



Bay Pines VA Healthcare System

Post Office Box 5005

Bay Pines, FL 33744

Dear Applicant:

I want to thank you for your interest in employment at Bay Pines VA Healthcare System. Our application process reflects our commitment to recruiting the best qualified and highly motivated nurses available. We compliment our nursing staff by extending to them a comprehensive health insurance program, generous paid time off, excellent opportunities for career development and further education, all within an environment that I believe reflects a culture of excellence and opportunity. Our salaries will be competitive and will reflect your education and previous experience.

Enclosed is an application package. Please complete and return it, as well as a copy of your current nursing license, any certifications you may have (CCRN, CNOR, CR-C, etc.) and three employment reference letters. One must be from your current or most recent employer. **A complete application package will include:**

- 1.____ APPLICATION FOR NURSES AND NURSE ANESTHETISTS (RN/ARNP) or APPLICATION FOR ASSOCIATED HEALTH OCCUPATIONS (LPN)- You must account for **all time frames** following the completion of your nursing education. This will include all professional work experience (month and year), as well as any periods of unemployment. With respect to your nursing experience, please provide the complete address of each employer.
- 2.____ DECLARATION OF FEDERAL EMPLOYMENT- Please complete all sections. If you have answered yes to any questions please attach a written explanation including the dates and disposition.
- 3.____ RESUME - This is a useful document in evaluating the previous work history and experiences. Do not delay your application to create this document if you do not have one.
- 4.____ PERFORMANCE EVALUATIONS/REFERENCES-All applicants will need to submit three written references. If you are a current VA employee a copy of your last two proficiencies and or performance appraisals should be included with your application.
- 5.____ LICENSE-include a copy of your current nursing license with CPR card (mandatory for employment).
- 6.____ CERTIFICATIONS- National certification and licensure as an advanced practice nurse is required of all ARNP/CRNA applicants. ACLS is required for nurses working on the units.

7.____TRANSCRIPTS- Selected Applicants must have their official transcripts sent directly to the Nurse Recruiter prior to hire. **Do not delay submitting your application however, waiting for transcripts.**

8.____ DD-214-Veterans Only.

9.____ Note: Applicants tentatively selected for employment at Bay Pines VA Healthcare System are subject to urinalysis to screen for illegal drug use prior to appointment (hire). Applicants who refuse to be tested, will be denied employment with the VA Healthcare System.

Your completed application may be submitted to:

via US Postal Service

via Express Services:

Department of Veterans Affairs
Adrian Griffin RN, Nurse Recruiter
BLDG 22 RM 116B
P.O. Box 5005 (118)
Bay Pines, FL 33744

Department of Veterans Affairs
Adrian Griffin RN, Nurse Recruiter
BLDG 22 RM 116B
10000 Bay Pines Blvd
Bay Pines, FL 33744

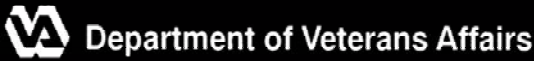
If you have any questions, please do not hesitate to contact me at (727) 398-6661 Ext 4661 or e-mail at adrian.griffin@va.gov. Fax number is (727) 398-9585. I appreciate your interest in our medical center and look forward to talking with you.

Sincerely,

Adrian Griffin RN, **CHCR**
Nurse Recruiter

Return to Nurse Recruiter

RN/LPN Application Packet



APPLICATION FOR NURSES AND NURSE ANESTHETISTS

SEE LAST PAGE FOR PAPERWORK REDUCTION ACT, PRIVACY ACT AND INFORMATION ABOUT DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER.

INSTRUCTIONS: Please submit this application furnishing all information in sufficient detail to enable the Department of Veterans Affairs to determine your eligibility for appointment in Veterans Health Administration. Type, or print in ink. If additional space is required, please attach a separate sheet and refer to items being answered by number.

1. NAME (Last, First, Middle)		2. APPLICATION FOR (Check one) <input type="checkbox"/> GENERAL PRACTICE <input type="checkbox"/> SPECIALTY (Identify below)	
3. PRESENT ADDRESS (Include ZIP Code)		4. TELEPHONE NUMBER (Include Area Code)	
		4A. RESIDENCE	4B. BUSINESS
5. DATE OF BIRTH	6. PLACE OF BIRTH	7. SOCIAL SECURITY NUMBER	
8A. CITIZENSHIP <input type="checkbox"/> U.S. CITIZEN BY BIRTH <input type="checkbox"/> NATURALIZED U. S. CITIZEN <input type="checkbox"/> NOT A U.S. CITIZEN (Complete item 8B)		8B. COUNTRY OF WHICH YOU ARE A CITIZEN	
9A. HAVE YOU EVER FILED APPLICATION FOR APPOINTMENT IN THE VA <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" complete items 9B and 9C)		9B. NAME OF OFFICE WHERE FILED	9C. DATE FILED
10. WHEN MAY INQUIRY BE MADE OF YOUR PRESENT EMPLOYER		11. DATE AVAILABLE FOR EMPLOYMENT	

I - ACTIVE MILITARY DUTY

12A. DATE FROM	12B. DATE TO	12C. SERIAL OR SERVICE NO.	12D. BRANCH OF SERVICE	12E. TYPE OF DISCHARGE <input type="checkbox"/> HONORABLE <input type="checkbox"/> Other (Explain on separate sheet)
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II - REGISTRATION AND CLINICAL PRIVILEGES

13A. LIST ALL STATES/TERRITORIES IN WHICH YOU ARE NOW OR HAVE EVER BEEN REGISTERED AS A NURSE (If necessary, continue on separate sheet)	13B. REGISTRATION NUMBER	13C. EXPIRATION DATE

14. ARE YOU FULLY REGISTERED IN EVERY STATE IN WHICH YOU ARE NOW REGISTERED <input type="checkbox"/> YES <input type="checkbox"/> NO (If restricted, limited or probational in any State(s), explain on separate sheet)	15. DO YOU HAVE PENDING OR HAVE YOU EVER HAD ANY REGISTRATION TO PRACTICE REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED, OR ISSUED/PLACED ON A PROBATIONAL STATUS OR VOLUNTARILY RELINQUISHED <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)	16. HAVE YOU EVER HELD A REGISTRATION TO PRACTICE THAT IS NO LONGER HELD OR CURRENT <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)
17A. DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD CLINICAL PRIVILEGES AT ANY HEALTH CARE INSTITUTION, AGENCY OR ORGANIZATION <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)	17B. NAME OF CURRENT OR MOST RECENT INSTITUTION, AGENCY OR ORGANIZATION WHERE HELD	17C. HAVE ANY OF YOUR STAFF APPOINTMENTS OR CLINICAL PRIVILEGES EVER BEEN DENIED, REVOKED, SUSPENDED, REDUCED, LIMITED, OR VOLUNTARILY RELINQUISHED <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)

III - NURSE ANESTHETIST CERTIFICATION (To be completed by Nurse Anesthetists only)

18A. ARE YOU CERTIFIED AS A NURSE ANESTHETIST BY THE COUNCIL ON CERTIFICATION OF NURSE ANESTHETISTS (CCNA) <input type="checkbox"/> YES <input type="checkbox"/> NO	18B. WHAT IS THE DATE OF YOUR CERTIFICATION OR MOST RECENT RECERTIFICATION (GIVE MONTH AND YEAR)	18C. WHAT IS YOUR AMERICAN ASSOCIATION OF NURSE ANESTHETISTS (AANA) IDENTIFICATION NUMBER	18D. HAS YOUR CCNA CERTIFICATION EVER BEEN REVOKED <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)
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IV - THIS SECTION TO BE COMPLETED BY FACILITY DIRECTOR OR DESIGNEE

CERTIFICATION: I certify that I have verified registration with State boards, and sighted visa or evidence of citizenship. Board certification has been verified (if appropriate).		
19. EVIDENCE HAS BEEN SIGHTED IN REGARDS TO:		
<input type="checkbox"/> CERTIFICATION AS A NURSE ANESTHETIST	<input type="checkbox"/> VISA	
<input type="checkbox"/> REGISTRATION FOR ALL STATES LISTED BY APPLICANT	<input type="checkbox"/> NATURALIZED CITIZENSHIP	
<input type="checkbox"/> CURRENT OR MOST RECENT CLINICAL PRIVILEGES		
<input type="checkbox"/> NO CURRENT OR PREVIOUS CLINICAL PRIVILEGES		
20A. SIGNATURE OF FACILITY DIRECTOR OR DESIGNEE	20B. TITLE	20C. DATE

