ICON HEALTH SERVICES APPLICATION PACKET

APPLICANT INFORMATION

Last Name	First	M.I.	Date
Street Address		Apartment/Unit #	
City		State	ZIP
Phone		E-mail Address	
Emergency Contact Name:		Phone #:	
Date Available	Social Security No.	Desired Salary	
Position Applying for			
State Nursing License Number		Expiration Date:	
Have you ever held a nursing license in another state?	YES ☐	NO ☐	
List where and when:			
Are you a citizen of the United States?	YES ☐ NO ☐	If no, are you authorized to work in the U.S.?	YES ☐ NO ☐
Working VISA #:		Expiration Date:	
Driver's License #:		Expiration Date:	
Have you ever worked for this company?	YES ☐ NO ☐	If so, when?	
Have you ever been convicted of a crime? (Not a complete condition of employment)	YES ☐ NO ☐	If yes, explain	

EDUCATION

High School					Address			
From		To		Did you graduate?	YES ☐	NO ☐	Degree	
College					Address			
From		To		Did you graduate?	YES ☐	NO ☐	Degree	
Other					Address			
From		To		Did you graduate?	YES ☐	NO ☐	Degree	

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PREVIOUS EMPLOYMENT		
Company	Phone	
Address	Supervisor	
Job Title	Starting Salary $	Ending Salary $
Responsibilities		
From To	Reason for Leaving	
May we contact your previous supervisor for a reference? YES ☐ NO ☐		
Company	Phone	
Address	Supervisor	
Job Title	Starting Salary $	Ending Salary $
Responsibilities		
From To	Reason for Leaving	
May we contact your previous supervisor for a reference? YES ☐ NO ☐		
Company	Phone	
Address	Supervisor	
Job Title	Starting Salary $	Ending Salary $
Responsibilities		
From To	Reason for Leaving	
May we contact your previous supervisor for a reference? YES ☐ NO ☐		

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DISCLAIMER AND SIGNATURE
I certify that my answers are true and complete to the best of my knowledge. If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release. I understand that this application is not an offer or contract for employment. If I am hired, I can be terminated at will, with or without a cause, at any time and for any reason at the option of ICON HEALTH SERVICES or myself. ICON HEALTH SERVICES may verify the information that I have presented with all those involved with my education, previous employment and law enforcement entities. I hereby release them and their companies from all liability for divulging the same. ICON HEALTH SERVICES is an equal opportunity employer and does not discriminate in its recruiting, interviewing, selection and hiring procedures due to race, color, gender, region, national origin, age, sexual orientation or disability status.
Signature Date

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PEDIATRIC NURSING EXPERIENCE AND TRAINING

Pediatric Home Health is a nursing environment that requires a very specific skill set. Not only do you need the medical skills to properly and successfully care for children, you must possess strong empathy for the special needs our precious patients require. In order for us to determine your readiness to join our amazing team, we would like to get to know a little more about your past experience and skill training in the world of pediatric nursing and home health care.
Please complete the table below to the best of your ability. The information you provide is for your **PEDIATRIC EXPERIENCE ONLY!**

Name of Facility/Phone #	Type of Pediatric Care Provided	Years Employed
Supervisor's Name/Title		
Name of Facility/Phone #	Type of Pediatric Care Provided	Years Employed
Supervisor's Name/Title		
Name of Facility/Phone #	Type of Pediatric Care Provided	Years Employed
Supervisor's Name/Title		
Name of Facility/Phone #	Type of Pediatric Care Provided	Years Employed
Supervisor's Name/Title		
Name of Facility/Phone #	Type of Pediatric Care Provided	Years Employed
Supervisor's Name/Title		

By signing this form, I attest that all information provided is correct. I also give consent for ICON HEALTH SERVICES to contact the individual supervisors listed above to verify my work experience.

Employee's Printed Name: _____

Employee's Signature: _____ Date: _____

ICON HEALTH SERVICES WITNESS: _____ Date; _____

ICON HEALTH SERVICES

Competency/Skills Self-Appraisal: Home Health ☐ RN ☐ LVN

Name _____ **Date** _____

Please check the column that applies to your skill level:

3 = Very Competent > 1yr Exp. 2 = Some Help needed <1 yr. Exp. 1 = Need Direction <6 months Exp. 0 = Never

SKILLS	3	2	1	0	SKILLS	3	2	1	0
BCLS Expires: _____					Restraint Application/Procedures/Safety				
PALS Expires: _____					End of Life Care				
CPN Date: _____					Isolation Criteria/Methods				
IV Certification Expires: _____					Monitoring of intake and output and weight.				
Other Certification (specify): _____					Patient positioning, Ambulation and ROM				
Computerized Charting System (specify) _____					Physician Orders				
Medication Administration System (specify) _____					Medication Administration and Documentation				
1. AGE SPECIFIC PRACTICE CRITERIA:					DME Supplies and Ordering				
Newborn/Neonate (birth to 30 days)					Routine Post-Op Care				
Infant (30 days to 1 year)					Specimen Collection				
Toddler (1 -3 years)					Recognizing Failure to Thrive				
Preschooler (3-5 years)					**4. CARDIAC:**				
School Age Children (5-12 years)					Pulse assessment (Peripheral, Apical)				
Adolescent (12-18 years)					Capillary refill assessment				
Young Adults (18-39 years)					Blood Pressure Monitoring				
2. EXPERIENCE WITH AGE GROUPS:					Auscultation/Interpretation Breath & Heart Sounds				
Able to adapt care to incorporate normal growth and development					Fluid retention				
Able to adapt method and terminology of patient instructions to their age, comprehension and maturity level					**5. RESPIRATORY:**				
Ensures safe environment reflecting specific needs of various age groups					Assessment/auscultation of lung sounds				
3. GENERAL SKILLS:					Nasal/oral suctioning				
Admission/Transfer/Discharge					Tracheostomy Care				
Head to Toe Patient Assessment					Tracheostomy Change				
Obtaining and monitoring vital signs					Tracheal suctioning				
Charting/Documentation/Consents/Care Plans					Humidified trach collar				

