

Today's Date:

Personal Data

Last Name	First Name	Middle	Social Security Number
Home Address	City	State	Zip
Cell Phone	Home Phone	Email Address	
Date of birth			

Emergency Contact Information

Name of Emergency Contact	Relation	Emergency Telephone Number/ Email Address
---------------------------	----------	---

Are you eligible for employment within the United States?..... <i>Proof of citizenship or immigration status will be required upon employment.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can you pass a pre-employment criminal history check inquiry and a drug screening test?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you now or have you ever been sanctioned by or excluded by the Health Authority in any state?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been employed by Vancouver Home Health Care Agency before?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Please explain?.....	
Do any of your friends or relatives are work in Vancouver Home Health Care Agency LLC Now?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, give name and relationship.....	

Education and Professional Development

	Name and address of School or University	Major Course of Study	Number of Years Completed	Degree / Diploma
High School				
Trade School				
College Undergraduate				
Other (specify)				

Professional Reference

Name of Reference	Address	Association	Phone #	Email Address	Years Known

Specialized Skills

- | | |
|---|---|
| <input type="checkbox"/> Analytical Skills | <input type="checkbox"/> Computer Skills |
| <input type="checkbox"/> Data entry | <input type="checkbox"/> Interpersonal and Communication Skills |
| <input type="checkbox"/> Legal Knowledge | <input type="checkbox"/> Medical billing and coding |
| <input type="checkbox"/> Medical Terminology | <input type="checkbox"/> medical transcriptionist |
| <input type="checkbox"/> Organizational And Clerical Skills | <input type="checkbox"/> Problem Sensitivity Skills |
| <input type="checkbox"/> Problem-Solving Skills & Critical Thinking | <input type="checkbox"/> Typing WPM: |

Computer Software:

Medical information system:

Other Qualifications

Please summarize special job-related Skills and qualifications or additional information you feel may be helpful to us on considering your application.

.....

.....

.....

.....

.....

.....

.....

.....

.....

Note to Applicants: DO NOT ANSWER THIS QUESTION UNLESS YOU HAVE BEEN INFORMED ABOUT THE REQUIREMENTS OF THE JOB FOR WHICH YOU ARE APPLYING.

Can you perform the essential functions of the job, for which you are applying for, either with or without reasonable accommodation?YES .NO

Career Information

Position (Job Class) Applying for:

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

Work Experience and 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 that you have experience : Please 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

When are you going to be available for work : Please check all that Apply –

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

Certifications: Please check all applicable certifications and enter expiration date:

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

License Type	License/Certification #	State	Expiration Date
License Type	License/Certification #	State	Expiration Date
License Type	License/Certification #	State	Expiration Date

Has your professional License/Registration/Certification ever been under review, revoked suspended or under investigation because of activity related to patient care or the performance of your duties in your profession?

Yes No

If Yes, Please explain:

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.

Employment Experience

Facility/Employer Name	Date Employed
Address	From:To: 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?
Facility/Employer Name	Date Employed
Address	From:To: 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?

Vancouver Home Health Care Agency LLC consider all applications for all positions without regard to race, color, religion, creed, gender, national origin, age, disability, sexual orientation, citizenship status, genetic information or any other legally protected status.

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

I also understand that I must wear all required personal protection equipment (PPE). Yes No
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 Vancouver Home Health Care Agency LLC 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 Vancouver Home Health Care Agency LLC 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, Vancouver Home Health Care Agency LLC may conduct a criminal background investigation and that my employment may be contingent on the results of such investigation. I release Vancouver Home Health Care Agency LLC, 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 Vancouver Home Health Care Agency LLC, 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 Vancouver Home Health Care Agency LLC 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 Vancouver Home Health Care Agency LLC, at any time, can constitute a contract of employment. No representative or agent of Vancouver Home Health Care Agency LLC, 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 Vancouver Home Health Care Agency LLC 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 Vancouver Home Health Care Agency LLC 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:

At Vancouver Home Health Care Agency, Caring and Compassion is our business.