Licensed Nurse Application

RNs, LVNs, LPNs

Complete and return to J3 healthcare Services.

Nurse Employment Application

In order to assure our ongoing compliance with the standards of both our clients and The Joint Commission, J3 Healthcare Services requires the following documentation on file.

Document

____ Application for Employment – All pages

• Application

• Employment History

• Emergency Contact

• EOE signature required

____ Professional Reference (1)

____ Professional Reference (2)

____ Essential Skills Checklist – Completed & Signed

____ Skill Specific Checklist – Completed & Signed

____ Professional Credentials - Copies of Current Relevant RN Licenses and Certifications

____ Physicians Statement (within 12 months of current date) & Vaccination Record

____@ Immunization Records or Current Test Results:

• TB/PPD Test (within 12 months) or

• Chest X-Ray with + TB or History of BCG Vaccine (within 24 months and annual symptoms update yearly)

• One MMR Required for Date of Birth Prior to 1957, or Two MMR for Date of Birth after 1957,

OR Rubella Titre

Rubeola Titre

Mumps Titre (if required by facility)

• Varicella Zoster Titre, Immunity by History of Disease as Verified by MD and Vaccination

____@ Physician Statement with Signature of MD

____@ Hepatitis B Declination, Proof of Series, or Titre Showing Immunity

____ Authorization to Disclose PHI (Personal Health Information)

____ Background Investigation Consent

____ Substance Abuse Testing Consent

THE JOINT COMMISSION REQUIRES UPDATES ANNUALLY OR AS INDICATED ON THE CREDENTIAL OR LICENSE

(Please complete even if attaching a resume)

Name (Last, First, Middle) _____ Maiden/Other_____

Address_____ City_____ State_____ Zip_____

E-mail Address_____

Home Phone #_____ Alternate Phone #_____ Cell Phone #_____

Primary Emergency Contact Name and Phone #_____

Secondary Emergency Contact Name and Phone #_____

Date Available: _____ Shift Preferred: Day_____ Night _____

Type of position applying for (circle all that applies): 4 wk. 8 wk. 13 wk. +

Do you speak any languages other than English? Yes or No If yes, please list _____

How were you referred to us? Advertising_____ Internet Site_____ Friend/Associate_____ Other_____

Can you, after employment, submit verification of your legal right to work in the United States? Yes_____ No _____

Are you able to perform the basic functions of the position for which you are applying with or without reasonable accommodations? Yes_____ No _____

If no, please explain: _____

Have you ever been convicted of a crime that would prohibit your employment in a healthcare facility? Yes_____ No _____

Are you willing to submit to a criminal background investigation? Yes_____ No _____

Have you ever had disciplinary action taken against any license, or are you currently the subject of a report or investigation?

Yes_____ No_____ If yes, please explain: _____

As a condition of employment, you may be required to take and pass a drug and/or alcohol screen in any or all of the following circumstances: PRE-EMPLOYMENT, POST-ACCIDENT, FOR CAUSE, & RANDOM SELECTION

Professional Credentials Section

College/University _____ Date Attended _____ Degree Earned _____

College/University _____ Date Attended _____ Degree Earned _____

Specialty (Please list most current experience first)

1. _____ Years of Experience _____ as of (Indicate Date) _____

2. _____ Years of Experience _____ as of (Indicate Date) _____

LICENSURE (Please include a copy of each)

State Professional License # Exp. Date	State Professional License # Exp. Date	State Professional License # Exp. Date
AK _____	KY _____	NY _____
AL _____	LA _____	OH _____
AR _____	MA _____	OK _____
AZ _____	MD _____	OR _____
CA _____	ME _____	PA _____
CO _____	MI _____	RI _____
CT _____	MN _____	SC _____
DC _____	MO _____	SD _____
DE _____	MS _____	TN _____
FL _____	MT _____	TX _____
GA _____	NC _____	UT _____
HI _____	ND _____	VA _____
IA _____	NE _____	VT _____
ID _____	NH _____	WA _____
IL _____	NJ _____	WI _____
IN _____	NM _____	WV _____
KS _____	NV _____	WY _____
Bermuda _____	U.S. Virgin Isles _____	Guam _____

