ALLIED
PROFESSIONAL NURSING CARE, INC.

APPLICATION FOR EMPLOYMENT

PRE-EMPLOYMENT QUESTIONNAIRE – AN EQUAL OPPORTUNITY EMPLOYER

PERSONAL INFORMATION

Name (Last Name, First Middle Initial)			Social Security Number
Address Apt. # City, State			Zip
Are you 18 Years or Older? Yes❑ No❑	Hm. Phone #	Cell Phone #	Email Address
Emergency Contact Person:		Contact's Phone Number:	

DESIRED EMPLOYMENT

Position	Date you can start	Salary desired
Are you currently employed? Yes❑ No❑	If so, may we contact your present employer? Yes❑ No❑	
Have you ever applied at this company before?	If yes, when?	

Who referred you to this company? Please specify:
❑ Post Card ❑ Newspaper Ad ❑ Walk In ❑ Other ______________________________
❑ Friend Name:______________________________

EDUCATION

School Level	Name & Location	# Of Years Attended	Did you graduate?	Subjects Studied
High School				
College				
Trade, Business or Correspondence School				

GENERAL

Subjects of Special Study, Research Work, Training, Special Skills:

Do you speak or write a foreign language? If yes, please specify:
Speak:______________________________Write:______________________________
Speak:______________________________Write:______________________________

FORMER EMPLOYERS

Please list below your last three employers, starting with the most recent one first.

NAME OF PRESENT OR PREVIOUS EMPLOYER:		
Address	City	State/Zip
Starting Date	Last Date Worked	Job Title
May we contact your current employer? Yes❑ No❑		Phone
Description of Work Duties:		
Reason for leaving?		

NAME OF PRESENT OR PREVIOUS EMPLOYER:		
Address	City	State/Zip
Starting Date	Last Date Worked	Job Title
May we contact your current employer? Yes❑ No❑		Phone
Description of Work Duties:		
Reason for leaving?		

NAME OF PREVIOUS EMPLOYER:		
Address	City	State/Zip
Starting Date	Last Date Worked	Job Title
May we contact your current employer? Yes❑ No❑		Phone
Description of Work Duties:		
Reason for leaving?		

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REFERENCES

Below, give the names of three persons you are not related to, whom you have known a least one year.

NAME AND ADDRESS	PHONE NUMBER	BUSINESS OR JOB TITLE	YEARS AQUAINTED
	( )		
	( )		
	( )		

POLICY

As part of the hiring process at Allied Professional Nursing each nurse is required to meet the following criteria before you are considered hired.

1. Completed application, forms, videos & skills review
2. Policy and Procedure review with quality assurance staffing
3. Copy of current nursing license
4. Copy of current CPR card
5. Copy of Drivers License
6. Copy of Social Security card or another federally approved form of identification
7. Copy of current PPD, placed and read within the past 6 months. If you do not have this, Allied Professional can place one for you at no charge. If a chest x-ray is needed we can refer you to our Cal-Care location.
8. Copy of current physical (within the last 6 months). If you do not have a current physical, Allied Professional Nursing can refer you to our Cal-Care Clinic location for a pre-employment physical.
9. Completion of orientation

The cost of the physical is ($35.00) or chest x-ray ($55.00) is the responsibility of the potential employee. Please select one of the following payment options:

◊ I elect to have Allied Professional Nursing Care. Inc. deduct the fee(s) from my first paycheck.

◊ I elect Allied Professional Nursing Care, Inc. to give me a PPD test free of charge..

***** (If I choose to the have the fee (s) deducted from my paycheck, I understand that if I do not become an employee of Allied Professional Nursing, or do not take an assignment, or desire a copy of my tests, I am responsible for payment of the fee(s) to Allied Professional Nursing

AUTHORIZATION

"I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed, falsified statements on the application shall be grounds for immediate dismissal.

I authorize investigation of all statements contained herein and the references and employers listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise and release the company from all liability for any damage that may result from utilization of such information. I authorize release of medical information for employment purposes

I understand and agree that no representative of the company has any authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the foregoing, unless it is in writing and signed by an authorized company representative.

Signature Date

INTERVIWER'S NOTES (FOR INTERVIEWER'S USE ONLY)

Interviewed By:	Date:
Interviewer's Signature & Title:	
Comments:	

Interviewed By:	Date:
Interviewer's Signature & Title:	
Comments:	

APPROVED

Hire Date:	
Reinstated Date:	Reinstated Date:
1.	
Human Resources Signature	Date
2.	
Director/Administrator Signature	Date

Server\Shared\human resources\application for employment

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PROFESSIONAL REFERENCE CARD

The applicant named below has applied for a position with, Allied Professional Nursing Care, Inc., and has listed you as a previous employer and/or reference. We would appreciate your assistance in verifying this applicant's history and employment and an evaluation of his/her job performance. All information provided will be held in the strictest of confidence. Thank you for your cooperation!

1. Does the information given below correspond with your own records? ☐ Yes ☐ No
   If no, please provide the correct information on the lines below.

   ____

   ____

2. Is this employee eligible for rehire? ☐ Yes ☐ No
3. Comments: ______________________________________
4. Name and title of evaluator: __________________________
5. If referenced by phone, name and title of person receiving the reference:
   ____
6. Evaluation: (Please check mark ✓ either Excellent/Good/Poor for each criteria listed)

Criteria	Excellent	Good	Poor	Criteria	Excellent	Good	Poor
Attendance				Job Knowledge			
Punctuality				Accepts Supervision			
Dependability				Personal Appearance			
Quality of Work				Attitude			

TO BE COMPLETED BY APPLICANT

______________________________   ______ - ____ - ______
Applicant Name (Print Clearly)   Social Security Number

____
Employer Name (Print Clearly)   Street   City   State   Zip

(   )   -
____
Employer Phone #   Dates of Employment   Title of Position Held

I hereby authorize you to disclose all and any information concerning my employment. I acknowledge and agree that Allied Professional Nursing, Inc. may do periodic background investigation checks.

Employee Signature ______________________________ Date: ____________

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6. Evaluation: (Please check mark ✓ either Excellent/Good/Poor for each criteria listed)

Criteria	Excellent	Good	Poor	Criteria	Excellent	Good	Poor
Attendance				Job Knowledge			
Punctuality				Accepts Supervision			
Dependability				Personal Appearance			
Quality of Work				Attitude			

<u>TO BE COMPLETED BY APPLICANT</u>

______________________________   ___ - ___ - ___

Applicant Name (Print Clearly)   Social Security Number

____

Employer Name (Print Clearly)   Street   City   State   Zip

( ) -

____

Employer Phone #   Dates of Employment   Title of Position Held

I hereby authorize you to disclose all and any information concerning my employment. I acknowledge and agree that Allied Professional Nursing, Inc. may do periodic background investigation checks.

Employee Signature ______________________________ Date: ____________

Employee Name: ______________________________ Circle One: RN / LVN

AVAILABILITY:

Shift Hours: (preference)

- 8 hours
- 10 hours
- 12 hours
- No Preference

Days of The Week: (check all that apply)

Shift	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM							
PM							
NOC							

Competent In:

LVN & RN:
- Oxygen
- G-Tube
- Trach
- Ventilator

RN Only:
- TPN
- IV
- Central Line

Miles you are willing to drive? __________________