Q
D
STAFFING

HEALTHCARE STAFFING SPECIALIST

CLINICAL SKILLS CHECKLIST

Name ______________________________ Date ______________

Levels of Proficiency

A = Perform Well (at least one year experience within the last two years)

B = Limited Experience (6 months to one year within the last two years)

C = Perform Infrequently (less than three months within the last two years)

D = No Experience

PSYCH. CONSIDERATIONS	A	B	C	D
Psychiatric patient assessment				
Care of acute psychotic				
Care of violent patient				
Administer psychiatric meds				
Use of restraints				
Takedown				
ECG				
Adult Pediatric				

GI/GU/REPRODUCTIVE/ ENDOCRINE/ INTEGUMENTARY	A	B	C	D
Administer med via NG/gastrostomy tube				
Assist with vas-cath insertion				
AV shunt/fistula care				
Catheter insertion				
Female				
Male				
Care of burn patients				
Hyperbaric oxygen therapy				
Dialysis				
Hemo				
Peritoneal				
CVVHD				
Insulin preparation and administration				
Blood glucose monitoring				
Equipment used				
Jejunostomy care				
NG tube insertion/lavage				
Normal physiology of renal and GI system				
Ostomy/stoma care				
Peritoneal lavage				
Poison control				
Wound care irrigations				
Care of patients with				
Acute cholecystitis				
Acute renal failure				
Bowel obstruction				
Diabetes				
GI bleed				
Hyper/hypoglycemia				

(CONT.) GI/GU/REPRODUCTIVE/ ENDOCRINE/ INTEGUMENTARY	A	B	C	D
Multiple abdominal wounds				
Renal transplant				
Pancreatitis				
Transplant/kidney				

IV THERAPY	A	B	C	D
Administration of chemotherapy medications				
Administration of antibiotic medications				
Administration/mixing of IV medications				
Medications via IV push				
Administration of continuous fluids				
Blood/blood product administration/ precautions				
Autotransfusion				
Calculate doses				
Calculate rates				
Mcg/min				
Mcg/kg/min				
Hang IV piggybacks				
Hyperalimentation				
Peripheral/central line				
Knowledge of solutions				
Caloric and fluid requirements				
Insertion of central line				
CVP tray set-up				
Use of Broviac and Hickman catheters				
Implanted venous access ports				
Dressing changes				
Insertion of peripheral line				
Dressing change				
Discontinuing line				
Pump operations				
IVAC				
IMED				
Other				
______________				

ADD'L NURSING RESPONS.	A	B	C	D
Specimen collection				
Capillary blood draw				
Sputum				
Stool				
Venipuncture				
Wound culture				
Central line blood draw				

PULMONARY	A	B	C	D
Ambu bag techniques				
Administer oxygen				
Use of apnea monitor				
Assess lung sounds				
Assist in intubation/extubation				
oropharyngeal airway				
nasopharyngeal airway				
Chest physiotherapy				
Complications of				
Chest tube insertion (assist in)				
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				
Trach tray set up				
Assist with emergency trach				
Changing of trach or tube				
Skin care				
Dressing changes				
Ventilator management				
Patient assessment				
Troubleshooting with vents				
Weaning from ventilator				
List types of ventilators				
______________				
______________				
Care of patients with				
Acute respiratory distress				
AIDS				
Asthma				
Collapsed lung				
COPD				
DIC				
Hemothorax				
Pneumonia				

(CONT.) PULMONARY.	A	B	C	D
Pulmonary embolism				
TB				
Transplant/pulmonary				
ECMO				
Monitoring				
Care				

MEDICATION ADMIN.	A	B	C	D
Injections				
Preparation of meds/syringe				
Site selection (i.e. SQ vs IM)				
PO administration				
SL administration				
Use of the following medications				
Activase				
Aminodarone				
Atropine				
Bicarbonate				
Bretylium				
Cardizem				
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				
Streptokinanse				
Verapamil				

PEDIATRICS	A	B	C	D
Administration of Medication				
Oral				
Subcutaneous				
Intramuscular				
Pediatric Nursing				
Anorexic patient care				
Assist with lumbar puncture				
Respiratory distress syndrome				
Broncho-pulmonary dysplasia				
Croup				
Epilogotitis				
Asthma				
Cystic fibrosis				
Pneumonia				
Near drowning				
Near SIDS				
Chest tubes				
Reye's syndrome				
Meningitis				
Hydrocephalus				
Spina bifida				
Lead play therapy				
Care of child with seizures				
Sickle cell				
Other problems				
___________				
___________				
Equipment				
Apnea monitor				
Cardiac monitor				
Ventilator				
ECMO				
Care of child with				
Child abuse				
Failure to thrive				
Cleft palate				
Post tonsillectomy				
Dying infant/child				
Diabetes mellitus				
Diabetic acidosis				
Psych. patients				
Other specialties				
___________				
___________				

MATERNAL/CHILD CARE	A	B	C	D
General Skills				
Admission assessment				
Legal principles of charting				
Patient education				
Specimen collection				
Lab value assessment				

