

# Tender Hand Healthcare Services LLC

## EMPLOYEE APPLICATION FORM

Tel: 998-884-96  
406 Abbi R  
Carteret, NJ 07

**Personal Data** Today's Date: \_\_\_\_\_

**Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **Soc. Sec. No.** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Home Phone #** \_\_\_\_\_

**Street Address** \_\_\_\_\_ **City** \_\_\_\_\_ **County** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Country** \_\_\_\_\_ **Cell Phone #** \_\_\_\_\_

**Previous Street Address** \_\_\_\_\_ **City** \_\_\_\_\_ **County** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Country** \_\_\_\_\_ **Best Time to Call** \_\_\_\_\_

**Name of Emergency Contact** \_\_\_\_\_ **Relation** \_\_\_\_\_ **Emergency Phone No.** \_\_\_\_\_

**Job Information**

**Position (Job Class) Applying for:**  HHA  LPN  RN  Other \_\_\_\_\_ **Date Available to Work:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Work Experience/Skills**

Please List the number of years you have experience in each area (minimum 1 yr exp.) and are clinically competent to work:

- |            |                |                  |                        |
|------------|----------------|------------------|------------------------|
| _____ Burn | _____ ENT      | _____ Pediatrics | _____ Detox/Drug Rehab |
| _____ L&D  | _____ Rehab    | _____ Telemetry  | _____ Post Partum      |
| _____ NICU | _____ Nursery  | _____ Psychiatry | _____ Orthopedics      |
| _____ CCU  | _____ Med/Surg | _____ Open Heart | _____ Emergency Room   |
- Other Specialty: \_\_\_\_\_

**Type of Work Desired: Check all that apply**

- Homecare Nursing  Nursing Home  Assisted Living  Other: \_\_\_\_\_

**Language Skills: Other than English, please check any other language you speak:**

- Spanish  French  German  Other: \_\_\_\_\_

**Check the days of the week you are available to work:**

- \_\_\_ Monday \_\_\_ Tuesday \_\_\_ Wednesday \_\_\_ Thursday \_\_\_ Friday \_\_\_ Saturday \_\_\_ Sunday

**Check the shift(s) you prefer below:**

- \_\_\_ 7AM-3PM \_\_\_ 3PM-11PM \_\_\_ 11PM-7AM \_\_\_ 7AM-7PM \_\_\_ 7PM-7AM \_\_\_ Other

**Education and Training: (Please list all schools attended, beginning with High Schools, then list all Colleges, Vocational/Military Service Schools).**

**High School Name** \_\_\_\_\_ **Street Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Country** \_\_\_\_\_ **Grade Completed** \_\_\_\_\_

**College/Vocational School** \_\_\_\_\_ **Street Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Country** \_\_\_\_\_

**Major Emphasis** \_\_\_\_\_ **Degree Completed** \_\_\_\_\_  Yes  No **Level and type** \_\_\_\_\_

**Graduate School Name** \_\_\_\_\_ **Street Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Country** \_\_\_\_\_

**Major Emphasis** \_\_\_\_\_ **Degree Completed** \_\_\_\_\_  Yes  No **Level and type** \_\_\_\_\_

**License/Certification:**

License Type	License/Certification No.	Issuing Authority/ Board	Expiration Date / /
License Type	License/Certification No.	Issuing Authority/ Board	Expiration Date / /
License Type	License/Certification No.	Issuing Authority/ Board	Expiration Date / /

Has your Professional License ever been suspended, revoked or under investigation?  Yes  No

If Yes, please explain: \_\_\_\_\_

Applicant's Malpractice Insurance: Malpractice Insurance Policy # \_\_\_\_\_ (Where Applicable)

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

**Certifications:** Check all applicable certifications and enter expiration date

ACLS _____ Exp. Date ____/____/____	Other _____ Exp. Date ____/____/____
BCLS _____ Exp. Date ____/____/____	IV _____ Exp. Date ____/____/____
CPR _____ Exp. Date ____/____/____	NALS _____ Exp. Date ____/____/____
PALS _____ Exp. Date ____/____/____	AANA _____ Exp. Date ____/____/____

**Work Experience:** List all of your work experience beginning with your most recent job. You will be asked to explain all gaps in employment. Attach additional sheet(s) if necessary