Certifications (Please include a copy of each)

BCLS/CPR Exp. Date _____ ACLS Exp. Date _____ NALS/NRP Exp. Date _____

PALS Exp. Date _____

Nurse

CEN Exp. Date _____ CCRN Exp. Date _____ ENCP Exp. Date _____

CNOR Exp. Date _____ CHEMO Exp. Date _____ TNCC Exp. Date _____

Other Exp. Date _____

Employment History (Please list in order, most recent first)

Date Employed, From _____ to _____ Business Phone _____

Facility _____ May We Contact? Yes _____ No _____

Position Held _____ Specialty/Unit _____

FT/ PT/ – Agency Name _____ Number of Beds _____

Employer Address _____ Average Pt. Ratio _____

Immediate Supervisor _____ Charge experience _____

Reason for Leaving _____

Date Employed, From _____ to _____ Business Phone _____

Facility _____ May We Contact? Yes _____ No _____

Position Held _____ Specialty/Unit _____

FT/ PT/ – Agency Name _____ Number of Beds _____

Employer Address _____ Average Pt. Ratio _____

Immediate Supervisor _____ Charge experience _____

Reason for Leaving _____

Date Employed, From _____ to _____

Business Phone _____

Facility _____

May We Contact? Yes _____ No _____

Position Held _____

Specialty/Unit _____

FT/ PT/ – Agency Name _____

Number of Beds _____

Employer Address _____

Average Pt. Ratio _____

Immediate Supervisor _____

Charge experience _____

Reason for Leaving _____

Emergency Contact

We would like to have the names of two contacts that we could call in the case of an emergency.

Employee Name _____ Date _____

Primary Contact _____

Relation _____

Address _____

Home Phone _____

Work Phone _____

Primary Contact _____

Relation _____

Address _____

Home Phone _____

Work Phone _____

J3 Healthcare Services ("Company") is an Equal Opportunity Employer. All applicants are considered for employment regardless of age, race, gender, religion, national origin, disability, marital status or any other factor prohibited by law.

Please take a moment to review and acknowledge your understanding and acceptance of this Agreement.

- I certify that the information provided on this Application is accurate. I understand that the withholding of information or the giving of false information on this Application may result in a refusal to hire or disciplinary action including, but not limited to, termination. I understand and agree that if I am offered employment by the company, it will be on an at-will basis. This means that either the Company or I may terminate the employment relationship at any time, for any reason, with or without cause or notice. I also understand and agree that only an officer of the Company can enter into an agreement on any other terms and he/she can only do so in writing signed by the officer and me. I have read the above before signing this Application.

- I further understand and waive my right of privacy in this investigation and release and hold harmless **J3 Healthcare Services** from any liability.

- I agree that any decision to hire me is contingent upon the results of my report, and certify that all statements and answers on my Application, resume, or interview are true and complete to the best of my knowledge. I understand that if any statements are false or that if information has been omitted, this will be cause for disqualification and immediate termination of my employment. I further authorize **J3 Healthcare Services** to check my conviction record as needed, on a continuous basis as it relates to my employment.

- I authorize **J3 Healthcare Services** to release any employment records, including health records submitted to **J3 Healthcare Services** to any customer of **J3 Healthcare Services** for consideration of employment at customer facility.

Applicant's Full Name _____

Applicant's Signature _____ Date _____

Essential/Practical Skills Self-Assessment

This profile is for use by ALL Nurses with more than one year's experience in his/her discipline and specialty. Please return this checklist to **J3 Healthcare Services**.

Name _____ Signature _____ Date _____

Directions: *Indicate your level of experience by circling the numbers below as follows*: 1 = Can Function Independently,

2 = Experienced, but May Need Review, 3 = Limited or No Experience

CORE SKILLS

Admission of a Patient – 1 2 3
Transfer of a Patient – 1 2 3
Discharge of a Patient – 1 2 3
Emergency Situations/Code Blue – 1 2 3
Vital Signs - 1 2 3
Post Mortem Care – 1 2 3
Defibrilation – 1 2 3
Cardioversion – 1 2 3
Documentation - 1 2 3
Patient and Family Education – 1 2 3
Assessment of Abuse – 1 2 3
Restraints – 1 2 3
Body Mechanics – 1 2 3
Aseptic Technique – 1 2 3
Isolation Precautions – 1 2 3

