



## 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:** \_\_\_\_\_



## **Certified Surgical Technician Job Description**

### **Summary**

Provides technical specialty support in the care and preparation of patients undergoing complex and/or high-risk surgical procedures. Functions as a member of the surgical team in the operating room. Performs specialized technical support activities as appropriate to the position.

### **Duties and Responsibilities**

- Provides technical assistance to surgical staff in the preparation of patients for surgery and in the preparation of operating room facilities, equipment, instruments, and supplies.
- Prepares instruments, sutures, sponges, and/or other surgical supplies as needed during procedures, as appropriate; assists as requested with routine surgical procedures.
- Performs specialized surgical support activities and procedures, as appropriate to the nature of the surgery.
- Performs cleaning and maintenance of the operating room between cases and at the end of the day; decontaminates, assembles, and sterilizes instruments, facilities, equipment, and supplies.
- Carries out preventive maintenance and troubleshooting of complex and/or advanced surgical instruments and equipment.
- Performs post-operative wound care procedures as appropriate, to include suture removal and application and/or changing of dressings.
- Gathers pre-operative and post-operative patient data using various media, instruments, and/or equipment, as appropriate; maintains relevant databases.
- May prepare surgical specimen forms for laboratory analysis, and assist in the maintenance and care of specimens.
- Procures and maintains inventories of instruments, supplies, and equipment used in the operating room.
- Follows established departmental policies, procedures, and objectives, continuous quality improvement objectives, and safety, environmental, and/or infection control standards.
- Performs miscellaneous job-related duties as assigned.





**Education**

Completion of a 24-month AMA approved School of Surgical Technology

**Experience**

ARST certification with a minimum of one year of current experience

**Degrees, Licensure, and/or Certification:**

ARST certification and BLS certification

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.