



COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH

SUPPLEMENTAL APPLICATION FORM for REGISTERED NURSE III (PH-5135A)

Last Name

First

MI

Social Security Number

Date

General Information

Before completing this form, carefully read the job summary and minimum requirements as stated in the official County job bulletin. Submit an application only if you meet the minimum requirements.

The supplementary application form provides you an opportunity to elaborate on the training/education and experience that prepares you for the position. The information you provide in this form will be used in a test part called an Evaluation of Training and Experience (T&E). The T&E is designed to identify candidates who are prepared to assume the responsibilities of the position and who are likely to be successful on the job if hired. Candidates who receive a successful score on the T&E will be evaluated in the Appraisal of Promotability process. **Note that ALL the information is subject to verification.**

Instructions for Completion

Print or type your name, your Social Security Number, and the date on each page of this form where indicated. Read the instructions for each section carefully. If you do not complete a section, the evaluator will assume that you do not have any experience or training/education in that particular area. Furthermore, if you place a checkmark next to more than one statement (unless instructed otherwise), the evaluator will assume that you possess the lesser experience. ***Resumes or referrals to a resume in lieu of a response on the supplementary application form will be considered a non-response.***

This supplementary application form must be returned along with the standard employment application to the Department of Public Health. It is the obligation of each applicant to make sure his/her application is received by the date published on the job bulletin.

CERTIFICATION

I hereby certify that all statements provided in this supplementary application form are true and complete to the best of my knowledge. I acknowledge that past employers or educators may be called to verify information provided in this application. I understand that any falsification or omission of material facts is in violation of the Los Angeles County Code-Civil Service Rules and may subject me to action up to and including being barred from future examinations.

Print Name

Signature

Date

Last Name

First

MI

Social Security Number

Date**PROFESSIONAL NURSING EXPERIENCE**A. Experience

All experience claimed in this supplemental application form must have been gained within the United States. Part-time experience, which must also have been gained within the United States, must be pro-rated to its full-time equivalent. Furthermore, you may only claim up to 40 hours per week towards receiving credit for full-time experience [Ex. In one month, you worked as a Registered Nurse in two hospitals/facilities, working a total of 60 hours per week. The first job was full-time (i.e., 40 hrs/wk) at a County hospital/facility, and the second job was part-time (e.g., 20 hrs/wk) at a non-County hospital/facility. In this scenario, you may only claim one month of credit for full-time experience; you may not pro-rate the hours to claim one month and two weeks of credit for full-time experience.].

The minimum experience requirements for Registered Nurse III are as follows:

Three years of full-time experience at the level of Registered Nurse II.

Experience at the level of Registered Nurse II:

- T refers to providing independent, comprehensive professional nursing care to a diverse and increasingly complex patient population in a patient care setting (e.g., critical care, emergency room, medical/surgical, operating room, neonatal intensive care, labor and delivery, intermediate care/telemetry, psychiatric care, correctional nursing, etc.). The primary scope of practice involves applying the nursing process to assess more complex patient conditions and needs; identify a nursing diagnosis; and develop, implement, and evaluate a patient-centered plan of care.
- T refers to acting in a *preceptor role*, which includes orienting new staff to the work area, imparting technical knowledge and skills to staff, assessing the level of knowledge and proficiency of staff, and participating in the evaluation and feedback of work performance; AND/OR a *lead role*, which includes providing general direction to nursing and non-nursing staff, determining work priorities, and assigning, delegating, and monitoring work activities.
- T may also refer to assisting a provider in performing special procedures and/or surgeries by performing specified nursing activities related to the type of procedure and/or surgery.
- T may also refer to conducting prospective, concurrent, and retrospective utilization reviews of patient services or hospitalization to maintain quality of care and fiscal responsibility.

Last Name

First

MI

Social Security Number

Date**PROFESSIONAL NURSING EXPERIENCE** (continued)A. Experience (continued)

1. Carefully read the description on page 2 and compare it to your professional nursing experience. Then, count the number of years/months of full-time experience that reflects the description on page 2. Finally, read each of the following statements and place a checkmark (✓) next to the ONE statement that BEST describes your professional nursing experience.
 - I possess 3 years but less than 3 years 6 months of full-time experience at the level of Registered Nurse II.
 - I possess at least 3 years 6 months but less than 4 years of full-time experience at the level of Registered Nurse II.
 - I possess at least 4 years but less than 4 years 6 months of full-time experience at the level of Registered Nurse II.
 - I possess at least 4 years 6 months but less than 5 years of full-time experience at the level of Registered Nurse II.
 - I possess 5 years or more of full-time experience at the level of Registered Nurse II.