Facility/Employer Name	Dates Employed From: Mo Yr To: Mo Yr
Company Street Address	Title
City State Zip Country	Unit
Number of beds in Unit: _____ In Hospital: _____	Name of Current Immediate Supervisor
Describe Duties and Specialty Areas:	Tel. No. (include country code if outside U.S.)
Pay Rate/Salary: <input type="checkbox"/> Yearly <input type="checkbox"/> Hourly \$ _____	May we Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No - If no, why not?
Reason for leaving:	If this was a travel assignment, name of agency:
Are your employment records listed under another name? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, what name?	Charge Experience: <input type="checkbox"/> Yes <input type="checkbox"/> No How Often? _____

Facility/Employer Name	Dates Employed From: Mo Yr To: Mo Yr
Company Street Address	Title
City State Zip Country	Unit
Number of beds in Unit: _____ In Hospital: _____	Name of Current Immediate Supervisor
Describe Duties and Specialty Areas:	Tel. No. (include country code if outside U.S.)
Pay Rate/Salary: <input type="checkbox"/> Yearly <input type="checkbox"/> Hourly \$ _____	May we Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No - If no, why not?
Reason for leaving:	If this was a travel assignment, name of agency:
Are your employment records listed under another name? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, what name?	Charge Experience: <input type="checkbox"/> Yes <input type="checkbox"/> No How Often? _____

Facility/Employer Name	Dates Employed From: Mo Yr To: Mo Yr
Company Street Address	Title
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Number of beds in Unit: _____ In Hospital: _____	Name of Current Immediate Supervisor
Describe Duties and Specialty Areas:	Tel. No. (include country code if outside U.S.)
Pay Rate/Salary: <input type="checkbox"/> Yearly <input type="checkbox"/> Hourly \$ _____	May we Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No - If no, why not?
Reason for leaving:	If this was a travel assignment, name of agency:
Are your employment records listed under another name? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, what name?	Charge Experience: <input type="checkbox"/> Yes <input type="checkbox"/> No How Often? _____

Please list any other work-related information you think would be helpful to us in considering you for employment, such as specialized training, certifications, additional work experience, etc.

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References (please list three individuals with whom you have worked who were in a position to evaluate your performance)

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Name	Title	Street Address	City	State	Zip	Telephone No.
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**Additional Information**

1. Are you legally authorized to work in the U.S.?  Yes  No

(Should you become employed by Tender Hand Healthcare Services LLC, you will be required to provide the documentation proving your eligibility to work in the U.S.).

2. Have you ever been convicted of a felony or misdemeanor crime?  Yes  No

3. I \_\_\_\_\_ hereby authorize **Tender Hand Healthcare Services LLC** to request and receive from all prior employers within One year of the date of this application, and all pertinent information concerning my prior employment and its termination, including the reason for such termination.

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**SIGNATURE**

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**DATE**

\*\*\*PLEASE BE SURE TO READ AND SIGN THE ACKNOWLEDGEMENT ON THE NEXT PAGE OF THIS APPLICATION\*\*\*



# Tender Hand Healthcare Services LLC

## WRITTEN REFERENCE CHECK FORM

APPLICANTS NAME: \_\_\_\_\_

COMPANY'S NAME AND ADDRESS: \_\_\_\_\_

EMPLOYEE'S POSITION: \_\_\_\_\_

EMPLOYED FROM: \_\_\_\_\_ TO: \_\_\_\_\_

PLEASE RATE THE FOLLOWING:

	EXCELLENT	GOOD	FAIR
JOB PERFORMANCE	( )	( )	( )
ATTENDANCE	( )	( )	( )
COOPERATION	( )	( )	( )
INITIATIVE	( )	( )	( )
HEALTH	( )	( )	( )

COMMENTS: \_\_\_\_\_

STRENGTHS: \_\_\_\_\_

WEAKNESSES: \_\_\_\_\_

WOULD YOU REHIRE THIS INDIVIDUAL? \_\_\_\_\_ YES \_\_\_\_\_ NO

COMPLETED BY: \_\_\_\_\_

TITLE: \_\_\_\_\_

I, \_\_\_\_\_, authorize my former employers to release the above information relating to my employment history. I release them from any and all liability resulting from filling out this form. I understand that any information received will be treated in a completely confidential manner.

