

Nursing Applicant Résumé Template

Goals:

I prefer to work in the following areas of specialities (i.e. Paediatrics, ICU, etc....):

- 1.
- 2.
- 3.

NOTE TO APPLICANT: This résumé template is in a standardized format so that your personal information (your education, skills and work history) can be entered into the jobs database contained in <http://www.cdnwork.com>. It has been designed to assist Canada's Registered Nurses Associations to evaluate your application. This Template also assists potential employers to match your skills and experience to the positions they have available.

Instructions

Fill in the blanks as specified in the instructions for that area. Note: if you are on a computer, just tab to the blank area and proceed. Do not leave blank spaces. **Put N/A** (Not Applicable) in spaces that do not apply. **If you are filling out a paper copy, please print** neatly. Use extra sheets of paper to add information when the space available is not enough.

SUMMARY OF SKILLS AND EXPERIENCE: Please write a few sentences outlining the following:

Supervisory: Have you supervised any other staff? How many? Who supervises you?

Facility: What type of facility have you worked in and what type do you presently work in? If it's a hospital, give details about the type of hospital, number of beds, types of wards. If it's something else, give details about the organization or clinic; type of patients; and anything that might be of interest to an employer

First Aid/Specialized Courses: While all courses are listed in a separate area, we need to have the employer quickly see that you have certain training. List First Aid, CPR or any other resuscitation courses. Also list any other major training like haemodialysis where you received a diploma.

Summary:

PART ONE: PERSONAL AND EDUCATION

Section 1.1: Personal Information

| | |
|--|--|
| Present Name: (last, first & Initial) | |
| Former Name: | |
| * Civil Status: (single/married/widow/separated) | |
| * Citizenship: | |
| * Gender (male or female): | |
| *# of Dependents: (or none) Your children or adopted children | |
| *Your Age | |
| * Date of Birth (dd/mm/y) | |

Note: Any field with an asterisk (*) has been filled out on a voluntary basis.

Section 1.2: Address**Current Address (where you are presently living):**

| | |
|--|--|
| Company or family name: | |
| Street Address or Box Number: | |
| District: (county or barrio or barangay) | |
| City: | |
| Province or State: | |
| Zip or Area Code: | |
| Country: | |

Method of Contact (please also state preferred method with an asterisk (*)):

| | |
|---|--|
| Home Telephone: | |
| Work Telephone: | |
| Cellular Telephone: | |
| Fax Number: | |
| E-Mail address: (Please note that ALL applicants need an e-mail address and need to check their e-mails regularly) | |

Permanent Address (your home base if different from 'Current' Address)

| | |
|--|--|
| C/o Name: | |
| Street Address or Box Number: | |
| District: (county or barrio or barangay) | |
| City: | |
| Province or State: | |
| Zip or Area Code: | |
| Country: | |

Section 1.3: Education

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|---|--|
| Secondary School Name/ Location(City/Country): | |
| Nursing Degree: | |

| | |
|----------------------------------|--|
| Name of Educational Institution: | |
| Location (City/Country): | |
| Start date (mm-yyyy) | |
| End Date (mm-yyyy) | |
| Diploma/Degree Obtained: | |
| Hours of Theory | |
| Hours of Practicum | |

(Note: Hours of Theory and Hours of Practicum are extremely important and MUST be included)

Other Degrees/Diplomas (i. e Midwifery):

| | |
|--|--|
| 2 nd Diploma/ Degree | |
| Name of Educational Institution: | |
| Location (City/Country): | |
| Date rec'd: (mm-yyyy) | |
| Diploma/Degree Obtained: | |
| Thesis Title (if applicable): | |
| 3 rd Post-Secondary Degree: | |
| Location: | |
| Date rec'd: (mm-yyyy) | |
| Program or Degree: | |
| Thesis Title: (if applicable): | |

Section 1.4: Professional Development and Further Training

Include the nursing courses or seminars, in date order taken after graduation. All certificate courses in First Aid, CPR, emergency preparedness, professional upgrading courses, management training, etc. should be listed. **If a certificate was received, please put a ✓ in the box.*** Do not put in religious or political courses (if in doubt, put them in and we will delete any that are not considered applicable to nursing).

