



**HOME HEALTH REGISTERED NURSE SKILLS CHECKLIST**

NAME: \_\_\_\_\_ SS#: \_\_\_\_\_ DATE: \_\_\_\_\_

In order to be able to better place you in the appropriate health care setting, Shay Health Care Services/Shay Nursing Services, Inc. asks that you fill in the information below. This will assist the nursing department in assigning you to the cases that best fit your skills.

<p>Please check the type of patients that you have had experience with:</p> <p>_____ care of newborns          _____ care of toddlers          _____ care of handicapped children          _____ care of handicapped adults          _____ care of Alzheimer's patients          _____ care of AIDS patients          _____ care of terminally ill patients          _____ care of quadriplegic patients          _____ care of paraplegic patients          _____ care of geriatric patients          _____ other, please explain</p>	<p>Please indicate the number of years experience in each setting below.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">_____ Hospital</td> <td style="width: 33%;">_____ Q. A.</td> </tr> <tr> <td>_____ Medicare</td> <td>_____ State Facility</td> </tr> <tr> <td>_____ School</td> <td>_____ Home Visits</td> </tr> <tr> <td>_____ Pediatric</td> <td>_____ Private Duty</td> </tr> <tr> <td>_____ Industrial</td> <td>_____ Case Management</td> </tr> <tr> <td>_____ Insurance</td> <td></td> </tr> <tr> <td>_____ Supervisor</td> <td></td> </tr> <tr> <td>_____ Hospice</td> <td></td> </tr> <tr> <td>_____ Day Care Center</td> <td></td> </tr> <tr> <td>_____ Other, please explain</td> <td></td> </tr> </table>	_____ Hospital	_____ Q. A.	_____ Medicare	_____ State Facility	_____ School	_____ Home Visits	_____ Pediatric	_____ Private Duty	_____ Industrial	_____ Case Management	_____ Insurance		_____ Supervisor		_____ Hospice		_____ Day Care Center		_____ Other, please explain	
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**SKILLS CHECKLIST**

Please check each skill area below using the following number system to indicate your experience:

**1** = Independent (requires no instruction)      **2** = Have had experience, but needs instruction      **3** = No experience

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|---|---|
| <p>_____ Suprapubic catheter changes</p> <p>_____ Tracheostomy change</p> <p>_____ Tracheostomy care</p> <p>_____ Starting IV's</p> <p>_____ Hyperalimentation/Lipids</p> <p>_____ Feeding pumps</p> <p>_____ IV antibiotics</p> <p>_____ G-tube</p> <p>_____ Colostomy</p> <p>_____ Urostomy</p> <p>_____ Medications</p> <p>_____ S.O.A.P. charting</p> <p>_____ Chemotherapy</p> <p>_____ Other (please explain) _____</p> | <p>_____ Central venous access device</p> <p>_____ Tracheostomy suctioning</p> <p>_____ Drawing blood (peripheral)</p> <p>_____ Maintaining IV's</p> <p>_____ Oxygen</p> <p>_____ Infusion pumps</p> <p>_____ J-tube</p> <p>_____ N/G tube</p> <p>_____ Ileostomy</p> <p>_____ IM Injections</p> <p>_____ Ventilators</p> <p>_____ Apnea monitors</p> |
|---|---|

APPLICANT SIGNATURE

DATE



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**REGISTERED NURSE APPLICANT CHECKLIST**

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Thank you for your interest in employment at Shay Health Care Services. We have developed this checklist to assist you in preparing for the next step in the application process and to streamline the application process.

After you complete the application packet the next step is to come into the office Mon – Thurs 9am – 2pm with your completed application and the below listed documents to:

**Shay Health Care Services, Inc.  
5730 W. 159th. St.  
Oak Forest, IL 60452  
The Shay Career Hotline is: 708-535-4309**

We ask that you please come as prepared as possible and provide the following:

- o Current Illinois Nursing License
- o Current CPR Card for Health Care Professionals
- o A Valid Drivers License
- o Proof of Current Auto Insurance Coverage

**These documents must be original. Copies will not be accepted.**

Please come appropriately dressed as though you would be working. We also ask you not to wear perfume or cologne.

**We look forward to meeting you!**

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SHAY Health Care Services/SHAY Nursing Services is an equal opportunity employer (EOE)