshooting with vents

weaning from ventilator

list types of ventilators:

**MEDICATION ADMINISTRATION**

1 2 3 4

injections:

preparation of meds/syringe

site selection (ie. SQ vs. IM)

PO administration

SL administration

use of the following medications:

Activase

Aminodarone

Atropine

Bicarbonate

Bretylium

Cardizen

Dextrose

Digitalis

Dopamine

Epinephrine

Esmolal

Heparin

Inderal

Inocor

Insulin

Isuprel

KCL

Levophed

Lidocaine

Mannitol

Magnesium Sulfate

Neo synephrine

Nipride

Nitroglycerin

Nitroprusside

Phenobarbital

Pavulon

Prednisone

Pitressin

Procainamide

Prostoglandins

Streptokinase

Verapamil

**PSYCHIATRIC CONSIDERATIONS**

psychiatric patient assessment

administer psychiatric medications

care of acute psychotic

care of violent patient

use of restraints

**ADDITIONAL NURSING RESPONSIBILITIES**

admission:

initial assessment and documentation

charge nurse responsibilities

lab value interpretation

organ procurement



ADDITIONAL NURSING RESPONSIBILITIES - *continued*

	1	2	3	4
pain management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCA pumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
use of IV narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
post mortum procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
problem oriented medical records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
specimen collection:				
capillary blood draw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
central line blood draw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sputum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
venipuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
wound culture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
universal isolation				
procedures/precautions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**GI/GU/REPRODUCTIVE/ENDOCRINE/
INTEGUMENTARY**

AV shunt/fistula care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
administer med via				
NG/gastrostomy tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
assist with vas-cath insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
care of burn patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
care of patients with:				
acute cholecystitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
acute renal failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bowel obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GI bleed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hyper/hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
multiple abdominal wounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
renal transplant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
transplant/kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cathether insertion:				
female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dialysis:				
hemo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
peritoneal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CERTIFICATIONS

	EXPIRATION DATE
ACLS	_____
BCLS	_____
CCRN	_____
Other _____	_____
Other _____	_____
Other _____	_____

SPECIALTY COURSE (Name)

1. _____
2. _____
3. _____



**GI/GU/REPRODUCTIVE/ENDOCRINE/
INTEGUMENTARY** - *continued*

	1	2	3	4
equipment used				
jejunostomy care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NG tube insertion/lavage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
normal physiology of renal and GI system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ostomy/stoma care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
peritoneal lavage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
poison control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
wound care irrigations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
insulin preparation and administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
blood glucose monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



IV THERAPY

administration of chemotherapy meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
administration of antibiotic meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
administration/mixing of IV meds meds via push	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
administration of continuous fluids blood/blood product	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
administration/precautions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
autotransfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
calculate doses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
calculate rates:				
mcg/min	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mcg/kg/min	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hang IV piggybacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hyperalimentation:				
caloric and fluid requirements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
knowledge of solutions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
peripheral/central line	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
insertion of central line:				
CVP tray set up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dressing changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
implanted venous access ports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
use of Broviac and Hickman catheters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
insertion of peripheral line:				
discontinuing line	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dressing change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
pump operations:				
IMED	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IVAC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DATE

LOCATION

Detail any additional experience which makes you exceptionally qualified to practice as a traveling registered nurse:

What additional languages do you speak?

RN Signature

Date



PROFESSIONAL REFERENCE

In order for Millenia Medical Staffing to obtain a professional reference, please complete the following. Thank you.

