



Nurse Care of North Carolina
3200 Croasdaile Drive, Suite 701, Durham, NC 27705
Phone: (919) 309-4333 Fax: (919) 309-4430

Required Documentation Checklist

Applicant Name: _____ Date _____

Copies of the following items must be in your file before we can place you on an assignment:

- Completed, signed application
- Essential Skills Checklist
- Unit specific checklist(s), if applicable
- Reference Forms (2)
- Signed Travel Nursing Authorization and Release
- Signed Confidentiality Statement
- Completed Consumer Reports & Criminal Background Check Profile
- Completed Health Statement and Release, signed by physician
- Signed Health Declinations page
- Documentation of all immunizations:
 - MMR boosters OR titre
 - Varicella immunity
 - Hepatitis B series
 - TB skin test (current within one year) OR Record of TB Screening Form and x-ray
 - Td/Diphtheria
 - Tetanus (within ten years)
- Copies of certifications (BLS, ACLS, etc.) - front and back of card
- Copies of all current nursing licenses - front and back of card(s)
- Copy of driver's license
- Copy of social security card
- Direct Deposit form with voided check



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TRAVEL NURSING APPLICATION

PERSONAL

Name:			Title	
			<input type="checkbox"/> RN	<input type="checkbox"/> LPN
Last	First	Middle Initial		
Address: _____				
Apt #:	City	State	Zip Code	
Phone & E-mail:			Social Security Number	
(home) _____			Date of Birth	
(cell) _____				
(Other) _____				
E-mail: _____				

EDUCATION

	Name & Address	Type Of Diploma
Nursing School		
Other College		

EXPERIENCE (1+ Years):

- Cardiac Crit. Care Dialysis ER ICU Med/Surg NICU OBG
 OR Ortho PACU PICU Pediatrics Psych Rehab Telemetry

EMPLOYMENT HISTORY (beginning with most recent position or attach resume)

Hospital	# of Beds
Address	
Phone:	Unit(s) Worked
Dates Employed: From	To
Average Caseload	
Travel Assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what agency?	
Nurse Manager Name & Title	Phone

Applicant Name: _____

EMPLOYMENT HISTORY (continued)

Hospital _____	# of Beds _____
Address _____	
Phone: _____	Unit(s) Worked _____
Dates Employed: From _____	To _____ Average Caseload _____
Travel Assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what agency? _____	
Nurse Manager Name & Title _____	Phone _____
Hospital _____	# of Beds _____
Address _____	
Phone: _____	Unit(s) Worked _____
Dates Employed: From _____	To _____ Average Caseload _____
Travel Assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what agency? _____	
Nurse Manager Name & Title _____	Phone _____
Hospital _____	# of Beds _____
Address _____	
Phone: _____	Unit(s) Worked _____
Dates Employed: From _____	To _____ Average Caseload _____
Travel Assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what agency? _____	
Nurse Manager Name & Title _____	Phone _____
Hospital _____	# of Beds _____
Address _____	
Phone: _____	Unit(s) Worked _____
Dates Employed: From _____	To _____ Average Caseload _____
Travel Assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what agency? _____	
Nurse Manager Name & Title _____	Phone _____

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Applicant Name: _____

LICENSE INFORMATION (if more space is needed, please list on the back)

State Licensed: _____ License #: _____ Expiration Date: _____

State Licensed: _____ License #: _____ Expiration Date: _____

State Licensed: _____ License #: _____ Expiration Date: _____

State Licensed: _____ License #: _____ Expiration Date: _____

State Licensed: _____ License #: _____ Expiration Date: _____

Have you ever had disciplinary action taken against any license, or are you currently the subject of a report or investigation in any state? No Yes
(If yes, please explain) _____

CERTIFICATIONS

BLS Expiration Date: _____ PALS Expiration Date: _____

ACLS Expiration Date: _____ NALS Expiration Date: _____

Other Certifications: _____

How Were You Referred to Nurse Care?

