



Application for Employment

Thank you for applying for a position with our Company. We appreciate the time you are giving to complete this application. It is important that you fully and accurately complete this form yourself and indicate the position(s) for which you wish to be considered. The following must be filled out completely for your application to be considered.

Name: _____
Last First Middle

Have you ever used another name? Yes No If yes, what: _____

Home Telephone: (____) _____ Other Telephone: (____) _____

Date of Birth: _____ Social Security #: _____

Have you ever used another Social Security Number? Yes No

Present Address: _____
No. Street City State Zip

Mailing Address: _____
(If different) No. Street City State Zip

Emergency Contact: _____ Phone: _____

Employment Desired:

Position applying for: _____

If hired, on what date can you start work? _____ Salary desired? _____

References:

How did you hear about our company? _____

List below three persons that have actually **supervised you** who have worked for/with within the last three years. A charge RN or supervisor would ideal.

Name	Title	Organization	Phone
1.) _____	_____	_____	_____
2.) _____	_____	_____	_____
3.) _____	_____	_____	_____



Education and Training

Name and State	Degree Obtained	Date Graduated
High School: _____	_____	_____
College/University: _____	_____	_____
Vocational/Business: _____	_____	_____

Employment History:

List below all present and past employment, starting with your most recent employer:

Are You Employed Now? Yes No May we contact your present employer? Yes No

Name of Employer: _____

Address: _____

No. Street City State Zip

Telephone: (____) _____ Your Supervisor's Name: _____

Position Held: _____

Date of Employment: From: _____ To: _____

Earnings: Starting: _____ / Ending: _____

Exact Reason for Leaving: _____

Name of Employer: _____

Address: _____

No. Street City State Zip

Telephone: (____) _____ Your Supervisor's Name: _____

Position Held: _____

Date of Employment: From: _____ To: _____

Earnings: Starting: _____ / Ending: _____

Exact Reason for Leaving: _____

Name of Employer: _____

Address: _____

No. Street City State Zip

Telephone: (____) _____ Your Supervisor's Name: _____

Position Held: _____

Date of Employment: From: _____ To: _____

Earnings: Starting: _____ / Ending: _____

Exact Reason for Leaving: _____



License Information

Answer the following questions if applying for a professional position:

Are you licensed for the job applied for? Yes No Type of license (RN/LVN/CNA): _____

Issuing state: _____ License/certification number: _____ Has your license ever

lapsed, been revoked or suspended? Yes No If yes, state reason(s), date of lapse,

revocation or suspension and date of reinstatement: _____

Have you ever, under your name or another name, been convicted of (or pleaded guilty or nolo contendere to) a Felony or Misdemeanor? Yes No

Have you ever, under your name or another name, been convicted of a crime, which resulted with your being in prison and released from prison or paroled? Yes No

(Do not identify convictions for marijuana-related offenses that are more than two years old; or convictions for which the criminal record has been expunged, sealed or eradicated by the court; or, misdemeanor convictions for which any probation has been completed and the case dismissed by the court.)

If yes, explain each conviction fully, when, where and of what you were convicted and disposition of the case(s):

Are you currently under arrest, or released on bond or your own recognizance, pending trial for a criminal offense? Yes No

If yes, state the nature of the crime charged, and when and where trial is pending:

The following section is for employment within the healthcare industry in California

Please answer the following only if:

1. The position for which you are applying will provide you access to patients. Have you ever been arrested for a sex related crime? Yes No If Yes, Please Explain:

2. The position for which you are applying will provide you access to drugs or medications. Have you ever been arrested for a drug related crime? Yes No Please Explain:



Authorization

Personally completed this form honestly and accurately

By my signature below, I promise that I have personally completed this application. I declare under penalty of perjury that the information provided in this employment application (and accompanying resume, if any) is true and complete, and I understand that any false information or significant omissions may disqualify me from further consideration for employment, and may be justification for my dismissal from employment if discovered at a later date. I understand that any job offer is conditional based on the satisfactory review of my qualifications including any and all background or drug screening which may be required.

