

MEDICARE RECRUITERS

Division of Skyline Airlink

Affiliated with Skyline Travel Inc. U.S.A

GENERAL INFORMATION

Recruiter: _____

Name: _____ Date: _____
Last First M.I.

Permanent Address: _____
Street City State Zip

Phone : () _____
Best times / days to reach you Friend/Magazine, Journal, Newspaper

E-mail : _____ Cell #: _____ Other #: _____

Temporary Address: _____
Street City State Zip

Phone : () _____
Will be at this location until (date) Best times / days to reach you

In Case of Emergency

Notify: _____
Name Relationship

_____ Street City State Zip Phone

Have you ever applied to U.S. before ? No Yes _____
U.S. Social Security Number Canadian Social Security Number

If yes, when ____/____/____

Can you, upon employment, submit verification of your legal right to work in the United States ? No Yes

RN LPN OT PT SLP ST Speciality: _____ Date you can start: _____

Travel Assignment: Perm Placement:

Areas of Clinical Experience and years experience:

1. _____ | 2. _____ | 3. _____ | 4. _____

The most important considerations in accepting a new assignment:

1. _____ 2. _____ 3. _____ 4. _____

Preferred Locations:

1. _____ 2. _____ 3. _____ 4. _____

CREDENTIALS

LICENSURE *Include copies of all state licenses*

State : _____ License # : _____ Exp. Date : _____

State : _____ License # : _____ Exp. Date : _____

State : _____ License # : _____ Exp. Date : _____

State : _____ License # : _____ Exp. Date : _____

Additional Certifications : (CPR, BCLS, ACLS, PALS, CCRN, etc.) Include copies of all certifications

Certification: _____ Exp. Date: _____ Certification: _____ Exp. Date: _____

Certification: _____ Exp. Date: _____ Certification: _____ Exp. Date: _____

Have you ever had disciplinary action taken against any of your state licenses ? No Yes

Have you ever been named as a defendant in a malpractice claim? No Yes

Have you ever been convicted of a felony (other than a minor traffic violation) ? No Yes

If yes, on any of the above, please attach separate sheet with explanation.

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EDUCATION			
Name and Location of School		Month/Year Graduated	Degree Received
College City, State			
Graduate School City, State			
Other School (If Applicable)			

Which month and year did you pass U.S. nursing boards / registration exams ? _____

REFERENCES

Professional references only; in accordance with the Fair Credit Reporting Act of 1970, References will be contacted for an opinion of your duties, ability, and performance. You have the right to request a complete and accurate disclosure of the nature and scope of these references.

Name : _____ Title : _____ Unit: _____
 Street Address: _____
 City, State Zip: _____ E-mail: _____
 Facility: _____ Location: (City, State) _____
 Work Phone: _____ Extension: _____ Home Phone: _____

Name : _____ Title : _____ Unit: _____
 Street Address: _____
 City, State Zip: _____ E-mail: _____
 Facility: _____ Location: (City, State) _____
 Work Phone: _____ Extension: _____ Home Phone: _____

Name : _____ Title : _____ Unit: _____
 Street Address: _____
 City, State Zip: _____ E-mail: _____
 Facility: _____ Location: (City, State) _____
 Work Phone: _____ Extension: _____ Home Phone: _____

Name : _____ Title : _____ Unit: _____
 Street Address: _____
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Applicant's Name: _____
Are you employed presently? No Yes If so, may we inquire of your present employer? No Yes
Please indicate all of your employment for the past ten (10) years, beginning with your most recent employer.
If working through an agency, please indicate the specific facility in which you are working, the supervisor at the facility, as well as the name of the agency. You may include verifiable volunteer work. Please document reasons for period of unemployment.

EMPLOYMENT HISTORY

Facility: _____ Position Held: _____ Speciality: _____
Street Address: _____ Unit: _____
City: _____ State: _____ Zip: _____ From: _____ To: _____
Supervisor's Name : _____ Title: _____ Phone #: _____
Reason for leaving : _____ Is / Was this Travel Perm or Per Diem

Facility: _____ Position Held: _____ Speciality: _____
Street Address: _____ Unit: _____
City: _____ State: _____ Zip: _____ From: _____ To: _____
Supervisor's Name : _____ Title: _____ Phone #: _____
Reason for leaving : _____ Was this Travel Perm or Per Diem

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City: _____ State: _____ Zip: _____ From: _____ To: _____
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City: _____ State: _____ Zip: _____ From: _____ To: _____
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EMPLOYMENT HISTORY Cont...

