

RP HOME CARE PERSONNEL APPLICATION
 INDEPENDENT CONTRACTOR PRE-CONTRACT INFORMATION

Personnel Category: ()RN ()LPN ()CNA ()HHA ()PT ()OT ()ST ()ECE/SI Other: _____

Name: _____ () Female () Male

Address: Street: _____ **City:** _____ **Zip:** _____
Are you 16 years of age or older? Yes No **Social Security #:** _____-_____-_____

Telephone #: () _____ **Alternate #:** () _____ **Cell #:** () _____

E-mail Address: _____

Emergency Contact Name: _____ **Relationship:** _____
Day Phone #: () _____ **Evening Phone #:** () _____

Referred By: _____

License/Certifications: RN LPN CNA PT OT ST ECE/SI MSW Other: _____
Number: _____ **State:** _____ **Number:** _____ **State:** _____
Number: _____ **State:** _____ **Number:** _____ **State:** _____
 RNs, LPNs, Therapists ___ I am CPR certified. Expir. Date: _____ ___ I will become CPR certified within 45 days of hire.
Foreign Languages: – Please List: _____

CURRENT EMPLOYER

<i>DATES EMPLOYED</i> (MONTH/YEAR) FROM: TO:	<i>EMPLOYER</i> NAME/ADDRESS	<i>POSITION/TITLE</i>	<i>SALARY</i>
<i>SUPERVISOR NAME:</i>	<i>TELEPHONE #:</i>	<i>REASON FOR LEAVING:</i>	
<i>DATES EMPLOYED</i> (MONTH/YEAR) FROM: TO:	<i>EMPLOYER</i> NAME/ADDRESS	<i>POSITION/TITLE</i>	<i>SALARY</i>
<i>SUPERVISOR NAME:</i>	<i>TELEPHONE #:</i>	<i>REASON FOR LEAVING:</i>	

WORK PREFERENCES

() Full Time () Part Time () Per Diem () Contract Hours Per Week Desired: _____ Travel Time to Work: _____
 () Visits () Shifts ___ Days ___ Evenings ___ Nights Days Available: _____
 () Public Transportation: () Car Desired Geographical Areas: _____

SKILLS/EXPERIENCE CHECKLISTS: CHECK ALL THAT APPLY

RNs/LPNs	Adult	Peds	Newborn	STORK WATCH RNs	No Exp.	Some	Extensive
TRACH CARE (TEST REQUIRED)				Use of fetal stethoscope			
VENTILATOR CARE (TEST REQUIRED)				Use of fetal doppler			
BOWEL/BLADDER TRAINING				Perform non-stress test and evaluate fetal strip			
CENTRAL LINE CARE				Determine uterine fundal height: antenatal			
IV SITE CARE				Determine uterine fundal height: postpartum			
VENIPUNCTURES				Teaching fetal kick counts.			
PULSE OXIMETER				Teach uterine self palp			
RESP/INHALATION TREATMENT				Gestational Diabetes Clients			
DIABETIC TEACHING				Pregnancy Induced Hypert. Clients			
PEDIATRICS (TEST REQUIRED)				Pre-Term Labor Clients			
HHAs/CNAs	Adult	Peds	Newborn	Neonatal gastrostomy			
TRANSFER BOARD () HOYER LIFT ()				Apnea Monitoring			
FOLEY CATHETER CARE				Infant with Reflux			
COLOSTOMY CARE				Assist with breast feeding			
FEEDING TUBE CARE				Baby-Heel sticks for labs			
VITAL SIGNS				Neonatal phototherapy			
CHILD CARE				Synagis			
NEWBORN CARE							
PT	Adult	Peds	Newborn	OT	Adult	Peds	Newborn
GROSS MOTOR ASSESSMENT				FINE MOTOR ASSESSMENT			
FUNCTIONAL ASSESSMENT				FUNCTIONAL ASSESSMENT			
ASSIST. DEV./POSITION EQUIP.				SSIST. DEV./POSITION EQUIP.			
ROM (PROM, AROM, AAROM)				ROM (PROM, AROM, AAROM)			
MUSCLE RE-EDUCATION/TONE				MUSCLE RE-EDUCATION/TONE			
GAIT TRAINING: 2 POINT				ADL TRAINING			
3 POINT				SPLINTING			
4 POINT				TRANSFERS: STAND PIVOT			
TRANSFER: STAND PIVOT				SLIDE BOARD			
SLIDE BOARD				HOYER LIFT			
HOYER LIFT				BED MOBILITY			
BED MOBILITY/POSITIONING				BED POSITIONING			
CHEST PERCUSSION/VIBRATION				FEEDING PROGRAMS			
ST	Adult	Peds	Newborn	ECE/SI	Adult	Peds	Newborn
DYSPHAGIA/FEEDING				COGNITION			
REFLUX				RECE/SIPTIVE LANGUAGE			
DYSARTHRIA				EXPRESSIVE LANGUAGE			
VOICE/FLUENCY				SOCIAL/EMOTIONAL SKILLS			
COGNITION				TYPICAL DEVELOPMENT			
RECEPTIVE LANGUAGE				ATYPICAL DEVELOPMENT			
EXPRESSIVE LANGUAGE							
NUTRITIONIST (list)							
SOCIAL WORKER (list)							

NAME _____

DATE SUBMITTED: _____