V – PROFESSIONAL LIABILITY INSURANCE

21A. PRESENT PROFESSIONAL LIABILITY INSURANCE CARRIER	21B. DATE COVERAGE BEGAN	21C. NAME OF PRIOR CARRIER	21D. DATES OF COVERAGE		22. HAS ANY CARRIER EVER CANCELLED, DENIED OR REFUSED TO RENEW YOUR INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)
			FROM	TO	

VI - QUALIFICATIONS

BASIC NURSING EDUCATION (Continue on separate sheet if necessary)

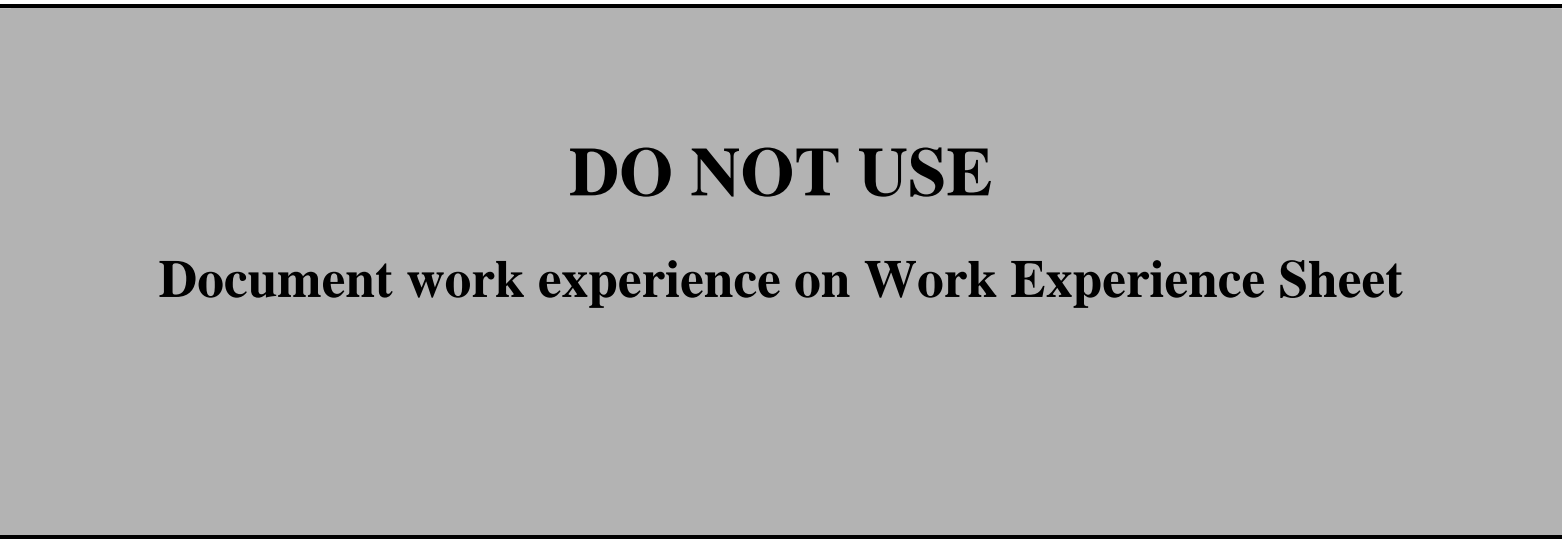
23A. NAME OF SCHOOL	23B. ADDRESS (City, State and ZIP Code)	23C. LENGTH OF PROGRAM	23D. DATE COMPLETED	23E. DIPLOMA OR DEGREE RECEIVED

ADDITIONAL EDUCATION (Continue on separate sheet if necessary)

24A. NAME OF SCHOOL	24B. ADDRESS (City, State and ZIP Code)	24C. MAJOR	24D. DATE COMPLETE	24E. CREDITS	24F. DEGREE

25. IS YOUR PROFESSIONAL BIOGRAPHY COMPILED <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" please forward a copy to the VA)	NOTE: IF YOUR COLLEGE OR UNIVERSITY STUDY IS NOT A PART OF YOUR PROFESSIONAL BIOGRAPHY, PLEASE SEND OFFICIAL TRANSCRIPT(S)
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VII – NURSING EXPERIENCE



VIII – GENERAL INFORMATION

27. NAME UNDER WHICH YOU WERE EMPLOYED, IF DIFFERENT FROM NAME GIVEN IN ITEM 1.

28. LIST ALL PROFESSIONAL PUBLICATIONS, SCIENTIFIC PAPERS, HONORS, AWARDS, RESEARCH GRANTS, FELLOWSHIPS AND SPECIALTY CERTIFICATION (If additional space is required, attach separate sheet).

NAME: _____ DATE: _____

Work Experience Sheet

Please note that you **must** account for all time since you completed your professional education. Use the following to list jobs and periods of unemployment, including periods in school. List all jobs, including registries, agencies and part time work. Where dates overlap on two jobs, provide clarification by listing them in separate blocks. Incomplete applications will not be processed or returned. Leave no blanks, do not write "N/A".

23. Nursing Expertise (begin with your current job and work backwards in time)						
Dates Employed MM/YY – MM/YY		Name and address of Employer	Your exact title and type of unit or ward	Your Immediate Supervisor's Name and Phone	Hours worked weekly	Reason for leaving
From	To					

I acknowledge that this is part of my application for Nursing employment at the Bay Pine VA Healthcare System (BPVAHCS). These statements are true and factual to the best of my knowledge. I understand that BPVAHCS officials may check this work history by contacting my current and former supervisors. Note: false statements on any part of your application may be grounds for not hiring you, or for terminating you after you begin work (U.S. Code, Title 38, Section 1001).

Signed: _____ Date: _____

NAME: _____ DATE: _____

Work Experience Sheet

23. Nursing Expertise (begin with your current job and work backwards in time)						
Dates Employed MM/YY – MM/YY		Name and address of Employer	Your exact title and type of unit or ward	Your Immediate Supervisor's Name and Phone	Hours worked weekly	Reason for leaving
From	To					

I acknowledge that this is part of my application for Nursing employment at the Bay Pine VA Healthcare System (BPVAHCS). These statements are true and factual to the best of my knowledge. I understand that BPVAHCS officials may check this work history by contacting my current and former supervisors. Note: false statements on any part of your application may be grounds for not hiring you, or for terminating you after you begin work (U.S. Code, Title 38, Section 1001).

Signed: _____ Date: _____

IX - REFERENCES

NOTE: LIST FOUR PERSONS LIVING IN THE UNITED STATES WHO ARE NOT RELATED TO YOU BY BLOOD OR MARRIAGE AND WHO HAVE BEEN IN A POSITION TO JUDGE YOUR PROFESSIONAL QUALIFICATIONS DURING THE PAST FIVE YEARS.

29A. NAME	29B. ADDRESS (Street, City, State and ZIP Code)	29C. AREA CODE/PHONE NO.	29D. BUSINESS OR OCCUPATION

ITEM NO.	PLACE AN "X" IN APPROPRIATE SPACE. IF "YES" EXPLAIN DETAILS ON SEPARATE SHEET OF PAPER	YES	NO
30.	Do you receive or do you have a pending application for retirement or retainer pay, pension, or other compensation based upon military, Federal civilian, or District of Columbia service?	<input type="checkbox"/>	<input type="checkbox"/>
31.	Does the Department of Veterans Affairs employ any relative of yours (by blood or marriage)? If "YES" give separately such relative's (1) full name; (2) relationship; (3) VA position and employment location.	<input type="checkbox"/>	<input type="checkbox"/>
32.	ARE YOU NOW, OR HAVE YOU EVER BEEN, INVOLVED IN ADMINISTRATIVE, PROFESSIONAL OR JUDICIAL PROCEEDINGS IN WHICH MALPRACTICE ON YOUR PART IS OR WAS ALLEGED? (If "YES" give details including name of action or proceedings, date filed, court or reviewing agency, and the status or disposition of case concerning allegations, together with your explanation of the circumstances involved.) (As a provider of health care services, the VA has an obligation to exercise reasonable care in determining that applicants are properly qualified. It is recognized that many allegations of professional malpractice are proven groundless. Any conclusion concerning your answer as it relates to professional qualifications will be made only after a full evaluation of the circumstances involved.)	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: A conviction or a discharge does not necessarily mean you cannot be appointed. The nature of the conviction or discharge and how long ago it occurred is important. Give all the facts so that a decision can be made. If your answer to question 35, 36 or 37 is "YES" give for each offense: (1) date; (2) charge; (3) place; (4) court and (5) action taken. When answering item 35 or 36, you may omit (1) traffic fines for which you paid a fine of \$100.00 or less; (2) any offense committed before your 18th birthday which was finally adjudicated in a juvenile court or under a youth offender law; (3) any conviction the record of which has been expunged under Federal or State law; and (4) any conviction set aside under the Federal Youth Corrections Act or similar State authority.