APPLICANT'S SIGNATURE: \_\_\_\_\_

Thank you for completing this form. Please return to:

**Tender Hand Healthcare Services LLC**  
406 Abbi Road Carteret, NJ 07008

# Tender Hand Healthcare Services LLC

## WRITTEN REFERENCE CHECK FORM

APPLICANTS NAME: \_\_\_\_\_

COMPANY'S NAME AND ADDRESS: \_\_\_\_\_

EMPLOYEE'S POSITION: \_\_\_\_\_

EMPLOYED FROM: \_\_\_\_\_ TO: \_\_\_\_\_

PLEASE RATE THE FOLLOWING:

	EXCELLENT	GOOD	FAIR
JOB PERFORMANCE	( )	( )	( )
ATTENDANCE	( )	( )	( )
COOPERATION	( )	( )	( )
INITIATIVE	( )	( )	( )
HEALTH	( )	( )	( )

COMMENTS: \_\_\_\_\_

STRENGTHS: \_\_\_\_\_

WEAKNESSES: \_\_\_\_\_

WOULD YOU REHIRE THIS INDIVIDUAL? \_\_\_\_\_ YES \_\_\_\_\_ NO

COMPLETED BY: \_\_\_\_\_

TITLE: \_\_\_\_\_

I, \_\_\_\_\_, authorize my former employers to release the above information relating to my employment history. I release them from any and all liability resulting from filling out this form. I understand that any information received will be treated in a completely confidential manner.

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## WRITTEN REFERENCE CHECK FORM

APPLICANTS NAME: \_\_\_\_\_

COMPANY'S NAME AND ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

EMPLOYEE'S POSITION: \_\_\_\_\_

EMPLOYED FROM: \_\_\_\_\_ TO: \_\_\_\_\_

PLEASE RATE THE FOLLOWING:

	EXCELLENT	GOOD	FAIR
JOB PERFORMANCE	( )	( )	( )
ATTENDANCE	( )	( )	( )
COOPERATION	( )	( )	( )
INITIATIVE	( )	( )	( )
HEALTH	( )	( )	( )

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

STRENGTHS: \_\_\_\_\_

WEAKNESSES: \_\_\_\_\_

WOULD YOU REHIRE THIS INDIVIDUAL? \_\_\_\_\_ YES \_\_\_\_\_ NO

COMPLETED BY: \_\_\_\_\_

TITLE: \_\_\_\_\_

I, \_\_\_\_\_, authorize my former employers to release the above information relating to my employment history. I release them from any and all liability resulting from filling out this form. I understand that any information received will be treated in a completely confidential manner.

APPLICANT'S SIGNATURE: \_\_\_\_\_  
\_\_\_\_\_

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406 Abbi Road Carteret, NJ 07008

# Tender Hand Healthcare Services LLC

406 Abbi Road  
Carteret, NJ 07008

## Physical Examination

Date: \_\_\_\_\_

Employee Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

First Mantoux: \_\_\_\_\_ Second Mantoux: \_\_\_\_\_ Chest X-Ray: \_\_\_\_\_

Weight	/
Height	/
Blood Pressure	/
Hernia	/
Free from Contagious Disease	/
Eyes	/
Ears	/
Throat	/
Extremities	/
Skin	/
Heart	/
Chest	/
Abdomen	/

### Back Assessment

Limitations: \_\_\_\_\_ No \_\_\_\_\_ Yes

Explain  
Limitations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Nurses Signature: \_\_\_\_\_

Names Of Physician: \_\_\_\_\_  
(PRINT)

Physician Signature: \_\_\_\_\_

# Tender Hand Healthcare Services LLC

406 Abbi Road  
Carteret, NJ 07008

## RELEASE OF INFORMATION

### FOR CRIMINAL HISTORY REPORTS & BACKGROUND CHECK

Name: (last) \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Current Address: \_\_\_\_\_

Previous Address: \_\_\_\_\_

Phone: \_\_\_\_\_

I hereby authorize **Tender Hand Healthcare Services LLC** to contact any of my previous employers, schools, companies, law enforcement agencies, persons, educational institutions, state agencies, and other sources as appropriate, including private agencies conducting criminal record searches, to supply any information concerning my background. I also hereby release any of the above from liability and responsibility arising from their doing so.

I hereby also give my permission, as a condition of employment or a part of my duties relating to employment, for the release of all appropriate background information regarding criminal record history, driving record history or other sources of information which is permissible by all governing law. I believe to the best of my knowledge that all information I have provided is accurate, true and correct and that I fully understand the terms of this release.

