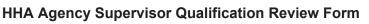
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## HOME HEALTH AGENCY ONLY Attachment B - Agency Supervisor Qualification Review Form

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 in Science of Nursing (BSN) program and has at least one year of nursing experience as a BSN; 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.

Agency Name		License Number				
Address						
City		State	ZIP Code _			
Agency Supervisor Information						
Last Name	First Name		Middle Initial			
Address						
City		_ State	ZIP Code			
Daytime Phone number (include area Section 245.30 requires that the againdicate the highest educational level	gency supervisor must be a Re					
OADN Opploma I	R.N. OB.S.N. OB.A. ne address, date of graduation, s			O Doctorate		
Name of College						
Address of College						
		_				
Date of Graduation	Specialty/Deg	ree				
Name of College						
Address of College						
City		_ State	ZIP Code			
Date of Graduation Please list the high school attende						
Flease list the high school attende	eu, the address, and date of gra	aduation.				
Name of High School		Date	of Graduation			
Address of High School						
City		_ State	ZIP Code			

## **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. ATTACH A COPY OF YOUR CURRENT ILLINOIS LICENSE. YOUR CURRENT EMPLOYER MUST BE THE AGENCY IDENTIFIED IN THIS APPLICATION. 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 each 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.

Current Employer Name			
Address of Current Employer _			
City _		State	ZIP Code
Starting (month and year)	Ending (month and year)		Total Hours Worked Weekly
Duties			
Previous Employer Name			
Trevious Employer Name			
Address of Previous Employer			
City		State	ZIP Code
Starting (month and year)	Ending (month and year)		Total Hours Worked Weekly
Duties			

Attachment B-Agency Supervisor Qualification Review Form Page 2
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## **HHA Agency Supervisor Qualification Review Form**



Signature of Appl	icant (Original Only)		Date
			pest of my knowledge and belief. In denial of this application, or future
pending or administratively		il, including	cribe the criminal offense and/or the the state of administrative action sary for the explanation.
○ Yes	○ No		
Are there any pending or ad another state?	ministratively resolved issues conce	rning your pr	ofessional license in Illinois or in
Have you ever been convicte	ed of a criminal offense?	Yes O <sub>N</sub>	0
Duties			
Starting (month and year)	Ending (month and year)		Total Hours Worked Weekly
City		State	ZIP Code
Address of Previous Employer			
Previous Employer Name			

Attachment B - Agency Supervisor Qualification Review Form Page 3
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