



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?



millenia
medical
staffing

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?	

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Nurse: Patient Ratio		Average Daily Census		Reason for Leaving	
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I hereby authorize the above information is true and accurate to the best of my knowledge

Signature

Date

MATERNAL/CHILD SKILLS CHECK LIST



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.

	1	2	3	4
AA MEDICATION ADMINISTRATION				
Knowledge of Administration Protocol and Side Effects of:				
Analgesics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anticonvulsants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calcium Chloride	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calcium Gluconate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corticosteroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heparin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hydralzine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insulin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Magnesium Sulfate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oxytocin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ritodrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	1	2	3	4
AA GENERAL OBSTETRICAL Management				
Assessment of Labor:				
Assess for Risk Factors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Dilation and Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Effacement and Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Duration of Contractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequency of Contractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Identity of Part	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obtain OB History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological/Behavioral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Status of Patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of Contractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Station of Presenting Part	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	1	2	3	4
AA LABOR MANAGEMENT				
Intrapartum Assessment				
Assess Maternal vs. Per Stage of Labor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assist with Fetal Scalp Blood Sampling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assist with Insertion of Intrauterine Pressure Catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assist with Placement of Fetal Scalp Electrodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	1	2	3	4
LABOR MANAGEMENT - continued				
Correctly Interpret and Document Fetal Status:				
Apply Tocotransducer and Ultrasonic FHM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Identify Indicators of Fetal Distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Initiate Emergency Measures for Fetal Distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Report fetal Distress to Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpret Data:				
Fetal Heart Pattern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine Contraction Pattern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledgeable of Calibration Machine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowledgeable of Lead Connections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of Doptone (US Doppler)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of FetoScope	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intrapartum Interventions				
Assist with Amniotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care of Patient for Anesthesia Administration:				
Assist Physician with Induction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Documentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Positioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Protocol for Consent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regional:				
Epidural	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Local Infiltration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coach With Breathing and Relaxation Technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct Vaginal Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prep:				
Cesarean	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perineal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prepare Patient Physical for Labor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provide for Care and Monitor After Rupture of Membranes:				
Artificial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spontaneous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Support Labor Coach as Needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**DELIVERY INTERVENTIONS**

Assist Physician with Anesthesia During Delivery

Circulate for:

- Cesarean Section
- Minor Surgical Procedure
- Post Partum Tubal Ligation
- Vaginal Delivery

Documents Delivery on Patient

Chart and Logbook Initiate emergency Protocols if Needed Knowledgeable of NAACOG/AOR and AWHONN Standards of Practice Performs Controlled Emergency Delivery in Absence of Physician

Scrub for:

- Cesarean Section
- Minor Surgical Procedure
- Post Partum Tubal Ligation
- Vaginal Delivery
- Sterile Set up:
- Birth Room
- Cesarean delivery
- Delivery Room
- Forceps Vaginal Delivery
- Spontaneous Vaginal Delivery

**CARE OF NEWBORN**Assess and Assign Apgar Score Chest Percussion Cord Blood Samples Dextrostix Establish and Maintain Patent Airway Eye Care Hematocrit Identification Process Bracelet/Footprints Initiate Emergency Measures Knowledgeable of S/S Infant Distress Physical Exam of Newborn: Assess for Anomalies Respiratory Status Prevention of Heat Loss Promote Bonding Process Suction: Bulb Delee Wall Transfer to Nursery Weight Use of Radiant Monitor

1 2 3 4

**POST PARTUM - RECOVERY PERIOD**

Accurate Assessment and

Documentation of:

- Amount and Character of Lochia
- Bladder Status
- Fundal Consistency and Height
- Incision
- Cesarean
- Episiotomy
- Perineal Care
- Post-Anesthesia Assessment Score
- Provide Period of Bonding
- Psychological Status
- Report Condition to Post Partum Unit

