



SKILLED NURSING EMPLOYMENT APPLICATION

Date: _____

PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell phone: _____ Email: _____

Do you require sponsorship to work in the US?: YES NO

Social Security Number: _____ Are you over the age of 18? YES NO

Emergency Contact: _____ Phone: _____

Position(s) Applying For: _____

AVAILABILITY						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning <input type="checkbox"/>						
Afternoon <input type="checkbox"/>						
Evening <input type="checkbox"/>						
Night <input type="checkbox"/>						

Are there any specific hours that you are not available for work? If so, please list below:

EDUCATION

Type of School	Name of School	Address	Number of Years Completed?	Major/Degree
High School				
College				
Trade School				
Graduate School				

HAVE YOU EVER BEEN CONVICTED OF A CRIME? YES NO

If yes, explain the number of convictions, the nature of the offense(s) leading to the conviction(s), how recently was/were the offense(s) committed, sentence(s) imposed, and type(s) of rehabilitation.

Please list any two references personal/professional references.

Name: _____

Name: _____

Position: _____

Position: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

EMPLOYMENT HISTORY

Please list your work experience starting with your most recent employer.

Employer Name Address and Phone Number	Name of Last Supervisor	Employment dates	Pay
		From: To:	Start: End:
		Last Job title:	
Job Duties and Responsibilities:		Reason for Leaving:	

Employer Name Address and Phone Number	Name of Last Supervisor	Employment dates	Pay
		From:	Start:
		To:	End:
		Last Job title:	
Job Duties and Responsibilities:		Reason for Leaving:	

Employer Name Address and Phone Number	Name of Last Supervisor	Employment dates	Pay
		From:	Start:
		To:	End:
		Last Job title:	
Job Duties and Responsibilities:		Reason for Leaving:	

Employer Name Address and Phone Number	Name of Last Supervisor	Employment dates	Pay
		From:	Start:
		To:	End:
		Last Job title:	
Job Duties and Responsibilities:		Reason for Leaving:	

Please list any additional skills, qualifications, certifications, or training that you feel is relevant to this position (e.g., speak a foreign language, CPR, or other training or special education).

For Skilled Nurses Only

Specialty: Check all that apply

<input type="checkbox"/> Medical/Surgical	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Autism
<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Hospice	<input type="checkbox"/> Other
<input type="checkbox"/> Case Management	<input type="checkbox"/> Home Health	
<input type="checkbox"/> Director of Nursing	<input type="checkbox"/> Alzheimer's or Dementia	

Experience

<input type="checkbox"/> less than a year	<input type="checkbox"/> 1-3 years	<input type="checkbox"/> 3-5 years	<input type="checkbox"/> More than 5 years
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Do you have a current license?: YES NO

If so, In which states?

Has your nursing license ever been suspended or revoked? YES NO

Have you ever been disciplined for being unprofessional or unethical nursing to include abuse or neglect?

YES NO

If so, explain

Skills Inventory

	Years of Experience	Training		Years of Experience	Training		Years of Experience	Training
Hospital			Transfer ROM			Geriatric Care		
Nursing Home			Bathing			Pediatric Care		
Private Home			TPR			Psychiatric Care		
Meal Prep			Blood Pressure			AIDS Care		
Special Diets			Dressing Change			Maternal		
CVA			Warm/Cold Compress			Intellectual Disability Care		
IV Therapy			Respiratory Care			Alzheimer's Care		
Foley Care			Ostomy Care			Oncology/ Hospice Care		
Tracheostomy			Ventilator					



PLEASE READ CAREFULLY

In exchange for the consideration of my job application by Agape Health Services, LLC, I agree that:

Neither the acceptance of this application nor the subsequent entry into any type of employment relationship, either in the position applied for or any other position. Both the undersigned and Agape Health Services, LLC may end the employment relationship at any time. _____

I further understand that my employment with the company shall be probationary for a period of ninety (90) days, and further that at any time during the probationary or thereafter, my employment relationship with Agape Health Services is terminable at will for any reason by either party. _____

I authorize investigation of all statements contained in this application. I understand that the misrepresentation or omission of facts called for is cause for dismissal at any time without any previous notice. I hereby give Agape Health Services, LLC permission to contact schools, all previous employers (unless otherwise indicated), references, and perform a criminal background check conducted by SLED as required by state law. I hereby release Agape Health Services from any liability as a result of such contact. _____

If I drive a vehicle for Agape or care, I will herein provide the following information:

- Valid Driver's License
- A copy of car insurance information

Signature of Applicant: _____ Date: _____

Agape Health Services, LLC is an equal employment opportunity employer. We adhere to a policy of making employment decisions without regard to race, color, religion, gender, sexual orientation, national origin, citizenship, age or disability. We assure you that your opportunity for employment with Agape Health Services depends solely on your qualifications.

Thank you for completing this application form and your interest in our business.