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Facility: _____ Position Held: _____ Speciality: _____
Street Address: _____ Unit: _____
City: _____ State: _____ Zip: _____ From: _____ To: _____
Supervisor's Name : _____ Title: _____ Phone #: _____
Reason for leaving : _____ Was this Travel Perm or Per Diem

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City: _____ State: _____ Zip: _____ From: _____ To: _____
Supervisor's Name : _____ Title: _____ Phone #: _____
Reason for leaving : _____ Was this Travel Perm or Per Diem

PRE-EMPLOYMENT STATEMENT (Please read carefully before signing)

Please check circle and initial if applicable.

_____ In lieu of completing the past experience section of this application, my resume is attached. I understand and agree that the following statements apply to my resume as well.

I certify that the information on this application and my resume is true, complete and correct. I authorize MR.com (henceforth called 'the company' to contact any and all former employers and / or references to verify the information that I have provided on this application. I release the company and any party providing reference information to the company from any and all liabilities or claims arising from the verification process. I have read and certify that the information I have provided in this application is true and correct. I understand that I may not be hired or if hired, my employment may be subject to termination if I have made any omissions or misrepresentations in completing this application. I also understand that this application is not an employment contract and that, if hired, any job I might have while with the company is considered at-will employment.

This Immigration Reform and Control Act of 1986 requires that the company verify the identity and right to work with the United States of each new employee. Accordingly, any offer of employment will be contingent upon you providing the appropriate documentation at the time of hire.

Signature of Applicant : _____

Date : _____

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ADDENDUM TO INITIAL APPLICATION

Name : _____

Date : _____

GENERAL QUESTIONS

1. Have you ever been denied an application for license, certification, or registration in any profession or occupation ?

Yes No

2. Has any authority restricted, suspended, revoked or taken any other disciplinary action against a license, certificate, or registration that you hold or held in any profession or occupation ?

Yes No

If the answer in 1 or 2 is "yes", provide a copy of the order or official notification of the Board action.

3. Have you or anyone in your family been convicted of a crime other than a minor traffic violation ?

Yes No

If "yes", explain in detail and provide copies of criminal record.

4. Do you have a physical or mental condition or disorder which in any way impairs or limits your ability to practice nursing with reasonable skill and safety?

Yes No

5. Does anyone in your family have a physical or mental condition or disorder which in any way impairs or limits their ability to function with reasonable skill and safety?

Yes No

If the answer in 4 and 5 is "yes", provide a physician's statement or medical confirmation of the disability.

6. Has your use of alcohol, drugs, or medications in any way impaired or limited your ability to practice nursing with reasonable skill and safety ?

Yes No

If "yes", explain in detail.

7. Are you currently participating in a supervised program or professional assistance program, which monitors you in order to assure that you are not engaging in the illegal use of, controlled dangerous substances ?

Yes No

If the answer is "yes", please provide the contract / stipulation under which you are practicing.

8. Are you under obligation to pay child support ?

Yes No

9. Have you ever been found guilty of tax evasion ?

Yes No

10. Have you ever applied for or taken the examination for registered nurses to work in the USA?

Yes No

11. Have you ever applied for or taken any other examinations to work in the US as a registered nurse ?

Yes No

12. Have you applied for or taken any of the following English examinations, TSE, TOEFL, TWE and / or MELAB?

Yes No

If "yes", in any numbers 8 to 12, please explain.

13. Provide the title of your registration / license in your country of education.

14. If your country does not issue a license, does your diploma/degree give you the right to practice as a registered nurse ?