Applicant/Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Tender Hand Healthcare Services LLC

## AGREEMENT OF STANDARDS

*Tender Hand Healthcare Services LLC., values each of its employees and the work they do. We expect to have a long and successful relationship with all who become part of our mission to provide compassionate, excellent and reliable service to clients in need. We respect the ongoing trust of our clients by providing them with the highest quality of care. For these reasons, it is important that you understand and strictly adhere to Tender Hand Healthcare Services LLC. conditions of employment and standards of conduct.*

1. **STANDARDS OF CONDUCT:** I understand that Tender Hand Healthcare Services LLC., expects a professional code of conduct at all times.
  - a. I will treat clients, coworkers and supervisors in a caring manner and speak to them in a respectful tone of voice.
  - b. I will refrain from the use of profanity, gossip or aggressive physical contact.
  - c. I will notify Tender Hand Healthcare Services LLC. immediately when unable to go to an assignment as scheduled.
  - d. I will be punctual and in attendance as scheduled, avoiding absenteeism and lateness.
  - e. I will demonstrate honesty in all actions, communications, and documentation (including time slips).
  - f. I will respect the clients' homes and property by not taking objects or money that belong to them or accepting any money or gifts from them.
  - g. I will refuse to act as a clients' financial agent or Power of Attorney relation to their financial matters or health care decisions.
  - h. I will perform *all* duties as assigned on the care plan in a satisfactory or more than satisfactory manner.
  - i. I will remain awake, alert and available to the client while on duty in the client's home.
  - j. I will maintain a healthy work environment, refraining from smoking or being under the influence or drugs/alcohol while on assignment.
  - k. I will abide by the rules of confidentiality *at all times* and not discuss clients or fellow employees with anyone outside of Tender Hand Healthcare Services LLC...
  - l. I will minimize safety risks by not taking any unauthorized person (such as a child, family member or friend) to assignments.
  - m. I will follow all Tender Hand Healthcare Services LLC. policies and procedures.
  - n. I will keep all client information confidential.

I agree to comply with these standards and all applicable laws and regulations. I understand that if a reasonable suspicion exists that I have breached these or other standards that relate to my profession, licensure or job duties that Tender Hand Healthcare Services LLC. may initiate disciplinary actions or separation of employment.

2. **CONFIDENTIALITY STATEMENT:** I understand that all client information, including his/her name, address, treatment information and other private matters that occur in a client's home are confidential. I will respect the privacy of my client by only using his/her personal and health information as needed to perform the duties of my job. While in my possession I will secure all client information to keep it confidential. I will not keep copies of any client information and will return it to the Tender Hand Healthcare Services LLC. office when no longer needed.
3. **PAYROLL:** If hired, I understand and agree that my pay, whether hourly or per visit, will include time spent for client care, charting/documentation and travel time. I also understand and agree that I will not be paid without signed time slips and client care documentation and that these items must be turned into the service office no later than Monday following the week services are rendered.
4. **RELEASE OF INFORMATION:** I hereby authorize Tender Hand Healthcare Services LLC. to seek any information from all my previous employers, references, and schools and to complete a background investigation. I release all of these and Services from any and all liability arising from their giving or receiving information about me and my suitability for employment with Tender Hand Healthcare Services LLC...
5. **COMPETITIVE SELECTION PROCESS:** I understand and agree that any offer of employment I may receive is contingent upon my successful completions of Tender Hand Healthcare

Services LLC. post-offer, pre-employment screening, and the availability of work. Tender Hand Healthcare Services LLC. only offers work assignment as they are available. I also understand that if there is more than one qualified candidate for a position, Tender Hand Healthcare Services LLC. retains sole discretion to offer employment to the applicant who it believes is the most qualified for the position.

**6. DRUG/ALCOHOL USE:** I certify that I am not addicted to or a habitual user of illegal drugs or substances. I also do not misuse any legally prescribed medications that could impair my ability to fully perform my job duties and exercise sound judgment at all times. If hired, I understand that my employment may be terminated for suspected use or for being under the influence of drugs or alcohol at work. I agree to submit drug/alcohol testing within the guidelines of state law.

**7. CRIMINAL BACKGROUND CHECK:** Other than any criminal convictions I have disclosed and explained and explained on the Employee Integrity Insurance Coverage Application, I do not have a criminal record and have not been excluded from participation in any federal or state health care program. If convicted of a crime or excluded from a federal or state health care program during my employment with Tender Hand Healthcare Services LLC., I will notify my director in writing within 5 days of the conviction or exclusion.