 Last Name First MI Social Security Number Date

PROFESSIONAL NURSING EXPERIENCE (continued)

A. Experience (continued)

2. In the space below, specify the dates of relevant experience performing at the level of Registered Nurse II (as described on page 2), the payroll title of your position, employer, whether the experience was full-time or part-time, and whether you acted in a preceptor and/or lead role (as described on page 2) as part of your regular job duties. Begin with the most recent experience and list each payroll title you have held as a separate entry.

| | |
|----|---|
| a) | Dates of experience (MM/DD/YY): _____ to _____ Payroll Title: _____ Employer: _____ Check <u>one</u> of the following: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time – Indicate number of hours per week: _____ In this position, is acting in a preceptor and/or lead role a part of your <u>regular</u> job duties? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) | Dates of experience (MM/DD/YY): _____ to _____ Payroll Title: _____ Employer: _____ Check <u>one</u> of the following: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time – Indicate number of hours per week: _____ In this position, was acting in a preceptor and/or lead role a part of your <u>regular</u> job duties? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c) | Dates of experience (MM/DD/YY): _____ to _____ Payroll Title: _____ Employer: _____ Check <u>one</u> of the following: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time – Indicate number of hours per week: _____ In this position, was acting in a preceptor and/or lead role a part of your <u>regular</u> job duties? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d) | Dates of experience (MM/DD/YY): _____ to _____ Payroll Title: _____ Employer: _____ Check <u>one</u> of the following: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time – Indicate number of hours per week: _____ In this position, was acting in a preceptor and/or lead role a part of your <u>regular</u> job duties? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e) | Dates of experience (MM/DD/YY): _____ to _____ Payroll Title: _____ Employer: _____ Check <u>one</u> of the following: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time – Indicate number of hours per week: _____ In this position, was acting in a preceptor and/or lead role a part of your <u>regular</u> job duties? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Attach additional pages as necessary.

Last Name

First

MI

Social Security Number

Date

PROFESSIONAL NURSING EXPERIENCE (continued)

B. Areas of Specialty

The following information may be used to generate a specialty sub-eligibility list. Place a checkmark (✓) next to each area of specialty in which you have at least 3 years, within the last 6 years, of full-time experience (within the United States) performing at the level of a Registered Nurse II. (You may check up to 2 specialties)

- | | |
|--|--|
| <input type="checkbox"/> Acute Care | <input type="checkbox"/> Oncology |
| <input type="checkbox"/> Adult Intensive Care | <input type="checkbox"/> Operating Room |
| <input type="checkbox"/> Ambulatory Care | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Correctional Health | <input type="checkbox"/> Pediatric and Neonatal Intensive Care |
| <input type="checkbox"/> Emergency Department | <input type="checkbox"/> Post-Anesthesia Recovery |
| <input type="checkbox"/> Hemodialysis | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Informatics | <input type="checkbox"/> Rehabilitation |
| <input type="checkbox"/> Labor and Delivery | <input type="checkbox"/> Stepdown/Telemetry |
| <input type="checkbox"/> Mental (Psychiatric) Health | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Nursing Case Management | |

C. If you receive a successful score on the Evaluation of Training & Experience, you will be evaluated in the Appraisal of Promotability process. To expedite this process, print the name of your current immediate supervisor and his/her work telephone number in the space provided below:

Name of Immediate Supervisor

Work Telephone Number

D. Current Location/Work Facility (For DHS applicants only)

Place a checkmark (✓) next to your current location/work facility (Dept. Number).

- Health Services Administration (110)
- Office of Managed Care (120)
- High Desert Health System (130)
- LAC+USC Healthcare Network (160)
- LAC+USC Healthcare Network Health Centers and Comprehensive Health Centers (161)
- Harbor-UCLA Medical Center (200)
- Coastal Health Centers and Comprehensive Health Centers (201)
- MLK-Harbor Hospital (225)
- Southwest Health Centers and Comprehensive Health Centers (226)
- Valleycare-Olive View Medical Center (240)
- Valleycare Health Centers and Comprehensive Health Centers (241)
- Rancho Los Amigos National Rehabilitation Center (260)
- Juvenile Court Health Services (290)

 Last Name

First

MI

 Social Security Number

 Date
TRAINING & EDUCATIONA. Required License

The minimum licensing requirements is as follows:

A license to practice as a Registered Nurse issued by the California Board of Registered Nursing.

