CAPABILITY
HEALTHCARE

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.) _____

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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: ____

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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:
_____
_____

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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: _____

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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: _____

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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?	☐ Yes	☐ No
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: _____

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Varicella (Chicken Pox) Declaration Form

I had the chickenpox when I was a child.

Month/Day/Year of Chicken Pox: _____

Signature: _____

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Registered Nurse Job Description

Summary

Responsible for the delivery of patient care through the nursing process of assessment, diagnosing, planning, implementation, and evaluation Responsible for directing and coordinating all nursing care for patients based on established clinical nursing practice standards; Collaborates with other professional disciplines to ensure effective and efficient patient care delivery and the achievement of desired patient outcomes; Serves in the Resource Nurse role when oriented and as directed; Utilizes knowledge of patient's age and cultural diversity into the provision of patient care; Contributes to the provision of quality nursing care through performance improvement techniques that demonstrate positive outcomes in patient care

Duties and Responsibilities

- Plan, provide, supervise and document professional nursing care utilizing the nursing process for patients in accordance with physician orders and established policies and procedures. Use professional nursing judgment to individualize the plan of care based on assessment of the patient's baseline needs and response to care.
- Delegate tasks and supervises the activities of other licensed and unlicensed care providers.
- Assist other nursing personnel in the delivery of nursing care and act as team leader or charge nurse for a group of patients or an entire unit as assigned.
- Monitor and initiate corrective action to maintain the environment of care including equipment and material resources.
- Participate in own professional development by maintaining required competencies, identifying learning needs and seeking appropriate assistance or educational offerings.
- May participate in the interview process and make hiring recommendations.
- Perform other related duties incidental to the work described herein.

Education

Graduation from an accredited Bachelor of Science in Nursing, Associate Degree in Nursing or Nursing Diploma program

Experience

A minimum of one year current experience

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Degrees, Licensure, and/or Certification

Must have current or compact licensure in the state of Washington

Knowledge, Skills, and Abilities

- Knowledge of scope of the registered nurse, licensed practical nurse and CNA
- Knowledge of and appropriate application of the nursing process
- Knowledge of professional theory, practice and procedure
- Ability to assess nursing needs of acute and chronically ill patients and their families
- Able to independently seek out resources and work collaboratively
- Ability to establish and maintain effective working relationships
- 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
- Able to use fine motor skills
- Competent in BLS and/or other specialized life support requirements designated by work area
- Able to record activities, document assessments, plan of care, interventions, evaluation and re-evaluation of patient status
- 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 procedures and techniques involved in administering routine and special treatments to patients
- Working knowledge of infection control procedures and safety precautions

Signature: _____ Date: _____

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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: _____

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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: _____

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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.