

Please Check Company Enrolled With:

- TCC- Broward
- TCMS- Hernando
- TCMSJ- St. Johns

Employment Application

APPLICANT INFORMATION			
Last Name	First	M.I.	Date
Street Address		Apartment/Unit #	
City	State	ZIP	
Phone	E-mail Address		
Date Available	Desired Salary		
Position Applied for			
Are you a citizen of the United States?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If no, are you authorized to work in the U.S.? YES <input type="checkbox"/> NO <input type="checkbox"/>
Have you ever worked for this company?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If so, when?
Have you ever been convicted of a felony?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	If yes, explain

EDUCATION			
High School		Address	
From	To	Did you graduate? YES <input type="checkbox"/> NO <input type="checkbox"/>	Degree
College		Address	
From	To	Did you graduate? YES <input type="checkbox"/> NO <input type="checkbox"/>	Degree
Other		Address	
From	To	Did you graduate? YES <input type="checkbox"/> NO <input type="checkbox"/>	Degree

REFERENCES	
<i>Please list three professional references.</i>	
Full Name	Relationship
Years known:	Phone ()
Full Name	Relationship
Years known:	Phone ()
Full Name	Relationship
Years Known:	Phone ()

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 <input type="checkbox"/> NO <input type="checkbox"/>			
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 <input type="checkbox"/> NO <input type="checkbox"/>			
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 <input type="checkbox"/> NO <input type="checkbox"/>			

MILITARY SERVICE	
Branch	From To
Rank at Discharge	Type of Discharge
If other than honorable, explain	

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 also understand and agree that no representative of the Company 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 company representative.	
Signature	Date

Applicants Name: _____

Dear Applicant:

Thank you for your interest in working with **Tender Care Medical Services, Inc.** If you are applying for a **Nursing** position or **Direct Care Personnel** position, you **MUST** be able to provide the following:

Nursing (RN):

- Hold a current Florida registered nursing license
- Hold a current certification in CPR
- Have a minimum of two years pediatric experience of which at least six months must have been spent caring for medically fragile or technologically dependent children.

Please outline in detail your experience including names, dates, and phone numbers so that we may verify this information: _____

Nursing (LPN):

- Hold a current Florida licensed practical nurse license
- Have two years experience in pediatrics

Please outline in detail your experience including names, dates, and phone numbers so that we may verify this information: _____

Direct Care Personnel (DCP):

- Hold a current certification in CPR
- Have one year experience in the care of infants and toddlers
- Employment references documenting skill in the care of infants and children

Please outline in detail your experience including names, dates, and phone numbers so that we may verify this information: _____

Applicant's Signature: _____ Date: _____

APPLICANT'S NAME: _____

PRE-EMPLOYMENT QUESTIONNAIRE

1. Are you legally eligible for employment in the United States?

Yes No

2. Do you have a current valid driver's license?

Yes No

3. Is your driver's license issued by the State of Florida?

Yes No

If not, what state is it issued by? _____

4. Do you have a commercial driver's license?

Yes No

5. What languages do you speak and write fluently? _____

6. Were you referred by someone who currently works for Tender Care Centers, Inc.?

Yes - If yes, please state individual's name: _____ No

NURSING MEDICATION ADMINISTRATION **COMPETENCY TEST**

TERMS & ABBREVIATIONS:

1. BID _____
2. Δ _____
3. pc _____
4. QID _____
5. OD _____
6. c _____
7. STAT _____
8. ac _____
9. hs _____
10. PRN _____
11. NPO _____
12. QD _____
13. S.C. _____

MEDICATION ADMINISTRATION:

14. Name 3 routes of medication administration.

15. Name 2 route that are considered topical.

16. Name 2 routes of administration that are considered parenteral.

17. Is this order complete? If no, what is wrong / missing?

John Smith
Reglan 5cc Q6 hours x 4 weeks.

V.O. Dr. Smith/SJ Nay RN

Yes No _____

18. List the 5 rights.

19. Name 3 types of medication orders. (Ex. STAT)

20. What is this order prescribing?

Ferrous Sulfate 350 mg ac po TID

21. Calculate Dosage. Show math.

Ordered:

Dilantin Suspension 30 mg

On Hand:

Dilantin Suspension 60mg/cc

Dosage = _____ cc

22. Calculate Dosage. Show math.

Ordered:

Infants Tylenol Drops 100mg po

On Hand:

Infants Tylenol Drops 80mg/0.8cc

Dosage = _____ cc

23. Calculate Dosage. Show math.

Ordered:

Tylenol Elixir gr. 5 po

On Hand:

Tylenol Elixir 160mg/5cc

Dosage = _____ cc

24. Calculate Dosage. Show math.

Ordered:

Phenobarbital 45mg

On Hand:

Phenobarbital 30mg tabs

Dosage = _____ tabs

25. Name 2 medications that require a 2 nurse check.

26. How often are narcotics counted?

- a. Once per day
- b. Once per week
- c. Only when individual medication is incorrect

27. When documenting a pain relief medication on the MAR, what is documented that is not on a routine medication MAR?

28. Name a medication administration route/method that **MUST** be given by an RN.

29. What is the procedure for a medication error?

30. List the procedure when receiving a new or changed order.

31. If a nurse is caring for the same patient for a consecutive 2-3 days (in the PPEC), is it necessary to check the MAR before administering medications?

