

Facility Information

Facility Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Manger/Supervisor: _____
Name Title Phone Number

APPLICANT: Please complete this reference request by completing the blanks above to correspond with your employment on this application. Please sign and return this form with your application.

The facility listed above has my consent to release any information to ProCare One Nurses pertaining to my employment on the application. I also authorize ProCare One Nurses to disclose this reference to any of its Client Facilities.

Signature: _____ Social Security Number: _____ - _____ - _____

Employee Profile

Employee's Name: _____ Position Held: _____

Employed From: _____ to _____ Is employee eligible for rehire? Yes No

If no, please explain: _____

FACILITY/UNIT PROFILE

Unit/Floor/Dept: _____ Specialty: _____ # of Beds: _____ Avg. patient load: _____

Teaching Non-Teaching # of beds in facility: _____ Charge Experience? Yes No

COMPETENCY STANDARDS

Our total Quality Management for continuous Performance Improvement considers our Employment Reference as an essential component of our applicant review. Information provided to us is available to authorized personnel only.

Key: A = Superior B = Exceeds Standards C = Meets Standards D = Does not meet standards

Adaptability		Professionalism	
Communication Skills		Quality of work	
Competency		Reliability/Attendance	
Follows safety/Emergency Protocols		Teamwork/Cooperation	
Initiative		Thorough/Accurate documentation	
Decision Making Abilities		Patient/Public Relations	

Age Specific Competency: (please check the employee population(s) the employee served)

- | | | |
|--|---|--|
| <input type="checkbox"/> Neonatal/Newborns | <input type="checkbox"/> Preschoolers | <input type="checkbox"/> Young Adults |
| <input type="checkbox"/> Infants | <input type="checkbox"/> Older Children | <input type="checkbox"/> Middle Adults |
| <input type="checkbox"/> Toddlers | <input type="checkbox"/> Adolescents | <input type="checkbox"/> Older Adults/Geriatrics |

Comments: _____

Name of evaluator: _____ Signature: _____

Title: _____ Phone Number: _____ Date: _____