

Application for Employment

Have you applied or worked with any of the First Assist branches before? Yes No If yes, which branch?

_____ Social Security #: Application Date:

Last Name: Middle Name: First Name:

How did you hear about us? Internet Magazine Convention Referral Other

Please elaborate on your selection:

Current Address:

Street Address: City: State: Zip:

Permanent Address (if different):

Street Address: City: State: Zip:

Contact Information:

Home Phone: Cell Phone: Work Phone:

Date available to start: Best time to reach you: Email:

Other names under which you have been employed:

Emergency Contact Information:

Name: Relationship: Phone:

Street Address: City: State: Zip:

Position Applying for:

Current Specialty: Other Specialty:

Licensure: (Please include photocopies of licenses held).

License Type: License #: State/Province: Exp Date:

License Type: License #: State/Province: Exp Date:

License Type: License #: State/Province: Exp Date:

Certification: (Please include photocopies of certifications held).

ACLS Exp. Date: CNOR Exp. Date: NRP Exp. Date:

BLS Exp. Date: CNRN Exp. Date: PALS Exp. Date:

CCRN Exp. Date: ENPC Exp. Date: RNC Exp. Date:

CEN Exp. Date: FHM Exp. Date: TNCC Exp. Date:

CHEMO Exp. Date: Other: Exp. Date:

Have you passed the NCLEX? Yes No

Software Competency: (Please check all that apply).

Cerner Meditec Eclipsys Other:

Has any professional license held by you in any state ever been investigated, suspended or non-renewed? Yes No

Have you ever been convicted of a crime other than a minor traffic violation? Yes No

(Exception for California applicants: marijuana-related convictions over two years old and offenses for which you participated in any pretrial or posttrial diversion program should not be disclosed).

Has any malpractice suit ever been brought against you? Yes No

Are you aware of any circumstance which may result in a malpractice claim or suit being made or brought against you? Yes No

Has professional liability insurance for you ever been denied, cancelled or non-renewed? Yes No

If you responded "yes" to any of the above, please give full details on a separate sheet.

Are you either a U.S. Citizen or can you submit verification of your legal right to work in the U.S? Yes No

If you will be employed on a visa, please specify type of work visa:

Education

Name of College:

City: State: Graduation Date: Degree(s)Received:

Graduate School:

City: State: Graduation Date: Degree(s)Received:

Other (if applicable):

City: State: Graduation Date: Degree(s)Received:

Employment Profile

Are you currently employed? Yes No If yes, may we contact your present employer? Yes No

Please indicate all of your employment for the past ten (10) years, beginning with your most recent employer. Please list each facility in which you have worked.

Facility/Employer Name: Unit/Floor/Dept.:

City: State: Zip Code:

Starting Date: End Date: Reason for leaving:

Position Held: Unit Specialty:

Direct Supervisor's Name and Title: Supervisor's Phone:

Other Supervisor's Name: Supervisor's Phone:

Travel Assignment? Yes No Travel Company: Per-diem Agency? Yes No

Facility/Employer Name: Unit/Floor/Dept.:

City: State: Zip Code:

Starting Date: End Date: Reason for leaving:

Position Held: Unit Specialty:

Direct Supervisor's Name and Title: Supervisor's Phone:

Other Supervisor's Name: Supervisor's Phone:

Travel Assignment? Yes No Travel Company: Per-diem Agency? Yes No

Facility/Employer Name: Unit/Floor/Dept.:
City: State: Zip Code:
Starting Date: End Date: Reason for leaving:
Position Held: Unit Specialty:
Direct Supervisor's Name and Title: Supervisor's Phone:
Other Supervisor's Name: Supervisor's Phone:
Travel Assignment? Yes No Travel Company: Per-diem Agency? Yes No

Facility/Employer Name: Unit/Floor/Dept.:
City: State: Zip Code:
Starting Date: End Date: Reason for leaving:
Position Held: Unit Specialty:
Direct Supervisor's Name and Title: Supervisor's Phone:
Other Supervisor's Name: Supervisor's Phone:
Travel Assignment? Yes No Travel Company: Per-diem Agency? Yes No

Facility/Employer Name: Unit/Floor/Dept.:
City: State: Zip Code:
Starting Date: End Date: Reason for leaving:
Position Held: Unit Specialty:
Direct Supervisor's Name and Title: Supervisor's Phone:
Other Supervisor's Name: Supervisor's Phone:
Travel Assignment? Yes No Travel Company: Per-diem Agency? Yes No

Facility/Employer Name: Unit/Floor/Dept.:
City: State: Zip Code:
Starting Date: End Date: Reason for leaving:
Position Held: Unit Specialty:
Direct Supervisor's Name and Title: Supervisor's Phone:
Other Supervisor's Name: Supervisor's Phone:
Travel Assignment? Yes No Travel Company: Per-diem Agency? Yes No

Please document reasons for periods you were not employed.

