



APPLICATION FOR EMPLOYMENT

Please Print

Date: _____

PERSONAL

Name: _____ Soc. Sec. # _____ Date Of Birth _____ / _____ / _____

Address: _____ City _____ State _____ Zip code _____

Gender M F Home Phone () _____ Cell Phone () _____

Are you 18 years of age or over? Yes No Are you a U.S. citizen? Yes No

If No, Are you legally eligible for employment in U.S.? Yes _____ No _____

EMERGENCY CONTACT

In case of an emergency notify: Name: _____ Relationship _____

Address: _____ city _____ state _____ Zip code _____

Phone: () _____ Cell () _____

EMPLOYMENT DESIRED

Position: _____ Date you can start: _____ / _____ / _____ Salary desired: _____

Type of Employment Desired: Part-time Full-time PRN Day Evenings Nights Live-in

Were you previously employed by us? Yes No If yes, when? _____ / _____ / _____

EDUCATION BACKGROUND

EDUCATION	Name and Location of School	Years Attended	Graduated Yes/No	Course/Major
High School				
College				
Other Education				

EMPLOYMENT HISTORY

List your record of employment beginning with your present or most recent position.

Name of Employer _____		Phone () _____		EXT _____	
Address _____		City _____		State _____ Zip _____	
Your Title _____		Supervisor's Name _____		Title _____	
Employment Dates From: _____		To: _____		Starting Salary: _____ Ending Salary _____	
Work Performed _____					
Reason for leaving _____					

Name of Employer _____		Phone () _____		EXT _____	
Address _____		City _____		State _____ Zip _____	
Your Title _____		Supervisor Name _____		Title _____	
Employment Dates From: _____		To: _____		Starting Salary: _____ Ending Salary _____	
Work Performed _____					
Reason for leaving _____					

Name of Employer _____		Phone () _____		EXT _____	
Address _____		City _____		State _____ Zip _____	
Your Title _____		Supervisor Name _____		Title _____	
Employment Dates From: _____		To: _____		Starting Salary: _____ Ending Salary _____	
Work Performed _____					
Reason for leaving _____					

May we contact the employers listed above? Yes No if no, Explain

REFERENCES

Three references required

1. Name_____	Relationship_____	Ph.() _____
2. Name_____	Relationship_____	Ph.() _____
3. Name_____	Relationship_____	Ph.() _____

AUTHORIZATION

I authorize Grace line Nursing Inc. to contact each former employer, firm or corporation. I authorize any of these persons to give all information concerning work-related items and I release all parties from liability for any damage that may result from furnishing same to you.