33.	Within the last five years have you been discharged from any position for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
34.	Within the last five years have you resigned or retired from a position after being notified you would be disciplined or discharged, or after questions about your clinical competence were raised?	<input type="checkbox"/>	<input type="checkbox"/>
35.	Have you ever been convicted, forfeited collateral, or are you now under charges for any felony or any firearms or explosives offense against the law? (A felony is defined as any offense punishable by imprisonment for a term exceeding one year, but does not include any offense classified as a misdemeanor under the laws of a State and punishable by a term of imprisonment of two years or less.)	<input type="checkbox"/>	<input type="checkbox"/>
36.	During the past seven years have you been convicted, imprisoned, on probation or parole, or forfeited collateral, or are you now under charges for any offense against the law not included in 35 above?	<input type="checkbox"/>	<input type="checkbox"/>
37.	While in the military service were you ever convicted by a general court-martial?	<input type="checkbox"/>	<input type="checkbox"/>
38.	If you were in the military service in one of these health occupations, did you ever receive a non-judicial punishment (Article 15)?	<input type="checkbox"/>	<input type="checkbox"/>
39.	Are you delinquent on any Federal debt? (Include delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults on any Federally guaranteed or insured loans such as student and home mortgage loans.) If "Yes" explain on a separate sheet the type, length, and amount of the delinquency or default and steps you are taking to correct errors or repay the debt. Give any identification numbers associated with the debt and the address of the Federal agency involved.	<input type="checkbox"/>	<input type="checkbox"/>

X - SIGNATURE OF APPLICANT

NOTE: A false statement on any part of your application may be grounds for not hiring you, or for terminating you after you begin work. Also, you may be punished by fine or imprisonment (U.S. Code, Title 18, Section 1001).

Un+ CERTIFICATION:

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL OF MY STATEMENTS ARE TRUE, CORRECT, COMPLETE, AND MADE IN GOOD FAITH.

40A. SIGNATURE OF APPLICANT (Sign in dark ink)

40B. DATE (Month, Day, Year)

AUTHORIZATION FOR RELEASE OF INFORMATION

In order for the Department of Veterans Affairs (VA) to assess and verify my educational background, professional qualifications and suitability for employment, I:

- Authorize the VA to make inquiries concerning such information about me to my previous employer(s), current employer, educational institutions, State licensing boards, professional liability insurance carriers, other professional organizations and/or persons, agencies, organizations or institutions listed by me as references, and to any other appropriate sources to whom the VA may be referred by those contacted or deemed appropriate;
- Authorize release of such information and copies of related records and/or documents to VA officials;
- Release from liability all those who provide information to the VA in good faith and without malice in response to such inquiries; and
- Authorize the VA to disclose to such persons, employers, institutions, boards or agencies identifying and other information about me to enable the VA to make such inquiries.

SIGNATURE	DATE
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PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

AUTHORITY: The information requested on the attached application form and Authorization for Release of Information is solicited under Title 38, United States Code, Chapters 73 and 74.

PURPOSES AND USES: The information requested on the application is collected primarily to determine your qualifications and suitability for employment. If you are employed by the VA, the information will be used to make pay and benefit determinations and, as necessary, in personnel administration processes carried out in accordance with established regulations and published notices of systems of records.

ROUTINE USES: Information on the form or the form itself may be released without your prior consent outside the VA to another Federal, State or local agency, to the National Practitioner Data Bank which is administered by the Department of Health and Human Services, to State licensing boards, and/or appropriate professional organizations or agencies to assist the VA in determining your suitability for hiring and for employment, to periodically verify, evaluate and update your clinical privileges and licensure status, to report apparent or potential violations of law, to provide statistical data upon proper request, or to provide information to a Congressional office in response to an inquiry made at your request. Such information may also be released without your prior consent to Federal agencies, State licensing boards, or similar boards or entities, in connection with the VA's reporting of information concerning your separation or resignation as a professional staff member under circumstances which raise serious concerns about your professional competence. Information concerning payments related to malpractice claims and adverse actions which affect clinical privileges also may be released to State licensing boards and the National Practitioner Data Bank. The information you supply may be verified through a computer matching program at any time.

EFFECTS OF NON-DISCLOSURE: See statement below concerning disclosure of your social security number. Disclosure of the other information is voluntary; however, failure to provide this information may delay or make impossible the proper application of Civil Service rules and regulations and VA personnel policies and thus may prevent you from obtaining employment, employees benefits, or other entitlements.

INFORMATION REGARDING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER UNDER PUBLIC LAW 93-579 SECTION 7(b)

Disclosure of your SSN (social security number) is mandatory to obtain the employment and related benefits that you are seeking. Solicitation of the SSN is authorized under the provisions of Executive Order 9397, dated November 22, 1943. The SSN is used as an identifier throughout your Federal career from the time of application through retirement. It will be used primarily to identify your records. The SSN also will be used by Federal agencies in connection with lawful requests for information about you from your former employers, educational institutions, and financial or other organizations. The information gathered through the use of the number will be used only as necessary in personnel administration processes carried out in accordance with established regulations and published notices of systems of records. The SSN also will be used for the selection of persons to be included in statistical studies of personnel management matters. The use of the SSN is made necessary because of the large number of present and former Federal employees and applicants who have identical names and birth dates, and whose identities can only be distinguished by the SSN.

APPLICATION FOR ASSOCIATED HEALTH OCCUPATIONS

SEE LAST PAGE FOR PAPERWORK REDUCTION ACT, PRIVACY ACT AND INFORMATION ABOUT DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER.

INSTRUCTIONS: Please submit this application furnishing all information in sufficient detail to enable the Department of Veterans Affairs to determine your eligibility for appointment in Veterans Health Administration. Type, or print in ink. If additional space is required, please attach a separate sheet and refer to items being answered by number.

1. OCCUPATION FOR WHICH APPLYING

- | | | |
|---|---|--|
| A <input type="checkbox"/> CERTIFIED RESPIRATORY THERAPY TECHNICIAN | E <input type="checkbox"/> LICENSED PHARMACIST | <input type="checkbox"/> OTHER (Specify) |
| B <input type="checkbox"/> REGISTERED RESPIRATORY THERAPIST | F <input type="checkbox"/> PHYSICIAN ASSISTANT | |
| C <input type="checkbox"/> LICENSED PHYSICAL THERAPIST | G <input type="checkbox"/> EXPANDED-FUNCTION DENTAL AUXILIARY | |
| D <input type="checkbox"/> LICENSED PRACTICAL/VOCATIONAL NURSE | H <input type="checkbox"/> OCCUPATIONAL THERAPIST | |

2. NAME (Last, First, Middle)		3. APPLICATION FOR (Check one) <input type="checkbox"/> GENERAL PRACTICE <input type="checkbox"/> SPECIALTY (Identify below)	
4. PRESENT ADDRESS (Include ZIP Code)		5. TELEPHONE NUMBER (Include Area Code)	
		5A. RESIDENCE	5B. BUSINESS
6. DATE OF BIRTH	7. PLACE OF BIRTH	8. SOCIAL SECURITY NUMBER	
9A. CITIZENSHIP <input type="checkbox"/> U.S. CITIZEN BY BIRTH <input type="checkbox"/> NATURALIZED U.S. CITIZEN <input type="checkbox"/> NOT A U.S. CITIZEN (Complete item 9B)		9B. COUNTRY OF WHICH YOU ARE A CITIZEN	
10A. HAVE YOU EVER FILED APPLICATION FOR APPOINTMENT IN THE VA <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" complete items 10B and 10C)		10B. NAME OF OFFICE WHERE FILED	10C. DATE FILED
11. WHEN MAY INQUIRY BE MADE OF YOUR PRESENT EMPLOYER		12. DATE AVAILABLE FOR EMPLOYMENT	