1 2 3 4

**CARE OF PATIENT WITH:**

- Abrupto Placenta
- Asthma
- Cardiac Disease
- Cystitis
- Diabetes Mellitus
- Drug Abuse
- Eclampsia
- Hemorrhage
- Hypotension from Regional Anesthesia
- Infections Disease
- Malpresentation
- Multiple Gestation
- Neuromuscular Disease
- Paralysis
- Placenta Previa
- Pre-Eclampsia
- Pregnancy-Induced Hypertension
- Premature Labor
- Prolapsed Cord
- Pyelonephritis
- Respiratory Arrest
- Rh Incompatibilities
- Ruptured Uterus
- Sickle Cell Disease
- Seizures

**OBSTETRICAL PROCEDURES**

- Adoption Protocol
- Aseptic Technique for Delivery Room
- Aseptic Technique for Labor Room
- Assist with Insertion/Care of:
- Arterial Lines
- CVP
- Swan Ganz
- Care of Patient on Respirator
- CPR:

**OBSTETRICAL PROCEDURES - continued**

	1	2	3	4
Adult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assist with Intubation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assist with Umbilical				
Artery Catheter Insertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C-PAP Bag	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Compressions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Documentation for Hospital/State				
Protocols	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fetal Demise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Induction of Labor:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comfort Measures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Protocol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provide Psychological Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Signs & Symptoms of Complications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intake and Output	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specimen Collection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Test - Oxytocin Challenge Test:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contraction Stress Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-Stress Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Surrogate Mother Protocol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**POST PARTUM SKILLS****Monitor/Instruct Patient:**

Bladder Care:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Empty Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intervention if Unable to Void	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Care:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incision Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perineal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Care:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bottle Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Episiotomy Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat Lamp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peri-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitz Bath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tubal Ligation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**MEDICATION**

	1	2	3	4
Depo Provera	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ergotomine Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hormone Preparations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MagSo4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methergine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oxytocin-Pitocin Drips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parlodel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rho Gam Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ritrodrene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rubella Vaccine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suppositories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal Creams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**BIRTH CERTIFICATION**

Complete a Birth Certificate & Record	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
---------------------------------------	--------------------------	--------------------------	--------------------------	--------------------------

**POST-BIRTH CARE**

C-Section:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incentive Spirometry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain relief				
Preeclampsia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transverse vs. Classic Incision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epidural Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Natural Childbirth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**DAILY CHECKS**

Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Episiotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fundus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lochia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**MATERNAL CARE****Home Instructions**

Activity Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Adjustments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follow-Up with Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovulation and Menstruation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perineal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recognizing Signs of Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1 2 3 4

NEWBORN NURSERY

Admission From:

- C-Section Birth
- Delivery Room - Vaginal Birth
- Outside Delivery Area

DAILY CARE

- Bathing
- Circumcision Care
- Cord Care
- Feeding:
 - Bottle
 - Breast
 - N/G
- Skin Care

DEMONSTRATE PROPER TECHNIQUE FOR THE FOLLOWING PROCEDURES:

- Assisting with Circumcisions
- Exchange Transfusion
- Gastric Lavage
- N/G Tube Insertion
- N/T Suction
- Nasogastric Suctioning:
 - Bulb
 - Delee Trap
- Phototherapy Lights
- Postural Drainage and PT

MEDICATION ADMINISTRATION

- Antibiotic
- Silver Nitrate
- Vitamin Preparation

USE AND MAINTAIN THE FOLLOWING EQUIPMENT

- Automatic B/P Machine
- Breast Pump
- Cardio-Respirator Monitor
- Infant Scales
- Isolette
- Radiant Warmer

SPECIMEN COLLECTION

- Cultures
- Blood
- Skin
- Gastric
- Cord
- Heel Sticks
- Stool
- Urine

1 2 3 4

INFANT CARE INSTRUCTION TO PRIMARY CAREGIVER

- Circumcision Care
- Cord Care
- Feeding:
 - Bottle
 - Breast
- Infant Bath
- Infant Elimination
- Infant Follow-Up
- Need for PKU/Thyroid Testing
- Recognize Signs of Infection

YOUR EXPERIENCE:

How many years have you worked in Newborn Nursery? _____

How many years have you worked in Labor & Delivery? _____

How many years have you worked Postpartum? _____

Is your experience primarily in:

- Labor/Delivery
- Postpartum
- Other

NAACOG Certified? Yes No

Infant Resuscitation Certified? Yes No

PALS Certified? Yes No

COMMENTS:

NAME: _____

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

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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