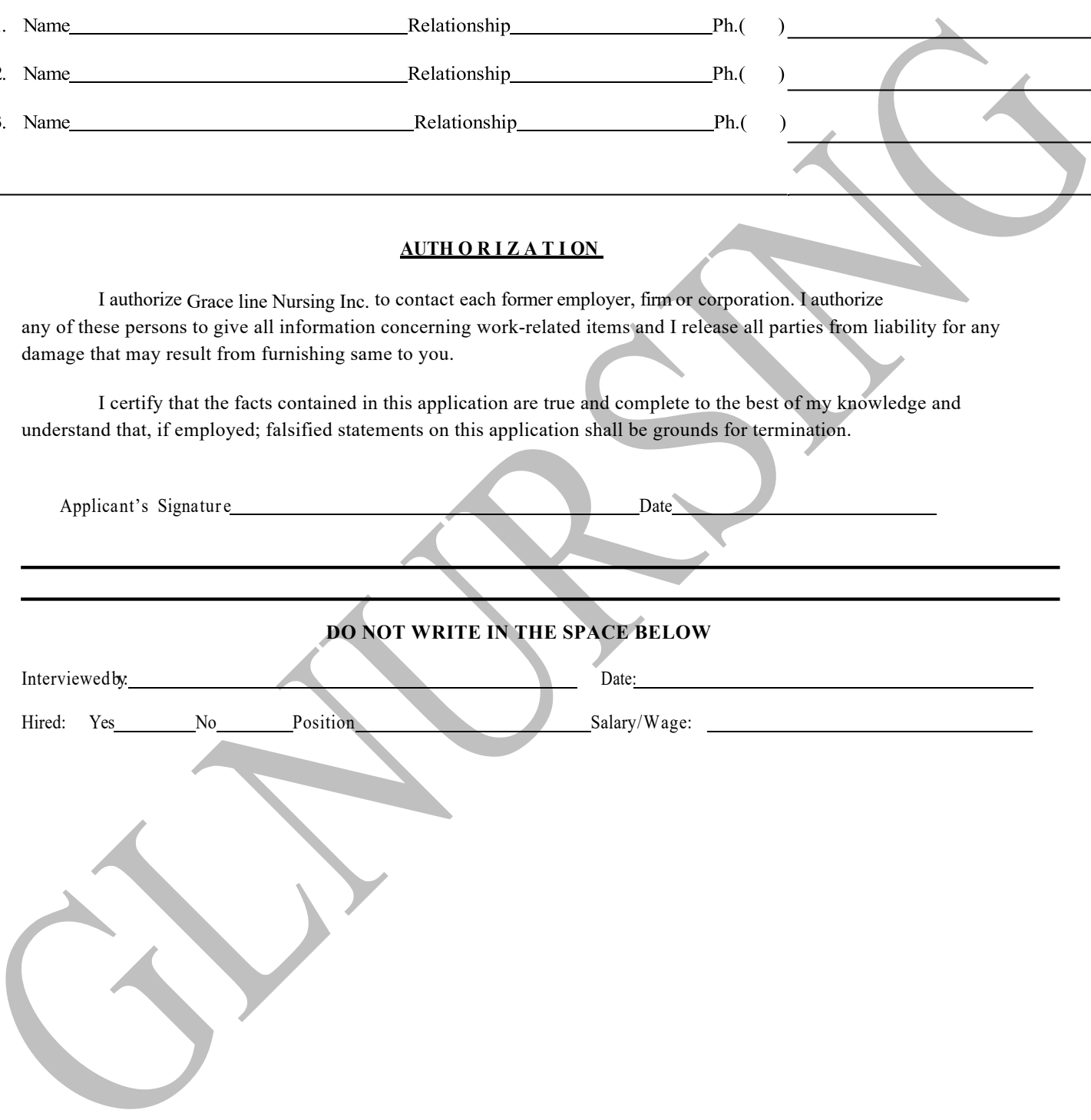
I certify that the facts contained in this application are true and complete to the best of my knowledge and understand that, if employed; falsified statements on this application shall be grounds for termination.

Applicant's Signature_____ Date_____

DO NOT WRITE IN THE SPACE BELOW

Interviewed by:_____ Date:_____

Hired: Yes_____ No_____ Position_____ Salary/Wage: _____





CONSENT TO PERFORM CRIMINAL HISTORY BACKGROUND CHECK

Date: _____ Driver's Lic # _____ State Issued _____
Last Name _____ First Name _____ Middle Initial _____
Address _____ City _____ County _____ State _____ Zip Code _____
Date of Birth ____ / ____ / ____ Social Security _____ Male Female
Previous Addresses _____

This authorization and consent for release of personal information acknowledges that

In connection with my employment at Graceline Nursing Inc., I hereby authorize the Graceline Nursing Inc to conduct a security background check on me. I understand that this security check will cover information such as criminal history, education and employment, eligibility, and professional licensure/certifications. I understand that this background check may include information from previous employers relating to my work experience. I hereby release Graceline Nursing Inc well as its employees from all liability resulting from the furnishing of this information. Graceline Nursing Inc I certify that the statements made by me on this form are true, complete, and correct to the best of my knowledge and belief, and are made in good faith. I understand that any false statements made herein could void my consideration for employment, or could result in disciplinary action up to, and including termination.

The following are my responses to questions about my criminal record history (if any) with descriptions to any question with a YES answer:

- (1) Have you ever been convicted or plead guilty before a court of any federal, state, or municipal criminal offense? (Excluding minor traffic violations) YES NO
If YES, please provide an explanation: _____
- (2) Have you ever received deferred adjudication or similar disposition for any federal, state or municipal criminal offense? YES NO
If YES, Please provide an explanation: _____
- (3) Have you ever received probation or community supervision for any federal, state or municipal criminal offense? YES NO
If YES, Please provide an explanation: _____
- (4) As of the date of this authorization, do you have any pending criminal charges against you? YES NO
If YES, Please provide an explanation: _____

I hereby certify that all the information provided in this authorization is true, correct and complete. I understand that if any information proves to be incorrect or incomplete that might be grounds for cancellation of any and all offers of employment.