Yes No

Signature _____

Date _____

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INTERNATIONAL TRAVELLING APPLICATION

Surname/Last Name / /	First	Middle	Maiden
Date of Birth (mm/dd/yyyy)	City and Country of Birth	Date Married (mm/dd/yyyy)	

Any other names used:	When last used:	Mother's Maiden Name
-----------------------	-----------------	----------------------

Nationality	Citizenship
-------------	-------------

Residential Address :	
Postal Address :	
E-mail Address :	
Home Telephone :	Cell Phone :
Work Telephone :	Fax Number :

EDUCATION

High School:		Highest Certification	
1. Nursing School:		Dates Attended:	From: To:
Name as it appears on Certificate:		Graduation Date:	(mm/dd/yyyy)
Qualifications:			
Languages Spoken:		Language of Education:	
2. Nursing School:		Dates Attended:	From: To:
Name as it appears on Certificate:		Graduation Date:	(mm/dd/yyyy)
Qualifications:			
Languages Spoken:		Language of Education:	

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1. Nursing License-Country		Council Registrations:	
Address:		Telephone Number:	
Registration #:		Expiration Date:	

2. Nursing License-Country		Council Registrations:	
Address:		Telephone Number:	
Registration #:		Expiration Date:	

FAMILY DETAILS

Surname/Last Name	First	Middle
	/ /	
Relationship	Date of Birth (mm/dd/yyyy)	Any Other Names Used

Residential Address: (If Different)
--

Nationality	Citizenship
-------------	-------------

Surname/Last Name	First	Middle
	/ /	
Relationship	Date of Birth (mm/dd/yyyy)	Any Other Names Used

Residential Address: (If Different)
--

Nationality	Citizenship
-------------	-------------

Desired Geographic Location: (In Order of Preference)	1.	2.	3.
	4.	5.	6.

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THORACIC / CARDIOVASCULAR/VASCULAR	Self Rating	Yrs. Exp.	S or C	Cont. Urology	Self Rating	Yrs. Exp.	S or C
Lobectomy / Pneumonectomy				Vasectomy			
Abdominal Aortic Aneurysm				Penile Prosthesis			
Mediastinoscopy				Bladder Suspension w/Mitek Anchors			
Carotid Endarterectomy				Cystoscopy			
Femoral-Popliteal Bypass				Ureteroscopy			
Bronchoschoscopy / Rigid				Ureteroscopy w/Candela Laster			
Thoracoscopy				TURP			
A - V Fistula/Gortex - Graft				TURP w/Yag Laser			
Amputation : Limb				TUR of Bladder			
				Neck w/Laser			
NEUROSURGERY	Self Rating	Yrs. Exp.	S or C	PLASTIC SURGERY	Self Rating	Yrs. Exp.	S or C
Craniotomy / Tumour				Abdominoplasty			
Craniotomy / Aneurysm				Face Lift / Rhytidectomy			
Transsphenoidal Hypophysectomy				Rhinoplasty			
Lumbar Laminectomy				Tram w/Breast Reconstruction			
Anterior Cervical Laminectomy				Cleft Palate			
Ulnar Nerve Transposition				Breast Augmentation			
Ventricular Peritoneal Shunt				Reduction Mammoplasty			
Twist Drill Craniotomy / Burr Holes				Blepharoplasty			
Rhizotomy				Cleft Lip			
Stereotactic Procedure				Breast Reconstruction			
				Suction Lipectomy			
OPHTHALMOLOGY	Self Rating	Yrs. Exp.	S or C	Brow Lift			
Cataract Extraction							
Intraocular Lens Implant				EAR / NOSE / THROAT	Self Rating	Yrs. Exp.	S or C
Scleral Buckling				Septoplasty			
Corneal Transplant				Submucous Resection			
Vitrectomy				Stapedectomy			
Vitrectomy w/Argon Laser				Tympanoplasty			
				Mastoidectomy			
UROLOGY	Self Rating	Yrs. Exp.	S or C	Parotidectomy			
Hypospadias Repair				Radical Neck Dissection			
Uretero Neocystomy				Sinoscopy			
Bladder Augmentation				Cadwell Luc			
Paediatric Cystoscopy				Nasal Polypectomy			
Nephrectomy				Myringotomy / Tube Insertion			
Kidney Transplant				Maxillofacial Cases			
Percutaneous Nephrolithotomy							
Ureterolithotomy							

KEY: 0 = No Experience, 1 = Minimal/Some Experience / Works with Supervision,

2 = Independent / Works without Supervision in most cases,

3 = Senior / Works at a Supervisory or Teaching level.