Medication Administration

PO medications – 1 2 3
IM Injections – 1 2 3
SQ Injections – 1 2 3
Z-track Injections – 1 2 3
Rectal Suppositories – 1 2 3
Nasal Sprays – 1 2 3
Ear Drops – 1 2 3
Eye Drops – 1 2 3
Inhalers – 1 2 3
Emergency Drugs/Code Cart – 1 2 3

CARDIOVASCULAR

Auscultation (Rate, Rhythm) – 1 2 3
Blood Pressure/Noninvasive – 1 2 3
Doppler – 1 2 3
Heart Sounds/Murmurs – 1 2 3

Interpretation of Lab Results

Cardiac Isoenzymes – 1 2 3
Blood Chemistries – 1 2 3

Equipment and Procedures

Basic arrhythmia interpretation – 1 2 3
Lead placement – 1 2 3
Basic 12 Lead EKG Interpretation – 1 2 3

PULMONARY

Breath Sounds – 1 2 3
Rate and Work of Breathing – 1 2 3

Interpretation of Lab Results

Arterial Blood Gases – 1 2 3

Equipment and Procedures

Endotracheal Tube/Suctioning – 1 2 3
Nasal Airway/Suctioning - 1 2 3
Oropharyngeal/Suctioning – 1 2 3
Sputum Specimen Collection – 1 2 3
Tracheostomy/Suctioning – 1 2 3
Assist with Intubation – 1 2 3
Assist with Thoracentesis – 1 2 3
Chest Tube Management – 1 2 3
Chest Physiotherapy – 1 2 3
Incentive Spirometry – 1 2 3
Pulse Oximetry – 1 2 3

Oxygen Therapy

Bag and Mask – 1 2 3
Face Mask – 1 2 3
Nasal Cannula – 1 2 3
Portable Oxygen Tank – 1 2 3

NEUROLOGICAL

Glascow Coma Scale – 1 2 3
Level of Consciousness – 1 2 3

Equipment and Procedures

Assist with Lumbar Puncture – 1 2 3
Use of Hypo-Hyperthermia Blanket – 1 2 3

ORTHOPAEDICS

Circulation Checks – 1 2 3
Gait – 1 2 3
Range of Motion – 1 2 3
Skin – 1 2 3

Equipment and Procedures

Wheelchair – 1 2 3

GASTROINTESTINAL

Abdominal/Bowel Sounds – 1 2 3
Fluid Balance – 1 2 3
Nutritional – 1 2 3

Equipment and Procedures

Placement of NG Tube – 1 2 3
Placement of Flexible Feeding Tube – 1 2 3
Administration of Tube Feeding – 1 2 3
Feeding Pumps – 1 2 3
Gravity Feeding – 1 2 3
Salem Sump to Suction – 1 2 3
Care of Gastrostomy Tube – 1 2 3
Colostomy Care – 1 2 3

RENAL/GENITOURINARY

Fluid Balance – 1 2 3
Urinary output – 1 2 3

Interpretation of Lab result

BUN & Creatinine – 1 2 3

Equipment and Procedures

Catheter Care – 1 2 3
Specimen Collection – 1 2 3
Routine – 1 2 3
24 Hour – 1 2 3

Insertion & Care of Straight and Foley Catheters

Female – 1 2 3
Male – 1 2 3

Endocrine/Metabolic

S/S Diabetic coma – 1 2 3
S/S Insulin Reaction – 1 2 3

Equipment and Procedures

Blood Glucose Monitoring – 1 2 3
Performing Finger/Heel Stick – 1 2 3
Sliding Scale Insulin Protocols – 1 2 3

WOUND MANAGEMENT

Skin for Impending Breakdown – 1 2 3
Surgical Wound Healing – 1 2 3

Equipment and Procedures

Sterile Dressing Change

INTRAVENOUS THERAPY

Site Assessment – 1 2 3

Equipment and Procedures

Admin of Blood & Blood Products – 1 2 3
Drawing Blood Fr. a Central Line – 1 2 3
Drawing Venous Blood – 1 2 3
Initiation of an IV – 1 2 3
Heplock Flushes – 1 2 3
Administration of IV Fluid – 1 2 3
Administration of Piggy Back – 1 2 3
Administration of IV Push Medications – 1 2 3

