JUST IN TIME MEDICAL STAFFING

: (319) 874-6934
: onboarding@jitmedstaffing.com
: www.jitmedstaffing.com
: 2180 Norcor Ave
Ste D202, Coralville, IA 52241

LPN Employment Application Packet

Please complete this application packet and send back by e-mail at *onboarding@jitmedstaffing.com*

To ensure our compliance with the standards of our clients, Just In Time Medical Staffing LLC, requires the following documentation in our system.

Requirements:

APPLICATION FOR EMPLOYMENT

- Just In Time Medical Staffing Application
- Identifying Information
- 7-year Employment History
- Legal Questionnaire
- Authorization for Background Check
- Authorization for Release of Child and Dependent Adult Abuse Information

AGENCY REQUIREMENTS

- Physician Statement (physical), taken within the last 12 months
- Chest X-ray or PPD Test
- Drug Screen
- Immunization Records (TB Test, COVID-19, Hepatitis B)
- LPN Skills Checklist
- Dependent Adult Abuse Certification
- LPN Supervisory Course Certification

PROFESSIONAL CREDENTIALS

- Driver's License
- BLS/CPR - front and back copies with signature
- State License

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Identifying Information

Name (last, first and middle initial) Maiden/Other

Street Address City State Zip

E-mail Address Social Security Number

Date of Birth Driver's License State Expiration Date

Home Phone # Alternate Phone # Cell Phone # Preferred call time

Primary Emergency Contact Name and Phone # Secondary Emergency Contact Name and Phone #

Date Available: Preferred Shift:

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Professional Credentials

Education:_____ From:_____ To: _____

Degree Earned:_____

Education:_____ From:_____ To: _____

Degree Earned:_____

Education:_____ From:_____ To: _____

Degree Earned:_____

Certifications (Please attach a copy of each including front and back copies)

1. _____ Expiration Date: _____

2._____ Expiration Date: _____

3._____ Expiration Date: _____

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Long-Term Care LPN Skills Checklist

Instructions: This checklist is meant to serve as a general guideline for our client facilities as to the level of your skills within your nursing specialty. Please use the scale below to describe your experience/expertise in each area listed below.

Proficiency Scale:
1 = No Experience
2 = Need Training
3 = Able to perform with supervision
4 = Able to perform independently

SKILLS	1	2	3	4
Activities of daily living				
Admission of a patient				
Administration of medication				
Ambulation				
Assist with medical examination				
Bandaging				
Body Systems Review (Head to Toe data collection)				
Cast care				
Catheterization / Foley catheter care				
Charting				
Colostomy Care and irrigation				
CPR				

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SKILLS	1	2	3	4
Crutch walking				
Decubitus care				
Discharge patients				
Dosage computation				
Infection Control: TB/ Airborne precautions				
Infection Control: MRSA/ VRE precautions				
IVs: Monitor rate and infusion site				
Medications: Oral, IM, SQ				
Pain assessment				
Computerized charting				
Transfer/transport patients: wheelchair				
Transfer/transport patients: gurney				
Transfer/transport patients: to chair				
Provide comfort, safety and privacy				
Patient care plans (revise and update)				
Patient safety standards/ precautions				
Restraints				

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AGE SPECIFIC COMPETENCIES	1	2	3	4
Infant (Birth - 1 year)				
Preschooler (ages 2 - 5 years)				
Childhood (ages 6 - 12 years)				
Adolescents (ages 13 - 21 years)				
Young Adults (ages 22 - 39 years)				
Adults (ages 40 - 64 years)				
Older Adults (ages 65 - 79 years)				
Elderly (ages 80+ years)				

I hereby certify that ALL information I have provided to FILL IN THE BLANK on this skills checklist and all other documentation, is true and accurate. I understand and acknowledge that any misrepresentation, or omission may result in disqualification from employment and/or immediate termination.

Employee Name: _____

Employee Signature:_____ Date: _____

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Employment History

Please provide a complete 7-year work history. Please explain any gaps in employment.

Date Employed: From:_____ To: _____
Facility/Hospital: _____
Position Held: _____
Supervisor: _____
Reason for leaving: _____

Date Employed: From:_____ To: _____
Facility/Hospital: _____
Position Held: _____
Supervisor: _____
Reason for leaving: _____

Date Employed: From:_____ To: _____
Facility/Hospital: _____
Position Held: _____
Supervisor: _____
Reason for leaving: _____

Employee Name: _____

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Legal Questionnaire

Have you ever:

1) been named as a defendant in a malpractice action? YES ☐ NO ☐

If yes, when? _____

2) had a license or certification in any jurisdiction limited, suspended, revoked or voluntary relinquished? YES ☐ NO ☐