I - ACTIVE MILITARY DUTY

13A. DATE FROM	13B. DATE TO	13C. SERIAL OR SERVICE NO.	13D. BRANCH OF SERVICE	13E. TYPE OF DISCHARGE <input type="checkbox"/> HONORABLE <input type="checkbox"/> OTHER (Explain on separate sheet)
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11 - LICENSURE, DEA CERTIFICATION, REGISTRATION AND CLINICAL PRIVILEGES (As applicable)

14A. LIST ALL STATES/TERRITORIES IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED <small>(If not held now, explain on separate sheet)</small>	14B. LICENSE NO.	14C. CURRENT REGISTRATION <small>(If "NO" explain on separate sheet)</small>			14D. EXPIRATION DATE
		YES	NO	NOT REQUIRED	

15A. ARE YOU FULLY LICENSED IN EVERY STATE IN WHICH YOU RECEIVED A LICENSE <small>(If restricted, limited or probational in any State(s), explain on separate sheet)</small>	15B. DO YOU HAVE PENDING OR HAVE YOU EVER HAD A STATE LICENSE TO PRACTICE REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED, OR ISSUED/PLACED ON A PROBATIONAL STATUS OR VOLUNTARILY RELINQUISHED	15C. HAVE YOU EVER HELD A REGISTRATION TO PRACTICE THAT IS NO LONGER HELD OR CURRENT
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT APPLICABLE	<input type="checkbox"/> YES <input type="checkbox"/> NO <small>(If "YES" explain on separate sheet)</small>	<input type="checkbox"/> YES <input type="checkbox"/> NO <small>(If "YES" explain on separate sheet)</small>

16A. NAME THE CERTIFYING BODY FOR YOUR HEALTH OCCUPATION	16B. DATE OF MOST RECENT REGISTRATION/ CERTIFICATION (Give Month and Year)	16C. WHAT IS YOUR REGISTRY/ CERTIFICATION NUMBER	16D. HAS ACTION EVER BEEN TAKEN AGAINST YOUR CERTIFICATION OR REGISTRATION <small>(If "YES" explain on separate sheet)</small>
			<input type="checkbox"/> YES <input type="checkbox"/> NO

17A. DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD CLINICAL PRIVILEGES AT ANY HEALTH CARE INSTITUTION, AGENCY OR ORGANIZATION	17B. NAME OF CURRENT OR MOST RECENT INSTITUTION, AGENCY OR ORGANIZATION WHERE HELD	17C. HAVE ANY OF YOUR STAFF APPOINTMENTS OR CLINICAL PRIVILEGES EVER BEEN DENIED, REVOKED, SUSPENDED, REDUCED, LIMITED, OR VOLUNTARILY RELINQUISHED
<input type="checkbox"/> YES <input type="checkbox"/> NO <small>(If "YES" complete Item 17B)</small>		<input type="checkbox"/> YES <input type="checkbox"/> NO <small>(If "YES" explain on separate sheet)</small>

III - THIS SECTION TO BE COMPLETED BY FACILITY DIRECTOR OR DESIGNEE

▶ CERTIFICATION: I certify that I have verified licensure and registration with State boards, and sighted visa or evidence of citizenship. Board certification has been verified (if appropriate).

18. EVIDENCE HAS BEEN SIGHTED IN REGARDS TO:			
<input type="checkbox"/> CERTIFICATION OR REGISTRATION	<input type="checkbox"/> VISA	<input type="checkbox"/> CURRENT OR MOST RECENT CLINICAL PRIVILEGES	<input type="checkbox"/> NO CURRENT OR PREVIOUS CLINICAL PRIVILEGES
<input type="checkbox"/> NATURALIZED CITIZENSHIP	<input type="checkbox"/> LICENSURE/REGISTRATION FOR ALL STATES LISTED BY APPLICANT		

19A. SIGNATURE OF AUTHORIZED OFFICIAL	19B. TITLE	19C. DATE (MONTH, DAY, YEAR)
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IV - LIABILITY INSURANCE (As applicable)

20A. PRESENT LIABILITY INSURANCE CARRIER	20B. DATE COVERAGE BEGAN	20C. NAMES OF PRIOR CARRIERS	20D. DATE OF COVERAGE		21. HAS ANY CARRIER EVER CANCELLED, DENIED OR REFUSED TO RENEW YOUR INSURANCE <input type="checkbox"/> YES <input type="checkbox"/> NO (If "YES" explain on separate sheet)
			FROM	TO	

V - QUALIFICATIONS

BASIC ALLIED HEALTH EDUCATION (Continue on separate sheet, if necessary)

22A. NAME OF SCHOOL	22B. ADDRESS (City, State and ZIP Code)	22C. LENGTH OF PROGRAM	22D. DATE COMPLETED	22E. DIPLOMA OR DEGREE RECEIVED

ADDITIONAL EDUCATION (Continue on separate sheet, if necessary)

23A. NAME OF SCHOOL	23B. ADDRESS (City, State and ZIP Code)	23C. MAJOR	23D. DATE COMPLETED	23E. CREDITS	23F. DEGREE

VI - PROFESSIONAL EXPERIENCE

24A. EMPLOYER	24B. ADDRESS (City, State and ZIP Code)	24C. POSITION (Where applicable, also specify whether General Practitioner or Specialist)	26D. FULL- TIME	26E. PART-TIME AVERAGE HOURS PER WEEK	26F. DATES EMPLOYED	
					FROM	TO

VII - GENERAL INFORMATION

25. NAMES UNDER WHICH YOU WERE EMPLOYED, IF DIFFERENT FROM NAME GIVEN IN ITEM 1.

26. LIST ALL PUBLICATIONS, SCIENTIFIC PAPERS, HONORS, AWARDS, RESEARCH GRANTS, FELLOWSHIPS (If additional space is required, attach separate sheet).

VIII - REFERENCES

27. REFERENCES: List at least four persons living in the United States who are not related to you by blood or marriage and who have been in a position to judge your qualifications during the past five years.

27A. NAME	27B. ADDRESS (Number, Street, City, State and ZIP Code)	27C. AREA CODE/PHONE NO.	27D. BUSINESS OR OCCUPATION

REFERENCES (Continued)

27A. NAME	27B. ADDRESS (Number, Street, City, State and ZIP Code)	27C. AREA CODE/PHONE NO.	27D. BUSINESS OR OCCUPATION


ITEM NO.	PLACE AN "X" IN APPROPRIATE SPACE. IF "YES" EXPLAIN DETAILS ON SEPARATE SHEET	YES	NO
28.	Do you receive or do you have a pending application for retirement or retainer pay, pension, or other compensation based upon military, Federal civilian, or District of Columbia service?		
29.	Does the Department of Veterans Affairs employ any relative of yours (by blood or marriage)? If "YES" give separately such relative's (1) full name; (2) relationship; (3) VA position and employment location.		
30.	<p>ARE YOU NOW, OR HAVE YOU EVER BEEN, INVOLVED IN ADMINISTRATIVE OR JUDICIAL PROCEEDINGS IN WHICH MALPRACTICE ON YOUR PART IS OR WAS ALLEGED? (If "YES" give details including name of action or proceedings, date filed, court or reviewing agency, and the status or disposition of case concerning allegations, together with your explanation of the circumstances involved.)</p> <p>(As a provider of health care services, the VA has an obligation to exercise reasonable care in determining that applicants are properly qualified. It is recognized that many allegations of malpractice are proven groundless. Any conclusion concerning your answer as it relates to your qualifications will be made only after a full evaluation of the circumstances involved.)</p>		

NOTE: A conviction or a discharge does not necessarily mean you cannot be appointed. The nature of the conviction or discharge and how long ago it occurred is important. Give all the facts so that a decision can be made. If your answer to question 33, 34 or 35 is "YES" give for each offense: (1) date; (2) charge; (3) place; (4) court and (5) action taken. When answering item 33 or 34, you may omit (1) traffic fines for which you paid a fine of \$100.00 or less; (2) any offense committed before your 18th birthday which was finally adjudicated in a juvenile court or under a youth offender law; (3) any conviction the record of which has been expunged under Federal or State law; and (4) any conviction set aside under the Federal Youth Corrections Act or similar State authority.