**8. UNEMPLOYMENT BENEFITS:** If hired, I understand that my state unemployment benefits may be denied for: separation from Tender Hand Healthcare Services LLC, failing to accept a suitable job; failing to contact my supervisor at the end of each assignment and on a regular basis thereafter to indicate that I am willing and able to accept new assignments; failing to return to work from a vacation or medical leave of absence.

**9. RELEASE OF EMPLOYMENT RECORDS:** If hired, I understand that Tender Hand Healthcare Services LLC is bound by law to report accurate information related to the work history of its employees to federal, state or local agencies when authorized to do so in writing.

**10. WORKING DIRECTLY FOR DEVOTED ASSISTANCE INC IS NOT PERMITTED:** If hired, I agree that in consideration of my employment with Tender Hand Healthcare Services LLC. I will not, for any reason, seek or accept employment from or directly/indirectly provide services to any client of Tender Hand Healthcare Services LLC.. to whom I have rendered services during my employment with the company and for a period of one hundred eighty (180) days after the separation of my employment. I further agree that if I breach the foregoing damages or compensation will not be an adequate remedy and that Tender Hand Healthcare Services LLC.. may implement any or all legal remedies available.

**11. AT WILL EMPLOYMENT:** If hired, I understand and agree that my employment by Tender Hand Healthcare Services LLC. would be "at will" and that both parties may terminate our employment relationship at any time and for any reason.

**BY SIGNING BELOW I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND AGREE TO EACH OF THE PRECEDING PARAGRAPHS AND THAT NO PROMISES REGARDING EMPLOYMENT HAVE BEEN MADE TO ME.**

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Date

## **TITLE OF POSITION: REGISTERED NURSE**

**TITLE OF IMMEDIATE SUPERVISOR: DIRECTOR OF NURSING  
RISK OF EXPOSURE TO BLOODBORNE PATHOGENS - HIGH  
DUTIES**

To provide nursing care in accordance with the patient's plan of care to include comprehensive health and psychosocial evaluation, monitoring of the patient's condition, health promotion and prevention coordination of services, teaching and training activities and direct nursing care

### **RESPONSIBILITIES**

1. Coordinates total patient care by conducting comprehensive health and psychosocial evaluation, monitoring the patient's condition, promoting sound preventive practices, coordinating services and teaching and training activities
2. Evaluates the effectiveness of nursing service to the patient and family on an ongoing basis
3. Performs admission, transfer, re-certification, resumption of care and discharge paperwork for the home care patient.
4. Prepares and presents patient's record to the Clinical Record Review Committee as indicated
5. Consults with the attending physician concerning alterations of Patient Care Plans, checks with the appropriate supervisor and makes changes, as appropriate
6. Coordinates patient services
7. Submits clinical notes no less often than weekly, and progress notes and other clinical record forms outlining the services rendered as indicated
8. Submits a tally of patient care visits made each day
9. Participates in case conferences, discusses with the supervisor problems concerning the patients and how they may best be handled
10. Discusses with the appropriate supervisor the need for the involvement of other members of the health team
11. Obtains orders for paraprofessional service and submits a referral to the appropriate personnel

12. Participates in the patient's discharge planning process
13. Cooperates with other agencies providing nursing or related services to provide continuity of care and to implement a comprehensive care plan
14. Participates in staff development meeting
15. Continually strives to improve his/her nursing care skills by attending in-service education, through formal education, attendance at workshops, conferences, active participation in professional and related organizations and individual research and reading
16. Participates in the development and periodic revision of the physician's Plan of Treatment and processes change orders as needed
17. Submits clinical notes within seventy-two (72) hours, and progress notes and other clinical record forms outlining the services rendered
18. Participates in the patient's discharge planning process
19. Maintains an on-going knowledge of current drug therapy
20. Adheres to Federal, NJ state and accreditation requirements
21. May be requested by Director of Nursing to fill in for the other nurses

#### COORDINATES THE ADMISSION OF A PATIENT TO THE FIRM

1. Conducts an initial and ongoing comprehensive assessment of the patient's needs at appropriate time frames
2. Obtains a medical history from the patient and/or a family member particularly as it relates to the present condition
3. Conducts a physical examination of the patient, including vital signs, physical assessment, mental status, appetite and type of diet, etc.
4. Evaluates the patient, family member(s) and home situation to determine what health teaching will be required
5. Evaluates the patient's environment to determine what assistance will be available from family members in caring for the patient

6. Evaluates the patient's condition and home situation to determine if the services of a Home Health Aide will be required and the frequency of this service
7. Explains nursing and other Firm services to patients and families as a part of planning for care
8. Develops and implements the nursing care plan
9. May be requested by the Director of Nursing to fill in for other nurses who are on vacation or sick.