If yes, when? _____ in what state? _____

3) been licensed or practiced professionally under a different name? YES ☐ NO ☐

If yes, under what name? _____ in what state? _____

4) Are you eligible to work in the U.S.? YES ☐ NO ☐ Alien ID (if applicable): _____

5) been denied a license? YES ☐ NO ☐ If yes, in what state? _____

6) been convicted by misdemeanor, felony including traffic violations? YES ☐ NO ☐

If yes, when and what state? _____

7) been arrested and are you out on bail on your own recognizance and still awaiting trial? YES ☐ NO ☐

8) been released or discharged from employment or resigned to avoid such release or discharge? YES ☐ NO ☐

9) had your driver's license suspended or revoked? YES ☐ NO ☐ If yes, when? _____

My signature certifies that all information contained in this application is correct and maybe verified by Just In Time Medical Staffing LLC, in compliance with the Iowa Law. It also acknowledges that I am aware that it is my responsibility to review the policy and procedure documents of each hospital/facility in which I work, prior to beginning my initial shift.

Employee Signature: _____

Date: _____

Voluntary Self-Identification of Disability

Form CC-305
Page 1 of 1

OMB Control Number 1250-0005
Expires 04/30/2026

Name: Date:

Employee ID:
(if applicable)

Why are you being asked to complete this form?

We are a federal contractor or subcontractor. The law requires us to provide equal employment opportunity to qualified people with disabilities. We have a goal of having at least 7% of our workers as people with disabilities. The law says we must measure our progress towards this goal. To do this, we must ask applicants and employees if they have a disability or have ever had one. People can become disabled, so we need to ask this question at least every five years.

Completing this form is voluntary, and we hope that you will choose to do so. Your answer is confidential. No one who makes hiring decisions will see it. Your decision to complete the form and your answer will not harm you in any way. If you want to learn more about the law or this form, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

A disability is a condition that substantially limits one or more of your "major life activities." If you have or have ever had such a condition, you are a person with a disability. **Disabilities include, but are not limited to:**

- Alcohol or other substance use disorder (not currently using drugs illegally)
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, HIV/AIDS
- Blind or low vision
- Cancer (past or present)
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or serious difficulty hearing
- Diabetes
- Disfigurement, for example, disfigurement caused by burns, wounds, accidents, or congenital disorders
- Epilepsy or other seizure disorder
- Gastrointestinal disorders, for example, Crohn's Disease, irritable bowel syndrome
- Intellectual or developmental disability
- Mental health conditions, for example, depression, bipolar disorder, anxiety disorder, schizophrenia, PTSD
- Missing limbs or partially missing limbs
- Mobility impairment, benefiting from the use of a wheelchair, scooter, walker, leg brace(s) and/or other supports
- Nervous system condition, for example, migraine headaches, Parkinson's disease, multiple sclerosis (MS)
- Neurodivergence, for example, attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder, dyslexia, dyspraxia, other learning disabilities
- Partial or complete paralysis (any cause)
- Pulmonary or respiratory conditions, for example, tuberculosis, asthma, emphysema
- Short stature (dwarfism)
- Traumatic brain injury

Please check one of the boxes below:

- ☐ Yes, I have a disability, or have had one in the past
- ☐ No, I do not have a disability and have not had one in the past
- ☐ I do not want to answer

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

For Employer Use Only

Employers may modify this section of the form as needed for recordkeeping purposes.
For example:
Job Title: Date of Hire:

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Authorization to Disclose information on Employment file, Background check, Medical Records and Drug Screening

By affixing my signature hereunder, I authorize Just In Time Medical Staffing, LLC to release any and all confidential employment background check and medical information contained in my employment file to any medical facility or entity with which Just In Time Medical Staffing LLC, has staffing agreement, and to any other governmental or regulatory agency such agency's request. For all other purposes, Just In Time Medical Staffing LLC, shall keep my employment confidential and shall advise any medical facility or other entity to which records have been provided to also keep such record confidential. I hereby hold Just In Time Medical Staffing LLC, harmless for any result (s) that arises with regards to the release of this confidential information by Just In Time Medical Staffing LLC, Medical records information is confidential and Just In Time Medical Staffing LLC, will instruct client facilities and/or other entities to treat the provided information confidential as well.

I consent to a urine, blood or breath sample for the purpose of an alcohol drug, intoxicant or substance abuse screening test. Furthermore, I consent to the release of the results for purposes for determining the fitness of employment or continued employment.

I authorize Just In Time Medical Staffing LLC, to contact past employers and references regarding my employment history. I hereby release all previous employers and references from any liability for furnishing this information in this application, reference information and medical information to Just In Time Medical Staffing LLC, and any facilities I might be sent on assignment.

My signature hereunder further indicated that I have read and understood the Employee authorization to release confidential information on employment file, background check, medical records and drug screening.