Site care and dressing changes

Central Line – 1 2 3
Peripheral Line – 1 2 3
Administration of TPN/Lipids – 1 2 3

PAIN MANAGEMENT

Assessment of Pain Level/Tolerance – 1 2 3

Equipment and Procedures

Administration of Narcotics Analgesia – 1 2 3
PCA Pumps – 1 2 3
IV Conscious Sedation – 1 2 3
Epidural Anesthesia – 1 2 3

AGE SPECIFIC CARE

Newborn/Neonatal (BIRTH – 30 DAYS) – 1 2 3
Infant (30 DAYS – 1 YEAR) – 1 2 3
Toddler (1 – 3 YEARS) – 1 2 3
Preschool (3 – 5 YEARS) – 1 2 3
School Age Children (5 – 12 YEARS) – 1 2 3
Adolescent (12 – 18 YEARS) – 1 2 3
Young Adults (18 – 39 YEARS) – 1 2 3
Middle Adults (39 – 64 YEARS) – 1 2 3
Older Adults (64 + YEARS) – 1 2 3

MISCELLANEOUS

Computerized Charting – 1 2 3
Automated Medication Dispensing Systems – 1 2 3

Physician's Statement and Vaccination Record

Patient's Full Name _____ Date _____

It is the responsibility of the applicant to have their physician complete and sign this section.

PHYSICIAN TO COMPLETE THIS SECTION

- **TB**

PPD Skin Test (required yearly) Date: _____ Results: _____
OR Chest X-Ray (required if TB-Positive) Date: _____ Results: _____

- **MMR** Booster 1) _____ 2) _____

(**1 MMR required prior to Birthdate of 1957, 2 MMR required after Birthdate of 1957**)

OR Mumps Titre Date: _____ Results: _____
Rubella Titre Date: _____ Results: _____
Rubeola Titre Date: _____ Results: _____

- **Varicella** (chicken pox)

Varicella Titre Date: _____ Results: _____
OR: Varivax Date: _____
OR Immunity by History of Disease Date: _____

- **Hepatitis B**

Vaccine #1 Date_____ #2 Date_____#3 Date_____ Booster Date_____
OR Hepatitis B Titre Date: _____ Results: _____
OR Hepatitis B Declination (Sign Below) Date: _____

Please submit supporting documentation of immunization records and all lab results

I have examined the individual named above, and to the best of my knowledge, he/she is in good physical and mental health, free of communicable diseases and is able to function in his/her profession in full capacity. By signing below I certify that the above documentation is valid.

Physician's Signature _____ Date _____

Printed Name _____ Lic #_____

HepatitisBVaccinationDeclination1 – Please complete Bloodborne Training before signing

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, at no charge to myself.

However, I decline Hepatitis B vaccination at this time. I understand that, by declining this vaccination, 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 at no charge to me.

I acknowledge, understand, and accept this Agreement/Statement. Signature_____ Date_____

This is a regulatory requirement under 29CFR 1910.1030. If you decline the vaccination and refuse to sign the Declination paragraph, your offer will be withdrawn or your assignment will be terminated

OR

HepatitisBVaccinationAcceptance – Please complete Bloodborne Training before signing

I, _____, choose to receive the Hepatitis B vaccine offered by **J3 Healthcare Services** in accordance with the OSHA Bloodborne Pathogen Standard 29CFR 1910.1030(f)(2)(i). I understand that administration of the vaccine may cause side effects, and under certain conditions is not medically advised. I have consulted with a physician and have determined that it is appropriate for me to receive the vaccine based on my potential exposure. I release **J3 Healthcare Services** and its employees from any liability in connection with the administration of this vaccine.

