



EMPLOYMENT FORM

Personal Data

Today's Date: _____	Email Address: _____
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Last Name	First Name	Middle	SSN
Home Address	City	State	Zip

Home Phone	Cell Phone	Pager
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Emergency Contact Information

Name of Emergency Contact	Relation	Emergency Telephone Number
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Job Information

Position (Job Class) Applying for:

- ☐ Rn
- ☐ PT
- ☐ LP/VN
- ☐ HHA
- ☐ OT
- ☐ PTA
- ☐ Other: _____

Date Available: _____

Work Experience/Skills: *Please list the number of years you have experience in each are (min 1 year exp.) and are clinically competent to work. [Ex. Burn: ✓ 2 years]*

Burn: _____	ENT: _____	Pediatrics: _____	Detox/Drug Rehab: _____
L&D: _____	Rehab: _____	Telemetry: _____	Post Partum: _____
MICU: _____	Nursery: _____	Psychiatry: _____	Orthopedics: _____
NICU: _____	Dialysis: _____	Stepdown: _____	Mother/Baby: _____
PACU: _____	Geriatric: _____	Oncology: _____	Recovery Room: _____
SICU: _____	Pedi ICU: _____	Neurology: _____	Operating Room: _____
OCU: _____	Med/Surg: _____	Open Heart: _____	Emergency Room: _____

Previous Family Types Worked (Check all that apply)

- ☐ Hospital
- ☐ Hospice
- ☐ Nursing Home
- ☐ Rehab
- ☐ Private Duty
- ☐ Assisted Living/Residential Treatment

<p>Language Skills: Other than English, please check any other language you speak-</p> <ul style="list-style-type: none"> <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Other: _____ 	<p>Check the type of work you are available for:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Per Visit <input type="checkbox"/> Contract
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Check the days of the week you are available for work:

- ☐ Monday
- ☐ Tuesday
- ☐ Wednesday
- ☐ Thursday
- ☐ Friday
- ☐ Saturday
- ☐ Sunday

Has your professional license ever been suspended, revoked, or under investigation?

- ☐ Yes
- ☐ No

If Yes, please explain: _____

Certifications: *Check all applicable certifications and enter expiration date*

- ☐ ACLS Expiration Date: _____
- ☐ BCLS Expiration Date: _____

- ☐ CPR Expiration Date: _____
☐ PALS Expiration Date: _____
☐ IV Expiration Date: _____
☐ Other: _____ Expiration Date: _____

Work Experience : *List all 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.*

Facility/ Employer Name	Date Employed From: _____ To: _____
Address	Title
City/State/ Zip Country	Telephone #:
Describe duties and speciality areas:	Pay Rate/Salary Hourly: _____ Yearly: _____
Facility/ Employer Name	Date Employed From: _____ To: _____
Address	Title
City/State/ Zip Country	Telephone #:
Describe duties and speciality areas:	Pay Rate/Salary Hourly: _____ Yearly: _____
Facility/ Employer Name	Date Employed From: _____ To: _____
Address	Title
City/State/ Zip Country	Telephone #:
Describe duties and speciality areas:	Pay Rate/Salary Hourly: _____ Yearly: _____

Please list any other work-related information you think would be helpful to us in considering you for employment, such specialized training certifications, additional work experience, etc.

Additional Information

1. Are you legally authorized to work in the USA? Yes: ☐ No: ☐
2. Have you ever been convicted of a felony? Yes: ☐ No: ☐
3. Are you willing to take a pre-employment drug test? Yes: ☐ No: ☐
4. How were you referred to Dreamer Healthcare?: _____

I understand that if I am hired, **I must** report all accidents to my immediate supervisor **and** to Dreamer Healthcare- No matter how SLIGHT Yes: ☐

I also understand that I must wear all required personal protection equipment (PPE): Yes: ☐
The penalty for not wearing PPE is disciplinary action, up to and including termination

Signature

Acknowledgement (*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 Dreamer Healthcare permission to use any information in this application and its agents to verify the information contained in this application. I also authorize presents and former employees, educational institutions I have attended, credit agencies, all references and any other persons to answer all questions asked by Dreamer Healthcare about any of the subjects covered by this application. I also understand that in connection with my application for employment, Dreamer Healthcare may conduct a criminal background investigation and that my employment may be contingent on the results of such investigation. I release Dreamer Healthcare, its agents, and all affiliated entities, as well as any person or situation that provides any information about me, from all liability whatsoever resulting from any investigation or the disclosure of such information

In consideration of my employment and of my being considered for employment by Dreamer Healthcare, 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. I understand that either Dreamer Healthcare 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 Dreamer Healthcare, at any time, can constitute a contract of employment. Norepresentative or Agent of Dreamer Healthcare had the authority to enter into any agreement for employment for any specific period of time or 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 according 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 Dreamer Healthcare is not involved in the day-to-day supervision or decision concerning patient care and dentistry. This remains with the Professional as part of the Professional's practice. The Professional fully indemnifies Dreamer Healthcare against 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 in state prime contract law.

*****I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT*****

Applicant Signature _____ Date _____