Job Fair Internet Friend or Associate _____

Other _____

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This profile is for use by all nurses with more than one year's experience in his/her discipline and specialty. Please return this checklist by mail or FAX it to (919) 309-4430

Full Name: _____ Signature _____ Date _____

Directions Indicate your level of experience by checking the boxes below as follows:	1	Can Function Independently
	2	Experienced, But May Need Review
	3	Limited or No Experience

Core Skills	1	2	3
Admission of a patient			
Transfer of a patient			
Discharge of a patient			
Emergency Situations/Code Blue			
Vital Signs			
Post Mortem Care			
Defibrillation			
Cardioversion			
Documentation			
Patient & Family Education			
Assessment of Abuse			
Restraints			
Body Mechanics			
Aseptic Technique			
Isolation Precautions			

Medication Administration

PO medications			
IM injections			
SQ injections			
Z-track injections			
Rectal suppositories			
Nasal sprays			
Ear drops			
Eye drops			
Inhalers			
Emergency drugs/code cart			

Cardiovascular

Assessment

Auscultation (rate, rhythm)			
Blood pressure/noninvasive Doppler			
Heart sounds/murmurs			

Interpretation of Lab Results

Cardiac Isoenzymes			
Blood Chemistries			

Equipment and Procedures

Basic arrhythmia interpretation			
Lead placement			
Basic 12 lead EKG interpretation			

Pulmonary

Assessment

Breath sounds			
Rate and work of breathing			

Pulmonary (continued)

Interpretation of Lab Results

Arterial Blood Gasses			
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Equipment and Procedures

Endotracheal tube/suctioning			
Nasal airway/suctioning			
Oropharyngeal/suctioning			
Sputum specimen collection			
Tracheostomy/suctioning			
Assist with intubation			
Assist with thoracentesis			
Chest tube management			
Chest Physiotherapy			
Incentive Spirometry			
Pulse Oximetry			

Oxygen Therapy

Bag and mask			
Face mask			
Nasal cannula			
Portable O2 tank			

Neurological

Assessment

Glascow coma scale			
Level of consciousness			

Equipment and Procedures

Assist with lumbar puncture			
Use of hypo-hyperthermia blanket			

Orthopaedics

Assessment

Circulation checks			
Gait			
Range of motion			
Skin			

Equipment and Procedures

Wheelchair			
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Gastrointestinal

Assessment

Abdominal/bowel sounds			
Fluid balance			
Nutritional			



Nurse Care of North Carolina Health Statement & Release

Applicant Name: _____

I hereby authorize release to Nurse Care of North Carolina and any of its client hospitals or institutions any information acquired in my recent medical examination, which is relevant to my employment.

Signature

Date

Childhood Illness/Immunization History - please attach documentation for all immunizations

Disease or Vaccine	Had at Age	Immunized (Year)	Titer (Year)	Dates & Results of most recent immunization & tests
Mumps				
Rubeola (Measles)				
Rubella (German Measles)				
Hepatitis-B				
Varicella (Chicken Pox)				
Tetanus (Td)				
TB Skin Test (if positive for TB, please complete questionnaire and provide documentation of chest x-ray within the last 5 years)				

Have you ever had an abnormality or injury to...?

	Yes	No	Explain
Head or Face			
Eyes, Ears, Nose			
Mouth, Teeth			
Neck, Throat			
Heart			
Chest, Lungs			
Abdomen			
Spine			
Extremities			

Do you have any injuries or disabilities that may affect any job-related duties? No Yes

If Yes, please explain _____

Physician's Statement

I have examined the individual named above, and to the best of my knowledge, he/she is in good physical and mental health, free of any communicable diseases, and is able to function in his/her profession at full capacity.

Physician Signature _____ Date _____

Physician Name & Address _____

Physician Phone: _____

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Nurse Care of North Carolina Record of Tuberculosis Screening

Name: _____

Note: If you have a negative PPD history, do not complete this form. If you have a positive history of PPD, complete this form as follows:

EITHER:

- Complete Section A and attach documentation of a current chest x-ray (dated within the last 5 years). **OR:**
- Complete Section A & have a licensed medical professional complete Section B if x-ray documentation not available.

