**Application for Employment**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Middle Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address City State Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone # Alternate # Social Security # Sex

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth Maiden Name

Are you a citizen of the United States? Y  N 

If not, do you have the right to remain permanently and work in the United States? Y  N 

Do you have authorization to work? Y  N 

Are you involved as a defendant in any professional litigation? Y  N 

Have you ever been convicted of a crime? If yes please explain Y  N 

Have you ever been convicted for negligence? Y  N 

Do you have any criminal convictions? Y  N 

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Valid New York Drivers License YES  NO 

License No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: RN  LPN  HHA  PCA 

Position Applied For: Full Time:  Part Time:  Per Diem: 

Availability: Sun Mon  Tue  Wed  Thu  Fri  Sat 

Preferred Shifts: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours: \_\_\_\_\_\_\_\_\_\_\_\_\_

Languages spoken\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Boros: BK QU BX MAN SI NA

**EDUCATION BACKGROUND**

School Name and Location of school Years Major Subject

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**EMPLOYMENT HISTORY**

List your job history, last two employers. Start with your present status and note any periods in which you were not employed.

Name of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of work performed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for leaving: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of work performed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for leaving: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICAL RECORD:**

Do you have any physical defects that preclude you from performing any work for which you are being considered? Yes  No 

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you ever injured? Yes  No  Give details

Have you any defects in hearing? Yes  No In vision Yes  No  In speech Yes  No 

In case of emergency notify:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Address Telephone

2ND emergency contact: Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Address Telephone

 Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I a free from any health impairment which is of potential risk to the patient or which might interfere with the performance of my duties including the habituation or addition to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter my behavior.

I authorize investigation of all statements contained in this application. I understand that misrepresentation or omission of facts called for is cause for dismissal. Further, I understand and agree that my employment is for no definite period and may, regardless of the date of payment of my wages and salary be terminated at any time without any previous notice.

Applicant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **HR USE ONLY. DO NOT WRITE BELOW THIS LINE** |

Comments by Interviewer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by HR management\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical Examination Form**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Date of Birth:  |  |

**General Physical Findings:**

Height: \_\_\_\_\_\_\_ Blood Pressure: \_\_\_\_\_\_\_\_\_\_ Pulse: \_\_\_\_\_\_\_\_ Respiration: \_\_\_\_\_\_\_\_ Weight: \_\_\_\_lbs

Heart: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lungs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Muscular-Skeletal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GU: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tests Required by Law of ALL Males & Females Specify Disease Immunization or Test**

(May be requested by state or client)

 Test Date Result in mm Result Date Dates(s)

PPD (Mantoux) \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ mm \_\_\_\_\_\_\_\_\_ Diphtheria \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PPD (Mantoux) 2nd \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_mm \_\_\_\_\_\_\_\_\_

X-Ray if positive PPD \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ Tetanus \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rubella Titre \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ Mumps \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rubeola Titre (If born after \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ Rubella Vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 11/1/57 Rubeola verified)

 Measles Vaccine 1: \_\_\_\_\_\_\_\_\_\_\_ 2: \_\_\_\_\_\_\_\_\_

 HB Vaccine 1: \_\_\_\_\_\_\_ 2: \_\_\_\_\_\_\_ 3: \_\_\_\_\_\_\_

Drug Screen:\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Specify any follow-up treatment needed for positive test results or delay due to pregnancy:**Medications** (List all medications prescribed on a continuing basis):**Physical Limitations** (to the best of your knowledge):a. Does this person require eyeglasses?  No  Yes hearing aide?  No  Yesb. Has this person been treated for any disease entity or injury which hampered his/her ability to function normally for extended periods?  No  Yes If yes, explain:c. Is this person presently being treated for any disorders of a chronic or recurring nature? (Please include any history of back injury,  congenital defect, brain or nervous disorders, etc.):  No  Yes If yes, explain: |

I certify that the above person is free from symptoms indicating the presence of an infectious disease, drug and alcohol abuse and does not have any condition which would interfere with the performance of his/her duties. He/She will be able to transfer patients; provide personal care; light housekeeping; shopping; laundry and skilled nursing functions (if a licensed nurse).

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please Print Signature

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REQUIRED EMPLOYEE HEALTH ASSESSMENT

** Initial  Annual  Other**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_ Sex:  M  F

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Address/Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate if you are suffering from or have a history of the following conditions:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CONDITION** | **YES** | **NO** | **CONDITION** | **YES** | **NO** |
| DIABETES |  |  | BACK PAIN |  |  |
| KIDNEY DISEASE |  |  | PAIN ON URINATION |  |  |
| HEART DISEASE |  |  | CHANGE IN BOWEL HABITS |  |  |
| HIGH BLOOD PRESSURE |  |  | INCREASED THIRST |  |  |
| ARTHRITIS |  |  | PERSISTENT SORES/LUMPS |  |  |
| MENTAL ILLNESS |  |  | INFECTIOUS DISEASE |  |  |
| EPILEPSY/CONVULSIONS |  |  | CANCER |  |  |
| SWELLING IN THE EXTREMITIES |  |  | ANY OTHER PHYSICAL DISABILITY |  |  |
| ALLERGIES: |  |  |  |  |  |

**TURBERCULOSIS QUESTIONNAIRE**

Indicate if you have been experiencing the following conditions:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CONDITION** | **YES** | **NO** | **CONDITION** | **YES** | **NO** |
| PERSISTENT COUGH FOR < 3 WEEKS |  |  | UNEXPLAINED WEIGHT LOSS |  |  |
| BLOOD IN THE SPUTUM |  |  | LOSS OF APPETITE |  |  |
| SHORTNESS OF BREATH |  |  | HOARSENESS |  |  |
| NIGHT SWEATS |  |  | FATIGUE |  |  |
| CHEST PAIN |  |  | FEVER |  |  |

Have you had a positive PPD reading?  Yes  No

Are you under the care of a physician?  Yes  No Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take depressants, stimulants, narcotic drugs that alter your behavior?  Yes  No

Do you take prescription medications?  Yes  No If yes, which medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If required in your position, would you be willing to have screening test for drugs/alcohol done on your blood /urine as a condition for employment?  Yes  No

Have you had any operations or hospitalization for illnesses past 5 years? Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read the above and declare that I have had no injury, illness or ailment other than as specifically identified. I certify that I am not habituated or addicted to any depressants, stimulants, narcotics, drugs, alcohol or other substances that may alter my behavior.

**Employee Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RN Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_