Yes

No

32. When is it not necessary to refer to the MAR when administering routine medications?

MATCH ALTERNATE NAMES FOR MEDICATIONS:

TYLENOL

VENTOLIN

VALPORIC ACID

METOCLOPRAMIDE

DIAZEPAM

IPRATROPIUM BROMIDE

REGLAN

LORAZEPAM

ALBUTEROL

CARBAMAZEPINE

INTAL

CROMOLYN

BENADRYL

NO MATCH

ATIVAN

DEPAKOTE

TEGRETOL

ACETAMINOPHEN

ATROVENT

IBRUPROFEN

XOPENEX

VALIUM

MOTRIN

DIPHENHYDRAMINE HCL

**BROWARD COMMUNITY COLLEGE
DEPARTMENT OF NURSING TECHNOLOGY
DRUG CALCULATIONS / CONVERSIONS**

Equivalents

Within Metric System:

1 cc	= 1 ml
1,000 ml	= 1 Liter
1,000 mg	= 1 Gram
1,000 mcg	= 1 mg

Apothecary To Metric System:

16 minims	= 1 ml
1 grain	= 60 mg
1 dram	= 4 ml
1 dram	= 4 cc

Metric To Household System:

1 Kg	= 2.2 lbs
30 ml	= 1 ounce
5 cc	= 1 teaspoon
15 cc	= 1 tablespoon
1 cm	= 2.54 inches

Rounding Rules

1. CC: If less than 1 cc, carry to thousandths, round to hundredths. If greater than 1 cc, carry to hundredths, round to tenths.
2. KG: Carry to hundredths, round to tenths.
3. MG: Carry to thousandths and leave as is.
4. DROPS, DRAMS, MINIMS: Round to nearest whole number.

Steps To Determine Rate of IV Flow

1. Divide total number of milliliters by the total number of hours to find ml/hr.
2. Divide the number of ml/hr by 60 minutes to find the ml/minute.
3. Convert ml/minute to drops/minute using the drop factor.

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- TCMSJ-St. Johns

EMPLOYMENT AUTHORIZATION AND VERIFICATION FORM

Applicant name: _____ Social Security #: xxx-xx-(_____)
(Last 4 digits only)

Name of Previous Employer: _____

Address: _____

Phone: _____ Fax: _____

The above named applicant is being considered for employment with Tender Care Centers, Inc./Tender Care Medical Services, Inc., and has listed your organization as a former employer. We would appreciate your verification and completion of this form at your earliest convenience. Information provided will be treated in confidence. Thank you for your assistance.

Please return this form via fax to: (____) _____
Any questions please call (____) _____.

APPLICANT'S AUTHORIZATION:

I consent to and authorize the above named former employer, and its agents and employees, to furnish any reference information concerning me, including achievement, wage history, performance, attendance, personal history, disciplinary information and reason for separation of employment, relating to my employment with the former employer. It is expressly understood that any information given is to be used for the purpose of determining my acceptability for employment. I also hereby release the above named former employer, and its agents and employee, from all liability for damages or claims, including but not limited to defamation, interference with contract, or prospective economic advantage and negligence, I have or may have which arise or result from any reference information provided pursuant to this authorization or any attempts with this information.

Applicant's signature: _____ Date: _____

**RECORD OF EMPLOYMENT:
(TO BE COMPLETED BY PREVIOUS EMPLOYER)**

Is the applicant still employed by you? _____ Position held: _____

Date of hire: _____ Last day of employment: _____

Reason for leaving: _____

If no longer employed, is the applicant eligible for rehire? _____

Was the employee reliable? _____ Did the employee get along well with his/her coworkers? _____

Comments: _____

Signature of person completing form _____ Title _____ Date _____

For office use only:

1st Attempt: Form FAXED/MAILED/VERBAL: Date: _____ Initials: _____

2nd Attempt: Form FAXED/MAILED/VERBAL: Date: _____ Initials: _____

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Tender Care Medical Services, Inc.

Availability Form

Employee Name: _____ Date: _____

Please check all boxes that you are available to work

(Please only note your availabilities).

	Monday	Tuesdays	Wednesdays	Thursdays	Fridays	Saturdays
0730 am to 1630						
AM Transport						
PM Transport						

Additional
Information: _____

Approved by: _____ Date: _____

Additional
Information: _____