| | |
|---|-------------------------|
| Training Course 1: Cert received? <input type="checkbox"/> | Name: Date (mm-yyyy) |
| Training Course 2: | Name: |

| | |
|---|-------------------------|
| Cert received? <input type="checkbox"/> | Date (mm-yyyy) |
| Training Course 3: Cert received? <input type="checkbox"/> | Name: Date (mm-yyyy) |
| Training Course 4: Cert received? <input type="checkbox"/> | Name: Date (mm-yyyy) |
| Training Course 5: Cert received? <input type="checkbox"/> | Name: Date (mm-yyyy) |
| Training Course 6: Cert received? <input type="checkbox"/> | Name: Date (mm-yyyy) |
| (Continue as required) | |

*Please ensure you include copies of the certificates in your application to the Nursing Associations.

Section 1.5: English test. Note: We need to know your marks but you should be aware that on the final résumé submitted to an employer, we will only note: “Candidate has passed an appropriate English Test and has submitted their marks to the appropriate Provincial Licensing Body”.

| Name of Test: | TOIEC | TOEFL | TSE | IELTS | MELAB |
|---------------|-------|-------|-----|---|-------|
| Score: | | | | Listening: Reading: Writing: Spoken: Over-all: | |
| Date: | | | | | |

Section 1.6: Academic/ Professional awards (if applicable)

| | |
|----------|--|
| Award 1: | |
| Award 2: | |
| Award 3: | |
| Award 4: | |

Section 1.7: List all Other Professional Nursing Certifications you have:
(i.e. UKCC, Canadian Provincial, or US National or State Boards)

| Certification type: | Country or Province | Date |
|---------------------|---------------------|------|
| | | |

PART TWO: WORK HISTORY

Section 2.1: Work

Enter your work history in order **starting with your most recent or current position**. If you are using this as a paper copy, use extra sheets as necessary.

Work Position 1:

| | |
|---|--|
| Name of Institution: | |
| Type of Institution: | |
| Location | |
| Start Date to End Date | |
| Job Title (s): | |
| Description and Name of Ward (include how many beds) | |
| If rotation, please advise which areas | |
| Reference (should be Supervisor) and phone number: | |

Duties & Responsibilities – Position #1

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Work Position 2

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|---|--|
| Name of Institution: | |
| Type of Institution: | |
| Location | |
| Start Date to End Date | |
| Description and Name of Ward (include how many beds) | |
| Description of Ward (include how many beds) | |
| If rotation, please advise which areas | |

| | |
|--|--|
| Reference (should be Supervisor) and phone number: | |
|--|--|

Duties & Responsibilities – Position #2

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Work Position 3

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|--|--|
| Name of Institution: | |
| Type of Institution: | |
| Location | |
| Start Date to End Date | |
| Job Title (s): | |
| Description and Name of Ward (include how many beds) | |
| If rotation, please advise which areas | |
| Reference (should be Supervisor) and phone number: | |

Duties & Responsibilities – Position #3

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Work Position 4

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|----------------------|--|
| Name of Institution: | |
|----------------------|--|

| | |
|---|--|
| Type of Institution: | |
| Location | |
| Start Date to End Date | |
| Job Title (s): | |
| Description and Name of Ward (include how many beds) | |
| If rotation, please advise which areas | |
| Reference (should be Supervisor) and phone number: | |

Duties & Responsibilities – Position #4

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(Add additional Work Position/Duties & Responsibilities by using another sheet of paper, or if on-line add more boxes by using the cut and paste functions.

Section 2.2: Nursing Specialities

Nursing specialities are entered using a category code followed by the number of hours of experience for the category. This only relates to hours worked AFTER you have obtained your degree (It does NOT include unpaid work related experience or practicum hours). There are 27 categories, plus an “other” category. Please enter the number of hours for each specialty that you have worked in:

(Note: If you work in more than one speciality on a rotation, the hours of experience must be divided between the specialities based on your best estimate. In other words, an 8-hour shift does not give you 8 hours in each speciality if your rotation is in more than one department). Only those areas that you have worked in will be shown on your final résumé. Note: The employer looks this area over carefully so ensure you follow the instructions. A good rule of thumb is: 8 hour day x 5 days x 52 weeks – 2,080 hours. So if you’ve only been a nurse for 3 years, you should have about 6000 hours.

