PRIMO
HEALTHCARE SERVICES

Employment Application

APPLICANT INFORMATION:

_______________________________________ _________________________________ ________________________________
Last Name First Name, M.I. Social Security Number

____
Current Address

____
Permanent Address (*if different*)

Home Phone: _______________________ Cell Phone: _______________________ Email Address: __________________________________

Emergency Contact: ____ Relationship: ____________________ Phone: ____________________

LICENSURE AND CERTIFICATION INFORMATION:

License Type: ____________________ License Number: _______________________ State:_______________ Exp. Date: ____________

License Type: ____________________ License Number: _______________________ State: _______________ Exp. Date: ____________

Discipline or Specialty: ____

Date available to work: ____

ACLS Exp. Date: _______________ CNOR Exp. Date: _______________ CHEMO Exp. Date: _________________

BLS Exp. Date: _______________ CNRN Exp. Date: _______________ NRP Exp. Date: _______________

CCRN Exp. Date: _______________ ENPC Exp. Date: _______________ PALS Exp. Date: _______________

CEN Exp. Date: _______________ FHM Exp. Date: _______________ RNC Exp. Date: _______________

TNCC Exp. Date: _______________

Have you passed the NCLEX? ☐ Yes ☐ No

Have you ever had your license or certification in any state, investigated, suspended or had disciplinary action taken against it? ☐ Yes ☐ No

Have you ever been convicted of a crime other than a minor traffic violation? ☐ Yes ☐ No

Have you ever been named as a defendant in a professional liability action? ☐ Yes ☐ No
If you responded "Yes" to any of the above, please attach a separate sheet with explanation.

Are you either a U.S. Citizen or can you submit verification of your legal right to work in the U.S.? ☐ Yes ☐ No

Other names under which you have been employed: ____

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EDUCATIONAL INFORMATION:

	SCHOOL NAME	GRADUATION DATE	DEGREE RECEIVED
COLLEGE			
GRADUATE SCHOOL			
OTHER SCHOOL			

EMPLOYMENT HISTORY:

Facility/Employer Name: ____

Department: ____

Phone: ______________________________

City: _______________________________ State/Providence: ____________________

Dates Employed: From _______________ To: _______________

Reason for leaving: ____

Position Held: _____________________________________ Specialty: _________________________

Supervisor's Name and Title: ____

Facility/Employer Name: ____

Department: ____

Phone: ______________________________

City: _______________________________ State/Providence: ____________________

Dates Employed: From _______________ To: _______________

Reason for leaving: ____

Position Held: _____________________________________ Specialty: _________________________

Supervisor's Name and Title: ____

Facility/Employer Name: ____

Department: ____

Phone: ______________________________

City: _______________________________ State/Providence: ____________________

Dates Employed: From _______________ To: _______________

Reason for leaving: ____

Position Held: _____________________________________ Specialty: _________________________

Supervisor's Name and Title: ____

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Facility/Employer Name: ____

Department: ____

Phone: ______________________________

City: _______________________________ State/Providence: ____________________

Dates Employed: From _______________ To: _______________

Reason for leaving: ____

Position Held: ____________________________________ Specialty: _________________________

Supervisor's Name and Title: ____

SPECIALTIES:
Please indicate the number of years and months of experience you have in these specialties. Include areas of float.

	YEARS	MONTHS		YEARS	MONTHS
ICU	_______	_______	Surgical	_______	_______
CCU			Telemetry	_______	_______
Open Heart Critical Care	_______	_______	Cardiac Step-down	_______	_______
SICU	_______	_______	Neurology	_______	_______
Emergency Room	_______	_______	Ortho	_______	_______
Geriatrics	_______	_______	Rehabilitation	_______	_______
Burn	_______	_______	Dialysis	_______	_______
Gynecology	_______	_______	Diabetic	_______	_______
GU	_______	_______	Psych	_______	_______
Labor/Delivery	_______	_______	Operating Room	_______	_______
Post-Partum	_______	_______	Recovery Room	_______	_______
Nursery	_______	_______	Home Health	_______	_______
NICU	_______	_______	Nursing Management	_______	_______
Pediatrics	_______	_______	Other (*indicate*)	_______	_______
Medical	_______	_______			

CERTIFICATION

I certify that the information provided on this Application is truthful and accurate. I understand that providing false or misleading information will be the basis for rejection of my Application, or if employment commences, immediate termination.