31.	Within the last five years have you been discharged from any position for any reason?		
32.	Within the last five years have you resigned or retired from a position after being notified you would be disciplined or discharged, or after questions about your clinical competence were raised?		
33.	Have you ever been convicted, forfeited collateral, or are you now under charges for any felony or any firearms or explosives offense against the law? (A felony is defined as any offense punishable by imprisonment for a term exceeding one year, but does not include any offense classified as a misdemeanor under the laws of a State and punishable by a term of imprisonment of two years or less.)		
34.	During the past seven years have you been convicted, imprisoned, on probation or parole, or forfeited collateral, or are you now under charges for any offense against the law not included in 33 above?		
35.	While in the military service were you ever convicted by a general court-martial?		
36.	If you were in the military service in one of these health occupations, did you ever receive a non-judicial punishment (Article 15)?		
37.	<p>Are you delinquent on any Federal debt? (Include delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults on any Federally guaranteed or insured loans such as student and home mortgage loans.)</p> <p>If "Yes" explain on a separate sheet the type, length, and amount of the delinquency or default and steps you are taking to correct errors or repay the debt. Give any identification numbers associated with the debt and the address of the Federal agency involved.</p>		

IX - SIGNATURE OF APPLICANT

NOTE: A false statement on any part of your application may be grounds for not hiring you, or for terminating you after you begin work. Also, you may be punished by fine or imprisonment (U.S. Code, Title 18, Section 1001).

 **CERTIFICATION: I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL OF MY STATEMENTS ARE TRUE, CORRECT, COMPLETE, AND MADE IN GOOD FAITH.**

38A. SIGNATURE OF APPLICANT (Sign in dark ink)	38B. DATE (Month, Day, Year)
--	------------------------------

AUTHORIZATION FOR RELEASE OF INFORMATION

In order for the Department of Veterans Affairs (VA) to assess and verify my educational background, professional qualifications and suitability for employment, I:

- Authorize the VA to make inquiries concerning such information about me to my previous employer(s), current employer, educational institutions, State licensing boards, professional liability insurance carriers, American Medical Association, other professional organizations and/or persons, agencies, organizations or institutions listed by me as references, and to any other appropriate sources to whom the VA may be referred by those contacted or deemed appropriate;
- Authorize release of such information and copies of related records and/or documents to VA officials;
- Release from liability all those who provide information to the VA in good faith and without malice in response to such inquiries; and
- Authorize the VA to disclose to such persons, employers, institutions, boards or agencies identifying and other information about me to enable the VA to make such inquiries.

SIGNATURE

DATE

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

AUTHORITY: The information requested on the attached application form and Authorization for Release of Information is solicited under Title 38, United States Code, Chapters 73 and 74.

PURPOSES AND USES: The information requested on the application is collected primarily to determine your qualifications and suitability for employment. If you are employed by the VA, the information will be used to make pay and benefit determinations and, as necessary, in personnel administration processes carried out in accordance with established regulations and published notices of systems of records.

ROUTINE USES: Information on the form or the form itself may be released without your prior consent outside the VA to another Federal, State or local agency, to the National Practitioner Data Bank which is administered by the Department of Health and Human Services, to State licensing boards, the American Medical Association, and/or appropriate professional organizations or agencies to assist the VA in determining your suitability for hiring and for employment, to periodically verify, evaluate and update your clinical privileges and licensure status, to report apparent or potential violations of law, to provide statistical data upon proper request, or to provide information to a Congressional office in response to an inquiry made at your request. Such information may also be released without your prior consent to Federal agencies, State licensing boards, or similar boards or entities, in connection with the VA's reporting of information concerning your separation or resignation as a professional staff member under circumstances which raise serious concerns about your professional competence. Information concerning payments related to malpractice claims and adverse actions which affect clinical privileges also may be released to State licensing boards and the National Practitioner Data Bank. The information you supply may be verified through a computer matching program at any time.

EFFECTS OF NON-DISCLOSURE: See statement below concerning disclosure of your social security number. Disclosure of the other information is voluntary; however, failure to provide this information may delay or make impossible the proper application of Civil Service rules and regulations and VA personnel policies and thus may prevent you from obtaining employment, employees benefits, or other entitlements.

INFORMATION REGARDING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER UNDER PUBLIC LAW 93-579 SECTION 7(b)

Disclosure of your SSN (social security number) is mandatory to obtain the employment and related benefits that you are seeking. Solicitation of the SSN is authorized under the provisions of Executive Order 9397, dated November 22, 1943. The SSN is used as an identifier throughout your Federal career from the time of application through retirement. It will be used primarily to identify your records. The SSN also will be used by Federal agencies in connection with lawful requests for information about you from your former employers, educational institutions, and financial or other organizations. The information gathered through the use of the number will be used only as necessary in personnel administration processes carried out in accordance with established regulations and published notices of systems of records. The SSN also will be used for the selection of persons to be included in statistical studies of personnel management matters. The use of the SSN is made necessary because of the large number of present and former Federal employees and applicants who have identical names and birth dates, and whose identities can only be distinguished by the SSN.

Declaration for Federal Employment

Form Approved:
O.M.B. No. 3206-0182

GENERAL INFORMATION

1 FULL NAME <i>(First, middle, last)</i> ▶	2 SOCIAL SECURITY NUMBER ▶
3 PLACE OF BIRTH <i>(Include City and State or Country)</i> ▶	4 DATE OF BIRTH <i>(MM/DD/YY)</i> ▶
5 OTHER NAMES EVER USED <i>(For example, maiden name, nickname, etc.)</i> ▶ ▶	6 PHONE NUMBERS <i>(Include Area Codes)</i> DAY ▶ NIGHT ▶

Selective Service Registration

If you are a male born after December 31, 1959, and are at least 18 years of age, civil service employment law (5 U.S.C. 3328) requires that you must register with the Selective Service System, unless you meet certain exemptions.

- 7a. Are you a male born after December 31, 1959? YES NO *If "NO" skip 7b and 7c. If "YES" go to 7b.*
- 7b. Have you registered with the Selective Service System? YES NO *If "NO" go to 7c.*
- 7c. If "NO," describe your reason(s) in item #16.

Military Service

8. Have you ever served in the United States military? YES *Provide information below* NO
*If you answered "YES," list the branch, dates, and type of discharge for all active duty.
 If your only active duty was training in the Reserves or National Guard, answer "NO."*

Branch	From <i>MM/DD/YYYY</i>	To <i>MM/DD/YYYY</i>	Type of Discharge

Background Information

For all questions, provide all additional requested information under item 16 or on attached sheets. The circumstances of each even you list will be considered. However, in most cases you can still be considered for Federal jobs.

For questions 9, 10, and 11, your answers should include convictions resulting from a plea *nolo contendere* (no contest), but omit (1) traffic fines of \$300 or less, (2) any violation of law committed before your 16th birthday, (3) any violation of law committed before your 18th birthday if finally decided in juvenile court or under a Youth Offender law, (4) any conviction set aside under the Federal Youth Corrections Act or similar state law, and (5) any conviction for which the record was expunged under Federal or state law.

- | | | |
|--|---------------------------------|--------------------------------|
| 9. During the last 10 years, have you been convicted, been imprisoned, been on probation, or been on parole?
<i>(Includes felonies, firearms or explosives violations, misdemeanors, and all other offenses.) If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.</i> | YES
<input type="checkbox"/> | NO
<input type="checkbox"/> |
| 10. Have you been convicted by a military court-martial in the past 10 years? <i>(If no military service, answer "NO." If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the military authority or court involved.)</i> | YES
<input type="checkbox"/> | NO
<input type="checkbox"/> |
| 11. Are you now under charges for any violation of law? <i>If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.</i> | YES
<input type="checkbox"/> | NO
<input type="checkbox"/> |
| 12. During the last 5 years, have you been fired from any job for any reason, did you quit after being told that you would be fired, did you leave any job by mutual agreement because of specific problems, or were you debarred from Federal employment by the Office of Personnel Management or any other Federal agency? <i>If "YES," use item 16 to provide the date, an explanation of the problem, reason for leaving, and the employer's name and address.</i> | YES
<input type="checkbox"/> | NO
<input type="checkbox"/> |
| 13. Are you delinquent on any Federal debt? <i>(Includes delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults of Federally guaranteed or insured loans such as student and home mortgage loans.) If "YES," use item 16 to provide the type, length, and amount of the delinquency or default, and steps that you are taking to correct the error or repay the debt.</i> | YES
<input type="checkbox"/> | NO
<input type="checkbox"/> |

Declaration for Federal Employment

Form Approved:
O.M.B. No. 3206-0182

Additional Questions

14. Do any of your relatives work for the agency or government organization to which you are submitting this form? (Include: father, mother, husband, wife, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half brother, and half sister.) *If "YES," use item 16 to provide the relative's name, relationship, and the department, agency, or branch of the Armed Forces for which your relative works.*
- YES NO
15. Do you receive, or have you ever applied for, retirement pay, pension, or other retired pay based on military, Federal civilian, or District of Columbia Government service?
- YES NO

Continuation Space / Agency Optional Questions

16. Provide details requested in items 7 through 15 and 18c in the space below or on attached sheets. Be sure to identify attached sheets with your name, Social Security Number, and item number, and to include ZIP Codes in all addresses. If any questions are printed below, please answer as instructed (*these questions are specific to your position and your agency is authorized to ask them*).