Availability:

- Sunday Monday Tuesday Wednesday Thursday Friday Saturday
- Days Nights Swing

I certify that the information provided in this application is true and correct. I understand that providing false, incomplete or misleading responses will result in the termination of my employment. I authorize First Assist, Inc. to verify the information I have provided and to contact past employers and references. I expressly release all such persons from liability for providing information requested by First Assist. I further authorize First Assist, Inc. to use this application and any additional information obtained for the purpose of evaluating my eligibility for employment or assignment. I also expressly authorize First Assist, Inc. to share such information with any First Assist client at any time that I seek or maintain employment or assignment with such client and I expressly release First Assist, Inc. from any liability which may result from obtaining, releasing and making an employment decision based upon, such information. I agree that First Assist may send me employment opportunity and related information via fax, email or any other means.

Signed By

Date

Age Specific Checklist Self Evaluation

Name:

Date:

I am confident that I can demonstrate the knowledge and skills necessary to provide care based on physical, psychosocial, educational, safety and related criteria appropriate to the patients serviced in my assigned area who are in the age groups noted in the chart below. The skills and knowledge needed to provide such care were gained through education, training, and experience.

| | <i>I possess the minimum knowledge, skills and abilities for the following patient populations:</i> | | | | | | | | | | | | | | |
|---|---|----|-----|------------|----|-----|-------------|----|-----|-------|----|-----|------------|----|-----|
| | Neo-Natal | | | Pediatrics | | | Adolescence | | | Adult | | | Geriatrics | | |
| | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A | Yes | No | N/A |
| Knowledge of growth and development | | | | | | | | | | | | | | | |
| Ability to assess age specific data | | | | | | | | | | | | | | | |
| Ability to provide age specific data | | | | | | | | | | | | | | | |
| Possess communication skills necessary to interpret age specific response to treatment | | | | | | | | | | | | | | | |
| Ability to involve family or significant others in decision making related to plan of care | | | | | | | | | | | | | | | |

Signed By _____

Date _____

Notification of Criminal Background Check

YOU ARE HEREBY NOTIFIED THAT FIRST ASSIST, INC. WILL OBTAIN CRIMINAL BACKGROUND CHECKS, NOW OR AT ANY TIME YOU SEEK OR MAINTAIN EMPLOYMENT, ASSIGNMENT OR PLACEMENT WITH OR THROUGH FIRST ASSIST. SUCH REPORTS WILL BE REQUESTED FROM ACXIOM INFORMATION SECURITY SERVICES, OR SUCH OTHER INVESTIGATIVE AGENCY AS FIRST ASSIST, INC. MAY DETERMINE IN ITS SOLE DISCRETION.

Employee Name (Please Print):

Please sign below to acknowledge receipt of this Notice.

Signed By

Date

Authorization to Obtain Background Checks

I, _____, **[Instruction to Applicant/Employee: Please print your name]**
 expressly authorize First Assist, Inc. to obtain background checks in accordance with client requirements, now or at any time I seek or maintain employment, assignment or placement with or through First Assist. Such background checks will consist of a criminal background check, social security number trace, sex offender registry check, license verification and OIG exclusion program check, and may include a motor vehicle check, employment and education verification and other checks if required by the client. I further authorize First Assist, Inc. to use the information obtained from such report(s) for the purpose of evaluating my eligibility for employment, assignment, placement or advancement. I also expressly authorize First Assist, Inc. to share such information with any First Assist client at any time that I seek or maintain employment, assignment or placement with such client.

I expressly release First Assist, Inc. from any and all liability of whatever kind and nature which, at any time, may result from obtaining, releasing and making an employment decision based upon, the above-authorized information.

I certify that the information provided below is true and correct.

 Signed By Date

Social Security #: Birth Date: Maiden Name:
 Driver's License #: State of issue:
 Address of current residence: Address 2:
 City: State: Zip: -

Addresses of all other residences for the past ten years:

Address: Address 2:
 City: State: Zip: -
 Dates: to

Address: Address 2:
 City: State: Zip: -
 Dates: to

Address: Address 2:
 City: State: Zip: -
 Dates: to

Consent to Substance Testing

I, _____, an employee of First Assist, Inc. ("the Company"), acknowledge and expressly agree, as follows:

1. I have been given a copy of the Company's Drug and Alcohol Free Policy ("the Policy"). I have read the Policy, and I acknowledge that I have been given an opportunity to ask, and have my questions answered, about it, which is section 1.50 in the Field Employee Manual.

2. I understand and expressly acknowledge all of my rights and obligations under the Policy. I further acknowledge that it is an express condition of my continued employment with the Company that I: (a) must sign this Consent to Substance Testing, and (b) if requested to do so, must promptly submit to alcohol and/or drug abuse test(s) in accordance with the Policy, I consent to such testing.