I certify that the facts contained in this application are true and accurate. I authorize the employer to investigate any and all questions relating to this application. I release all parties from all liability, including but not limited to, the employer and any person, firm or corporation who provides information concerning my prior education, employment or character.

Just In Time Medical Staffing LLC, does not discriminate in respect to hiring, termination, compensations and all other terms and conditions of privileges of employment on the basis of race, color, national origin, ancestry, sex, age, pregnancy or related medical conditions, marital status, religious creed or disability.

Name (Please Print)	Signature	Date

Just In Time Medical Staffing Flu and COVID-19 Form/Declination for Nurse Job Employment

Please complete this form to provide information about your Flu and COVID-19 vaccination status. Vaccination is an important aspect of ensuring the safety of our patients and staff.

Flu Vaccination Status:

Please indicate your Flu vaccination status by selecting the appropriate option below:

- ☐ I have received the Flu vaccine for the current season.
- ☐ I have not received the Flu vaccine for the current season but would like to receive it.
- ☐ I do not want to receive the Flu vaccine.
  - Please provide a reason for your declination below:

Reason for Declination (if applicable):

_____

COVID-19 Vaccination Status:

Please indicate your COVID-19 vaccination status by selecting the appropriate option below:

- ☐ I have received the complete COVID-19 vaccination series.
- ☐ I have received some doses of the COVID-19 vaccine but not the complete series.
- ☐ I have not received any doses of the COVID-19 vaccine but would like to receive it.
- ☐ I do not want to receive the COVID-19 vaccine.
  - Please provide a reason for your declination below:

Reason for Declination (if applicable):

_____

Employee Name: _____

Employee Signature:_____ Date: _____

Just In Time Medical Staffing Hepatitis B Vaccination Status/Declination Form for Nurse Job Employment

Please complete this form to provide information about your Hepatitis B vaccination status

Hepatitis B Vaccination Status:

Please indicate your Hepatitis B vaccination status by selecting the appropriate option below:

- ☐ I have completed the entire Hepatitis B vaccination series.
  - If "Yes," please provide documentation.
- ☐ I have had the Hepatitis B vaccination series but cannot find my documentation.
  - Please make efforts to obtain your vaccination records.
- ☐ I do not want to receive the Hepatitis B vaccination.
  - Please provide a reason for your declination below:

OSHA Hepatitis B Declination Statement

Declination Statement: 1910.1030 App A

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine. 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 series.

Reason for Declination (if applicable):

_____

_____

Employee Name: _____

Employee Signature:_____ Date: _____

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TB Questionnaire

Employee Name: _____ Date: _____

	YES	NO
1. Unplanned loss of weight (>10% of body weight)	☐	☐
2. Night sweats	☐	☐
3. Fever lasting several weeks	☐	☐
4. Frequent coughing in the absence of a cold or flue	☐	☐
5. Coughing blood-streaked sputum	☐	☐
6. Unusual tiredness or weakness lasting weeks	☐	☐
7. Pain in chest when taking a breath	☐	☐
8. Have you been recently diagnosed with diabetes, silicosis, HIV disease, renal disease or liver disease?	☐	☐
9. Have you been recently exposed to a family member or other with Active TB?	☐	☐

If you checked YES to any of the above questions, are you currently treating with a physician? ☐ ☐

IF YOU DEVELOP ANY OF THE SYMPTOMS LISTED ABOVE, PLEASE CONTACT YOUR PHYSICIAN AND AGENCY IMMEDIATELY. A CHEST XRAY MUST BE PERFORMED PRIOR TO WORKING AGAIN.

Employee Signature:_____

JUST IN TIME MEDICAL STAFFING

Pre-Employment Annual Health Certification

Please indicate the following:

☐ RN ☐ LPN ☐ CNA ☐ Other:

_____

(Print Name)

I HEREBY grant authorization for the disclosure of any medical information obtained during my physical examination to Just In Time Medical Staffing LLC. This information may be utilized or shared with its client facilities and vendor partners as necessary for evaluating my suitability for employment opportunities and associated activities.

_____ _____

Signature Date

----------(To be completed by the Health Care Professional)----------

The individual underwent a thorough physical examination, revealing the following findings:

☐ Able to perform the essential functions of the job without accommodation.

☐ Not able to perform the essential functions of the job without accommodations. Attach summary for explanation.

☐ Not qualified to perform the essential functions of the job with or without accommodations. Attach summary for explanation.

☐ Other: _____

I certify that I have examined the above-named individual on_____/_____/_____and found him/her to be in good physical and mental health and free of communicable disease.

_____ _____

Medical Practitioner's Signature (REQUIRED) Medical Practitioner's Printed Name and Credentials (REQUIRED)

_____ _____

Date (REQUIRED) License # (REQUIRED)

_____

Phone # (REQUIRED)

_____

_____

Practitioners Address (REQUIRED):