S or C: KEY: S = Scrub and C = Circulate

INDIA: Suite 120A & 120B, Penta Menaka,
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LASER	<i>Self Rating</i>	<i>Yrs. Exp.</i>	<i>S or C</i>	OPHTHALMOLOGY	<i>Self Rating</i>	<i>Yrs. Exp.</i>	<i>S or C</i>
Use of Yag				Use of Alcon Microvit Machine			
Use of CO2				Use of Site / Phaco Machine			
Use of Argon				Use of Frigitrionic Cryo Machine			
Use of Candela				Use of Ocutome Machine			
				Use of Diathermy Machine			
				Use of Weiss Microscope			
EQUIPMENT							
GENERAL	<i>Self Rating</i>	<i>Yrs. Exp.</i>	<i>S or C</i>	NEURO	<i>Self Rating</i>	<i>Yrs. Exp.</i>	<i>S or C</i>
Use of Karl Storz Video Equipment				Use of CUSA			
Use of Twin Video Set-up				Use of Contraves Microscope			
Cholangiogram Picture Taking				Use of Neuro Microscope			
Use of Cabot Irrigation System				Use of Andrews Spinal Surgery Frame			
Use of Argon Beam Coagulator							
Use of Vital Vue				ENT / DENTAL			
Use of Slush/ Heat Machine (Sani Serve)				<i>Self Rating</i>	<i>Yrs. Exp.</i>	<i>S or C</i>	
Use of Burn Pump				Use of ENT Microscope			
				Use of Karl Storz			
GYN	<i>Self Rating</i>	<i>Yrs. Exp.</i>	<i>S or C</i>	ENT / Dental Video Set up			
Use of Zimmer CDIS							
Hysteroscopy Pump							
Use of Harmonic Scalpel							
Use of Nezhat Dorsey Pump							
Use of Hysteroflater							
ORTHOPEDICS	<i>Self Rating</i>	<i>Yrs. Exp.</i>	<i>S or C</i>				
Use of Dyonics Video Equipment							
Use of Zimmer Pulsavac							
Use of 3M Arthroscopy Pump							
Use of Chick Fracture Table							
Use of Amsco Fracture Table							
Use of Ortho/Plastic GYN Microscope							
GU	<i>Self Rating</i>	<i>Yrs. Exp.</i>	<i>S or C</i>				
Use of GU Video Equipment							
Use of Karl Storz							
Calcutripor							
Use of Cysto Table							

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NURSING SKILL INVENTORY

NAME : _____

DATE : _____

PLEASE CHECK CERTIFICATIONS HELD:

CERTIFICATIONS

Basic life support _____
Advanced life support _____
Pediatric advanced life support _____
Neonatal Resuscitation program _____

NATIONAL ADVANCED CERTIFICATIONS

Certified Registered Nurse Anaesthetist _____
Certified Critical Care Registered Nurse _____
Certified Trauma Nurse _____
Certified Coronary Care _____
Certified Emergency Nurse (Trauma Nurse) _____
Certified Chemotherapy Administration _____
Certified Registered Nurse Intravenous Therapy _____
Oncology Nurse Certified _____
Advanced Oncology Certified Nurse _____
Certified Post Anesthesia Nurse _____
Certified Ambulatory Post-Anesthesia Nurse _____

Certified Nurse Operating Room _____
Certified Infection Control _____
Aids Certified Registered Nurse _____
Certified Haemodialysis Nurse _____
Certified Peritoneal Dialysis Nurse _____
Certified Urology Registered Nurse _____
Certified Registered Nurse Practitioner _____
Adult Nurse Practitioner _____
Family Nurse Practitioner _____
Certified Paediatric Nurse Practitioner _____
Certified Registered Nurse Hospice _____
Clinical Nurse Specialist _____
Certified Vascular Nurse _____
Orthopedic Nurse Certified _____
Registered Nurse Certified _____
Registered Nurse Certified Specialist _____
Paediatric Nurse Practitioner _____
Other _____

PLEASE CHECK POSITIONS HELD:

Director of Nursing _____
Clinical Director _____
Clinical Supervisor _____
Clinical Manager _____
Clinical Leader _____

Trauma Team _____
Code Team _____
Per Diem / Float Nurse _____
Patient Assessment _____
Documentation _____
Shift Reporting _____

PLEASE CHECK PATIENT GROUPS WORKED WITH:

Neonate _____
Infant _____
Pediatric _____

Adolescent _____
Adult _____
Geriatric _____

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NURSING SKILL INVENTORY

<i>SPECIALITY AREAS (FACILITY TYPE)</i>	Self Rating	Yrs. Exp.		Self Rating	Yrs. Exp.
<i>ACUTE CARE</i>			<i>Outpatient</i>		
General Acute	_____	_____	General Outpatient	_____	_____
Medical	_____	_____	Surgical Outpatient	_____	_____
Surgical	_____	_____	<i>Psychiatric</i>		
Medical / Surgical	_____	_____	Acute Mental Health	_____	_____
Obstetrics	_____	_____	Outpatient	_____	_____
Labor and Delivery	_____	_____	Alcohol and Drug Abuse	_____	_____
Ante Partum	_____	_____	Halfway House	_____	_____
Post Partum	_____	_____	Home Care	_____	_____
Gynecology	_____	_____	<i>Rehabilitation</i>		
Obstetrics / Gynecology	_____	_____	Acute Inpatient Rehabilitation	_____	_____
Orthopedics	_____	_____	Cardiac Rehabilitation	_____	_____
Neurology	_____	_____	Pulmonary Rehabilitation	_____	_____
Cardiology	_____	_____	<i>Long Term Care</i>		
Oncology	_____	_____	Sub Acute	_____	_____
Pediatrics	_____	_____	Skilled Nursing	_____	_____
Dialysis	_____	_____	Intermediate (Custodial)	_____	_____
Urology	_____	_____	Assisted Living	_____	_____
Speciality Acute	_____	_____	Hospice	_____	_____
Post Anesthesia Care Unit	_____	_____	<i>Industrial Nursing</i>	_____	_____
Burn Unit	_____	_____	<i>Home Care</i>	_____	_____
Out Patient Unit	_____	_____			
Pulmonary Care Unit	_____	_____			
Pediatric Intensive Care Unit	_____	_____			
Neuro Intensive Care	_____	_____			
Short Stay Unit (One Day) Surgical Day	_____	_____			
Oncology Unit	_____	_____			
Emergency Room	_____	_____			
Trauma	_____	_____			
Coronary Care Unit	_____	_____			
Cardiac Surgical Care Unit	_____	_____			
Cardiac Medical Care Unit	_____	_____			
Cardiovascular Unit	_____	_____			
Neonatal Intensive Care Unit	_____	_____			
Recovery Room	_____	_____			
Pre-Operative	_____	_____			
Post-Operative	_____	_____			
Operating Room -Circulating Nurse	_____	_____			
Operating Room-Scrub	_____	_____			
Telemetry Unit	_____	_____			
Stepdown Unit	_____	_____			
Intensive Care / Critical Care Unit	_____	_____			
Medical Intensive Care Unit	_____	_____			
Surgical Intensive Care Unit	_____	_____			
Respiratory Intensive Care Unit	_____	_____			

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	Self Rating	Yrs. Exp.		Self Rating	Yrs. Exp.
PROCEDURES					
General Procedures					
Specimen Collection	_____	_____		_____	_____
Venous Blood Sampling	_____	_____		_____	_____
Indwelling Urinary Catheter Insertion	_____	_____		_____	_____
Straight Catheter	_____	_____		_____	_____
External Catheter	_____	_____		_____	_____
Three Way Catheter	_____	_____		_____	_____
Urinary Catheter Maintenance	_____	_____		_____	_____
Nasogastric Tube Insertion	_____	_____		_____	_____
Nasogastric Tube Maintenance	_____	_____		_____	_____
Nasogastric Tube Feeding	_____	_____		_____	_____
Gastro-Intestinal Tube Insertion	_____	_____		_____	_____
Gastro-Intestinal Tube Maintenance	_____	_____		_____	_____
Gastro-Intestinal Tube Feeding	_____	_____		_____	_____
Ostomy Care	_____	_____		_____	_____
Hemovac	_____	_____		_____	_____
Isolation Techniques	_____	_____		_____	_____
Reverse Isolation	_____	_____		_____	_____
Hypothermia Blanket	_____	_____		_____	_____
Hyperthermia Blanket	_____	_____		_____	_____
Specialized Procedures					
Cardiac	_____	_____		_____	_____
Heart Sounds	_____	_____		_____	_____
ECG Interpretation - 12 Lead	_____	_____		_____	_____
Cardiac Monitoring	_____	_____		_____	_____
Telemetry	_____	_____		_____	_____
Defibrillator	_____	_____		_____	_____
Cardioversion	_____	_____		_____	_____
Pacemaker	_____	_____		_____	_____
Doppler	_____	_____		_____	_____
Central Venous Pressure (Manometer)	_____	_____		_____	_____
Central Venous Pressure (Infusion Pump)	_____	_____		_____	_____
Swan-Ganz Monitoring	_____	_____		_____	_____
Cardiac Output Calc	_____	_____		_____	_____
Cardiac Stress Testing	_____	_____		_____	_____
			Medications & IV's		
			Unit Dose	_____	_____
			Narcotic Administration	_____	_____
			Start IV's Angiocath	_____	_____
			Start IV's Butterfly	_____	_____
			IV Drip	_____	_____
			IV Push	_____	_____
			IV Ports (Access & Maintenance)	_____	_____
			IV Infusion Pumps	_____	_____
			Mix IV's	_____	_____
			IV Chemotherapy Admin.	_____	_____
			Midline / PICC Line	_____	_____
			Blood Product Administration	_____	_____
			Heparin Lock	_____	_____
			Central Line Maintenance	_____	_____
			Arterial Lines		
			Arterial Line Maintenance	_____	_____
			Arterial Line Sampling	_____	_____
			Pulmonary		
			Breath Sounds	_____	_____
			Nasotracheal Suction	_____	_____
			Endotracheal Suction	_____	_____
			Tracheotomy Care	_____	_____
			Chest Physical Therapy	_____	_____
			Fetal Monitoring	_____	_____
			Nebulizer Therapy	_____	_____
			Oxygen Therapy	_____	_____
			Ventilator Care	_____	_____
			Apnea Monitoring	_____	_____
			Oximetry	_____	_____
			Chest Tubes	_____	_____