To be completed by Traveler

Applicant's Name: _____ Classification: _____ Clinical Specialty: _____
 Employment dates: From _____ To: _____ Facility Name: _____
 City/State: _____ Contact: _____ Phone #: _____

To be completed by Facility or Agency

Please indicate whether the above information is correct: _____ Yes _____ No Average Patient Case Load: _____
 # beds in the unit: _____ Charge experience? _____ Yes _____ No Teaching hospital? _____ Yes _____ No
 Reason for leaving: _____ Would you rehire? _____ Yes _____ No

Performance Evaluation:	Exceptional	Above Standard	Standard	Below Standard
1. Demonstrates competency in caring for patients.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provides a safe & therapeutic patient environment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Implements a coordinated plan or patient care.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Adheres to facility policies & procedures.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Communicates appropriately with patients & families.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Completes accurate documentation of patient care.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional Attributes:				
7. Flexibility & adaptability.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Willingness & ability to float (if applicable).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Interest & enthusiasm.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Ability to communicate with staff.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Attendance & punctuality.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Overall professionalism.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Evaluator / Title: _____ Date: _____ Phone: _____

This information was obtained from: Written reference Evaluation Verbal reference Recommendation letter



PROFESSIONAL REFERENCE

In order for Millenia Medical Staffing to obtain a professional reference, please complete the following. Thank you.

To be completed by Traveler

Applicant's Name: _____ Classification: _____ Clinical Specialty: _____
 Employment dates: From _____ To: _____ Facility Name: _____
 City/State: _____ Contact: _____ Phone #: _____

To be completed by Facility or Agency

Please indicate whether the above information is correct: _____ Yes _____ No Average Patient Case Load: _____
 # beds in the unit: _____ Charge experience? _____ Yes _____ No Teaching hospital? _____ Yes _____ No
 Reason for leaving: _____ Would you rehire? _____ Yes _____ No

Performance Evaluation:	Exceptional	Above Standard	Standard	Below Standard
1. Demonstrates competency in caring for patients.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provides a safe & therapeutic patient environment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Implements a coordinated plan or patient care.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Adheres to facility policies & procedures.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Communicates appropriately with patients & families.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Completes accurate documentation of patient care.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional Attributes:				
7. Flexibility & adaptability.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Willingness & ability to float (if applicable).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Interest & enthusiasm.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Ability to communicate with staff.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Attendance & punctuality.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Overall professionalism.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Evaluator / Title: _____ Date: _____ Phone: _____

This information was obtained from: Written reference Evaluation Verbal reference Recommendation letter



DISCLOSURE STATEMENT AND AUTHORIZATION RELEASE

I hereby consent and give authority to the representatives of Millenia Medical Services, Inc (DBA Millenia Medical Staffing) and all of its clients or customers, including hospitals, or clinics to obtain and review all records or other information that may be pertinent to the evaluation of my professional qualifications and competence to carry out services for Millenia Medical's clients. Additionally, I consent to representatives of Millenia Medical and all of its clients or customers, including hospitals, or clinics to conduct a personal and professional background reference check including verification of licensing and certifications, verification of education and transcripts and and all other records or information concerning my past activities relating to my driving, criminal, civil and other experiences.

If you are denied employment because of the consumer investigation, it is your right under the Fair Credit Reporting Act (Law 91-508) SS 606 to have the name of the agency or agencies from whom information concerning you was obtained. You are also entitled to receive free copies of the information supplied by those agencies within sixty days upon written request. You have the right to directly dispute with the consumer reporting agency the accuracy and completeness of any information furnished by that agency.

I hereby release Millenia Medical and all of its representatives from any liability from any and all of their activities conducted in connection with this authorization. Additionally, I hereby release from liability any and all individuals and organizations who provide information to Millenia Medical or its representatives, in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for provision of services to Millenia Medical clients, and I hereby consent to the release of any and all such information.

Have you ever been convicted of a felony _____ or a misdemeanor _____? If yes, provide an explanation:

I UNDERSTAND THAT ANY FALSIFYING OR OMISSIONS CONTAINED IN MY APPLICATION, CONSTITUTES CAUSE FOR TERMINATION OF CONTRACT WITH MILLENIA MEDICAL OR DECLINING ANY PENDING JOB OFFERS. ALL INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE TO MY BEST KNOWLEDGE AND BELIEF.

Applicant's Printed Name

Date

Applicant's Signature

Social Security Number

MMS Representative Signature

Date