Patient/Family/Caregiver teaching					O2 Therapy and Medication Delivery Systems - Ambu bag and mask				
Advance Directives					Sputum specimen collection				
Universal Precautions/Infection Control Procedures					Nebulizer via mask and trach adapter				
Rescue breathing/CPR					Administration of O2-Portable and Concentrator				
SKILLS	**3**	**2**	**1**	**0**	**SKILLS**	**3**	**2**	**1**	**0**
Pulse Oximetry					Tube Feeding-Pump				
Manual CPT					Tube Feeding-Medication Administration				
CPT vest					Colostomy				
IPV					PR Medication Administration				
Cough Assist					**8. RENAL/GENITOURNARY SYSTEM:**				
Ventilator Experience					Input/Output Recording				
CPAP/BiPAP					Fluid and electrolyte balance				
Apnea Monitoring					Insertion and care of straight and Foley catheter – male and female				
Asthma Care and Protocols					Long-term catheter care				
6. NEUROLOGICAL:					Assessment for Urinary Tract Infection				
Neurological assessment					Nephrostomy tube care				
Glasgow Coma Scale					Bladder irrigation				
Seizure precautions					Mitrofanoff cathing				
VNS Stimulator					Kidney stone management				
Diastat Administration					Straining urine				
VP Shunt s/s of malfunction					Incontinence care				
Quadraplegia/Paraplegia Experience					**9. METABOLIC AND ENDOCRINE SYSTEM:**				
Traumatic brain injury					Use of electronic blood glucose monitoring device				
7. GASTROINTESTINAL:					Performing finger stick				
Assessment of GI patient - abdominal/bowel sounds					Insulin Administration				
Fluid balance					Recognizing diabetic complications/emergencies				
Nutritional requirements					Indwelling insulin pump management				
Placement of NG tube					**10. EYES, EARS, NOSE and THROAT:**				
NG Medication Administration					Nosebleeds				
NG Tube care					Ear infections				
PEG Tube Care					Ear tubes				
Gastrostomy Placement					Cataracts/Glaucoma				

Gastrostomy Stoma Care					Eye drop administration				
Tube Feeding- Gravity					Ear drop administration				

SKILLS	3	2	1	0	SKILLS	3	2	1	0
11. ORTHOPEDICS:					**13. VASCULAR:**				
Assessment of orthopedic patient – Circulation checks					Peripheral pulses				
Ambulation/Gait					Peripheral Line dressings				
Range of Motion					Fluid overload				
Body repositioning					Heparin Lock				
Transfer Board					Port a cath				
Casts					Management of ports				
Hand Splints					TPN/Hyperalimentation				
AFO/SMO/KFO					Knowledge of normal serum blood values				
TLSO/BENIK					**14. INFECTIOUS DISEASES:**				
Fractures					Fever Management				
Osteoporosis Management					Isolation Precautions				
Post Harrington Rod insertion					MRSA Management				
Spina bifida					Universal Precautions/Hand Washing				
Skeletal traction					**15. PAIN MANAGEMENT:**				
12. WOUND MANAGEMENT/ SKINCARE:					Pain Assessments				
Assessment of skin at risk for breakdown					Pain Medication Management				
Pressure area management					**17. OTHER:**				
Care of staged decubitis ulcers					Calculations of pediatric dosages				
Surgical wound healing					Phototherapy				
Wound healing with JP drains					Cord and circumcision care				
Wound irrigation					Overdose/poison ingestion				
Sterile dressing changes					Burns				
Use of wound vac					Post-transplant care				
IV Pump set up									
IV Starts									
Drawing venous blood									
Drawing blood from central line									
Central line/catheter dressing									

Reference Request

Date: _____ Check method of gathering reference data: ☐ Verbal ☐ Mail

Name of person giving reference: _____ Facility: _____

The individual named below is applying for a position as _____ and has given you as a reference. As we place great importance on the thorough screening of all our applicants, we would appreciate a prompt and thoughtful response.

Thank you in advance _____
(Name of Company Representative)

Applicant Release

Applicant _____ _____
Last First MI Maiden

Position Held _____

Social Security # _____ Dates Employed: From _____ To _____

I hereby release from all liability the company or person completing this form, and authorize them to release all information regarding my employment with them. I understand that this information may be released to clients of the requesting company and other requesting third parties on a need to know basis. I also release the requesting company from all liability for any damages from the disclosure of this information.

_____ _____
Applicant Signature Date

1) Please confirm the applicant's employment. From _____ To _____
Date Date

2) Please comment on the applicant's attributes using the following scale:
4 = Excellent 3 = Good 2 = Fair 1 = Poor N/A = Not applicable

Quality of Work _____

Knowledge & Skills _____

Reliability & Attendance _____

Cooperation _____

Competence _____

Supervisory ability & capacity _____

Grooming _____

3) Please indicate specialty areas in which the applicant has had experience: _____

_____

4) Please indicate any special considerations necessary when giving assignments to this individual:

_____

5) Is applicant eligible for rehire? ☐ Yes ☐ No If no, why not? _____

_____

Please attach any additional comments.

_____ _____ _____
Signature Position/Title Date

HCL / Reference Check
Org. 110100

Reference Request

Date: _____ Check method of gathering reference data: ☐ Verbal ☐ Mail

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