URGENT NURSING RESOURCE, INC.
14752 BEACH BLVD, SUITE 133 LA MIRADA, CA 90638 PHONE (714) 523-4178 FAX (714) 523-4255 INFO@URGENTNURSING.COM

Age Specific Criteria Self-Assessment

Name: ________________________________ Nursing License Number: ____________

You must be able to demonstrate the knowledge and skills necessary to provide care based on physical, psychosocial, educational, safety, cultural and related criteria appropriate to the age of the patients served in his/her assigned service area. The skill and knowledge needed to provide such care may be gained through education, training, or experience.

Please fill out the table with appropriate numbers listed below:

1. No knowledge/no experience
2. Knowledge only
3. Knowledge/extensive experience

	Infant/Child	Adolescent	Young Adult	Middle Adult	Geriatric
1. Knowledge of growth development					
2. Ability to assess Age Specific safety issues					
3. Ability to assess Age Specific Health Needs					
4. Ability to assess Age Specific Social Development					
5. Exhibits communication skill necessary to interpret the specific response.					
6. Ability to involve family/ significant other in decision making related to plan of care.					
7. Ability to obtain and interpret information in terms of the patient's needs and nursing related to physical development.					

I certify the above information is true and correct to the best of my knowledge.

Applicant Signature: ____________________________ Date: ______________________

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Health Questionnaire

Name: (Last, First)	SSN:	Date:

This section to be completed by applicant

Do you have or ever been told you have:	**Yes**	**No**	**If yes, explain:**
Allergies, Asthma, Wheezing			
Chronic cough, Colds			
Rheumatic Fever			
Heart Trouble			
High Blood Pressure			
Frequent Headaches			
Fainting or Dizziness			
Epilepsy or Convulsions			
Nervous Breakdown			
Difficulty Hearing			
Need Hearing Aid			
Use Hearing Aid			
Difficulty Seeing			
Need Corrective Lenses			
Use Corrective Lenses			
Hernia			
Diabetes			
Varicose Veins			
Do you have any physical limitations?			
Do you take any prescription medications?			
Have you ever been treated for a drug or alcohol habit?			
Have you ever been treated for any back disorder?			
Are you in good health to the best of your knowledge?			
Are you under a physician care?			

Name of Physician ______________________________ Phone No. __________________

Address ____ ________

I hereby authorize the above information to be released to Urgent Nursing Resource, Inc.

Applicant Signature ______________________________ Date __________________

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Tuberculosis Questionnaires

Name ________________________ Birth date: Mo ______ Day ______ Yr. ______

Home Phone No. ________________ Cell Phone ______________ Sex ______

Read Carefully! All questions must be answered by all staff whether they have a (-) or (+) PPD.

(-) Negative PPD, fill out questionnaire and have PPD done
(+) Positive PPD, fill out questionnaire and please have a chest x-ray

1. **Yes No** Have you changed your last name? If "yes", give old __________ new _______
2. **Yes No** Have you had any new problem, which currently is infectious or would prevent you from performing your assigned duties at this time? If "yes" please describe: ______________________________
3. **Yes No** Have you had an unexplained weight loss in the last year? If "yes", please describe : ______________________________
4. **Yes No** Do you have a persistent cough (lasting 3 weeks or more)?
5. **Yes No** Do you cough up blood?
6. **Yes No** Do you have persistent, unexplained fevers or night sweats?
7. **Yes No** Do you have a rash? If "yes", how long? ____________________
8. **Yes No** Have you seen a doctor for any of the above? If "yes", which numbered item? ____
9. **Yes No** Do you have any reason to believe that your immune system may been altered or damaged due to any of the following conditions or medications, which could increase your risk for tuberculosis (i.e. cancer, sarcoidosis, HIV/AIDS, chemotherapy, chronic steroid therapy or medications to prevent transplant rejection)?
10. **Yes No** If you have a positive TB test, do you also have any one of the following conditions (you do not have to divulge your medical diagnosis); part of your stomach removed, underweight/malnourished, infection with the AIDS virus or a risk for it, diabetes , silicosis lung disease, leukemia or lymphoma, kidney failure, head/neck cancer?
11. **Yes No** Have you completed the hepatitis B vaccine series? How many shots have you had? ______________
12. **Yes No** Do you handle IV cytotoxic (chemotherapy) drugs as part of your work assignment? **Example: Prepare, administer or handle at least once per week.**
13. **Yes No** Do you work with lasers? Type ____________________
14. **Yes No** Have you had any skin or other reaction after contact with latex gloves or other latex products?

Signature ________________________________ **Date** __________________

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2007 National Patient Safety Goals Acknowledgement

This is to acknowledge that I have read and understand the 2006 National Patient Safety Goals. A copy was provided to me as a reference material.

______________________________ __________________

Employee Signature Date

____

Print Name