3. I HEREBY RELEASE FIRST ASSIST, INC., ITS EMPLOYEES, OFFICERS, DIRECTORS, AND SHAREHOLDERS, THE TESTING LABORATORY, AND THE INDIVIDUAL(S) ADMINISTERING SUCH TEST(S) FROM ANY LIABILITY WHATSOEVER ARISING FROM THE ADMINISTRATION OF TEST(S) AS PROVIDED IN THE POLICY, THIS ACKNOWLEDGMENT, INFORMED CONSENT, AND RELEASE OF LIABILITY AND/OR FROM ANY DECISION MADE CONCERNING MY EMPLOYMENT, BASED UPON THE RESULTS OF THE TESTS(S).

4. I expressly agree that the results of any such test(s) may be reported to appropriate officials of the Company. I also expressly authorize First Assist, Inc. to share such information with any First Assist Inc. client at any time that I seek or maintain employment, assignment or placement with such client. I further acknowledge that if any of the test results are confirmed as positive, the Company may take appropriate action, including subjecting me to discipline, up to and including discharge.

Please sign below to acknowledge receipt of this Notice.

Signed By

Date

Employee Name (Please Print): _____

Employment Verification

Applicant Name: Date:

Employer Name:

Please return form to: Fax Number:

To whom it may concern:

1. Hire Date: End Date:

2. Job Title:

3. Facility Name:

4. Department Name:

Name of person verifying information:

Signed By

Date

Authorization and Release by Applicant: I am applying for employment with First Assist, Inc. I hereby request and authorize the reference named above to answer all questions that may be asked, and to provide all information that may be requested by First Assist, Inc. in connection with my application. I HEREBY EXPRESSLY RELEASE THE REFERENCE NAMED ABOVE FROM ANY AND ALL LIABILITY OF WHATEVER KIND AND NATURE WHICH, AT ANY TIME, MAY RESULT FROM PROVIDING THE REQUESTED INFORMATION.

Signed By

Date

Hepatitis B Vaccine Declination

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be a risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination at no charge to me.

I am declining the Hepatitis B vaccine because:

- I have received the Hepatitis B Vaccine.
- I have titers that show immunity.
- I have signed the waiver denying the vaccination.
- Other _____

Signed By

Date

Printed Name (full legal name):

Reference Form

| | |
|---|---|
| Applicant Name: <input style="width: 90%;" type="text"/> | Date: <input style="width: 90%;" type="text"/> |
| Reference Name: <input style="width: 90%;" type="text"/> | Facility Name: <input style="width: 90%;" type="text"/> |
| Reference Title: <input style="width: 90%;" type="text"/> | Contact Phone #: <input style="width: 90%;" type="text"/> |
| | Email: <input style="width: 90%;" type="text"/> |
| Please return form to: <input style="width: 90%;" type="text"/> | Phone Number: <input style="width: 90%;" type="text"/> |
| | Fax Number: <input style="width: 90%;" type="text"/> |

To whom it may concern:

The applicant named above has applied to First Assist for employment and has furnished your name as a reference. Please note the Authorization and Release signed by the applicant below and provide us with the answers to the following questions. Your prompt response is appreciated.

1. Reason employment ended:

2. How was his/her attendance? Please check one: Excellent Good Fair Poor

3. What were his/her duties?

4. How were his/her clinical skills? Please check one: Excellent Good Fair Poor

5. What are his/her strong points?

6. Any areas needing improvement?

| | | | |
|--|--|----------------------|--|
| 7. How did he/she get along with others? Please check one: | | Peers: | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| | | Subordinates: | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| | | Managers: | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |

Additional Comments:

| | |
|---|--|
| SIGNED BY (Reference signature) _____ | DATE _____ |
| Evaluation taken by: <input style="width: 90%;" type="text"/> | Date: <input style="width: 90%;" type="text"/> |

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| | |
|---------------------------------------|------------|
| SIGNED BY (Applicant signature) _____ | DATE _____ |
|---------------------------------------|------------|

Reference Form

| | |
|---|---|
| Applicant Name: <input style="width: 90%;" type="text"/> | Date: <input style="width: 90%;" type="text"/> |
| Reference Name: <input style="width: 90%;" type="text"/> | Facility Name: <input style="width: 90%;" type="text"/> |
| Reference Title: <input style="width: 90%;" type="text"/> | Contact Phone #: <input style="width: 90%;" type="text"/> |
| | Email: <input style="width: 90%;" type="text"/> |
| Please return form to: <input style="width: 90%;" type="text"/> | Phone Number: <input style="width: 90%;" type="text"/> |
| | Fax Number: <input style="width: 90%;" type="text"/> |

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5. What are his/her strong points?

6. Any areas needing improvement?

| | | | |
|--|--|----------------------|--|
| 7. How did he/she get along with others? Please check one: | | Peers: | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| | | Subordinates: | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |
| | | Managers: | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor |

Additional Comments:

| | |
|---|--|
| SIGNED BY (Reference signature) _____ | DATE _____ |
| Evaluation taken by: <input style="width: 90%;" type="text"/> | Date: <input style="width: 90%;" type="text"/> |

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| | |
|---------------------------------------|------------|
| SIGNED BY (Applicant signature) _____ | DATE _____ |
|---------------------------------------|------------|