

POSITION DESCRIPTION

POSITION TITLE: Nurse Practitioner/Psychiatric-Mental Health

DEPARTMENT: Vinton Family Medical Clinic

INCUMBENT:

DATE EFFECTIVE:

REPORTS TO: Medical Director
Director of Clinic Operations

EXPOSURE CATEGORY 3

GENERAL STATEMENT OF DUTIES:

Works a combination of 4 days per week in clinic and 1 day on administrative matters and colleague consultation on cases, but hours may be long and irregular. May occasionally work more than 40 hours per week including week-ends as necessary. The duties to be performed by the Nurse Practitioner shall in all events be consistent with the general practice of medicine in accordance with the customary rules and ethics and conduct of the Iowa Board of Nursing and such other bodies, formal or informal, government or otherwise.

SUPERVISION RECEIVED:

By Director of Clinic Operations on administrative issues.

SUPERVISION EXERCISED:

The incumbent will ensure that all support staff under him/her shall operate in a clinically and fiscally responsible manner.

TYPICAL PHYSICAL DEMANDS:

- Must be able to move intermittently throughout the workday.
- Must be able to speak and write the English language in an understandable manner.
- Must be able to cope with the mental and emotional stress of the position.
- Must possess sight/hearing senses or use of prosthetics that will enable these senses to function so that the requirements of this position can be fully met.
- Must function independently, have flexibility, personal integrity, and the ability to work effectively with patients, personnel, and support agencies.
- Must be in good general health and demonstrate emotional stability.
- Must be able to relate to and work with the ill, disabled, elderly, emotionally upset, and at times hostile people within the facility.

- Must be able to assist in the evacuation of residents and patients.

TYPICAL WORKING CONDITIONS:

- Works in office areas as well as throughout the facility.
- Sits, stands, bends, lifts, and moves intermittently during working hours.
- Is subject to frequent interruptions.
- Is involved with residents, family members, personnel, visitors, government agencies/personnel, etc., under all conditions/circumstances.
- Is subject to hostile and emotionally upset residents, patients, family members, personnel, visitors, etc.
- Works beyond normal working hours when necessary.
- May be exposed to diseases and viruses.

ESSENTIAL DUTIES:

Medical Records

- The Nurse Practitioner shall maintain medical records on behalf of each patient seen. Such records shall at all times be the property of the employer.
- Patient dictation shall be completed in a timely manner and in accordance with the by-laws of the Virginia Gay Hospital Medical Staff.

Nurse Practitioner Responsibilities

- The incumbent will provide mental health and family medicine services to patients including therapy, social rehabilitation, crisis intervention and outreach services.
- The incumbent will see patients of all ages and life stages performing initial assessments, medication checks and working with the integrative team to ensure the care of the patient is met.
- Assess and develop individualized plans of care for all patients.
- Incumbent will include explaining treatment plans to patients and their families, maintaining patient records, preparing reports, monitoring progress toward treatment goals and conducting annual reviews of active treatment plans.
- Participate in the development, execution and periodic review of the written policies governing the services the clinic furnishes.
- Provide services in accordance with those policies.
- Arrange for, or refer patients to, needed services that cannot be provided at the clinics.
- Assure that adequate patient health records are maintained and transferred as required when patients are referred.
- Nurse Practitioner shall perform medical services in accordance with the rules of ethics governing the practice of medicine. The mid-level is under no obligation or requirement to refer patients to any healthcare provider and the amount of compensation will not vary based upon referrals made.
- Employee is responsible to attend required educational offerings to maintain licensure in the State of Iowa.
- Employee shall delegate duties to support staff as appropriate.

- Employee shall maintain medical staff privileges at Virginia Gay Hospital.
- Appropriate duties as assigned

Acceptance of Patients

Nurse Practitioner, and employer shall have mutual authority over acceptance or refusal of any patient and delegation of patients among employees of the employer.

Marginal/Incidental Duties:

- Conducts educational offerings.
- Speaks to hospital and community groups.
- Participates in health-related activities and groups.
Maintains membership in professional organizations.

Education/Experience:

Must be AANP or ANCC certified with active RN license. Master's degree or higher from a psychiatric- mental health nurse practitioner program with at least 500 clinical hours accredited by the Commission of Collegiate Nursing Education (CCNE) of the American Commission for Education in Nursing (ACEN). Should also have Psychiatric-Mental Health Nurse Practitioner Certification (PMHNP-BC). Must have or be eligible for DEA or CSA registration.

Application for Employment

Date of Application: _____

Position Desired: _____ *please circle one:* Full Time Part Time

Date available to start work? : _____

What shifts are you available to work? Day Evening Night

Can you work rotating shifts? Yes No

Are you willing to work weekends and holidays when necessary? Yes No

IMPORTANT: Please print or write plainly.

Last Name: _____ First Name: _____ Middle Name: _____ Maiden Name: _____

E-Mail Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Area Code: () Phone Number: _____

Have you been previously employed at Virginia Gay Hospital Clinics, Home Health & Nursing & Rehab? Yes No

If "Yes", please give position held and dates of employment: _____

Were you referred to apply here? Yes No

If "Yes", please give name and department of who referred you: _____

Record of Education

	Name and Address of Educational Institution	Circle Highest Year Completed	Major	List Diploma or Degree
High School		7 8 9 10 11 12		
College or University		1 2 3 4 5 6		
Technical or Nursing School		1 2 3 4 5		
Other (Specify)				

Are you attending school now? Yes No

Professional License or Registration

Type:	State(s) Iowa	YES	NO	License or Certificate	Expiration Date
	Other:				
Type:	State(s) Iowa	YES	NO	License or Certificate	Expiration Date
	Other:				

Professional Organizations List all you belong or hold office.