Certifications / Additional Questions

APPLICANT: *If you are applying for a position and have not yet been selected,* carefully review your answers on this form and any attached sheets. When this form and all attached materials are accurate, read item 17, and complete 17a.

APPOINTEE: *If you are being appointed,* carefully review your answers on this form and any attached sheets, including any other application materials that your agency has attached to this form. If any information requires correction to be accurate as of the date you are signing, make changes on this form or the attachments and/or provide updated information on additional sheets, initialing and dating all changes and additions. When this form and all attached materials are accurate, read item 17, complete 17b, read 18, and answer 18a, 18b, and 18c as appropriate.

17. **I certify** that, to the best of my knowledge and belief, all of the information on and attached to this Declaration for Federal Employment, including any attached application materials, is true, correct, complete, and made in good faith. **I understand that a false or fraudulent answer to any question or item on any part of this declaration or its attachments may be grounds for not hiring me, or for firing me after I begin work, and may be punishable by fine or imprisonment.** I understand that any information I give may be investigated for purposes of determining eligibility for Federal employment as allowed by law or Presidential order. **I consent** to the release of information about my ability and fitness for Federal employment by employers, schools, law enforcement agencies, and other individuals and organizations to investigators, personnel specialists, and other authorized employees or representatives of the Federal Government. **I understand** that for financial or lending institutions, medical institutions, hospitals, health care professionals, and some other sources of information, a separate specific release may be needed, and I may be contacted for such a release at a later date

17a Applicant's Signature ► _____ Date ► _____
(Sign in ink)

17b Appointee's Signature ► _____ Date ► _____
(Sign in ink)

Appointing Officer: Enter Date of Appointment or Conversion MM/DD/YYYY

18. **Appointee (Only respond if you have been employed by the Federal Government before):** Your elections of life insurance during previous Federal employment may affect your eligibility for life insurance during your new appointment. These questions are asked to help your personnel office make a correct determination.

MM/DD/YYYY

18a. When did you leave your last Federal job? DATE:

18b. When you worked for the Federal Government the last time, did you waive Basic Life Insurance or any type of optional life insurance?

YES NO Do Not Know

18c. If you answered "YES" to item 18b, did you later cancel the waiver(s)? If your answer to item 18c is "NO," use item 16 to identify the type(s) of insurance for which waivers were not canceled.

YES NO Do Not Know

Clinical Preferences and Understanding Sheet

Clinical Preferences

Please rate your first, second and third choices using a "1, 2 or 3". If you are applying for a position with a specific announcement number write that number in the correct space.

<input type="checkbox"/> MICU	<input type="checkbox"/> SICU	<input type="checkbox"/> Emergency Department
<input type="checkbox"/> Operating Room	<input type="checkbox"/> PACU	<input type="checkbox"/> Day Surgery
<input type="checkbox"/> Telemetry/CPCU	<input type="checkbox"/> CCU	<input type="checkbox"/> Oncology
<input type="checkbox"/> Medicine Ward	<input type="checkbox"/> Surgical Ward	<input type="checkbox"/> Long Term Care
<input type="checkbox"/> Ambulatory Care	<input type="checkbox"/> Inpatient Psych	<input type="checkbox"/> Other Psych: _____
<input type="checkbox"/> Hemodialysis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Announcement #: _____		

Shift Preferences

(CHECK ALL THAT APPLY)

<input type="checkbox"/> Full Time	<input type="checkbox"/> Day Shift	<input type="checkbox"/> No preferences
<input type="checkbox"/> Part Time	<input type="checkbox"/> Evening Shift	<input type="checkbox"/> Day/Evenings
<input type="checkbox"/> Per Diem (pool)	<input type="checkbox"/> Night Shift	<input type="checkbox"/> Day/Night
<input type="checkbox"/> 8-hour shifts		<input type="checkbox"/> Evening/Night
<input type="checkbox"/> 12-hour shifts		

Acknowledgement and Understanding Statement

References: Offers for employment are contingent upon satisfactory references as well as satisfactory background checks (SF 85) and suitability for federal employment. It is the responsibility of the applicant to provide those references and provide necessary background information.

Pre-employment Physical: I understand that all offers for hire are contingent upon passing a pre-employment physical.

Drug Screening: I acknowledge that random drug screening of tentative selected candidates and employees is now required by the Department of Veterans Affairs. I further understand that the Bay Pines VA Healthcare System is a drug free work place.

Shift Rotation/Weekend Duty: I understand that it may be necessary to rotate my shifts in order to meet patient care needs even though I have previously stated my preferences. Further, given the nature of hospital census fluctuations, I understand that I may be required to float to another unit from time to time.

Leave Requests: I understand that vacation days, sick days, military leave, jury duty or administrative leave **MUST BE GRANTED BY MY SUPERVISOR**. I understand that the Nurse Recruiter is not authorized to grant leave.

I hereby acknowledge that I have read and understand this information

Print Name

E-mail Address

Applicant Signature

Date

Keep as a reference

Information Packet

Contents:

- ❖ Benefit Sheet

- ❖ Nurse Qualification Standards
 - RNs



EMPLOYER OF CHOICE



A great place to work, a better place to grow.

The Department of Veterans Affairs (VA) was established on March 15, 1989, succeeding the Veterans Administration. It is responsible for providing federal benefits to veterans and their dependents. Headed by the Secretary of Veterans Affairs, The VA is the second largest of the 15 Cabinet departments and operates nationwide programs for health care, financial assistance and burial benefits.

The VA employs over 39,000 Nurses making it one of the largest nursing employers in the country.

At the VA we recognize that our employees are our most valuable asset. Our complete benefits package is one of the most comprehensive found in government. and we employ diverse REGISTERED NURSES with a variety of educational backgrounds; diplomas, ASN, BSN, Masters and PhD.

Our benefit package includes:

- Computerized charting for all staff including MDs
- Comprehensive orientations
- Manageable Staff to patient ratios
- Ward clerks and pharmacists 24 hours a day
- No hospital convenience time or "call offs" if you are scheduled to work
- CEUs and education offerings on site
- Health Insurance – variety of plans to choose from
- Life Insurance - with available additions for family coverage
- Long Term Care Insurance
- Dental Insurance
- Vision Insurance
- Flexible Spending Accounts
- 13 days Sick Leave per year
- 26 Vacation Days per year
- Holidays – 10 paid Holidays each year
- Competitive salary package based on education, tenure, certifications
- 10% shift differential for off tours, 25% for weekends
- Generous Retirement Plans with agency contributions
- Thrift Savings Plan (TSP) - similar to private sector 401(k)
- Educational Assistance Programs for BSN or MSN completion
- Family and Medical Leave
- Employee Assistance Program

The Best Care

Adrian Griffin RN, Nurse Recruiter
(727) 398-6661 Ext 4661 or
adrian.griffin@va.gov

APPENDIX G6. NURSE QUALIFICATION STANDARD

Veterans Health Administration

1. SECTION A. COVERAGE

a. Appointments

(1) Effective on or after December 10, 1999, individuals appointed to VHA RN positions will be subject to all qualification requirements stated in section B of this Qualification Standard. These requirements apply to:

- (a) Individuals not on VA rolls, and
- (b) VA employees in other positions who are appointed or reappointed as RNs

(2) [RNs Appointed Prior to December 10, 1999:

(a) RNs who have had a break in service of more than one year who are subsequently considered for the same or different RN position are subject to all qualification requirements stated in this Nurse Qualification Standard.