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NURSING SKILL INVENTORY

	Self Rating	Yrs. Exp.		Self Rating	Yrs. Exp.
PATIENT CARE					
Paediatric			Neurologic		
Asthma	_____	_____	Neurological Assessment	_____	_____
Cystic Fibrosis	_____	_____	Head Trauma	_____	_____
BPD	_____	_____	CVA	_____	_____
Respiratory Distress Syndrome	_____	_____	Spinal Cord Injury	_____	_____
Leukemia	_____	_____	Craniotomy	_____	_____
Bone Marrow Transplant	_____	_____	Neuromuscular Disease	_____	_____
Diabetes	_____	_____	Seizures	_____	_____
Meningitis	_____	_____	Gastro-Intestinal		
Failure to Thrive	_____	_____	GI Bleeding	_____	_____
Sickle Cell Anemia	_____	_____	GI Surgery	_____	_____
Seizures	_____	_____	Abdominal Assessment	_____	_____
Abuse / Neglect	_____	_____	Enteral Feeding	_____	_____
Orthopedics			Total Parenteral Nutrition	_____	_____
Sports Injuries	_____	_____	Ostomy Care	_____	_____
General Fractures	_____	_____	Endocrine		
Total Knee Replacement	_____	_____	Diabetes	_____	_____
Total Hip Replacement	_____	_____	Diabetic Teaching	_____	_____
Casts	_____	_____	Blood Glucose Testing	_____	_____
Traction	_____	_____	Insulin Administration	_____	_____
Renal			Endocrine Disorders	_____	_____
Continuous Bladder Irrigation	_____	_____	Oncology		
Intermittent Bladder Irrigation	_____	_____	Chemotherapy Administration	_____	_____
AV Fistula / Dialysis Catheter	_____	_____	Nutrition	_____	_____
Renal Transplant	_____	_____	Bone Marrow Transplant Patient	_____	_____
Renal Failure	_____	_____	Reverse Isolation	_____	_____
Peritoneal Dialysis	_____	_____	Other		
Pulmonary			Plastic Surgery	_____	_____
Chronic Obstructive Lung Disease	_____	_____	Eye Surgery	_____	_____
Restrictive Lung Disease	_____	_____	ENT Surgery	_____	_____
Adult Respiratory Distress Syndrome	_____	_____	AIDS Patient	_____	_____
Pulmonary Edema	_____	_____	Transplant Patient	_____	_____
Wound					
Irrigations	_____	_____			
Sterile Dressing	_____	_____			
Burn Care	_____	_____			
Decubitis Ulcer Care	_____	_____			
Surgical Drainage (Vacuum)	_____	_____			

