



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	
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Nurse: Patient Ratio		Average Daily Census		Reason for Leaving	
Shift	Supervisor		Phone	Travel Assignment?	

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Signature

Date

MEDICAL/SURGICAL 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.



NEUROLOGICAL SYSTEM

	1	2	3	4
assess cranial nerves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
assess level of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
assess sensory motor function				
of 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:				
acute head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
aphasia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
autonomic dysreflexia	<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"/>
cancer of the brain	<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"/>
head trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
impending D.T.s	<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"/>
Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
quadriplegia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
seizure disorders	<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"/>
documentation of seizures	<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"/>
pre/post op 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"/>
shunts (ie: ventriculoperitoneal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
use of anticonvulsants:				
IM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
oral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
use of Glasgow Scale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



CV/CIRCULATORY

ability to perform 1 person rescue:				
(CPR) adult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
infant/child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
assess heart sounds (normal vs.				
abnormal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
basic EKG interpretation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
care of patients with:				
acute CHF	<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"/>

CV/CIRCULATORY - continued

	1	2	3	4
aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
blood lymph disease	<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"/>
cardiac surgeries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
femoral bypass/vascular				
procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
pacemakers	<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"/>
initiation of arrest procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
administration of meds during				
arrest procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
set up/run 12 lead EKG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
use of cardiac monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
use of dropper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



RESPIRATORY

Ambu techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
apnea monitor usage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
assess lung sounds				
knowledge of abnormal &				
adventitious breath sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
care of patients with:				
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
asthma/wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CA of lung	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
transplant/pulmonary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
chest tube maintenance and care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IPPB Machine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
incentive spirometer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nebulizers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oxygen therapy:				
face mask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
nasal cannula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
precautions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
use of portable oxygen tank	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1 2 3 4

RESPIRATORY - continued

Pulmonary Hygiene:

- chest physiotherapy (CPT)
- determining proper catheter size
- nasotracheal suctioning
- oral suctioning
- tracheostomy suctioning
- thoracentesis

Tracheostomy:

- changing trach or tube
- cleaning of inner cannula
- emergency management of
- dressings changes
- S&S of infection
- skin care

Ventilators:

- CPAP
- PEEP
- portables
- pressure pre-set
- volume pre-set

list types of ventilators:

- _____
- _____
- _____
- _____



GI/NUTRITION

abdominal drains:

- care and maintenance of
- assess GI status
- bowel training

care of patients with:

- anorexia
- bowel disease
- cancer of colon
- cancer of esophagus
- cancer of rectum
- GI bleeds
- hepatic encephalopathy
- hepatitis
- inflammatory bowel disease
- liver failure
- liver transplant
- enemas (Fleet or soapsuds)

Gastrostomy tube care:

- G-tube change
- G-tube feedings

N-G tube insertion/reinsertion:

- N-G tube feedings
- N-G tubes (ie: Levine,

1 2 3 4

GI/NUTRITION- continued

Salem Sump)

nasal intestinal tubes
(ie: Miller-Abbot, Cantor)

ostomy/stoma care

ostomy irrigations

education to new patients

paracentesis

parenteral feedings:

complications of

indications for

routes of administration

verification of fluid and

caloric requirements

removal of fecal impaction

use of pumps for enteral feedings

list types of pumps:



GI/ENDOCRINE

bladder irrigations

bladder training

care, maintenance and removal

of indwelling catheter

supra pubic catheter

3-way catheter

care of patients with:

AV shunt/fistula

bladder disease

cancer of kidney

cancer of prostate

female reproductive organ cancer

hysterectomy

hypo/hyperthyroidism

mastectomy

nephrectomy

renal failure

transurethral resection

catheter insertion:

female

male

diabetic care:

ADA diet

blood glucose testing

foot care

infection prevention

insulin prep and

administration

insulin site rotation and

1 2 3 4

GI/ENDOCRINE - continued

education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
skin care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S&S hypo/hyperglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
urine glucose testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
use of blood test meters	<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"/>
GYN exam/PAP procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ileostomy care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
intermittent catheterization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S&S of UTI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
urinary diversions (ileo-conduit)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

INTEGUMENTARY/ORTHOPEDIC

amputations/stump care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
assist in use of prosthetic devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
care of patient with:				
amputation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
arthritic disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
burns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
decubitus ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
gun shot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hip replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
incisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
knee replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
laminectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
stab wounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cast care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cast/splint application and removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
circo-electric bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
range of motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spika cast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stryker frame	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TENS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
traction:				
skeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
transfers:				
documentation of wounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
preventative skin care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sterile dressing changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
use of Braden scale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
wound enzyme debriders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
wound irrigations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ONCOLOGY

assessing analgesic effectiveness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bone marrow transplant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1 2 3 4

ONCOLOGY - continued

counseling for:				
altered image	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
grieving process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
imagery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
relaxation techniques	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
morphine pumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
narcotics via continuous infusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
radium implants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
side effects of chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IV THERAPY

administration of chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
administration/mixing IV meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
blood/blood products administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
calculate dosages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
calculate rates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
care of central lines:				
care of insertion site	<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"/>
hanging IV piggybacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
infusion procedures	<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"/>
record keeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S&S of complications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S&S of infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S&S of infiltration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
insertion of peripheral line:				
adult	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
elderly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
intralipids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
nursing care, maintenance of:				
Broviac catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buretois	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
heparin lock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
insertion of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hickman catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
peripheral lines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
porta-cath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
triple lumen catheter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ADDITIONAL NURSING RESPONSIBILITIES

admission procedure and				
initial assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
charge nurse responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
discharge planning and teaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1 2 3 4

ADDITIONAL NURSING RESPONSIBILITIES - continued

injections:

preparation of meds/syringe

record keeping

site prep, rotation and selection

knowledge of unit doses

lab value interpretation

pre/post op teaching

primary nurse responsibilities

problem oriented medical records

SOAP Charting

Specimen Collection:

arterial blood gas draw

interpretation

1 2 3 4

ADDITIONAL NURSING RESPONSIBILITIES - continued

capillary draw

clean catch urine

heelstick

sputum

stool

24 hour urine

urine via indwelling catheter

venipuncture

wound culture

team leading

universal isolation

procedures/precautions

use of restraints



CERTIFICATIONS

- ACLS
- BCLS
- Chemotherapy
- Diabetic Certification
- IV Therapy

EXPIRATION DATE

CERTIFICATIONS

- M/S
- Other _____
- Other _____
- Other _____

EXPIRATION DATE

SPECIALTY COURSE (Name)

DATE

LOCATION

1. _____

2. _____

3. _____

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



millenia
medical
staffing

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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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