| No. of Hours | Code | Speciality |
|--------------|------|------------------------------|
| | 01 | Administration/Management |
| | 02 | Adult Care/Respite/Geriatric |
| | 03 | Cardiology |

| | | |
|--|----|---|
| | 04 | Case Management |
| | 05 | Child Development Centre |
| | 06 | Community Health Services |
| | 07 | Critical Care |
| | 08 | Dayroom/Outpatient |
| | 09 | Emergency |
| | 10 | Extended Care |
| | 11 | General Duty/Float |
| | 12 | Home Care |
| | 13 | Home Support (RN Supervisor) |
| | 14 | Intensive Care |
| | 15 | Kidney Dialysis |
| | 16 | Labour and Delivery (Ob-Gyne or Obst. & Gyn or Maternity) |
| | 17 | Licensed Practical Nurse |
| | 18 | Medical/Surgical (Medical; Surgical) |
| | 19 | Mental Health |
| | 20 | Oncology |
| | 21 | Operating/Recovery Room |
| | 22 | Paediatrics (Pediatrics; Infant) |
| | 23 | Psychiatry |
| | 24 | Residential Care |
| | 25 | Special Care |
| | 26 | Clinical Nurse Specialist (Public Health Nurse) |
| | 27 | Orthopaedics |
| | 99 | Other (name): |
| | | Total of all Hours Worked |

Section 2.3: Other skills (management training for business purposes, computer courses, etc.)
Name of Course/Length/Date (mm-yyyy)

| | |
|----------|--|
| Skill 1: | |
| Skill 2: | |
| Skill 3: | |

Continue as necessary

Section 2.4: Professional Affiliations

List any affiliations you belong to:

| | |
|-----------------|--|
| Organisation 1: | |
| Organisation 2: | |
| Organisation 3: | |

Continue as necessary

PART THREE: DETAILED INFORMATION FOR REGISTERED NURSES ASSOCIATIONS

Section 3.1: Nursing Association Requirements:

| Nursing Course Category | Institution & Location(s) /city& country |
|--|--|
| Medical | |
| Surgical | |
| Maternity (Ob-Gyne) | |
| Children (Paediatrics) | |
| Psychiatric (Mental Health) | |
| Nursing Theory (this includes the theory and practice of nursing this does not include any of the other courses in this section) | |
| Anatomy | |
| Biology | |
| Pharmaceutical | |
| Chemistry | |
| Pathophysiology | |
| Other Related Course | |
| Other Related Course | |

Note to Applicant:

The following pages are the revised Skills Check List. There are 3 sections: A) General-Medical-Surgical, B) Emergency Room and C) Obstetrics (or Maternity, Labour Delivery, Ob-Gyne, etc). ALL nurses need to complete Section A. You should only complete section B or C if you have worked in those areas. There are 3 columns: Current, Past, Never Done. Check 'Current' if you can perform the skill without review or supervision, 'Past' if you performed the skill in the past but now would need review, instruction or supervision to perform the skill, and 'Never Done' is ticked if you have never performed the skill, either as a student or as a nurse. If Section B or Section C are not completed, I will delete those sections on your final résumé.

A) GENERAL – MEDICAL/SURGICAL CHECK LIST

| SKILL AREA: | CURRENT | PAST | NEVER DONE |
|-------------------------------------|---------|------|------------|
| BASIC SKILLS | | | |
| Physical Assessment | | | |
| Cardiovascular Assessment | | | |
| Gastrointestinal Assessment | | | |
| Genitourinary Assessment | | | |
| Psychological Assessment | | | |
| Patient/Relative Teaching | | | |
| Neurological Assessment | | | |
| Glasgow coma score | | | |
| Universal precautions | | | |
| Isolation technique | | | |
| Aseptic Technique | | | |
| Wound dressing | | | |
| Suture/clip/staple removal | | | |
| Bandaging | | | |
| Cast/Fibreglass (POP) care | | | |
| Fluid balance monitoring | | | |
| Nasogastric tube insertion | | | |
| Nasogastric/jejunal/E-tube feedings | | | |
| Gastric irrigation | | | |
| Eye irrigation | | | |
| Tracheal suctioning | | | |
| Nasopharyngeal suctioning | | | |
| Tracheostomy care | | | |
| Chest physiotherapy | | | |
| Incentive spirometry | | | |
| Burn dressings | | | |
| Redivac Cares Removal | | | |
| Hemovac Cares Removal | | | |
| Drain shortening/removal | | | |
| Wound irrigation | | | |
| Urinary catheter care | | | |
| Urinary catheter irrigation | | | |
| Urinary catheter insertion (female) | | | |
| Urinary catheter insertion (male) | | | |
| Urinary catheter removal | | | |
| Perineal care | | | |
| Pre-operative care | | | |
| Post-operative immediate care | | | |
| Post-operative care (ward) | | | |
| Pain assessment | | | |
| Pain management | | | |
| Decubitis ulcer care | | | |
| Skin traction care | | | |
| Skin traction application | | | |
| Skeletal traction care | | | |
| Skeletal traction (set up) | | | |