#### PROVIDES SKILLED NURSING CARE AS OUTLINED IN THE NURSING CARE PLAN

1. Nursing services, treatments and preventative procedures requiring substantial specialized skill and ordered by the physician
2. The initiation of preventative and rehabilitative nursing procedures as appropriate for the patient's care and safety
3. Observing signs and symptoms and reporting to the physician reactions to treatments, including drugs, as well as changes in the patient's physical or emotional condition
4. Teaching, supervising and counseling the patient and caregivers regarding the nursing care needs and other related problems of the patient at home

#### ASSUMES RESPONSIBILITY FOR THE CARE GIVEN BY THE CHHHA

1. Supervises and evaluates the care given by the CHHHAs per Firm policy
2. Submits to the appropriate department/individual a written evaluation of the Aides who are providing service to the patients in his/her geographical area
3. Participates in periodic conferences with the Aide supervisor concerning the Aide's performance
4. Charts those services rendered to the patient by the staff nurse and changes that have been noted in the patient's condition and/or family and home situation, makes revisions in the nursing care plan as needed, records supervisory visits conducted with the CHHHA, evaluates patient care and progress and closes charts of discharged patients
5. Evaluates the effectiveness of her nursing service to the individual and family
6. Consults with the attending physician concerning alteration of the plan of treatment in consultation with the supervisor

7. Submits clinical notes no less often than weekly, and progress notes and other clinical record forms outlining the services rendered as indicated
8. Submits a tally of visits made each day
9. Participates in case conferences
10. Discusses with the supervisor problems concerning the patients and possible resolution
11. Discusses with the supervisor the need for involvement of other members of the health team such as the home health aide, physical therapist, speech therapist, occupational therapist, social worker, etc.
12. Obtains orders for paraprofessional service and submits referral to appropriate personnel
13. Provides guidance and supervision to the LPN and supervises the LPN per Firm policy
14. Coordinates total patient care
15. Cooperates with other agencies providing nursing or related services to provide continuity of care and to implement a comprehensive care plan
16. Participates in staff development meetings
17. Participates in the educational experiences for student nurses
18. Continually strives to improve his/her nursing care by attending in-service education, through formal education, attendance at workshops, conferences, goal setting, active participation in professional and related organizations and individual research and reading
19. Participates in the planning, operation and evaluation of the nursing service
20. Participates in the development and periodic revision of the physician's Plan of Treatment and processes change orders as needed
21. Participates in the patient's discharge planning
22. Maintains an on-going knowledge of current drug therapy
23. Prepares the care plan for the CHHA

## JOB CONDITIONS

1. Must have a driver's license and be willing and able to drive to patient's residences.
2. The ability to access patients' homes which may not be routinely wheelchair accessible is required. Hearing, eyesight and physical dexterity must be sufficient to perform a physical assessment of the patient's condition and to perform and demonstrate patient care.
3. Physical activities will include, walking, sitting, stooping, and standing and minimal to maximum lifting of patients and the turning of patients.
4. The ability to communicate both verbally and in writing is required as frequent communication by telephone and in writing in English is involved.

## EQUIPMENT OPERATION

Thermometer, B/P cuff, glucometer, penlight, hand washing materials

## COMPANY INFORMATION

Has access to all patient medical records, personnel records and patient financial accounts which may be discussed with the Director of Nursing.

## QUALIFICATIONS

1. Must be a graduate from an accredited School of Nursing
2. Must be licensed in New Jersey as a Registered Nurse
3. One or more years of experience in community/home health services firm or in a hospital setting is preferred
4. Must have a working knowledge of home care and the principles and techniques of professional nursing and required documentation that pertains to it
5. Should be skillful in organization and in the principles of time management and have knowledge of management processes
6. Must be able to contribute to the quality of care being rendered through constructive communication with nursing managers and staff
7. Must have a criminal background check
8. Must have a current CPR certification

ACKNOWLEDGMENT

Employee Signature

Date: