CONTRA COSTA COUNTY
CHARGE NURSE VWTF-2011A
SUPPLEMENTAL QUESTIONNAIRE

NAME: _____
SSN:_____

A completed supplemental questionnaire is required for this recruitment. An application submitted without the supplemental questionnaire will be considered incomplete and will therefore be disqualified.

The purpose of this supplemental questionnaire is to provide applicants the opportunity to elaborate on their qualifications and to assist the Applications Screening and Evaluation Committee in assessing each applicant's experience and training. Your supplemental questionnaire responses will be evaluated to determine your score and rank on the employment list.
Please answer the questions below. Place your name on each submitted sheet and attach your responses to your application. **DO NOT** answer any of the questions by indicating, "see attached resume". Be concise, limiting your response to the information that is relevant to each question. Your responses should be typed or neatly printed. Although you may submit a resume or additional information, such items may not be substituted for the information requested in this questionnaire.

NOTE: All applicants must submit copies of all applicable licenses and certifications and completed supplemental questionnaire at the time of application. All documents can be faxed to 925-957-5260, scanned and attached to your application on line, or sent to Health Services Personnel Department, 1320 Arnold Drive, Suite 261, Martinez, CA 94553. Please include your name and 'recruitment CHARGE NURSE VWTF-2011A' on all documents.

_____

1. **Possession of a valid and unrestricted license as a Registered Nurse in the State of California:**

   YES _____ NO _____ RN license number _____ Expiration Date _____

2. **Indicate all professional nursing education you have completed. Include the following information: Degree awarded (AA, BSN, MSN, other), Name of the school attended, graduation date.**

   _____
   _____
   _____

3. **RN ACUTE CARE EXPERIENCE**
   List your RN experience in acute care setting. Include employer's name, employment dates, type of care facility, contact information, **number of hours worked per week**.

   Facility Name and contact: _____

   Dates of service: _____ Hours per Week: _____

4. **AMBULATORY CARE EXPERIENCE**

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List your RN experience in ambulatory care setting. Include employer's name, employment dates, type of care facility, contact information, **number of hours worked per week.**

Facility Name and contact: _____

Dates of service: _____ Hours per Week: _____

5. NURSING SPECIALTY EXPERIENCE

Select all applicable RN specialty area experience. For each category selected, include employer's name, employment dates, contact information, **number of hours worked per week** .

CNMS - MEDICAL SURGICAL Facility Name and contact:_____

Dates of service: _____ Hours per Week: _____

CNPS - PSYCHIATRY Facility Name and contact:_____

Dates of service: _____ Hours per Week: _____

CNLD - LABOR AND DELIVERY Facility Name and contact: _____

Dates of service: _____ Hours per Week: _____

CNPP - POSTPARTUM Facility Name and contact: _____

Dates of service: _____ Hours per Week: _____

CNNY - NURSERY Facility Name and contact: _____

Dates of service: _____ Hours per Week: _____

CNED - EMERGENCY DEPARTMENT Facility Name and contact:_____

Dates of service: _____ Hours per Week: _____

CNOR - OPERATING ROOM Facility Name and contact:_____

Dates of service: _____ Hours per Week: _____

CNPU - POST ANAESTHESIA CARE UNIT (PACU) Facility Name and Contact:_____

Dates of service: _____ Hours per Week: _____

CNCI - CRITICAL CARE Facility Name and contact:_____

Dates of service: _____ Hours per Week: _____

CNDN - DETENTION Facility Name and contact:_____

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Dates of service: _____ Hours per Week: _____

CNAS - AMBULATORY CARE SPECIALTY CLINICS (Dysplasia, Anti-Coagulation, INH, Resource, AFI/NST,Hematology/Oncology) Facility Name and contact: _____

Dates of service: _____ Hours per Week: _____

Facility Name and contact: _____

Dates of service: _____ Hours per Week: _____

6. CERTIFICATIONS

List all **current** professional nursing certifications held, including any **National Certifications** . (Must attach a copy of each certification).

_____

_____

_____

_____

7. LEAD, SUPERVISORY AND MANAGERIAL EXPERIENCE

a. Describe your RN experience and indicate the number of months working as a Nurse Lead, Nurse Supervisor, Nurse Manager in an **acute care setting** . Include employer's name, employment dates, your title, contact information, **number of hours worked per week** and your specific lead, supervisory or managerial responsibilities.
(1-18 months exp) _____ **(19-36 months exp)** _____ **(over 36 months exp)** _____

_____

_____

_____

_____

b. Describe your RN experience and indicate the number of months working as a Nurse Lead, Nurse Supervisor, Nurse Manager in an **ambulatory care setting** . Include employer's name, employment dates, your title, contact information**, number of hours worked per week** and your specific lead, supervisory or managerial responsibilities.
(1-18 months exp) _____ **(19-36 months exp)** _____ **(over 36 months exp)** _____

_____

_____

_____

_____

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c. Indicate the number of months experience in the preparation of staffing schedules in a hospital unit and/or ambulatory care center:
(1-24 months) _____ (over 24 months) _____

d. Indicate the number of months experience in assigning tasks and responsibilities to subordinate staff as an Acting Nurse Lead.
(1-24 months) _____ (over 24 months) _____

8. PROJECT LEADERSHIP
Indicate if you have experience in **leading special nursing projects and work committees** . Include specific information about the focus of the project/committee, your role and responsibilities.
YES _____ NO _____

_____
_____
_____
_____

_____ _____
Applicant Signature **Date**