

# HHA Agency Supervisor Qualification Review Form

#### HOME HEALTH AGENCY ONLY

#### Attachment B - Agency Supervisor Qualification Review Form

Section 245.30 of the 77 Illinois Administrative Code requires this position to be filled by an individual who is a registered nurse who has completed a baccalaureate degree program and has at least one year of nursing experience as a Bachelor of Science of Nursing; or a registered nurse without a baccalaureate degree, who has at least three years of nursing experience as an Registered Nurse within the last five years (two of those years in a home health agency, a community health program caring for the sick, or a family centered nursing program in a community health agency). Section 245.20 defines a registered nurse as a person currently licensed as an Registered Nurse under the Illinois Nursing Act.

Home Health Agency I	Name						
Address							
City				State	ZIP Code		
Agency Supervisor Info							
Last Name		Firs	t Name			Middle Initial	
Address							
City				State	ZIP Code		
Daytime Phone number	r (include area code	and extens	ion)				
Section 245.30 requires Indicate the highest edu			st be a Registe	red Nurse.			
OADN Please list the college(s	Oiploma R.N. s) attended, the addr					O Doctorate	
Name of College							
Address of College							
City					ZIP Code		
Date of Graduation			Specialty/Deg	ree			
Name of College							
Address of College							
City				State	ZIP Code		
Date of Graduation Please list the high sch	ool attended, the ad	dress, and c	Specialty/Degi late of graduati	ree on.			
Name of High School				Date of	Date of Graduation		
Address of High School	ol						
City				<u> </u>	ZIP Code		
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# HHA Agency Supervisor Qualification Review Form

List applicable professional licenses, registrations and/or certifications currently held with the license number, date of expiration and state that issued the license, registration or certification. <u>ATTACH A COPY OF YOUR</u> <u>CURRENT ILLINOIS LICENSE IF APPLICABLE.</u> YOUR CURRENTLY EMPLOYER MUST BE THE AGENCY <u>IDENTIFIED IN THIS APPLICATION.</u> Please include a letter of intentions with this application (the agency supervisor is required to be full time upon licensure. Provide documentation that the applicant is resigning present employment upon licensure, or if working part time elsewhere, the applicant's other employment is outside the agency's hours of operation).

#### Describe your relevant work experience for the last five years.

(1) List your most recent position with THIS AGENCY FIRST and work backward.

(2) Give the starting and ending dates (month and year) for <u>each</u> employment and the weekly hours worked.

(3) Describe the administrative functions performed for each position, with each agency, that qualify you to function as the agency supervisor of a home health agency.

(4) Include the names, addresses and telephone numbers of organizations.

You may use an additional sheet of paper to complete this section. Resumes are <u>not</u> accepted in lieu of completion of this portion of the form.

0.4	State	
	State	e ZIP Code
Starting (month and year)	Ending (month and year)	Total Hours Worked Weekly
Duties		
Previous Employer Name		
Address of Previous Employer		
City	State	
Starting (month and year)	Ending (month and year)	Total Hours Worked Weekly
Duties		
D. Han		

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## HHA Agency Supervisor Qualification Review Form



Previous Employer Name								
Address of Previous Employer								
City		State	ZIP Code					
Starting (month and year)	Ending (month and	year)	Total Hours	Worked Weekly				
Duties								
Have you ever been convicte	ed of a criminal offense?	⊖ <sub>Yes</sub> ⊂	) No					
Are there any pending or administratively resolved issues concerning your professional license								
in Illinois or in another state?		⊖ <sub>Yes</sub> ⊂	No					

If you answered "yes" to either or both of the above statements, please describe the criminal offense and/or the pending or administratively resolved licensure issues in detail, including the state of administrative action [Section 245.130 b) 2]. You may attach an additional sheet of paper if necessary for the explanation.

I signify that the information contained in this form is true and correct to the best of my knowledge and belief. I realize that misrepresentation of this information at any time may be cause for denial of this application, or future revocation of a license.

Signature of Applicant (Original Only)

Date

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