Section A

Have you received the BCG Vaccine in the past? Yes No

Since completion of your last questionnaire, have you Yes No

	Yes	No
Had an unexplained productive cough?		
Coughed or spit up blood?		
Had an unexplained, recurrent fever?		
Had recurrent night sweats?		
Had shortness of breath and/or chest pain?		
Had unexplained loss of weight or appetite?		
Had unexplained, chronic fatigue?		
Been advised that you are immunosuppressed for any reason?		

The above health statement is accurate to the best of my knowledge. I will see my doctor and/or the health department if my health status changes.

Signature

Date

Section B (To be completed by a licensed medical professional)

This is to certify that the above-named person (a) had a tuberculin skin test on ___/___/___ which was read as _____ mm., and (b) had a chest X-ray done on ___/___/___ which showed no sign of active inflammatory disease. This person has no symptoms suggestive of active tuberculosis disease. A chest X-ray for tuberculosis is not indicated.

Licensed Medical Professional

Date

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Nurse Care of North Carolina Health Declinations

Applicant Name: _____

Hepatitis-B Declination

I decline the Hepatitis B vaccination and/or titer. I have been informed of the health risks involved with a declination of the Hepatitis-B vaccine and will not hold anyone or any facility liable for any reason, situation or occurrence that would involve this disease.

Signature: _____ Date: _____

Varicella Declination

I have had chicken pox as a child at age _____. I will not hold anyone or any facility liable for any reason, situation or occurrence that would involve this disease.

Signature: _____ Date: _____

Polio Declination

I decline the Polio vaccination and/or titer. I have had the polio vaccine in the past. I will not hold anyone or any facility liable for any reason, situation or occurrence that would involve this disease.

Signature: _____ Date: _____

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Nurse Care of North Carolina Travel Nursing Authorization & Release

"I certify that the facts contained in this application are true and complete to the best of my knowledge. I understand that falsified statements on this application shall be grounds for termination of my contract.

In connection with my application with Nurse Care of North Carolina, I understand that a Criminal Background Check will be performed and that prior to my assignment, and after I am on site, I may be required to take and pass a drug and/or alcohol screening. Investigative consumer reports, which may contain public information, may be requested or made on me including prior employer verification, driving record, education, workers compensation claims and others. Further, I understand that you will be requesting information from various Federal, State and Local agencies regarding my credentials and past activities.

I hereby authorize the investigation of all statements contained herein and the agencies, references and employers listed above to furnish any and all information concerning my previous employment and any other pertinent information they may have, personal or otherwise. I release Nurse Care of North Carolina and my former employers from all liability for any damage that may result from utilization of such information. I further authorize ongoing procurement of the above-mentioned reports at any time during my tenure with Nurse Care of North Carolina. A telephone facsimile (fax) or xerographic copy of this consent shall be considered as valid as the original consent.

I agree that Nurse Care of North Carolina may release any and all personal information in my file, including medical records. I understand that this information will only be released to facilities where I may work an assignment and is only for purposes of verifying that all information has been obtained by the agency for assignment at the said facility.

I understand and agree that no representative of Nurse Care Of North Carolina has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized Nurse Care Of North Carolina representative.

I further understand and agree that I am an independent contractor of Nurse Care of North Carolina and not an employee of the Company for any purpose whatsoever. I have full responsibility for payment of my federal and state income taxes, unemployment insurance, FICA, FUTA, social security taxes and payments.

This waiver does not permit the release or use of disability-related or medical information in a manner prohibited by the Americans with Disabilities Act (ADA) and other relevant federal and state laws."

Print Full Name: _____

Signed: _____ Date: _____

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Nurse Care of North Carolina Consumer Reports and Criminal Background Check Profile

Note: The following information is required to ensure positive identification and is in no manner used as qualification for employment.

