



EMPLOYMENT APPLICATION

EDUCATIONAL INFORMATION:

	SCHOOL NAME	GRADUATION DATE	DEGREE RECEIVED
COLLEGE			
GRADUATE SCHOOL			
OTHER SCHOOL			

EMPLOYMENT HISTORY:

Facility/Employer Name: _____

Department: _____

Phone: _____

City: _____ State/Providence: _____

Dates Employed: From _____ To: _____

Reason for leaving: _____

Position Held: _____ Specialty: _____

Supervisor's Name and Title: _____

Facility/Employer Name: _____

Department: _____

Phone: _____

City: _____ State/Providence: _____

Dates Employed: From _____ To: _____

Reason for leaving: _____

Position Held: _____ Specialty: _____

Supervisor's Name and Title: _____

Facility/Employer Name: _____

Department: _____

Phone: _____

City: _____ State/Providence: _____

Dates Employed: From _____ To: _____

Reason for leaving: _____

Position Held: _____ Specialty: _____

Supervisor's Name and Title: _____



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Facility/Employer Name: _____

Department: _____

Phone: _____

City: _____ State/Providence: _____

Dates Employed: From _____ To: _____

Reason for leaving: _____

Position Held: _____ Specialty: _____

Supervisor's Name and Title: _____

SPECIALTIES:

Please indicate the number of years and months of experience you have in these specialties. Include areas of float.

	<u>YEARS</u>	<u>MONTHS</u>		<u>YEARS</u>	<u>MONTHS</u>
ICU	_____	_____	Surgical	_____	_____
CCU	_____	_____	Telemetry	_____	_____
Open Heart Critical Care	_____	_____	Cardiac Step-down	_____	_____
SICU	_____	_____	Neurology	_____	_____
Emergency Room	_____	_____	Ortho	_____	_____
Geriatrics	_____	_____	Rehabilitation	_____	_____
Burn	_____	_____	Dialysis	_____	_____
Gynecology	_____	_____	Diabetic	_____	_____
GU	_____	_____	Psych	_____	_____
Labor/Delivery	_____	_____	Operating Room	_____	_____
Post-Partum	_____	_____	Recovery Room	_____	_____
Nursery	_____	_____	Home Health	_____	_____
NICU	_____	_____	Nursing Management	_____	_____
Pediatrics	_____	_____	Other (<i>indicate</i>)	_____	_____
Medical	_____	_____			

CERTIFICATION

I certify that the information provided on this Application is truthful and accurate. I understand that providing false or misleading information will be the basis for rejection of my Application, or if employment commences, immediate termination.

I authorize Competent Nursing Staff, LLC to contact former employers and education organizations regarding my employment and education. I authorize my former employers and educational organizations to fully and freely communicate information regarding my previous employment, attendance, and grades. I authorize those persons designated as references to fully and freely communicate information regarding my previous employment and education.

If an employment relationship is created, I understand that unless I am offered a specific written contract of employment signed on behalf of the organization by its Owner, the employment relationship will be entirely voluntary in nature. In other words, with appropriate notice, I will have the full and complete discretion to end the employment relationship when I choose and for reasons of my choice. Similarly, my employer would have the same right. Moreover, no agent, representative, or employee of Competent Nursing Staff, LLC, expect in a specific written contract of employment signed on behalf of the organization by its Owner, has the power to alter or vary the voluntary nature of the employment relationship.

I HAVE CAREFULLY READ THE ABOVE CERTIFICATION AND I UNDERSTAND AND AGREE TO ITS TERMS.

Applicant Signature: _____

Date: _____



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EEO INFORMATION SURVEY

Federal regulations require the collection of certain data for our Equal Employment Opportunity reporting and planning. We are requesting your cooperation in completing this self-evaluation form.

THIS INFORMATION IS COLLECTED FROM APPLICANTS ON A VOLUNTARY BASIS AND IS KEPT IN THE HUMAN RESOURCES DEPARTMENT FOR FEDERAL REPORTING PURPOSES. THE FOLLOWING VOLUNTARY INFORMATION SHALL SERVE NO PURPOSE IN EVALUATING AN APPLICANT'S QUALIFICATIONS FOR EMPLOYMENT.

Name of Applicant: _____

Date of Application: _____

Gender: Male Female

Racial/Ethnic Classification (Please designate one group only)

White (not of Hispanic origin)

Any person having origin in any of the original peoples of Europe, North Africa, or the Middle East.

Black (not of Hispanic origin)

Any person having origins in any of the Black racial groups.

Hispanic

Any person of Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

Asian or Pacific Islander

Any person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands, and Samoa.

American Indian or Alaskan Native

Any person having origins in any of the original peoples of North American and whose main cultural identification is through tribal affiliation or community recognition. One-quarter Indian is the usual requirement for inclusion on a tribal roll.