I understand that this procedure is a series of three shots. The second dose is to be administered 30 days after the initial dose, and the third dose is to be administered six months after the initial dose. All three shots are required to complete the vaccination process. If I am not employed by **J3 Healthcare Services** when the other shots are due, it will be my responsibility to see that they are completed. I also understand that the vaccine may lose its effectiveness over time and may require periodic booster shots. These are also my responsibility if I am not employed by **J3 Healthcare Services**.

I acknowledge, understand, and accept this Agreement/Statement. Signature_____ Date_____

Authorization for Use Disclosure of Health Information

I authorize the use or disclosure of my health information as described below.

1. Person(s) or class of persons authorized to use or disclose the information: (Note: e.g., Name of Provider, lab, etc. that will disclose the information)

Please List _____

2. Person(s) or class of persons authorized to receive the information: **J3 Healthcare Services**, LLC.

3. Description of information that may be used or disclosed: (Note: e.g., all information related to a specific test or type of evaluation)

Please List _____

4. The information will be used or disclosed for the following purposes: For use by **J3 Healthcare Services,** and its clients in evaluating my qualifications for employment opportunities and related activities.

5. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

6. I understand that I may revoke this authorization at any time by sending a written request to the party identified in paragraph 1, except to the extent that action has been taken in reliance on this authorization.

7. This authorization expires_____ [Please insert a date or describe the termination of an event or activity related to the individual or to the purpose of the authorization. This date relates to the termination of the right for the provider to disclose the information and not to **J3 Healthcare Service's** right to use this information, which, once the information is disclosed, does not terminate].

I acknowledge, understand, and accept this Agreement/Statement.

_____ _____

Signature Date

_____

Patient Name

_____ _____

Name of Personal Representative (if applicable) Relationship to Patient

(A copy of this signed form will be provided to the patient)

Background Investigation Consent

I, _____, hereby authorize **J3 Healthcare Services** and/or its agents to make an independent investigation of my background, references, character, past employment, education, credit history, motor vehicle operation history, criminal or police records, including those maintained by both public and private organizations and all public records for the purpose of confirming the information contained on my Application and/or obtaining other information which may be material to my qualifications for employment. I release **J3 Healthcare Services** and/or its agents and any person or entity, which provides information pursuant to this authorization, from any and all liabilities, claims or law suits in regards to the information obtained from any and all above referenced sources used. I understand that all or part of this information, including my social security number may be released to clients as part of the hiring process, and agree to the release of any part or all of this information including my social security number.

This is a consumer notification that a Background Report will be requested and obtained, and that the report will be used for the purpose of evaluating me for employment, promotion, reassignment or retention as an employee.

The following is my true and complete legal name and all information is true and correct to the best of my knowledge:

Full Name Printed _____

Maiden Name or Other Names Used _____

_____	_____	_____	_____
*Date of Birth	Social Security Number	Driver's License Number	State of License Issue

Addresses - Note: We need to go back 7 years. Use an extra sheet if required.

1. Present Address _____ How Long? _____

City/State _____ Zip Code _____

2. Former Address _____ How Long? _____

City/State _____ Zip Code _____

Signature _____ Date _____

*Note: The above information is required for identification purposes only, and is in no manner used for qualifications for employment.

J3 Healthcare Services is an Equal Opportunity Employer, and does not discriminate on the basis of Sex, Race, Religion, Age (40 and over), Handicap or National Origin.

Substance Abuse Testing Consent

I understand that I may be offered a position with **J3 Healthcare Services** that requires pre-employment and periodic substance abuse testing due to the nature of the duties performed, and to specific requirements of clients of **J3 Healthcare Services**. Periodic testing could include, but is not limited to, random, post-accident, scheduled or for-cause testing. I further understand that I may not begin/continue employment with **J3 Healthcare Services** unless I pass (receive negative results) on a test for illegal drugs and/or alcohol (the Test) when such Test is required. I agree to provide an appropriate sample as determined by **J3 Healthcare Services** and/or its clients in accordance with the requirements of **J3 Healthcare Services** policies, and to have such samples tested for evidence of drug and/or alcohol use. If the creatinine, specific gravity, nitrates, temperature or other parameters typically used to determine if a sample is representative of normal are outside the normal range, I may be required to return to the collection point for a witnessed collection. I understand that results of the Test may be disclosed to clients of **J3 Healthcare Services** to whom I may be assigned as required by **J3 Healthcare Services** to do business with the client. I understand that a full copy of the Drug and Alcohol policy is available in the local office.