NOTE: *Facilities are to review the grades and step rates of employees affected by the provisions of paragraph 1a(2) of the Nurse Qualification Standard dated April 15, 2002, which required application of the requirements in Section B after a break in service of one day or more, to determine whether prospective adjustment of that grade or step rate are appropriate.*

(b) RNs initially appointed prior to December 10, 1999, who are reappointed after a break in service of one year or less, are not considered to have had a break in service.

(c) Employees separated due to work-related injuries, or restored based on military service are not considered to have had a break in service for purposes of applying all the qualification requirements in this Nurse Qualification Standard, provided the employee is reappointed within 1 year of becoming eligible for reappointment.

NOTE: *Employees in paragraphs 1a(2)(b) and (c) above are still subject to all the qualification requirements in this Nurse Qualification Standard on and after October 1, 2005.]*

b. Promotions and Advancements

(1) [] RNs covered by this Qualification Standard [who are eligible for promotion consideration shall] be considered for promotion and advancement under the procedures in chapter 4 of part III, this handbook.

(2) [Deleted.]

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APPENDIX G6**

(3) [Deleted.]

(4) From June 18, 2001 to September 30, 2005, RNs appointed before December 10, 1999, will be considered for promotion and advancement based on the Interim Educational Requirements in section C of this Standard and the nine "dimensions" contained in section B of this Standard.

(5) Effective October 1, 2005, all VA RNs will be considered for promotion and advancement based solely on the criteria in section B of this Standard.

(6) RNs appointed before December 10, 1999, who maintain continuous employment in VHA as a RN will not be reduced in grade based on application of this Standard.

(7) The Under Secretary for Health or designee is authorized to act upon requests for promotion reconsideration for RNs.

c. **Periodic Step Increases.** RNs appointed before December 10, 1999, will not be denied a periodic step increase on the basis of not meeting the educational requirements specified in section B of this Qualification Standard for their current grade.

d. **Transfer and Reassignment.** RNs appointed before December 10, 1999, will not be subject to the educational requirements in section B of this Qualification Standard until October 1, 2005, for the purpose of transfer or reassignment to another position at the same grade. All RNs appointed on or after December 10, 1999 will be required to meet the educational requirements in section B for transfer or reassignment.

2. SECTION B. NURSE QUALIFICATION STANDARD**a. Basic Requirements**

(1) **Citizenship.** Citizen of the United States. (Noncitizens may be appointed when it is not possible to recruit qualified citizens in accordance with chapter 3, section A, paragraph 3g, this part.)

(2) Graduation from School of Nursing

(a) Graduate of a school of professional nursing approved by the appropriate State [] agency [, and accredited by one of the following accrediting bodies] at the time the program was completed by the applicant.

(b) [Deleted.]

1. The National League for Nursing Accrediting Commission (NLNAC), an accrediting arm of the National League for Nursing located at 61 Broadway, 33rd Floor, New York, New York 10006 or call (800) 669-1656 extension 153. [The NLNAC accredits all levels of nursing programs.] Additional information may be obtained from the [\[NLNAC web site\]](#); **or**

2. The Commission on Collegiate Nursing Education (CCNE), an accrediting arm of the American Association of Colleges of Nursing (AACN). [The CCNE accredits bachelors and masters degree programs, and] is located at One Dupont Circle N.W., Suite 530, Washington, DC 20036 or call (202) 463-6930. [Additional information may be obtained from [the [CCNE web site](#).]

(c) In cases of graduates of foreign schools of professional nursing, possession of current, full, active, and unrestricted registration (see paragraph [(3)] below) [and the possession of a Certificate from the Commission on Graduates of Foreign Nursing Schools (CGFNS)] will meet the requirement of graduation from an approved school of professional nursing.

[NOTE: *The CGFNS Certification Program is a three-part program designed to predict an applicant's likelihood of passing the NCLEX-RN® examination and becoming licensed as an RN in the United States. The three parts of the program include a credentials review, a Qualifying Exam of nursing knowledge, and an English language proficiency examination (i.e., the Test of English Language Proficiency, or TOEFL). Additional information about the CGFNS may be obtained from the [CGFNS web site](#).*

(d) [Deleted.]

(3) **Registration**

(a) **Condition of Employment.** A nurse will have a current, full, active and unrestricted registration as a graduate professional nurse in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the U.S. or in the District of Columbia. The appointing official may waive this registration if the RN is to serve in a country other than the U.S. and the RN has registration in that country (e.g., Philippines). *The RN must maintain a current, full, active and unrestricted registration to continue employment with VA.*

(b) **Impaired Registration.** Any registration(s) revoked, suspended, denied, restricted, limited, or issued/placed in a probationary status. A nurse who has or ever had any such impairment to their registration as listed above may be appointed only in accordance with the provisions of chapter 3, section B, paragraph 15 of this part.

(4) **Physical Standards.** See VA Directive and Handbook 5019.

(5) **English Language Proficiency.** RNs appointed to direct patient care positions must be proficient in spoken and written English as required by 38 U.S.C. 7402(d) and 7407(d).

[(6) **Nurse Practitioners and Clinical Nurse Specialists.** On and after the date of this change, nurses appointed or otherwise moving into these assignments must meet and maintain the following additional qualifications. This includes employees appointed before this change who obtain such qualifications on or after the date of this change.

(a) **Nurse Practitioners.** A nurse practitioner must be licensed or otherwise recognized as a nurse practitioner in a State, and maintain full and current certification as a nurse practitioner from the American Nurses Association or another nationally recognized certifying body.

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(b) Clinical Nurse Specialists. A clinical nurse specialist must possess a Masters degree from an academic program accredited by the NLNAC or CCNE with a major in the clinical nursing specialty to which the nurse is to be assigned.

(c) Prescriptive Authority. This handbook does not address any additional requirements that nurse practitioners and clinical nurse specialists must meet before they are granted prescriptive authority.]

b. [Definitions]

(1) **Successful Nursing Practice.** Documented evidence of [] experience as [an] RN that is determined to be [sustained and consistently at or above] an acceptable level of quality. This may include experience as a Graduate Nurse Technician (GNT) provided the candidate was utilized as a professional nurse and passed the State licensing (board) examination on the first attempt[, and] experience as a Nurse Technician Pending Graduation provided the candidate possessed an active, current registration to practice nursing in a State and was utilized as a professional nurse (See chapter 3, section G, paragraph 5, this part). [It may also include performance as a VA nurse that is at or above the fully satisfactory level.] Professional nursing experience should be documented on [the Proficiency Report, VA Form 10-2623, the] VA Form 10-2850a, Application for Employment – Nurses and Nurse Anesthetists, or on a candidate’s resume.

(2) **Length of Nursing Practice (Experience).** The amount of time documented on VA Form 10-2850a or on a candidate’s resume. (A performance evaluation or reference covering the candidate’s most recent employment as a RN is essential.) Part-time experience as a RN is credited according to the relationship it bears to the full-time workweek. For example, a RN who worked 20 hours a week (i.e., on a half-time basis) would receive one full-time workweek of credit for each 2 weeks of such service.

(3) **Degree in a Related Field.** Baccalaureate and graduate degrees in fields related to nursing from a college or university which was accredited by the state at the time the candidate completed the program. Information on accredited colleges and universities is contained in Accredited Institutions of Post-secondary Education, published annually by the American Council on Education, One Dupont Circle NW, Washington, DC 20036, or call (202) 939-9300. Information can be obtained from [the [ACE web site](#).]

(4) **Level Within a Grade.** The Locality Pay System (LPS) recognizes that some employees at the Nurse I grade have higher qualifications assignments than other employees within the same grade. The qualification requirements for attainment of a higher level within the Nurse I grade are contained in [paragraph c], Grade Determinations, below.

(5) **Nine Dimensions of Nursing.** Nine criteria define the performance requirements for RNs at each grade and/or level in the Nurse Qualification Standard. These requirements listed below, are based on the American Nurses Association (ANA) Standards of Care and Standards of Professional Performance.

(a) **Practice.** Extent to which the RN effectively uses the nursing process components of assessment, diagnosis, outcome identification, planning, implementation, and evaluation in varied practice settings.

(b) **Quality of Care.** Extent to which the RN systematically evaluates and improves the quality and effectiveness of nursing practice and health care delivery.