(CONT.) MATERNAL/CHILD CARE	A	B	C	D
Pain management				
Isolation procedures				
Wound and skin care				
Diabetic teaching				
Discharge teaching				
Use of restraints				
Maternal/Child				
Antepartum patient care				
Pre-natal care teaching				
LaMaze instructor				
Labor and delivery patient care				
High risk labor patient care				
Assist regional anesthesia (epidural)				
Internal monitor/lead connection and calibration				
Pitocin therapy				
Magnesium sulfate therapy				
Vag exam				
Use of fetoscope doppler				
Assist with vaginal delivery				
Forceps vaginal delivery				
Circulate for c-section				
Scrub for c-section				
Fetal stress testing				
Hyperbilirubin infant care				
Newborn infant care				
Post natal care teaching				
Post natal patient care				
Breast care				
Provide intrapartum care to patient with				
Pregnancy induced hypertension				
Preeclampsia/eclampsia				
Multiple gestation				
Placenta previa				
Abruptio placenta				
Malpresentations				
Premature labor				
Diabetes mellitus				
Rh incompatibilities				
DIC				
Neonatal resuscitation				
Apgar score				
Postpartum assessment				
Fundus consistency				
Lochia				
Bladder distention				
Episiotomy/incision for caesarean				
LDR				
LDRP				

RADIOLOGY	A	B	C	D
Conscious sedation				
Hemodynamic monitoring – A-lines				
IV insertion				
Ventilator therapy				
Vasoactive drips				
Thrombolytic therapy				
Ionic & non-ionic IV contrast admin.				
Needle biopsy				
ECG monitoring / interpretation				

CATH LAB	A	B	C	D
Assist with angiograms				

CERTIFICATIONS	EXP. DATE
ACLS	
BCLS	
CCRN	
IV Therapy	
Chemotherapy	
TNCC	
ENC	
Other	

CV/CIRCULATORY	A	B	C	D
Arterial line/Swan Ganz set up				
Blood sample from line				
Remove arterial line				
Arterial Blood Gases				
Pressure reading				
Maintain patency				
Assess heart sounds				
Assist with pacemaker insertion				
Temporary/single/double lumen				
Recognize pacemaker malfunction				
Pacemaker care				
Paceport Swan Ganz				
Assist with pericardiocentesis				
External pacemaker maintenance				
Blood pressure monitoring/automatic machine				
Assist in				
Arterial line insertion				
Swan Ganz insertion with or without fluroscopy				
Dysrhythmia recognition and intervention				
Normal anatomy of heart				
Left side				
Right side				
Normal physiology of CV system				
Post angiogram care				
Post open heart care (OH)				
Removal of arterial/venous sheaths				
Resuscitation				
Team member				
Perform defibrillation				
Perform/set up emergency cardioversion				

(CONT.) CV/CIRCULATORY	A	B	C	D
Prepare and administer medications				
Set up, run, interpret 12 lead EKG				
SVO2 monitoring				
Interpretation				
Troubleshooting				
Swan Ganz hemodynamic monitoring				
Knowledge of RA/PAP/PCWP/CO/SVR/PVR/CI				
Obtaining and troubleshooting waveforms				
Pre/post cardiac cath care				
Aortic Balloon Pump care/ monitoring				
LVAD				
Perform EKG				
Use of cardiac monitor				
Proper lead placement				
Use of doppler				
Care of patients with				
Acute aneurysm				
Acute MI				
Angina				
CHF				
Airway maintenance				
Deep vein thrombosis				
Pulmonary edema				
Shock				
Cardiogenic				
Hypervolemic				
Septic				
Transplant/cardiac				
Post TPA				
Post CABG (Immediate)				
Post CABG (After 3 days)				

NEUROLOGICAL SYSTEM	A	B	C	D
Assessing sensory-motor function extremities				
Assist with lumbar puncture				
Cervical traction				
Cranial nerve assessment				
Crutchfield tongs				
Halo traction				
LOC assessment				
Monitoring of ICP				
Appropriate interventions for changes in pressure				
Pre/post neuro surgical care				
Seizure precautions				
Use of Glascow coma scale				
Visual acuity measurement				

QD

Staffing

Healthcare Staffing Specialist-Medical Evaluation

Have you ever had any of the following? Select Yes or No.

	Yes	No		Yes	No
Anemia			Lung disease		
Allergy to drugs			Shortness of breath		
If yes, which drug(s)?			Hemorrhoids		
			Rheumatic fever		
			Rheumatism		
Asthma			Arthritis		
Back Trouble			Hernia/Rupture		
Bronchitis			Teeth problems		
Blackouts or dizziness			Tuberculosis (+ skin test)		
Chronic Colds			Swallowing issues		
Cancer or Tumor			Varicose veins		
Chest Pain			Venereal disease		
Emphysema			Weakness		
Epilepsy			Skin issues-boils, rashes…		
Eye Trouble			Spinal injury		
Diabetes			Glasses		
Frequent Headaches			Psychiatric disorder		
Foot Pain			Hearing problem		
GI-Indigestion			Smoker		
Gallbladder dysfunction			Tetanus shot?		
Head Injury			When?		
Heart trouble			Hx. Of Surgery?		
High blood pressure			When?		
Kidney disease			What?		
Liver disease (Hepatitis)			Any communicable disease		

Signature if above information is true to the best of your knowledge.