Do you possess a license to practice as a Registered Nurse issued by the California Board of Registered Nursing? Yes No

B. National Certifications

The following is a list of national certifications. Place a checkmark (✓) next to each certification that you possess, if any. Check all that apply. If one is not listed, use the space provided to write the name of the certification (Note: The certification must be one for which you can provide proof of completion and will be considered for credit.). If you do not possess a national certification, place a checkmark (✓) next to the statement to indicate so. **Be sure to attach to your application a copy of the certification(s) that you possess.**

- American Nurses Credentialing Center-issued (ANCC) certification
 - Indicate Specialty Area: _____
- Association of Operating Room Nurse (AORN) Certification
- Association of Rehabilitation Nurse (ARN) Certification
- Certified Corrections Nurse (CCN)
- Certified Critical Care Nurse (CCRN)
- Certified Emergency Room Nurse (CEN)
- Certified Neuroscience Registered Nurse (CNRN)
- Oncology Nursing Society (ONS) Certification
- Mobile Intensive Care Nurse (MICN) Certification
- National Commission on Correctional Healthcare Certification (CCHP)
- Other: _____
- I do not possess a national certification.

 Last Name

First

MI

 Social Security Number

 Date
TRAINING & EDUCATION (continued)C. Local Certifications

The following is a list of local certifications. Place a checkmark (✓) next to each certification that you possess, if any. Check all that apply. If one is not listed, use the space provided to write the name of the certification (Note: The certification must be one for which you can provide proof of completion and will be considered for credit.). If you do not possess a local certification, place a checkmark (✓) next to the statement to indicate so. **Be sure to attach to your application a copy of the certification(s) or verification(s) of completion (e.g., certificates) that you possess.**

- | | |
|--|--|
| <input type="checkbox"/> Advanced Cardiac Life Support | <input type="checkbox"/> Pediatric Advanced Life Support |
| <input type="checkbox"/> Basic Cardiac Life Support | <input type="checkbox"/> Specialized training in care of Pediatric patient |
| <input type="checkbox"/> Basic Trauma Life Support | <input type="checkbox"/> Specialized training in nursing case management |
| <input type="checkbox"/> Certificate for Phase II Advanced Critical Care | <input type="checkbox"/> Specialized training in electronic, fetal monitoring obstetrical vaginal exams, circulation in cesarean section |
| <input type="checkbox"/> Certification of Hemodialysis | <input type="checkbox"/> Specialized training in the management of assaultive/aggressive behavior |
| <input type="checkbox"/> Completion of a basic arrhythmia course | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Completion of a course in chemotherapy | <input type="checkbox"/> I do not possess a local certification. |
| <input type="checkbox"/> Completion of a County basic adult or equivalent approved critical care adult program | |
| <input type="checkbox"/> Completion of a basic County or equivalent approved critical care program | |
| <input type="checkbox"/> Completion of a specialized Emergency Department Training | |
| <input type="checkbox"/> Completion of a specialized operating room training program | |
| <input type="checkbox"/> Completion of the Correctional Health Core Curriculum | |
| <input type="checkbox"/> Completion of the Trauma Nurse Core Curriculum (TNCC) | |
| <input type="checkbox"/> DHS certification in tuberculosis or sexually transmitted diseases for an Extended Role Nurse (ERN) | |

Last Name_____
First_____
MI_____
Social Security Number_____
Date**TRAINING & EDUCATION** (continued)D. Education

Answer the following questions that relate to educational degrees that you may possess. If you place a checkmark next to "Yes" to any of the questions, **be sure to attach to your application a copy of either the degree(s) or the official transcripts.**

1. Do you possess a bachelor's degree from an accredited institution and in a health-related field as listed below? Yes No

If yes, place a checkmark (✓) next to the field in which you have earned a bachelor's degree:

- | | |
|--|--|
| <input type="checkbox"/> Nursing | <input type="checkbox"/> Healthcare Management |
| <input type="checkbox"/> Nurse Administration | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Nurse Education | <input type="checkbox"/> Other health-related field (e.g., Nutritional Science, Physiological Science, Biology, Biochemistry, etc.): _____ |
| <input type="checkbox"/> Health Education | |
| <input type="checkbox"/> Health Sciences | |
| <input type="checkbox"/> Healthcare Administration | |
| <input type="checkbox"/> Healthcare Education | |

2. Do you possess a master's degree from an accredited institution and in one of the health-related fields below? Yes No

If yes, place a checkmark (✓) next to the field in which you have earned a master's degree:

- | | |
|---|--|
| <input type="checkbox"/> Nursing | <input type="checkbox"/> Healthcare Administration |
| <input type="checkbox"/> Nurse Administration | <input type="checkbox"/> Healthcare Education |
| <input type="checkbox"/> Nurse Education | <input type="checkbox"/> Healthcare Management |
| <input type="checkbox"/> Health Education | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Health Sciences | <input type="checkbox"/> Public Health Nursing |