(c) **Performance.** Extent to which the RN evaluates his/her own nursing practice as well as the performance of others.

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(d) **Education/Career Development.** Extent to which the RN acquires and uses current knowledge for self and others.

(e) **Collegiality.** Extent to which the RN contributes to the professional development of peers, colleagues, and others.

(f) **Ethics.** Extent to which the RN makes decisions and takes action in an ethical manner.

(g) **Collaboration.** Extent to which the RN collaborates with clients, significant others, and other health care and service providers.

(h) **Research.** Extent to which the RN uses research in practice.

(i) **Resource Utilization.** Extent to which the RN considers factors related to safety, effectiveness, and cost in planning and delivering care.

[c.] **Grade Determinations.** In addition to the Basic Requirements specified in paragraph a above, the following criteria must be met in determining the grade assignment of candidates, and if appropriate, the level within a grade. With regard to the "dimension" requirements, the requirements for all "dimensions" at a particular grade/level must be met in order for a RN to be qualified at that particular grade/level.

[(1)] Nurse I Level 1

Scope: Delivers fundamental, knowledge-based care to assigned clients while developing technical competencies.

NURSE I LEVEL 1

EDUCATION	EXPERIENCE	DIMENSION REQUIREMENTS
Associate Degree or Diploma [in Nursing]	None	<p>1. Practice: Uses the nursing process (assessment, diagnosis, outcome identification, planning, implementation, and evaluation). Accurately documents care of clients.</p> <p>2. Quality of Care: Describes the quality improvement process, roles and responsibilities, and identifies quality improvement activities on the unit.</p> <p>3. Performance: Participates in appraisal of own performance.</p> <p>4. Education/Career Development: Seeks opportunities to acquire and develop basic skills.</p> <p>5. Collegiality: Establishes professional relationships with peers. Seeks out colleagues for mutual information exchange.</p> <p>6. Ethics: Safeguards client privacy and confidentiality. Provides care in a non-judgmental, non-discriminatory manner, respecting the values and beliefs of members of all cultures.</p> <p>7. Collaboration: Communicates with clients and other healthcare providers regarding client care.</p> <p>8. Research: Assists in identifying problem areas in nursing practice.</p> <p>9. Resource Utilization: Provides care in a safe and cost-effective manner.</p>

NOTE: As used in this and subsequent tables, “Experience” refers to total years of successful nursing practice rather than experience at current grade level.

[(2)] Nurse I Level 2

Scope: Demonstrates integration of biopsychosocial concepts, cognitive skills, and technically competent practice in providing care to clients with basic or complex needs.

NURSE I LEVEL 2

EDUCATION	EXPERIENCE	DIMENSION REQUIREMENTS
Associate Degree or Diploma [in Nursing]	Approx. 1 year	<p>1. Practice: Demonstrates competency using the nursing process in providing care for clients. Directs others who provide care.</p> <p>2. Quality of Care: Uses quality improvement findings to guide and direct own practice.</p>
(OR)		
[Associate Degree or Diploma in Nursing and bachelors degree in a related field]	[None]	<p>3. Performance: Incorporates feedback regarding performance and interpersonal skills to enhance professional development. Participates in the performance evaluations of others.</p> <p>4. Education/Career Development: Seeks knowledge and skills appropriate to the practice setting to improve performance.</p> <p>5. Collegiality: Shares knowledge/skills with colleagues/others.</p>
(OR)]		
Bachelor of Science in Nursing (BSN) []	None	<p>6. Ethics: Assumes responsibility and accountability for individual nursing judgments and actions. Acts as a client advocate.</p> <p>7. Collaboration: Participates effectively on teams to plan and manage client care.</p> <p>8. Research: Demonstrates awareness of research application to practice.</p> <p>9. Resource Utilization: Plans and organizes care based on client needs and provider competencies to assure safe, efficient and cost-effective care.</p>

[(3)] Nurse I Level 3

Scope: Demonstrates proficiency in practice based on conscious *and* deliberate planning. Self-directed in goal setting for managing complex client situations.

NURSE I LEVEL 3

EDUCATION	EXPERIENCE	DIMENSION REQUIREMENTS
Associate Degree or Diploma [in Nursing] (OR)	Approximately 2-3 years	<p>1. Practice: Demonstrates proficiency using the nursing process in providing care for clients with complex nursing care needs. Guides and directs others who provide care.</p> <p>2. Quality of Care: Participates in established quality improvement studies and/or activities.</p>
[Associate Degree or Diploma in Nursing and bachelors degree in a related field. (OR)]	[Approximately 1-2 years]	<p>3. Performance: Conducts self-assessment of performance and identifies own learning needs. Assesses performance of others.</p> <p>4. Education/Career Development: Implements an ongoing educational plan to support own professional development.</p> <p>5. Collegiality: Provides feedback regarding the practice of others to improve client care.</p>
BSN [] (OR)	Approximately 1-2 years	<p>6. Ethics: Identifies ethical issues in practice and takes appropriate action.</p> <p>7. Collaboration: Refers to, consults with, and makes provision for continuity of care with other health care providers.</p>
Master's degree in nursing or related field with a BSN []	None	<p>8. Research: Uses a body of research to validate and/or change own professional practice.</p> <p>9. Resource Utilization: Delegates care in a safe, efficient, and cost-effective manner. Assists clients in identifying and securing appropriate services.</p>

NOTE: *Employees at Nurse I must successfully advance through each level of the grade before being promoted to Nurse II.*

PART II
APPENDIX G6

[(4)] **Nurse II**

Scope: Demonstrates leadership in delivering and improving holistic care through collaborative strategies with others.

NURSE II

EDUCATION	EXPERIENCE	DIMENSION REQUIREMENTS
BSN [] (OR) [Associate Degree or Diploma in Nursing and bachelors degree in a related field (OR)]	Approximately 2-3 years [Approximately 2-3 years]	<p>1. Practice: Applies the nursing process to systems or processes at the unit/team/work group level to improve care. Demonstrates leadership by involving others in improving care.</p> <p>2. Quality of Care: Initiates/participates in quality improvement activities that result in approved outcomes.</p> <p>3. Performance: Evaluates practice of self and others using professional standards, relevant statutes, and regulations. Takes action to improve performance.</p> <p>4. Education/Career Development: Acquires knowledge and skills to maintain expertise in area of practice. Participates in educational activities to improve clinical knowledge and enhance role performance.</p>
Master's degree in nursing or related field with BSN [] (OR)	Approximately 1-2 years	<p>5. Collegiality: Educates colleagues and/or students and serves as a preceptor and/or mentor.</p> <p>6. Ethics: Supports and enhances client self-determination. Serves as a resource for clients and staff in addressing ethical issues.</p>
Doctoral degree in nursing or [meets basic requirements for appointment and has doctoral degree in related field]	None	<p>7. Collaboration: Uses group process to identify, analyze, and resolve care problems.</p> <p>8. Research: Uses a body of research to validate and/or change work group practice.</p> <p>9. Resource Utilization: Identifies and assesses resource utilization and safety issues, taking appropriate action.</p>

[(5)] Nurse III

Scope: Executes position responsibilities that demonstrate leadership, experience, and creative approaches to management of complex client care.

NURSE III

EDUCATION	EXPERIENCE	DIMENSION REQUIREMENTS
Master's degree in nursing or related field with BSN [] (OR) Doctoral degree in nursing or related field []	Approximately 2-3 years Approximately 2-3 years	<ol style="list-style-type: none"> 1. Practice: Provides leadership in the application of the nursing process to client care, organizational processes and/or systems, improving outcomes at the program or service level. 2. Quality of Care: Initiates interdisciplinary projects to improve organizational performance. 3. Performance: Uses professional standards of care and practice to evaluate programs and/or service activities. 4. Education/Career Development: Implements an educational plan to meet changing program or service needs for self and others. Maintains knowledge of current techniques, trends, and professional issues. 5. Collegiality: Coaches colleagues in team building. Makes sustained contributions to health care by sharing expertise within and/or outside the medical facility 6. Ethics: Provides leadership in identifying and addressing ethical issues that impact clients and staff, including initiating and participating in ethics consultations. 7. Collaboration: Uses the group process to identify, analyze, and resolve care problems. 8. Research: Collaborates with others in research activities to improve care. 9. Resource Utilization: Manages program resources (financial, human, material, or informational) to facilitate safe, effective, and efficient care.