Drug and Alcohol screening

I give permission for a pre-employment drug/alcohol screening exam, and, if the company makes a conditional job offer, I give permission for a complete employment physical and mental examination. I also consent to the appropriate release of any and all medical information, as may be deemed necessary. (See separate Agreement)

Authorization to obtain information

I voluntarily and knowingly authorize any present or past employer; supervisor; administrator; educational institution; law enforcement agency; state, local, or federal agency; credit bureau; collection agency; private business; military branch; the national personnel records center; personal reference; and/or other persons; to give records or information they may have concerning my criminal history, motor vehicle report, educational history, licensing, employment (including character, earnings history and reasons for termination) or any other information requested by the company requested to determine my eligibility for employment.

Release

I voluntarily waive all recourse and release any company, individual or organization from liability for complying with any request from the company or agents of the company (including any consumer reporting agency) to obtain any information from any source whatsoever relating to my application for employment. I further release the company or any individual within the company regarding the use any information received which may have bearing on my application for employment.

Notification and compliance with rules

I agree to immediately notify the company if I should be convicted of a crime while my job application is pending, or during my employment if hired. If I become employed, in consideration of my employment, I agree to comply with the rules, regulations, policies and procedures of the company.

I certify that all of the information provided by me on this Application is true and accurate.

Signature: _____

Date: _____

Print Name: _____



Hepatitis B Vaccine

OSHA requires all health care workers at risk to have the opportunity to have the Hepatitis B Vaccination offered to them by their employer.

1. If you have completed the vaccination series, please indicate such at the appropriate statement, date and sign the bottom of this letter.
2. If you are in the process of receiving the series, please indicate, date and sign at the bottom of this letter. Please indicate if you require a dose of the vaccine while working on this contract. Capability Healthcare will provide it to you at no cost.
3. If you decline to have the Hepatitis B Vaccine indicate this at the bottom of this letter, sign and date.

*****Please Choose Only One*****

I understand the OSHA guidelines and have completed the Hepatitis B Vaccine series
Signed: _____ Date: _____

I understand the OSHA guidelines and need #____ or booster, in the series. Please make arrangements with us to receive this dose of the vaccine.
Signed: _____ Date: _____

I understand the OSHA guidelines and DECLINE the Hepatitis B Vaccination.
Signed: _____ Date: _____



TB Questionnaire

- 1.) Have you ever had a positive TB skin test? Yes No
- 2.) Have you ever had an abnormal chest x-ray?
If yes, how long ago _____ Yes No
- 3.) Have you had a persistent cough lasting for more than 3 weeks? Yes No
- 4.) Do you cough up blood or mucous? Yes No
- 5.) Have you lost your appetite? Yes No
- 6.) Have you lost weight (more than 10 pounds) in the last two months without trying to? Yes No
- 7.) Do you currently have night sweats? Yes No
- 8.) Have you recently had your mucous tested for TB? Yes No
- 9.) Have you ever had a positive TB test on mucous that you coughed up? Yes No
- 10.) Have you ever been told you have Infectious Tuberculosis?
If yes, how long ago _____ Yes No
- 11.) Have you ever been treated with medication for Infectious TB?
If so, how long ago _____, and did you take all the TB medicine until the health care professional told you that you were finished? Yes No
- 12.) Do you live with or have you been in close contact with someone who was recently diagnosed with TB?
(i.e. shelter roommate, close friend, relative). Yes No

Employee Signature: _____ Date: _____



Varicella (Chicken Pox) Declaration Form

I had the chickenpox when I was a child.

Month/Day/Year of Chicken Pox: _____

Signature: _____



Licensed Vocational/Practical Nurse Job Description

Summary

Assume responsibilities for direct nursing care of assigned patients under the supervision of a registered nurse or physician in patient care area. Provides nursing services to patients and families in accordance with the scope of the LPN as defined by the Washington Board of Nursing

Duties and Responsibilities

- Provide and document direct nursing care of assigned patients under the supervision of a registered nurse or physician. Nursing care is guided by the physician orders and the nursing plan of care. Patient response to care is reported to a registered nurse for evaluation, intervention and modification of the plan of care. Assist other health care personnel in the delivery of patient care.
- Participate in maintaining the environment of care including equipment and other material resources.
- Participate in own professional development by maintaining required competencies and attending educational offerings. Supports the development of other staff and formal learners.
- Perform other related duties incidental to the work described herein.

