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)*

- ❑ Baccalaureate Degree Completion Program (BDCP)
- ❑ Uniformed Services Univ. of Health Sciences (USUHS)
- ❑ Enlisted Commissioning Program (ECP)
- ❑ Financial Assistance Program (FAP)
- ❑ Health Professional Scholarship Program (HPSP)
- ❑ Reserve Officer Training Corps (ROTC)
- ❑ Direct Accession (DA)
- ❑ National Guard
- ❑ Reserve
- ❑ Foreign National
- ❑ Civilian Civil Service
- ❑ Civilian Contractor
- ❑ Civilian Consultant
- ❑ Civilian Volunteer
- ❑ 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**