Other (please specify) _____

Person with a Disability: Yes No

United States Veteran: Yes No

If Yes, please check all that apply:

Pre-Vietnam Era Vietnam Era

Post-Vietnam Era Disabled Veteran



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REQUIRED DOCUMENTATION

In order for your application to begin the approval process, you will need to provide the following documents.

APPLICATION: (MUST BE RESUBMITTED IF OUT OF WORK FOR 6 MONTHS)

Applications must be updated every 2 years in its entirety, including education, **FULL** work history, residence, and emergency contacts.

RESUME: (MUST BE RESUBMITTED IF OUT OF WORK FOR 6 MONTHS)

Applications must submit most recent resume.

REFERENCES: (MUST BE RESUBMITTED IF OUT OF WORK FOR 6 MONTHS)

Applicant is required to submit 2 recent references from Charge Nurses, Clinic Managers, Area Managers, or Supervisors. The reference must be an evaluation of the applicant's skills as it pertains to their specialty from within the last 12 months.

Once your application is approved, you will need to provide a copy of the following documents.

All expiration timelines given are per state rules. If a unit requests a more recent document, the staff member must provide it for the unit.

I-9, DRIVER'S LICENSE or PASSPORT, and SOCIAL SECURITY CARD: (AS EXPIRES)

Please fill out Section 1 completely with a signature and date. If you are not a U.S. Citizen, please provide documentation of authorization to work.

LICENSE and CERTIFICATIONS: (AS EXPIRES)

A copy of the current Registered Nursing license's front, back, and signature of the applicant is required.

BCLS/CPR: (AS EXPIRES)

Certification must be from AHA, ARC, or ASHI. This must be at Healthcare Provider Level. A copy of the current certification's front, back, and signature of the applicant is required. Online BLS is NOT acceptable.

WORKPLACE SAFETY AND PATIENT CARE STANDARDS CERTIFICATE: (ANNUAL)

Once login information is created for you. Please go to <http://www.rn.com> and complete the "Workplace Safety and Patient Care Standards" course and test with the username and password provided to you. This course covers fire safety, infection control, universal precautions, blood borne pathogens, TB, employee right to know, hazardous materials, Age Specific Competency, and HIPPA. Must pass with an 80% or higher.

PHYSICAL: (within 12 months prior to first case, every 4 years after)

A physical is required annually. The examining practitioner must complete a statement that the applicant is physically able to do their job without accommodations (or discusses accommodations) and is free from communicable diseases.

MEDICAL RECORDS and RELEASE STATEMENT: (ANNUAL)

Please be sure to complete the bottom of this form in its entirety. Please sign and date as this form allows Competent Nursing Staff, LLC to submit your documentation to facilities requesting coverage on your behalf.



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COLOR BLIND EXAM: (ONE TIME SUBMISSION)

Documentation must show date of exam and results.

DRUG SCREEN: (WHEN REQUESTED)

A 10-panel drug screen is required when requested. If there is a gap in employment greater than 30 days, a drug screen will be required again. Drug screening scripts will be provided by our company.

MMR and VARICELLA: (ONE TIME SUBMISSION)

MMR (Measles, Mumps, and Rubella) and Varicella titer results must be provided and show immunity. If low, or no immunity is shown, proof of vaccination record must be provided. Once re-vaccinated, titers will need to be drawn again approximately 30 days post vaccination administration.

HEPATITIS B: (ANNUAL)

Positive antibody within 365 days and must be repeated annually. Negative HepB antigen within 30 days prior to start date. If antibody is negative, the antigen is required and must be done every 6 months AND proof of vaccination or declination is required. If positive for antigen, a repeated HBeAG and HBeAB is required. If HBeAB is negative, a third draw to confirm results is required.

TUBERCULOSIS (PPD): (ANNUAL AFTER FIRST INITIAL 2 STEP)

Upon initial submission a 2-step PPD is required. Following the initial requirement a 1-step PPD test or a negative QuantiFERON TB Gold result is required annually and must have the applicant's name, facility and facility address where administered, month, day, and year read, NEGATIVE or POSITIVE results, and signature of the individual reading the test. The reader cannot be the applicant. If the PPD test is positive, an annual questionnaire and a chest x-ray is required every 5 years.

FLU DOCUMENTATION: (ANNUAL)

FLU vaccination administration record or declination record must be completed annually.

DIALYSIS SKILL'S TESTING: (ANNUAL – for Applicants interested in Dialysis Positions ONLY)

Please download our "Dialysis Test" from our website and complete the exam. Applicant's name must be on each sheet and dated. This exam tests the competency of hemodialysis and peritoneal Dialysis treatment.

DIALYSIS SKILLS CHECKLIST: (ANNUAL – for Applicants interest in Dialysis Positions ONLY)

*It is important to note that many facilities have individual or unique requirements that may not be listed above. Facilities at any time may ask for additional or updated documentation in which you may or may not provide.



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