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

Special Skills & Qualifications List all for the position you are applying.

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

Employment Record

List all employment for past fifteen years including self employment.

	From: (mo./yr.)	To: (mo./yr.)	Base Wages/Salary
■ Employer (Present or Most Recent):			\$ per
Address (City, State, Zip):			
Job Title:	Supervisor's Name:		
Describe Major Job Duties:			
Reason for Leaving:			
If presently employed may we contact your employer for references? Yes No If "Yes", please enter area code and phone: ()			

	From: (mo./yr.)	To: (mo./yr.)	Base Wages/Salary
■ Employer (Present or Most Recent):			\$ per
Address (City, State, Zip):			
Job Title:	Supervisor's Name:		
Describe Major Job Duties:			
Reason for Leaving:			

	From: (mo./yr.)	To: (mo./yr.)	Base Wages/Salary
■ Employer (Present or Most Recent):			\$ per
Address (City, State, Zip):			
Job Title:	Supervisor's Name:		
Describe Major Job Duties:			
Reason for Leaving:			

	From: (mo./yr.)	To: (mo./yr.)	Base Wages/Salary
■ Employer (Present or Most Recent):			\$ per
Address (City, State, Zip):			
Job Title:	Supervisor's Name:		
Describe Major Job Duties:			
Reason for Leaving:			

Personal Reference

Name:

Address (City, State, Zip):

Name:

Address (City, State, Zip):

Military Service

Branch of Service:

Rank: Dates of Service: From To

Specialty Training Received:

Are you a U.S. Citizen? Yes No

If you are not a citizen of the U.S., please enter type of Visa held and Alien Registration Number.

Type of Visa: Alien Registration No. :

Have you ever been convicted in a criminal court case (except of minor traffic violations)? Yes No

If "Yes", give details to where, when and on what charge:

Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime in this state or any other state?

Yes No If "Yes", give details as to Where, When and on What Charge:

Are you on the OIG excluded provider list? Yes No If "Yes", date and why?

Virginia Gay Hospital is an equal employment opportunity employer. No person is unlawfully excluded from consideration for employment because of race, color, religious creed, national origin, ancestry, gender, age, veteran status, marital status, sexual orientation, transgender identity, or physical challenges. This policy applies not only to recruitment and hiring practices, but also in the areas of placement, promotion, transfer, rate of pay, and termination. No question on this application is intended to secure information to be used for such discrimination.

I voluntarily give this institution the right to make a thorough investigation of my past employment and activities, agree to cooperate in such investigation and release from all liability or responsibility all persons, companies or corporations supplying such information. I consent to take the physical examination and such future examinations as may be required of this institution at such times and places as the institution shall designate. I understand that an offer of employment may be contingent on passing the physician examination which relates to the essential duties I would be required to perform.

I understand that my employment is at will and that either party is free to terminate the employment relationship at any time without cause. I also understand that my employment may terminate for any misstatement or omission of fact appearing on this application form.

If employed I will be required to complete an Employment Verification Form (I-9) and within three days show satisfactory evidence of identity and eligibility of employment.

Signature of Applicant Date

Applicant's Statement

IMPORTANT: Read carefully and initial each paragraph before signing.

By my signature and initials placed below, I certify that the information provided in this employment application (and accompanying resume, if any) is true and complete, and I understand that any false information or significant omissions may disqualify me from further consideration for employment and may be justification for my dismissal from employment if discovered at a later date. I agree to immediately notify the hospital if I should be convicted of a felony or any crime involving dishonesty or a breach of trust while my application is pending or during my period of employment, if hired.

_____ Initials

I give permission for a complete post-offer assessment and physical examination, and I consent to the release to the hospital of any and all medical information as may be deemed necessary by the hospital in judging my capability to do the work for which I am applying. I further understand that if medical conditions are diagnosed through the post-offer assessment or physical exam that would make it impossible for me to perform the duties as listed on the job description, the job offer may be withdrawn.

_____ Initials

I authorize the investigation of all statements contained in this application. I also authorize the hospital to contact my present employer, past employers and listed references.

_____ Initials

I authorize any person, school, current employer, and organizations named in this application from to provide the hospital with relevant information and opinion that may be useful to the hospital in making a hiring decision, and I release such persons and organizations from any legal liability in making such statements.

_____ Initials

I understand that this application does not, by itself, create a contract of employment. I understand and agree that, if hired, MY EMPLOYMENT IS FOR NO DEFINITE PERIOD OF TIME, and may, regardless of the date of payment of my wages or salary, BE TERMINATED AT ANYTIME.

_____ Initials

I understand also that I am required to abide by all rules and regulations of the employer.

_____ Initials

Date:

Signed:

State of Iowa
NON-LAW ENFORCEMENT RECORD CHECK REQUEST
FORM A

ACCOUNT NUMBER _____

**TO: Iowa Division of Criminal
Investigation
Bureau of Identification, 1st Floor
215 E 7th Street
Des Moines, Iowa 50319
(515) 281-4776
(515) 725-6080 (fax)**

FROM: _____

Phone # _____
Fax # _____

I am requesting an **IOWA CRIMINAL HISTORY** check on:

(Type or Print Legibly)

REQUEST

Last Name

(mandatory)

First Name

(mandatory)

Middle Name

(recommended)

Date of Birth

(mandatory)

Sex

(mandatory)

Social Security Number

(recommended)

Signature of Requester

There is a separate Form "A" required for each last name submitted

(DCI Use Only)

RESULTS

As of _____, a name and date of birth check revealed:

CCH record attached

No CCH record found

DCI initials _____

WAIVER

I hereby give permission for the above requesting official to conduct an Iowa criminal history record check with the Division of Criminal Investigation. Any information maintained by the DCI may be released as allowed by law.

Signature

Date