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MEDICARE RECRUITERS

Division of Skyline Airlink

Affiliated with Skyline Travel Inc. U.S.A

NURSING SKILL INVENTORY

	Self Rating	Yrs. Exp.		Self Rating	Yrs. Exp.
<u>VASCULAR</u>			<u>MATERNAL-CHILD (cont)</u>		
Peripheral pulses	_____	_____	<i>Newborn Care: (cont)</i>		
Dehydration	_____	_____	Draw Blood from U-line	_____	_____
Fluid Overload	_____	_____	Suction with Catheter	_____	_____
Ultrasonic doppler	_____	_____	Cord and Circ. Care	_____	_____
Starting IV's	_____	_____	Phototherapy	_____	_____
Heparin Locks	_____	_____	NG Feedings	_____	_____
TPN/Hyperal	_____	_____	Admin Blood & Blood Pressure	_____	_____
Normal Serum Lab Values	_____	_____	Use of Equipment:	_____	_____
Infusion Plumps	_____	_____	Cardiac Monitors	_____	_____
Hickman/Broviac Caths.	_____	_____	Apnea Monitors	_____	_____
Hemodialysis	_____	_____	Oxyhood	_____	_____
Peritoneal Dialysis	_____	_____	Ventilators	_____	_____
Shock	_____	_____			
<u>MATERNAL-CHILD</u>			<u>PEDIATRICS</u>		
Magnesium Sulfate Rx	_____	_____	Calculation of Pedi Dosages	_____	_____
Labor Suppressants	_____	_____	PICU	_____	_____
Oxytocin Induction / Augment	_____	_____	Starting IV Therapy	_____	_____
Assist with Vag Del	_____	_____	Scalp Veins	_____	_____
Forceps Vag Del	_____	_____	Apnea Monitor	_____	_____
Circ for C-Section	_____	_____	Cardiac Monitor	_____	_____
Scrub for C-Section	_____	_____	CPR - Infant / Child	_____	_____
Internal Monitor	_____	_____	Prep. Of Emergency Drugs	_____	_____
Intrauterine Pres. Cath.	_____	_____	Trach Care & Suctioning	_____	_____
Fetal Scalp Blood Sample	_____	_____	Assist with LP	_____	_____
Labor Assessment	_____	_____	Oxygen	_____	_____
Vag Exams	_____	_____	Croup Test	_____	_____
Fetoscope / Doppler	_____	_____	Ventilation	_____	_____
Identify FHR Patterns	_____	_____	Bone Marrow Biopsy	_____	_____
Pregnancy - Induced Hypertension	_____	_____	Cardiac Surgery	_____	_____
Preeclampsia	_____	_____	CHF	_____	_____
Abruptio Placenta	_____	_____	Cystic Fibrosis	_____	_____
Malpresentation	_____	_____	Diabetes Mellinus	_____	_____
Premature Labor	_____	_____	Epiglottitis	_____	_____
Diabetes Mellinus	_____	_____	Failure to Thrive	_____	_____
Infectious Disease	_____	_____	Leukemia	_____	_____
Sickle Cell Disease	_____	_____	Meningitis	_____	_____
Rh Incompatibilities	_____	_____	Near Drowning	_____	_____
Fundus Consistency	_____	_____	Overdose / Poison Ingestion	_____	_____
Lochia	_____	_____	PDA Ligation	_____	_____
Bladder Distention	_____	_____	RDS	_____	_____
Episiotomy / Incision for C-Section	_____	_____	Raye's Syndrome	_____	_____
			Sickle Cell Disease	_____	_____
			Spina Bifida	_____	_____

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	Self Rating	Yrs. Exp.		Self Rating	Yrs. Exp.
<u>MATERNAL-CHILD (CONT)</u>			<u>PAEDIATRICS (CONT)</u>		
IMMEDIATE NEONATE CARE:			Tracheoesophageal	_____	_____
Assign Apgar Scores	_____	_____	OTHER		
Suction	_____	_____	Oncology	_____	_____
Eye Prophylaxis	_____	_____	Bone Marrow Biopsy	_____	_____
Collect Cord Blood	_____	_____	Diabetic Teaching	_____	_____
Newborn Care:			Isolation Techniques	_____	_____
Calc. Of Neonatal Dosages	_____	_____	Liver Transplant	_____	_____
Neonatal Level I	_____	_____			
Neonatal Level II	_____	_____			
Neonatal Level III	_____	_____			

SIGNATURE : _____ DATE: _____

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