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|--|--|--|--|
| Oxygen administration | | | |
| Colostomy, ileostomy care | | | |
| Cardiac monitor use | | | |
| Cardiac monitor tracing interpretation – Lead II | | | |
| ECG – Obtaining 12, 15, 18 Lead | | | |
| Nursing care plans | | | |
| Discharge planning | | | |
| | | | |
| ASSISTED WITH: | | | |
| Chest tube insertion | | | |
| Lumbar puncture | | | |
| Bone marrow aspiration | | | |
| Joint injections | | | |
| Endotracheal tube insertion | | | |
| Thoracentesis | | | |
| Abdominal tap | | | |
| Subclavian line insertion | | | |
| | | | |
| SPECIMEN COLLECTION: | | | |
| Eye/ENT swabs | | | |
| Wound cultures | | | |
| Sputum | | | |
| Stool | | | |
| Routine urine | | | |
| Mid-stream urine | | | |
| Catheter – urinary | | | |
| 24 hour urine collection | | | |
| Nasopharyngeal | | | |
| Tracheal specimen | | | |
| Testing by reagents | | | |
| | | | |
| MEDICATION ADMINISTRATION: | | | |
| Oral | | | |
| Ear | | | |
| Nose | | | |
| Vaginal | | | |
| Rectal | | | |
| Topical | | | |
| Eyes | | | |
| Tubes | | | |
| IM | | | |
| Sublingual | | | |
| Intradermal | | | |
| Inhalation Therapy | | | |
| Z-track | | | |
| IV push | | | |
| Subcutaneous | | | |
| IV piggypack | | | |
| IV infusions (via graduated chamber) | | | |
| IV pumps | | | |
| Heparin | | | |
| Chemotherapy | | | |

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|---|--|--|--|
| Narcotic infusion | | | |
| Central lines | | | |
| Port-A-Cath | | | |
| Calculation of drug dosages | | | |
| Saline/Heparin locks (use of) | | | |
| Ventolin inhalations | | | |
| Thrombolytics | | | |
| | | | |
| OTHER IV MANAGEMENT: | | | |
| TPN | | | |
| IV pumps e.g. IVAC pumps | | | |
| PCA pumps | | | |
| Blood product administration | | | |
| Peripheral IV insertion (angiocath) intucath, cathlon | | | |
| Peripheral IV insertion (butterfly) | | | |
| Removal of IV | | | |
| Flow regulation | | | |
| CARE OF PATIENT WITH – Cardiac Problems: | | | |
| Myocardial infarction | | | |
| Angina | | | |
| Congestive heart failure | | | |
| Congenital cardiac anomalies | | | |
| Pre/Post cardiac surgery | | | |
| Post cardiac catheterization | | | |
| Arrhythmias | | | |
| Pulmonary embolism | | | |
| CARE OF PATIENT WITH – Respiratory Problems: | | | |
| Asthma | | | |
| Ventilator dependent | | | |
| Oxygen dependent | | | |
| Pneumothorax haemothorax | | | |
| Chest infection | | | |
| Pneumonia | | | |
| Sedated patient | | | |
| COPD | | | |
| CARE OF PATIENT WITH – Haematological problems: | | | |
| Anaemia | | | |
| Thrombocytopenia | | | |
| Post splenectomy | | | |
| Leukaemia | | | |
| Post bone marrow aspiration | | | |
| Pre/post bone marrow transplant | | | |
| CARE OF PATIENT WITH – Oncology Problems: | | | |
| Hodgkin's | | | |
| Non-Hodgkin's Lymphoma | | | |
| Chemotherapy | | | |
| Radiotherapy | | | |
| With Central Venous Lines Port-A-Caths | | | |
| Palliative care | | | |
| CARE OF PATIENT WITH – Renal Problems: | | | |
| Acute/chronic renal failure | | | |
| Peritoneal dialysis | | | |