Name: _____
Last First Middle Maiden

Other or Former Names: _____

Current Address: _____

City _____ County _____ State _____ Zip Code _____

Dates of Residence: _____ to Present

Previous Address: _____

City _____ County _____ State _____ Zip Code _____

Dates of Residence: _____ to _____

Other cities and states lived in at least six months during the past seven years:

City _____ State _____ Dates of Residence: _____ to _____

City _____ State _____ Dates of Residence: _____ to _____

City _____ State _____ Dates of Residence: _____ to _____

City _____ State _____ Dates of Residence: _____ to _____

Driver's License State: _____ Driver's License Number: _____

Social Security Number: _____

Date of Birth (MM/DD/YY): _____ Race: _____ Gender: _____

Signature: _____ Date: _____

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Reference Form

To be completed by Applicant

Applicant Name: _____ **Social Security Number** _____

I have applied for employment with Nurse Care of North Carolina. I authorize my past and present employers to provide information on my performance while in their employment.

Applicant Signature _____ **Date** _____

Reference Name & Title: _____

Facility Name: _____ **Phone:** _____

Dates of employment: From: _____ To: _____

To be completed by Facility or Agency

Reference Name & Title: _____

Dates of employment: From: _____ To: _____

Position(s) held: _____ **Eligible for rehire?** Yes No Unable to Comment

Personal Evaluation - please rate the employee's performance by checking the appropriate boxes:

	Exceeds Expectations	Meets Expectations	Below Average	Unacceptable	Unable to Comment
Competency in caring for patients					
Implements a coordinated plan of patient care					
Adheres to facility policies and procedures					
Communicates appropriately with patients & families					
Completes accurate documentation of patient care					
Flexibility and adaptability					
Willingness & ability to float (if applicable)					
Attendance & punctuality					
Overall professionalism					

Additional Comments: _____

Reference Signature _____ **Date:** _____



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Reference Name & Title: _____

Facility Name: _____ **Phone:** _____

Dates of employment: From: _____ To: _____

To be completed by Facility or Agency

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Implements a coordinated plan of patient care					
Adheres to facility policies and procedures					
Communicates appropriately with patients & families					
Completes accurate documentation of patient care					
Flexibility and adaptability					
Willingness & ability to float (if applicable)					
Attendance & punctuality					
Overall professionalism					

Additional Comments: _____

Reference Signature _____ **Date:** _____



Nurse Care of North Carolina Confidentiality Statement

Important Information about HIPAA

What is HIPAA?

HIPAA stands for: Health Insurance Portability and Accountability Act. It is a *federal law* that protects all patients' rights to privacy. It is important to understand the law to protect yourself and the patients under your care. You may lose your job and *be charged with a felony* if you break the HIPAA rules.

How does HIPAA affect me?

HIPAA affects anyone who works in patient care. The law states that anyone working around patients must keep all patient information completely private. You are responsible for any patient information you see or hear. Ask your supervisor for help if you have questions about how to handle a privacy situation or if the situation is unclear.

What kind of information is considered private?

A patient's health status, medical record and all personal information is considered private. This includes any written or spoken information about the patient. You are not allowed to share this information with anyone, unless it relates to the patient's care on the job site.

What about computer information?

All patient information on facility computers is considered private. You may only use facility computers if you have been given a password by that facility, and you may not share your password with anyone else. You also may not use the computer for anything other than your job-related duties.

I have read and understand the information about HIPAA. I understand that as a contractor of Nurse Care of North Carolina, I have both a legal and ethical responsibility to protect the privacy of employees, client nurses and hospitals, and all proprietary information of Nurse Care of North Carolina. All information that I see or hear regarding nurses, staff, or patients, directly or indirectly, will not be discussed or released in any form, except when required in the performance of my duties. I understand that any violation of this agreement is cause for immediate termination of my contract with Nurse Care of North Carolina.

Printed name _____

Signature _____ Date _____

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Direct Deposit Authorization

Applicant Name: _____ Date _____

Mailing Address: _____

Phone Number _____

I hereby authorize Nurse Care of North Carolina to make payroll deposits directly to my account. I will notify Nurse Care in writing if I ever decide to discontinue this service. The address listed above is the address to mail my weekly pay stub and annual 1099 form.

Signature

Date

Please attach a voided check or complete the information below:

Banking Institution Name: _____

Address: _____

Bank Phone Number: _____

Bank Routing Number: _____

(this is the first set of numbers located at the bottom of your check)

Checking Account Number _____

(this is printed on your check, immediately after the routing number)