Education

Graduation from an accredited Practical Nurse program

Experience

A minimum of one year of current experience

Degrees, Licensure, and/or Certification

Current LPN license from the state of Washington

Knowledge, Skills, and Abilities:

- Knowledge of scope of licensed practical nurse, ability to delegate to the CNA
- Considerable knowledge of the care and treatment of patients and special procedures that apply to practical nursing
- Able to independently seek out resources and work collaboratively



- Able to communicate clearly with patients, families, visitors, healthcare team, physicians, administrators and others
- Able to teach patients and families in accordance with the nursing plan of care
- Able to use sensory and cognitive functions to process and prioritize information, treatment, and follow-up
- Competent in BLS and/or other specialized life support requirements designated by work area or unit assigned
- Able to use fine motor skills
- Able to record activities and document interventions
- Able to withstand prolonged standing and walking with the ability to move or lift at least fifty pounds
- Able to remain focused and organized
- Working knowledge of sterile techniques and special procedures that are applicable to work performed
- Working knowledge of sanitation, personal hygiene and basic health and safety precautions applicable to work in a hospital or Long Term Care (LTC) facility
- Working knowledge of infection control procedures and safety precautions
- Ability to understand English and follow oral and written instructions

Signature: _____ Date: _____



Education Acknowledgment Form

This is to acknowledge that I have received training on and a copy of Capability Healthcare's Annual Education Booklet which contains information and verification of procedures related to the following:

Blood borne Pathogens and Universal Precautions
Infection Control
Latex Allergies
Hospital and Fire Safety
Emergency Preparedness
Security and Workplace Violence
Tuberculosis Education
HIPAA Education
Patient Rights
Ethics
Risk Management
Age Specific Competency
Use of Restraints
Abuse Reporting
Cultural Diversity
Sexual Harassment
Conscious Sedation
Advance Directives
Organ Donation
Medication Errors
Preventing Workplace Injuries
National Patient Safety Goals

In addition to our annual Education Booklet, Capability Healthcare will provide ongoing education curriculum via nurse.com for any employee (6 months+ tenure) of our organization. Please contact your recruitment manager with any further questions.

I understand that the above mentioned materials provide guidelines and summary information about the company's policies and procedures. I also understand that it is my responsibility to read, understand, become familiar with, and comply with the standards that have been established.

Signature: _____

Print Name: _____

Date: _____



POLICIES & PROCEDURES / ORIENTATION ACKNOWLEDGMENT

This is to certify that I have received a copy of the Policies & Procedures document during my orientation with Capability Healthcare.

I will familiarize myself with the manual and I understand that I am governed by it.

I am also familiar with the policies and procedures of my current assignment.

I understand that violation of any of the rules and regulations set forth therein can subject me to discipline and/or termination.

Signature: _____

Print Name: _____

Date: _____



What Happens Now?

Thank you for applying with Capability Healthcare. Once we get your application, we begin the process of putting together your employee file, and completing background checks. In the meantime, please return to our office the following checked items:

- Proof of MMR
- Hep B series or positive titer
- Proof of Tb (PPD Skin Test within one year)
- Varicella titer or past history
- Completed 10 panel Urine Drug Screen
- Completed Competency Exams from nursetesting.com
- Completed Skills Checklist
- Two Professional References (from a direct supervisor)
- Copy of current license
- Copy of CPR / ACLS / PALS / NRP (if applicable)
- Other: _____

Once your chart is complete, we will contact you to determine a start date. You can pre-book up to one year in advance, or call us an hour before a shift and inform us if you would like to work. You can also specify how frequently or infrequently you would like to be contacted by us.

Contact Information:

Capability Healthcare
410 Bellevue Way SE, Suite 301
Bellevue, WA 98004
425.679.5779 (office)
425.930.3030 (fax)

Once again, thank you, and please feel free to contact us at any time and let us know what we can do better to serve you.