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|---|--|--|--|
| Pre/Post kidney transplant | | | |
| Ileo conduits | | | |
| Nephrostomy tube | | | |
| Haemolytic uraemia syndrome | | | |
| CARE OF PATIENT WITH – Gastrointestinal Problems: | | | |
| Hepatitis | | | |
| Cirrhosis | | | |
| GI bleed | | | |
| Diabetes | | | |
| Gastro-enteritis | | | |
| Bowel obstruction | | | |
| Cholysystectomy | | | |
| Post gastrectomy | | | |
| Cleft palate | | | |
| CARE OF PATIENT WITH – Orthopaedic Problems: | | | |
| Traction | | | |
| Joint replacement | | | |
| Spinal injury | | | |
| Post amputation | | | |
| Neck or femur fracture | | | |
| Spinal surgery | | | |
| Major trauma | | | |
| CARE OF PATIENT WITH – Neurological Problems: | | | |
| Cerebral vascular accident | | | |
| Head injury | | | |
| Post craniotomy | | | |
| Post lumbar puncture | | | |
| Meningitis | | | |
| Seizures | | | |
| Brain tumour | | | |
| CARE OF PATIENT WITH – Dermatology Problems: | | | |
| Burns | | | |
| Post skin graft | | | |
| CARE OF PATIENT WITH – Breast Disorders: | | | |
| Breast cancer | | | |
| CARE OF PATIENT WITH – Gynaecologic Problems: | | | |
| Endometrial cancer | | | |
| Ovarian cancer | | | |
| Ectopic pregnancy | | | |
| Abortion | | | |
| Uterine displacement | | | |
| CARE OF PATIENT WITH – Urologic Problems: | | | |
| Urinary retention | | | |
| Incontinence | | | |
| Prostatectomy | | | |
| CARE OF PATIENT WITH – Other Problems: | | | |
| Multiple trauma | | | |
| Infectious diseases | | | |
| Behavioural problems | | | |
| | | | |
| OTHER EQUIPMENT: | | | |
| Oxygen masks | | | |

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|-------------------------------|--|--|--|
| Oxygen hoods | | | |
| Oxygen nasal prongs | | | |
| Humidifiers | | | |
| Ventilation masks | | | |
| Oxygen tents | | | |
| Burretols | | | |
| Stryker beds | | | |
| 12 lead ECG machine | | | |
| Blood Glucose monitoring | | | |
| Hickman catheters | | | |
| Defibrillators | | | |
| Ambu bags | | | |
| Monitors telemetry | | | |
| Oxygen saturation monitors | | | |
| Electronic infusion pumps | | | |
| Syringe pumps | | | |
| Tympanic thermometers | | | |
| Other electronic thermometers | | | |
| Electronic BP machine | | | |
| Feeding pump | | | |
| | | | |
| OTHER RESPONSIBILITIES: | | | |
| Unit management | | | |
| Rosters | | | |
| In-service presentations | | | |
| Quality assurance | | | |
| Peer review | | | |
| Preceptor | | | |
| | | | |

B) GENERAL – EMERGENCY ROOM CHECK LIST

| SKILL AREA: | CURRENT | PAST | NEVER DONE |
|--|---------|------|------------|
| Physical assessment | | | |
| Neurological assessment | | | |
| Triage | | | |
| APGAR | | | |
| Glasgow Coma Scale | | | |
| Ambu bag | | | |
| Resuscitation | | | |
| Management of cardiopulmonary arrest | | | |
| ECG interpretation – Lead II and 12 Lead | | | |
| Defibrillation/cardioversion | | | |
| Arterial puncture for blood gas analysis | | | |
| Interpretation of ABC | | | |
| Suctioning (oral pharyngeal) | | | |
| Suctioning (nasopharyngeal) | | | |