Date: _____

Full Name: _____

I acknowledge, understand, and accept this Agreement/Statement.

Signature: _____

Job Capabilities Questionnaire

As a candidate for employment at **J3 Healthcare Services**, you have met the basic requirements of skills, experience, education and availability needed by our Clients. Clients request that our employees work at their location for a specific period of time to complete various work duties. As a **J3 Healthcare Services** employee, you will typically be assigned to positions in healthcare, research and development and/or many different types of facilities. These positions may involve working with various potentially hazardous substances and physical agents, including, but not limited to, the following:

● Various organic volatile and non-volatile chemicals, corrosives, potential carcinogens, mutagens and teratogens.

● Biological agents, Bloodborne pathogens and radioactive sources and materials

● Heat, cold, pressure (including compressed gasses), and noise

● working with glassware, pipetting, repetitive tasks

These assignments may also include physical requirements that involve sitting/standing/walking for extended periods, bending and stooping, lifting or moving heavy objects and lifting up to 50 lbs. above the shoulders. They may also involve repetitive tasks such as using a keyboard, operating equipment or manipulating small objects. A safe working environment is important not only to you, but also to **J3 Healthcare Services** and our Clients. You are expected to take all reasonable safety precautions, and to follow all **J3 Healthcare Services** and client safety policies and procedures. This may include, but is not limited to Standard Operating Procedures, appropriate use of personal protective equipment and devices, and personal hygiene. To assist us in assuring that we select the best possible assignment for you, please complete the following Job Capabilities questionnaire.

1. Can you perform all of these and similar tasks with reasonable accommodation? Yes No

If no explain:

2. Do you have any health reasons that would prohibit you from performing these or similar tasks? Yes No

If yes explain:

3. Do you have any restrictions preventing you from performing these tasks? Yes No

If yes explain:

4. Do you have any known allergies? Yes No List:

a. Do you have dermatitis? Yes No

b. Are you allergic to latex gloves? Yes No

5. Are there any assignments that you cannot or prefer not to do? Yes No

If yes explain:

I certify this information is correct, and understand that withholding or giving false information will result in refusal to hire or disciplinary action up to, and including, termination.

Signed by: _____ **J3 Healthcare Services Rep**: _____

Printed Name: _____ Printed Name: _____

Date: _____ Date: _____

APPLICATION EEO-1 INFORMATION COLLECTION FORM

Dear Applicant,

Please fill out the Affirmatives Action data below. To ensure that **J3 Healthcare Services** complies with pertinent hiring practices, **J3 Healthcare Services** must keep records about our applicant for employment. This questionnaire will be kept in a confidential file, separate from the application for employment. Failure to provide this information will in no way adversely affect your candidacy for this position. However, we would greatly appreciate your willingness to submit this information for our commitment to equal opportunity.

Please print your name and city information. This information is strictly confidential however your information must be legible for reporting purposes.

Last Name: _____ First Name: _____

Which city and state do you work in? _____

Note that all definitions as listed below were provided by the U.S. Federal Government Equal Employment Opportunity Commission (EEOC)

EEO Ethnicity Code:

- Hispanic or Latino
- NON-HISPANIC OR LATINO
- White
- Black
- Native Hawaiian or other Pacific Islander
- Asian
- American Indian or Alaska Native
- Two or more races

Gender: FEMALE ____ MALE _____

Handicap Status: NO _____ YES _____

(Any person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairments or is regarded as having such impairments)

Veteran Status:

Vietnam Era Veteran: Person who served on active duty for a period of more than 180 days, any part of which occurred between 8/5/64 and 5/7/74 and has any discharge other than dishonorable.

Disabled Vietnam Veteran: 30% or more V.A. certified disability incurred or aggravated in the line of duty before 8/5/64 or after 5/7/74.

Disabled Veteran (not Vietnam era): 30% or more V.A. certified disability incurred or aggravated in the line of duty before 8/5/64 or after 5/7/74.

Age: Are you over age 40 but under the age of 70?

Yes_____ No _____