Action Supportive Care Services

Date: _____

Name: _____
Last First M.I.

Address: _____
Number Street

_____
City State Zip Code

Employment Desired

Days ☐ PM's ☐ Nights ☐

Full time ☐ Part time ☐

Social Security Number: _____ Primary Phone: Home ☐ Cell ☐

Home Phone: _____ Cell Phone: _____

Email Address: _____

Are you at least 18 years of age? yes ☐ no ☐ Do you have proof of U.S. citizenship? _____

Have you ever been convicted of a criminal offense?_____If yes, explain _____

Have you ever been employed by Action Supportive Care?_____When? _____

How did you hear about the position? (newspaper, friend, yellow pages…) _____

How were you referred to our company? _____

Name of any friends or relatives employed here:_____

Type of School	Name and Location of School	Years	Grad.	Degree/Major

Please list any special courses, training, languages, etc._____

Professional Licenses, Registrations and/or Certifications:

Type: _____ Number: _____ Exp. Date: _____

Action Supportive Care is an equal opportunuty employer and does not discriminate on the basis of race, color, religion, gender or national origin as established in the Civil Rights Act of 1964. Title 1 provisions of the Americans With Disabilities Act of 1990 prohibits discrimination against qualified individuals with disabilities in job application procedures.

Experience: Please give a complete record of all employment and reasons for periods unemployed.

If you have been employed under a different name, please list name:______________________

*** List your most recent employment first**

(Please list 10 years of employment history) Dates

Employer:	From	To	Duties:
Address:			
Telephone number:	Hourly rate/Salary		
Title: Supervisor:			
Reason for leaving:			
Employer:	From	To	Duties:
Address:			
Telephone number:	Hourly rate/Salary		
Title: Supervisor:			
Reason for leaving:			
Employer:	From	To	Duties:
Address:			
Telephone number:	Hourly rate/Salary		
Title: Supervisor:			
Reason for leaving:			
Employer:	From	To	Duties:
Address:			
Telephone number:	Hourly rate/Salary		
Title: Supervisor:			
Reason for leaving:			

May we contact your present employer for a reference? ☐ yes ☐ no

Acknowledgement (please read carefully)

Employment is subject to passing of a physical examination and the receipt of satisfactory references. I agree to submit to a physical exam. I further authorize all previous employers and schools named to give any information regarding my employment or physical condition.

I hereby certify that all information furnished on this application is complete and accurate. I understand/agree that any misrepresentation, falsification, or material omission of information on this application may result in my failure to receive an offer or, if I am hired, in my dismissal from employment.

Applicant's Signature **Date**

SKILLS ASSESSMENT

Please indicate all areas in which you have experience:

Procedure	Education	Training	Current (6 mo.)	Recent (6-12 mo.)	Previous (12-18 mo.)	Review Needed	Never Performed
Auscultate Lung Sounds							
Use Manual Resuscitator Bag							
Use O_2							
Give Nebulizer Treatments							
Suction Patient: Nasal							
Suction Patient: Oral							
Suction Patient: Trach							
Perform Trach Tube Change							
Perform Trach Cannula Change							
Change Trach Ties							
Artificial Nose Function							
Passey-Muir Valve Function							
Administer GT Feeds/Meds							
Administer NG Feeds/Meds							
Insert/Change GT Tube/Button							
Insert/Change NG Tube							
Flush Tube/Button							
Stoma Care							
Wound Care							
Pump Feeds: Bolus							
Pump Feeds: Continuous							
Gravity Feeding: Bolus							
Gravity Feeding: Continuous							
Bowel Care: Ostomy Irrigation							
Bowel Care: Digital Stim							
Bowel Care: Enema/Suppository							

Procedure	Education	Training	Current (6 mo.)	Recent (6-12 mo.)	Previous (12-18 mo.)	Review Needed	Never Performed
Foley Cath: Insertion							
Foley Cath: Removal							
Foley Cath: Irrigation							
Clean Intermittent Cath (CIC)							
Supra Pubic Cath: Insertion							
Supra Pubic Cath: Removal							
Supra Pubic Cath: Irrigation							
Condom Cath							
Pt. Transfers: Mechanical Lift							
Pt. Transfers: Slide Board							
Wheelchair: Standard							
Wheelchair: Electric							
Beds: Crib							
Beds: Standard							
Beds: Specialized							
Vent: Volume							
Vent: Pressure							
Bi-PAP/C-PAP							
Apnea Monitors							
Suction Machine: Bedside							
Suction Machine: Portable							
O_2 Cylinders							
Concentrators							
Pulse Oximetry							
Specimen Collection: Urine							
Spec. Coll.: Stool							
Spec. Coll.: Sputum							
Spec. Coll.: Throat/Wound							
Spec. Coll.:Tracheal Aspirate							
Spec: Blood Glucose Monitoring							
Glucometer							
Urine Dipsticks							
Implanted Devices: Shunts							
Pumps							

Procedure	Education	Training	Current (6 mo.)	Recent (6-12 mo.)	Previous (12-18 mo.)	Review Needed	Never Performed
IV ☐ Peripheral ☐ Broviac ☐ Midline ☐ PICC							
MDI's							
PPD							
ROM Position							
Compression Hose							
Diet							
Fluids							
Emergency							
Cardiac/Resp. Arrest							
Bleeding (Severe)							
Head Injury/Seizures							
Shock							
Autonomic Dysreflexia							
Evacuation Plan							
ER Plan/Code Status							
Home Safety							
Infection Control							
Handwashing							
Gloves							
Personal Protective Equip.							
Sharps							
MSDS (Hazard Comm.)							
Hazardous Waste Disposal							
Patient Assessment							
Temp ☐ Oral ☐ Rectal ☐ Axilary							
Pulse ☐ Apical ☐ Radial							
B/P							
Skin ☐ Color ☐ Tugor							
Wound Assessment							
EENT ☐ Pupil Rxn							
Cardiopulmonary							
Airway Management							
Breath sounds							
s/s Resp. Distress Management							
Secretion, description, mgmnt.							
Edema							
Peripheral Pulse ☐ CRT							

Procedure	Education	Training	Current (6 mo.)	Recent (6-12 mo.)	Previous (12-18 mo.)	Review Needed	Never Performed
GI/GU							
☐ Bowel Fxn							
☐ Bowel Sounds							
☐ Bladder Fxn							
☐ Bladder Sounds							
Endocrine							
☐ s/s ☐ ↓BS ☐ ↑BS							
Neuro							
Mental Status/loc							
☐ Tone ☐ Reflexes							
Musculoskeletal							
☐ Muscle Strength ☐ ROM							
Growth & Development							
☐ Normal ☐ Delays							
Psycosocial Assessment							
☐ Coping ☐ Referral Process							
Charting							
Verbal MD Orders							
Incident Reporting							
Objective Notes							

Knowledge Testing

Ventilators ☐ Yes ☐ No Specify:

Special Certifications:

Inservices/CEU's:

Employee/Applicant Signature: _____ **Date** _____

ASCS Representative Signature: _____ **Date** _____