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|--|--|--|--|
| Tracheostomy suctioning | | | |
| NG tube insertion | | | |
| Gastric lavage | | | |
| Urinary catheter insertion | | | |
| Suturing | | | |
| Removal of sutures | | | |
| Plaster cast application | | | |
| Bandaging | | | |
| Medicated inhalations (Ventolin) | | | |
| Intravenous cannulation | | | |
| Cervical spine immobilisation | | | |
| Eye irrigation | | | |
| Care of violent patient | | | |
| Pre operative preparation | | | |
| Post operative recovery | | | |
| Airway management | | | |
| | | | |
| ASSIST WITH: | | | |
| Open chest | | | |
| Chest tubes | | | |
| Endotracheal tube insertion | | | |
| Lumbar puncture | | | |
| Peritoneal lavage | | | |
| Suturing | | | |
| IV cutdowns | | | |
| Subclavian lines | | | |
| PICC | | | |
| Paracentesis | | | |
| Emergency vaginal delivery | | | |
| EQUIPMENT (EXPERIENCE WITH): | | | |
| Cardiac monitor | | | |
| Pulse Oximetry | | | |
| Infusion pumps | | | |
| Electronic BP machines | | | |
| Defibrillator | | | |
| Telemetry | | | |
| Blood Glucose measuring devices | | | |
| | | | |
| PATIENT CARE OF: Cardiac Problems: | | | |
| Acute myocardial infarction | | | |
| Aneurysms | | | |
| Hypertension | | | |
| Shock | | | |
| | | | |
| PATIENT CARE OF: Respiratory Problems: | | | |
| Acute respiratory distress | | | |
| Asthma | | | |
| Pulmonary embolism | | | |
| Pulmonary oedema | | | |
| Pneumothorax | | | |
| COPD | | | |
| Carbon monoxide poisoning | | | |

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| Rib fractures | | | |
| | | | |
| PATIENT CARE OF: Neurological Problems: | | | |
| CVA | | | |
| Head Injury | | | |
| Overdose | | | |
| Seizures | | | |
| Meningitis | | | |
| Cranial haemorrhage | | | |
| | | | |
| PATIENT CARE OF: Trauma: | | | |
| Acute multiple trauma | | | |
| Acute abdomen | | | |
| Multiple fractures | | | |
| Road crash | | | |
| Sexual assault | | | |
| Cardiac tamponade | | | |
| Burns | | | |
| Open chest wounds | | | |
| | | | |
| PATIENT CARE OF: Orthopaedic problems: | | | |
| Simple fractures | | | |
| Complicated fractures | | | |
| Amputations | | | |
| Cervical injury | | | |
| PATIENT CARE OF: Gastrointestinal problems: | | | |
| Acute bleeding | | | |
| Bowel obstructions | | | |
| Cirrhosis | | | |
| Pancreatitis | | | |
| Hepatitis | | | |
| Abdominal pain | | | |
| | | | |
| PATIENT CARE OF: Other problems: | | | |
| Paediatric disorders | | | |
| Haemophilia | | | |
| HIV/AIDS | | | |
| Infectious diseases | | | |
| Incomplete abortions | | | |
| Ectopic pregnancy | | | |
| Trauma with pregnancy | | | |
| Emergency childbirth | | | |
| Psychiatric emergencies | | | |
| | | | |