I authorize Primo Healthcare Services to contact former employers and education organizations regarding my employment and education. I authorize my former employers and educational organizations to fully and freely communicate information regarding my previous employment, attendance, and grades. I authorize those persons designated as references to fully and freely communicate information regarding my previous employment and education.

If an employment relationship is created, I understand that unless I am offered a specific written contract of employment signed on behalf of the organization by its Owner, the employment relationship will be entirely voluntary in nature. In other words, with appropriate notice, I will have the full and complete discretion to end the employment relationship when I choose and for reasons of my choice. Similarly, my employer would have the same right. Moreover, no agent, representative, or employee of Primo Healthcare Services expect in a specific written contract of employment signed on behalf of the organization by its Owner, has the power to alter or vary the voluntary nature of the employment relationship.

I HAVE CAREFULLY READ THE ABOVE CERTIFICATION AND I UNDERSTAND AND AGREE TO ITS TERMS.

Applicant Signature: ____ Date: ____

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EEO INFORMAITON SURVEY

Federal regulations require the collection of certain data for our Equal Employment Opportunity reporting and planning. We are requesting your cooperation in completing this self-evaluation form.

THIS INFORMATION IS COLLECTED FROM APPLICANTS ON A VOLUNTARY BASIS AND IS KEPT IN THE HUMAN RESOURCES DEPARTMENT FOR FEDERAL REPORTING PURPOSES. THE FOLLOWING VOLUNTARY INFORMATION SHALL SERVE NO PURPOSE IN EVALUATING AN APPLICANT'S QUALIFICATIONS FOR EMPLOYMENT.

Name of Applicant: ____

Date of Application: ________________

Gender: ☐ Male ☐ Female

Racial/Ethnic Classification (Please designate one group only)

☐ **White (not of Hispanic origin)**
Any person having origin in any of the original peoples of Europe, North Africa, or the Middle East.

☐ **Black (not of Hispanic origin)**
Any person having origins in any of the Black racial groups.

☐ **Hispanic**
Any person of Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin, regardless of race.

☐ **Asian or Pacific Islander**
Any person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands, and Samoa.

☐ **American Indian or Alaskan Native**
Any person having origins in any of the original peoples of North American and whose main cultural identification is through tribal affiliation or community recognition. One-quarter Indian is the usual requirement for inclusion on a tribal roll.

☐ **Other (please specify)** ____

Person with a Disability: ☐ Yes ☐ No

United States Veteran: ☐ Yes ☐ No

If Yes, please check all that apply:

☐ Pre-Vietnam Era ☐ Vietnam Era

☐ Post-Vietnam Era ☐ Disabled Veteran

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REQUIRED DOCUMENTATION

In order for your application to begin the approval process, you will need to provide the following documents.

APPLICATION: (MUST BE RESUBMITTED IF OUT OF WORK FOR 6 MONTHS)
Applications must be updated every 2 years in its entirety, including education, **FULL** work history, residence, and emergency contacts.

RESUME: (MUST BE RESUBMITTED IF OUT OF WORK FOR 6 MONTHS)
Applications must submit most recent resume.

REFERENCES: (MUST BE RESUBMITTED IF OUT OF WORK FOR 6 MONTHS)
Applicant is required to submit 2 recent references from Charge Nurses, Clinic Managers, Area Managers, or Supervisors. The reference must be an evaluation of the applicant's skills as it pertains to their specialty from within the last 12 months.

