

# CCQAS Nurse Data Collection Tool

## Personal Information:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
SSN: \_\_\_\_\_ Names Previously Used: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Branch Service: \_\_\_\_\_ Rank/Grade: \_\_\_\_\_  
AFSC/Design: \_\_\_\_\_ Dept: \_\_\_\_\_ Work Center: \_\_\_\_\_

## Source of Accession: (Check One)

- |                                                                              |                                                                |                                                 |
|------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Baccalaureate Degree Completion Program (BDCP)      | <input type="checkbox"/> Reserve Officer Training Corps (ROTC) | <input type="checkbox"/> Civilian Civil Service |
| <input type="checkbox"/> Uniformed Services Univ. of Health Sciences (USUHS) | <input type="checkbox"/> Direct Accession (DA)                 | <input type="checkbox"/> Civilian Contractor    |
| <input type="checkbox"/> Enlisted Commissioning Program (ECP)                | <input type="checkbox"/> National Guard                        | <input type="checkbox"/> Civilian Consultant    |
| <input type="checkbox"/> Financial Assistance Program (FAP)                  | <input type="checkbox"/> Reserve                               | <input type="checkbox"/> Civilian Volunteer     |
| <input type="checkbox"/> Health Professional Scholarship Program (HPSP)      | <input type="checkbox"/> Foreign National                      | <input type="checkbox"/> Other: _____           |

## Contractor: (Type) Personal Service Contractor (PSC) or Non-Personal Service Contractor (NPSC)

Contract Employer: \_\_\_\_\_  
Contract Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
Malpractice Carrier/Expiration: (NPSC only) \_\_\_\_\_

## Contact Information:

Home Address: \_\_\_\_\_  
Work Address: \_\_\_\_\_  
Contact Phone Number: \_\_\_\_\_ Duty Phone Number: \_\_\_\_\_  
Duty Email Address: \_\_\_\_\_  
Alternate Email Address: \_\_\_\_\_

## Education:

Qualifying Degree: \_\_\_\_\_ Nursing School: \_\_\_\_\_ Graduation Date: \_\_\_\_\_  
Nurse Transition Program: \_\_\_\_\_ Name of Institution: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_  
Post-graduate Training: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

## License: List all license(s) active or inactive.

State	License Number	Status	Expiration Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## Specialty Certification(s):

Area of Specialty	Organization	Issued	Expiration
_____	_____	_____	_____
_____	_____	_____	_____

## Contingency Training: Include copy of card(s)

BLS: (exp) \_\_\_\_\_ ACLS: (exp) \_\_\_\_\_ PALS: (exp) \_\_\_\_\_ NRP: (exp) \_\_\_\_\_  
TNCC: (exp) \_\_\_\_\_ Other: \_\_\_\_\_

The information provided on this form is complete and accurate to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date