Signature: ______________________ Date:__________________

QD
Staffing
Healthcare Staffing Specialist

Name____
Last First Middle

S.S.#____________________________

Classification: RN_____ LPN_____

License #________________ State Issued_______________
Exp. Date________

Have you ever had your license suspended or revoked? Yes___ No___

Present Address

Street____
City_________________________ State_______ Zip___________
Home phone #__________________ Work phone #________________________
How did you learn about Q-Day Medical?
____
Date of last physical exam__________ Chest x-ray__________
PPD___________
Do you have any impairments, physical or mental, which would interfere with your ability to perform assignments for which you have applied? Yes___ No___ If yes, please describe the impairments and explain any work limitations. ________
____
____
Do you have malpractice insurance? Yes___ No___ If yes, please give policy name and number____
Specify date your available to start with Q-Day Medical____________________

QD Staffing

References

Name three persons in the nursing profession, not related to you, that you have worked for at least one year

Name	Address and Ph#	Relationship (supervisor, co-worker)	Years Known
1)			
2)			
3)			

Authorization given to QD Staffing to contact all references and authorization for references to give QD Staffing requested information.

Date ________________ Signature ___________________________________

Education Data

	Name and Address	Dates Attended	Graduated	Courses/Major Degree
High School			YES NO	
Vocational/ Technical			YES NO	
College/ University			YES NO	

List Previous Employers

Prior Employer____

Address____

City_____________________________State____________Zip_______________

Date of Employment_____/_____/______ Phone( ) -

Job Duties___________________________Name of Supervisor_______________________

Prior Employer____

Address____

City_____________________________State____________Zip_______________

Date of Employment_____/_____/______ Phone( ) -

Job Duties___________________________Name of Supervisor_______________________

QD Staffing

I have had experience in the following areas:

- ❑ Burns
- ❑ ICU
- ❑ Nursing Home
- ❑ Orthopedics
- ❑ Pediatrics
- ❑ Cardiac Care
- ❑ Urology Pediatrics
- ❑ Operating Room
- ❑ Nursery
- ❑ Med/Surg
- ❑ Doctors Office
- ❑ Labor and Delivery
- ❑ Neurology
- ❑ Oncology
- ❑ OB/GYN
- ❑ Rehab
- ❑ Alcohol and Drug Treatment
- ❑ Cardiac Cath Lab
- ❑ Charge/Supervisory duty
- ❑ Dialysis (Hemodialysis)
- ❑ Dialysis (Peritineal)
- ❑ Endoscopic Lab
- ❑ Emergency Room
- ❑ Recovery Room
- ❑ Surgical Intensive Care
- ❑ Step-down Unit
- ❑ Telemetry Unit
- ❑ Ventilators
- ❑ ______________________
- ❑ ______________________

- ♦ From above list what are your preferred areas to work?____
- ♦ Shift preference 7a-7p______or 7p-7a_______
- ♦ I will work any area listed above on any shift. Yes__ No__
- ♦ How many hours do you prefer to work a week?________

Important information to complete your application

1. Copy Professional License
2. Copy of current CPR card
3. Copy of Social Security Card
4. Copy of PPD of Chest X-ray last 12 months
5. Copy of current drivers license
6. Copy of physical within last 12 months
7. Copy of drug screen within last month

QD STAFFING

Applicant's Name:
Position Applied For:
Company Contacted:
Reference's Name and Title:
Telephone Number:
Date:

Thank you for taking my call. (Applicant's name) is a finalist for the position of (job title) at the

QD STAFFING

1. In what capacity have you known the applicant, and for how long?

2. What were the applicant's title, salary and dates of employment with your organization?

3. How would you describe the applicant's duties in this position?

4. How would you describe the applicant's style of relating to people?

5. How well did the applicant follow direction?

6. How well did the applicant perform assignments?

7. Did the applicant follow-through on assignments in a timely manner? Please describe.

8. How was the applicant's decision making ability and ability to work independently?

9. What are the applicant's strongest job skills?

10. Have you perceived any weaknesses in work performance?

11. What was the reason for leaving?

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	**OR**	**List B** Identity	**AND**	**List C** Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				**3-D Barcode Do Not Write In This Space**
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: ________________ *(See instructions for exemptions.)*

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative	
Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name	
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)* Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	B. Date of Rehire *(if applicable) (mm/dd/yyyy)*:

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date *(if any)(mm/dd/yyyy)*:

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	- -		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): ____________

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) ____________. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: ____________

OR

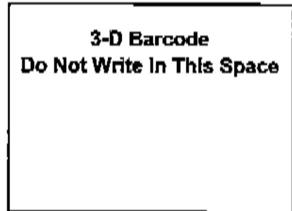
2. Form I-94 Admission Number: ____________

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: ____________

Country of Issuance: ____________

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. *(See instructions)*



Signature of Employee:	Date *(mm/dd/yyyy)*:

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:	Date *(mm/dd/yyyy)*:

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP