



For Office Use Only

Hire Date _____
 Job Title _____
 Pay Rate _____
 Authorize Hire _____
 Termination/Resign Date _____

Employment Application

Applicant Information

Full Name: _____ Date: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Phone: _____ Email _____

Date Available: _____ Social Security No.: _____ Desired Salary: \$ _____

Position Applied for: _____

Are you a citizen of the United States? YES NO If no, are you authorized to work in the U.S.? YES NO

Have you ever worked for this company? YES NO If yes, when? _____

Have you had any experience as a nurse or caregiver? YES NO If yes, how many years? _____

Is there any type of work which your physical condition prohibits, or have you been advised by a physician not to perform certain types of work? YES NO If yes, please explain. _____

Have you ever been convicted of a felony? YES NO

If yes, explain: _____

Education

High School: _____ Address: _____

From: _____ To: _____ Did you graduate? YES NO Diploma: _____

College: _____ Address: _____

From: _____ To: _____ Did you graduate? YES NO Degree: _____

Other: _____ Address: _____

From: _____ To: _____ Did you graduate? YES NO Degree: _____

References

Please list three references.

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Full Name: _____ Relationship: _____

Company: _____ Phone: _____

Address: _____

Previous Employment

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: \$ _____ Ending Salary: \$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES NO

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary: \$ _____ Ending Salary: \$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES NO

Company: _____ Phone: _____

Address: _____ Supervisor: _____

Job Title: _____ Starting Salary:\$ _____ Ending Salary:\$ _____

Responsibilities: _____

From: _____ To: _____ Reason for Leaving: _____

May we contact your previous supervisor for a reference? YES NO

Military Service

Branch: _____ From: _____ To: _____

Rank at Discharge: _____ Type of Discharge: _____

If other than honorable, explain: _____

Disclaimer and Signature

I certify that my application and all attachments are true and complete to the best of my knowledge. I understand that any incorrect, incomplete, or false statements or information furnished by me may, at the discretion of SHCR, disqualify me from employment, or cause my dismissal. I hereby authorize SHCR to make a thorough investigation of my past employment and activities. I release from all liability SHCR, former employers, or any persons supplying such information. The language in this application is not intended to create, nor is it to constitute a contract of employment.

Signature: _____ Date: _____



INTRODUCTION AND CHECKLIST

Nurse Name: _____ Phone: _____

Email Address: _____

Please submit the following:

1. Completed Application
2. Current TB Skin Test
3. Current CPR Card
4. Background Check
5. Social Security Card
6. Driver's License



Consent for Drug Screening

I _____, am aware that as a contract laborer, pre-employment drug testing is not necessary but that it may be requested that I voluntarily consent to a drug-screening at my own expense. I hereby give my consent for this screening. Star Healthcare Registry Nursing Agency will give site location of where this service may be performed. I am also aware that I will be limited to work offered if I do not have the test done before my shift is confirmed.

SIGNATURE _____

PRINT NAME _____ DATE _____



Emergency Contact Form

Name: _____

This information can be extremely important in the event of an accident or medical emergency. Please complete all fields below.

Emergency Contact Name: _____

Relationship _____

Phone (DAY) _____

Phone (EVENING) _____

Address: _____

Emergency Contact Name: _____

Relationship _____

Phone (DAY) _____

Phone (EVENING) _____

Address: _____



HEPATITIS B VIRUS VACCINE CONSENT OR DECLINATION

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 infection (HBV). At this time I choose the following: Check one, and sign at bottom.

I have already received the vaccine and so I am declining at this times.

I choose not to receive the vaccine at this time.

I may choose to be vaccinated against Hepatitis B while working as an active employee with Star Healthcare Registry Nursing Agency. I understand that I will be reimbursed for the cost of any shots in the Hepatitis B series taken during the time I am working through Star Healthcare Registry. In addition, I agree to request reimbursement while I am still actively accepting work and understand my request may be denied if it is made after I am terminated or inactivated for any reason.

SIGNATURE _____

PRINT NAME _____



OSHA REGULATIONS AND GUIDELINES

In accordance with OSHA regulations, each contractor must review the Blood Borne Pathogen, Hazard Communications, Emergency Action Plan, Fire Prevention and Escape Routes.

Excel has notified each facility that they are responsible and must review their facility's specific plan with each contractor that works in that facility.

Please review all enclosed material, sign and date this sheet. Fax or mail this sheet back to Star Healthcare Registry Nursing Agency for your personnel file.

I _____ have reviewed and understand the presented material as stated. I have been given the opportunity to clarify any questions that I may have.

SIGNATURE _____

DATE _____



PATIENT'S BILL OF RIGHTS

I feel each resident should expect the highest quality of personal and professional care. In keeping with this philosophy, I support and adhere to the Patient's Bill of Rights. Because of the importance of these expectations in my role, I am attesting to the portions of the Patient's Bill of Rights highlighted which affirm the rights of a resident:

1. To be treated with consideration, respect and full recognition of personal dignity and individuality.
2. To receive care, treatment and services which are adequate.
3. To receive respect and privacy of his or her personal and medical records.
4. To be free from mental and physical abuse.
5. To enjoy privacy in his or her space.
6. To associate and communicate privately with persons of his or her choice and send and receive his or her personal mail unopened.
7. To meet with and participate in activities of social, religious and community groups at his or her discretion.

No roster or right can guarantee for the resident the kind of treatment they have a right to expect. It is very important that each of my actions is conducted with a main concern for the resident and the recognition of their dignity as a human being. Violation of the Patient's Bill of Rights may result in disciplinary action up to and including revocation of license, termination and jail



Personal Character Reference

Name of Applicant _____
 Position Applied For _____
 Name of Reference _____
 Address of Reference _____
 Reference's Telephone _____

Your name has been submitted as a reference by _____, who has made an application for employment at Star Healthcare Registry Nursing Agency, Jackson, MS. In order to give adequate consideration to the application, we would appreciate your honest evaluation of the above mentioned as far as character, experience, and ability by selecting an answer below (5 is highest and 1 is lowest)

Attendance	5	4	3	2	1
Honesty	5	4	3	2	1
Cooperation	5	4	3	2	1
Dependability	5	4	3	2	1
Initiative	5	4	3	2	1
Courtesy	5	4	3	2	1
Quantity of Work	5	4	3	2	1
Ability to Learn	5	4	3	2	1
Ability to work with others	5	4	3	2	1

Comments

Please Return to:
 Star Healthcare Registry
 1900 Dunbarton Drive, Suite J
 Jackson, MS 39216

Signature of Ref. _____ Title _____ Date _____



Star Healthcare Registry Abuse/Exploitation Policy

It is Star Healthcare Registry policy for all employees to report any abuse, neglect, or exploitation. This should be reported to the Supervisor at the facility and to the administrative staff at Star Healthcare Registry. Any and all alleged abuse will be reported to proper authorities.

I have read and understand the above statement and agree to such policy.

SIGNATURE _____

DATE _____