Applicant Name (Print) _____ Signature _____ Date ____ / ____ / ____



DRUG/ALCOHOL TEST CONSENT AND RELEASE FORM

I hereby consent to submit to a drug or alcohol test and to furnish a sample of my urine, breath, and/or blood for analysis, as shall be determined by Graceline Nursing Inc in order to meet with their policy regarding the selection of applicants for employment.

I further authorize and give full permission to have the Company and/or its authorized agents and physicians to send the specimen or specimens so collected to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to the Company. I further agree to and hereby authorize the release of the results of said tests to the Company.

I understand that it is the current use of illegal drugs that would prohibit me from being employed at this Company.

I further agree to hold harmless the Company and its agents and physicians from any liability arising in whole or part, out of the collection of specimens, testing, and use of the information from said testing in connection with the Company's consideration of my application of employment.

I further agree that a reproduced copy of this pre-employment consent and release form shall have the same force and effect as the original.

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced into signing this document by anyone.

APPLICANT: Print Name: _____ S.S. #: _____

Signature: _____ Date: _____

WITNESS: Print Name: _____ Signature: _____



Confidentiality Statement

All patient Protected Health Information (PHI—which includes patient medical and financial information), employee records, financial and operating data of the practice, and any other information of a private or sensitive nature are considered confidential. Confidential information should not be read or discussed by any employee unless pertaining to his or her specific job requirements. Examples of inappropriate disclosures include:

- Employees discussing or revealing PHI or other confidential information to friends or family members.
- The disclosure of a patient's presence in the office, hospital, or other medical facility, without the patient's consent, to an unauthorized party without a legitimate need to know, and that may indicate the nature of the illness and jeopardize confidentiality.

The unauthorized disclosure of PHI or other confidential information by employees can subject each individual employee and the practice to civil and criminal liability. Disclosure of PHI or other confidential information to unauthorized persons, or unauthorized access to, or misuse, theft, destruction, alteration, or sabotage of such information, is grounds for immediate disciplinary action up to and including termination.

Employee Confidentiality Agreement

I hereby acknowledge, by my signature below, that I understand that the PHI, other confidential records, and data to which I have knowledge and access in the course of my employment with Graceline Nursing Inc. is to be kept confidential, and this confidentiality is a condition of my employment. This information shall not be disclosed to anyone under any circumstances, except to the extent necessary to fulfill my job requirements. I understand that my duty to maintain confidentiality continues even after I am no longer employed.

I am familiar with the guidelines in place at Graceline Nursing Inc. pertaining to the use and disclosure of patient PHI or other confidential information. Approval should first be obtained before any disclosure of PHI or other confidential information not addressed in the guidelines and policies and procedures of Graceline Nursing Inc. is made. I also understand that the unauthorized disclosure of patient PHI and other confidential or proprietary information of Graceline Nursing Inc. is grounds for disciplinary action, up to and including immediate dismissal.

Print Name _____ Date _____

Signature of Employee _____ Supervisor _____



Physical Examination Form
To be filled by the Physician

Employee Information

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Weight _____ Hgt _____ Allergies _____

Medical Information

I have examined the above parson; he/she is in sound health to perform the duty of patient care provider.

- Does not have signs and symptoms of communicable disease such as tuberculosis.
- Does not have Physical disability or any form of handicap, which could impact his/ her ability performing patient care services.
- Does not have any chronic conditions that will affect his /her ability to work as patient care provider.

Recommendations: _____

Physician Signature _____ Date _____

Physician Name _____

Office Address _____

Telephone Number. _____



HEPATITIS B VACCINE CONSENT FORM

Employee Name _____ SS# _____ Title _____

I _____ understand that due to 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, if I decline a hepatitis B vaccination at this time and 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 understand that adverse reactions are rare; the most common being local irritation at the injection site. The vaccine cannot transmit the disease; however, the vaccine is contra-indicated during pregnancy. I am not pregnant .

With this understanding, I choose

- To be vaccinated Not to be vaccinated.

- I have been vaccinated within the last 5 years at another place of employment and do not need current vaccination.

Employee Signature _____ Date _____

Witness _____ Date _____

1st Dose (Date _____) lot# _____ Exp _____ RT Deltoid LT Deltoid RN Signature _____

2nd Dose (Date _____) lot# _____ Exp _____ RT Deltoid LT Deltoid RN Signature _____

3rd Dose (Date _____) lot# _____ Exp _____ RT Deltoid LT Deltoid RN Signature _____

Blood work Results (Date _____) RN Signature _____

(Date _____) RN Signature _____