Once your application is approved, you will need to provide a copy of the following documents. All expiration timelines given are per state rules. If a unit requests a more recent document, the staff member must provide it for the unit.

I-9, DRIVER'S LICENSE or PASSPORT, and SOCIAL SECURITY CARD: (AS EXPIRES)
Please fill out Section 1 completely with a signature and date. If you are not a U.S. Citizen, please provide documentation of authorization to work.

LICENSE and CERTIFICATIONS: (AS EXPIRES)
A copy of the current Registered Nursing license's front, back, and signature of the applicant is required.

BCLS/CPR: (AS EXPIRES)
Certification must be from AHA, ARC, or ASHI. This must be at Healthcare Provider Level. A copy of the current certification's front, back, and signature of the applicant is required. Online BLS is NOT acceptable.

WORKPLACE SAFETY AND PATIENT CARE STANDARDS CERTIFICATE: (ANNUAL)
Once login information is created for you. Please go to http://www.rn.com and complete the "Workplace Safety and Patient Care Standards" course and test with the username and password provided to you. This course covers fire safety, infection control, universal precautions, blood borne pathogens, TB, employee right to know, hazardous materials, Age Specific Competency, and HIPPA. Must pass with an 80% or higher.

PHYSICAL: (within 12 months prior to first case, every 4 years after)
A physical is required annually. The examining practitioner must complete a statement that the applicant is physically able to do their job without accommodations (or discusses accommodations) and is free from communicable diseases.

MEDICAL RECORDS and RELEASE STATEMENT: (ANNUAL)
Please be sure to complete the bottom of this form in its entirety. Please sign and date as this form allows Competent Nursing Staff, LLC to submit your documentation to facilities requesting coverage on your behalf.

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COLOR BLIND EXAM: (ONE TIME SUBMISSION)
Documentation must show date of exam and results.

DRUG SCREEN: (WHEN REQUESTED)
A 10-panel drug screen is required when requested. If there is a gap in employment greater than 30 days, a drug screen will be required again. Drug screening scripts will be provided by our company.

MMR and VARICELLA: (ONE TIME SUBMISSION)
MMR (Measles, Mumps, and Rubella) and Varicella titer results must be provided and show immunity. If low, or no immunity is shown, proof of vaccination record must be provided. Once re-vaccinated, titers will need to be drawn again approximately 30 days post vaccination administration.

HEPATITIS B: (ANNUAL)
Positive antibody within 365 days and must be repeated annually. Negative HepB antigen within 30 days prior to start date. If antibody is negative, the antigen is required and must be done every 6 months AND proof of vaccination or declination is required. If positive for antigen, a repeated HBeAG and HBeAB is required. If HBeAB is negative, a third draw to confirm results is required.

TUBERCULOSIS (PPD): (ANNUAL AFTER FIRST INITIAL 2 STEP)
Upon initial submission a 2-step PPD is required. Following the initial requirement a 1-step PPD test or a negative QuantiFERON TB Gold result is required annually and must have the applicant's name, facility and facility address where administered, month, day, and year read, NEGATIVE or POSITIVE results, and signature of the individual reading the test. The reader cannot be the applicant. If the PPD test is positive, an annual questionnaire and a chest x-ray is required every 5 years.

FLU DOCUMENTATION: (ANNUAL)
FLU vaccination administration record or declination record must be completed annually.

DIALYSIS SKILL'S TESTING: (ANNUAL – for Applicants interested in Dialysis Positions ONLY)
Please download our "Dialysis Test" from our website and complete the exam. Applicant's name must be on each sheet and dated. This exam tests the competency of hemodialysis and peritoneal Dialysis treatment.

DIALYSIS SKILLS CHECKLIST: (ANNUAL – for Applicants interest in Dialysis Positions ONLY)

*It is important to note that many facilities have individual or unique requirements that may not be listed above. Facilities at any time may ask for additional or updated documentation in which you may or may not provide.

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