



Application for Employment

Today's Date: _____

Personal Data					
Last Name			First Name	Middle	SSN
Home Address		City	State	Zip	
Home Phone		Cell Phone		Pager	

Emergency Contact Information		
Name of Emergency Contact	Relation	Emergency Telephone Number

Job Information

Position (Job Class) Applying for:

RN PT LPN/LVN CNA OT PTA Clerical Other _____ Date Available: _____

Work Experience/Skills

Please list the number of years you have experience in each area (min 1 year exp.) and are clinically competent to work:

- | | | | |
|--------------------------------|------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Burn | <input type="checkbox"/> ENT | <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Detox/Drug Rehab |
| <input type="checkbox"/> L & D | <input type="checkbox"/> Rehab | <input type="checkbox"/> Telemetry | <input type="checkbox"/> Post Partum |
| <input type="checkbox"/> MICU | <input type="checkbox"/> Nursery | <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Orthopedics |
| <input type="checkbox"/> NICU | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Stepdown | <input type="checkbox"/> Mother/Baby |
| <input type="checkbox"/> PACU | <input type="checkbox"/> Geriatric | <input type="checkbox"/> Oncology | <input type="checkbox"/> Recovery Room |
| <input type="checkbox"/> SICU | <input type="checkbox"/> Pedi ICU | <input type="checkbox"/> Neurology | <input type="checkbox"/> Operating Room |
| <input type="checkbox"/> CCU | <input type="checkbox"/> Med/Surg | <input type="checkbox"/> Open Heart | <input type="checkbox"/> Emergency Room |
| <input type="checkbox"/> Other | <input type="checkbox"/> Other | <input type="checkbox"/> Other | <input type="checkbox"/> Other |

Previous Facility Types Worked: Check All That Apply –

Hospital Hospice Nursing Home Rehab Private Duty Assisted Living / Residential Treatment

Language Skills: **Other than English, please check any other languages you speak –**

Spanish French German Other: _____

Check the type of assignment you are available for:

Full-time Part-time Contract Travel



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Check the days of the week you are available to work:

- Monday
 Tuesday
 Wednesday
 Thursday
 Friday
 Saturday
 Sunday
 Holidays available to work: _____

License Type	License/Certification #	State	Expiration Date

Has your professional license ever been suspended, revoked or under investigation? Yes No
 If Yes, Please explain: _____

Certifications: Check all applicable certifications and enter expiration date:

- | | |
|---|--|
| <input type="checkbox"/> ACLS Expiration Date: _____ | <input type="checkbox"/> Other Expiration Date: _____ |
| <input type="checkbox"/> BCLS Expiration Date: _____ | <input type="checkbox"/> IV Expiration Date: _____ |
| <input type="checkbox"/> CPR Expiration Date: _____ | <input type="checkbox"/> NALS Expiration Date: _____ |
| <input type="checkbox"/> PALS Expiration Date: _____ | |

Work Experience: List all of your work experience beginning with your most recent job. You will be asked to explain all gaps in employment. Attach additional sheet(s) if necessary.

Facility/Employer Name	Date Employed From: _____ To: _____
Address	Title
City/State/Zip Country	Unit
Number of Beds in Unit: _____ In Hospital: _____	Name of Current Immediate Supervisor
Describe duties and specialty areas:	Telephone #:
Pay Rate/Salary: Hourly _____ Yearly _____	May We Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No – If no, why?
Reason for leaving:	If this was a travel assignment, name of agency:
Are your employment records listed under another name? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what name?	Supervisory Experience: <input type="checkbox"/> Yes <input type="checkbox"/> No – How often?



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Facility/Employer Name	Date Employed
Address	From: _____ To: _____
City/State/Zip	Title
Country	Unit
Number of Beds in Unit: _____	Name of Current Immediate Supervisor
In Hospital: _____	
Describe duties and specialty areas:	Telephone #:
Pay Rate/Salary: Hourly _____ Yearly _____	May We Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No – If no, why?
Reason for leaving:	If this was a travel assignment, name of agency:
Are your employment records listed under another name? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, what name?	Supervisory Experience: <input type="checkbox"/> Yes <input type="checkbox"/> No – How often?
Facility/Employer Name	Date Employed
Address	From: _____ To: _____
City/State/Zip	Title
Country	Unit
Number of Beds in Unit: _____	Name of Current Immediate Supervisor
In Hospital: _____	
Describe duties and specialty areas:	Telephone #:
Pay Rate/Salary: Hourly _____ Yearly _____	May We Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No – If no, why?
Reason for leaving:	If this was a travel assignment, name of agency:
Are your employment records listed under another name? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what name?	Supervisory Experience: <input type="checkbox"/> Yes <input type="checkbox"/> No – How often?

Please list any other work related information you think would be helpful to us in considering you for employment, such as specialized training, certifications, additional work experience, etc.



Additional Information:

- 1. Are you legally authorized to work in the USA? Yes No
- 2. Have you ever been convicted of a felony? Yes No
- 3. Can you pass a pre-employment drug test? Yes No
- 4. How were you referred to Summit Home Health Care?
 Newspaper Trade Publication Job Fair/Open House Internet Site
 Company Employee – Name: _____

I understand that I **must** report all accidents to my immediate supervisor **and** to Summit Home Health Care - - No MATTER HOW SLIGHT. Yes

I also understand that I must wear all required personal protection equipment (PPE). Yes
The penalty for not wearing PPE is disciplinary action, up to and including termination.

Signature

ACKNOWLEDGMENT (Please read carefully and sign)

In signing this application, I certify that I have read and fully understand the questions asked in this application and that all answers given by me are true, accurate, and complete. I also understand that the omission, concealment, or misrepresentation of any fact on this application or during any interview for employment may jeopardize my chances for employment and be cause for my immediate dismissal from employment.

I give Summit Home Health Care permission to use any information in this application to enable it and its agents to verify the information contained in this application I also authorize present and former employers, educational institutions I have attended, credit agencies, all references, and any other persons to answer all questions asked by Summit Home Health Care with regard to any of the subjects covered by this application. I also understand that in connection with my application for employment or my employment, Summit Home Health Care may conduct a criminal background investigation and that my employment may be contingent on the results of such investigation. I release Summit Home Health Care, its agents, and all affiliated entities, as well as any person or situation that provides any information about me, from any and all liability whatsoever resulting from any such investigation or the disclosure of such information.

In consideration of my employment and of my being considered for employment by Summit Home Health Care, I agree to abide by all rules and regulations, which I understand are subject to change at any time for any reason without prior notice. I also understand that if employed, I will be an employee at will and employed for no definite period of time. I understand that either Summit Home Health Care or I can terminate my employment at any time, with or without cause and with or without advance notice. I further understand that no communication, whether oral or written, by any representative of Summit Home Health Care, at any time, can constitute a contract of employment. No representative or agent of Summit Home Health Care, has the authority to enter into any agreement for employment for any specific period of time or to make any agreement contrary to the foregoing.

I am willing to submit to a physical examination, including the analysis for the detection of the use of unlawful drugs or substances in accordance with the applicable laws. If I receive an offer of employment I agree that my continued employment may be contingent on the results.

I understand that Summit Home Health Care is not involved in the day-to-day supervision or decision concerning patient care or dentistry. This remains with the Professional as part of the Professional's practice. The Professional fully indemnifies Summit Home Health Care against any and all liability and responsibility associated with his or her professional duties. The Professional maintains his or her license as required by law, professional liability coverage and other responsibilities as found under state prime contract law.

I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.

Applicant Signature _____ Date _____