C) OBSTETRICS

| SKILL AREA: | CURRENT | PAST | NEVER DONE |
|--|---------|------|---------------|
| Antenatal care | | | |
| Antenatal education | | | |
| Application of fetal scalp electrodes | | | |
| Fetal blood sampling | | | |
| Delivery (normal) – perform | | | |
| Delivery – assist | | | |
| Episiotomy – perform | | | |
| Episiotomy – assist | | | |
| Suturing – perform | | | |
| Suturing – assist | | | |
| Fetal heart rate / Doppler | | | |
| CPR Adult | | | |
| CPR newborn | | | |
| Urethral catheter insertion | | | |
| Blood sugar monitoring | | | |
| IV insertion | | | |
| IV (manage) | | | |
| Non-stress testing | | | |
| Oxygen administration | | | |
| Delivery of infant with spina bifida | | | |
| Delivery of infant with hydrocephaly | | | |
| Delivery of infant with meningocoele | | | |
| Delivery of infant with multiple anomalies | | | |
| Stillbirth | | | |
| Intubation (assist) | | | |
| Intubation (perform) | | | |
| APGAR | | | |
| Breech deliveries | | | |
| Multiple births | | | |
| Forceps delivery | | | |
| Vacuum/Ventouse extractions | | | |
| Attend OR for C sections | | | |
| Breast feeding (patient teaching) | | | |
| Breast expression | | | |
| Cord care | | | |
| Circumcision site care | | | |
| Wound care | | | |
| Pain management | | | |
| Suture removal | | | |
| Clip removal | | | |
| | | | |
| CARE OF: | | | |
| Patients with pre-eclampsia/eclampsia | | | |
| Gestational diabetes | | | |
| Ante partum haemorrhage | | | |
| Post partum haemorrhage | | | |
| Premature rupture of membranes | | | |

| | | | |
|--|--|--|--|
| Prolapsed cord | | | |
| Placenta abruption | | | |
| Premature labour | | | |
| Induction of labour using syntocinon IV and Prostaglandin per vagina | | | |
| Assist with epidural and or spinal | | | |
| Hyperemesis gravidarium | | | |
| Incompetent cervix | | | |
| Asthmatic patient | | | |
| Epileptic patient | | | |
| Cardiac patient | | | |
| | | | |
| CARE OF NEONATES WITH: | | | |
| Electronic fetal monitor | | | |
| Fetal Doppler | | | |
| Infusion pumps | | | |
| Cardiac monitor | | | |
| Breast pump | | | |
| Blood warmer/infuser | | | |
| | | | |
| EXPERIENCE IN | | | |
| Antenatal clinics | | | |
| Parent education | | | |
| NICU | | | |
| Labour and delivery | | | |
| Antenatal unit | | | |
| Post natal unit | | | |
| Home care | | | |
| | | | |
| | | | |
| | | | |
| | | | |

RNABC FILE NO: _____

NURSING APPLICATION CHECKLIST

NAME OF APPLICANT: _____

Applicant: Please use this form to ensure that we have all the information that is required by the Registered Nurses Association of BC (RNABC). If RNABC does not have all the information, your application will have a lengthy delay while they attempt to contact you directly for the information.

Have you:

| | <u>Yes/No</u> | <u>Attached:</u> |
|---|---------------|---------------------|
| Filled out the RNABC Form, answering all questions? | | |
| Fully completed your résumé according to our template? | | Disk: Hard Copy: |
| Attached a copy of your Birth Certificate? | | |
| Attached a copy of your Marriage Certificate* (if applicable)? | | |
| Attached a copy of your English Test results? | | |
| Attached copies of Certificates received for other courses taken? | | |

* Or other “change of name” documentation (adoption, legal change, affidavit from parents/school officials/cleric).

English test information required: (We would like to know what form of English exam you wrote and from whom you requested the test results to be sent to RNABC so that we can contact that company representative to check that they did send those results. Include a photocopy of your exam results in the material you return)

| Type of test | Company/Institution Name | Contact person | Contact Phone |
|--------------|--------------------------|----------------|---------------|
| | | | |

Board Exam Results (Please state the type of nursing board exam you took and tell us when the results were sent to the RNABC. You can simply photocopy your request with the date on it)

| Address | Date Mailed |
|---------|-------------|
| | |

Employment Verification (We have to be able to check whether the past employer has received and answered your request for previous employment. You can also attach a copy of the letter requesting for a certification of past employment)

| Company/Institution (s) | Address: | Contact Person: | Contact Phone: |
|-------------------------|----------|-----------------|----------------|
| | _____ | | |

Post-Secondary Institution information: (Your school of nursing, college, or university has to send a copy of your transcript directly to the RNABC. You can attach a copy of the letter you sent to the institution, or provide in the boxes below the information that will allow us to verify that they have received your request and have acted on it).

| Institution Name: | Contact Person: | Contact Tel. No: | Date Requested: | Transcript Attached: |
|-------------------|-----------------|------------------|-----------------|----------------------|
| | | | | |