

EMPLOYMENT APPLICATION



PERSONAL INFORMATION		TODAYS DATE:	
FIRST NAME	LAST NAME	SSN	
HOME ADDRESS	CITY	STATE	ZIP
CELL PHONE	HOME PHONE	EMAIL	
EMERGENCY CONTACT INFORMATION			
NAME	RELATION	PHONE NUMBER	
NAME	RELATION	PHONE NUMBER	
JOB INFORMATION			

Position (job class) applying for:

- RN
 PT
 LP/VN
 CNA
 OT
 PTA
 COTA
 OFFICE
 OTHER

Date Available: _____

Work Experience/Skills

Please list the number of years you have experience in each area (min 1 yr. exp.) and are clinically competent to work:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Home Health _____ | <input type="checkbox"/> Geriatric _____ | <input type="checkbox"/> Hospice _____ | <input type="checkbox"/> Pediatrics _____ |
| <input type="checkbox"/> Operating Room _____ | <input type="checkbox"/> Rehab _____ | <input type="checkbox"/> Telemetry _____ | <input type="checkbox"/> Post-Partum _____ |
| <input type="checkbox"/> Operating Room _____ | <input type="checkbox"/> Nursery _____ | <input type="checkbox"/> Psychiatry _____ | <input type="checkbox"/> Orthopedics _____ |
| <input type="checkbox"/> Detox/Drug Rehab _____ | <input type="checkbox"/> Dialysis _____ | <input type="checkbox"/> Burn _____ | <input type="checkbox"/> Mother/Baby _____ |
| <input type="checkbox"/> Recovery Room _____ | <input type="checkbox"/> ENT _____ | <input type="checkbox"/> Stepdown _____ | <input type="checkbox"/> PACU _____ |
| <input type="checkbox"/> Oncology _____ | <input type="checkbox"/> NICU _____ | <input type="checkbox"/> SICU _____ | <input type="checkbox"/> MICU _____ |
| <input type="checkbox"/> Pedi ICU _____ | <input type="checkbox"/> Neurology _____ | <input type="checkbox"/> CCU _____ | <input type="checkbox"/> L&D _____ |
| <input type="checkbox"/> Med/Surg _____ | <input type="checkbox"/> Open Heart _____ | <input type="checkbox"/> Emergency Room _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |



Previous Facility Types Worked: Check all that apply

- Hospital Nursing Home
 Rehab Private Duty Assisted Living/Residential Treatment

LANGUAGE SKILLS – Other than English please check any other languages you speak

- Spanish French Italian German Other

CHECK THE TIME YOU ARE AVAILABLE FOR

- Full-time Part-time PRN Contract Travel

DAYS OF THE WEEK YOU ARE AVAILABLE

- Sunday Monday Tuesday Wednesday Thursday Friday Saturday
 Available to work holidays

License Type	License Number	State	Expiration Date
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License Type	License Number	State	Expiration Date
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Has your professional license ever been suspended, revoked or under investigation? Yes No

If Yes, please explain: _____

Certifications: Check all applicable certifications and enter expiration date:

- ACLS – EXPIRATION: _____ IV – EXPIRATION: _____
 BCLS – EXPIRATION: _____ NALS – EXPIRATION: _____
 CPR – EXPIRATION: _____ OTHER: _____ EXPIRATION: _____
 PALS - EXPIRATION: _____

Additional Information:

Are you legally authorized to work in the United States? Yes No

Have you ever been convicted of a felony? Yes No

If yes please explain charges: _____

Can you pass a pre-employment drug test? Yes No

How were you referred to Avalon Home Health and Hospice? Yes No



Work Experiences:

List all of your work experience beginning with your most recent job. You will be asked to explain all gaps in employment. Attach additional sheet(s) if necessary.

FACILITY/EMPLOYER NAME	DATES EMPLOYED
ADDRESS	FROM: _____ TO: _____ CITY/STATE/ZIP _____ COUNTRY _____
TITLE	UNIT
SUPERVISOR	NUMBER OF BEDS IN UNIT _____ HOSPITAL _____
PHONE NUMBER	DESCRIBE DUTIES
PAY RATE/SALARY	MAY WE CONTACT- <input type="checkbox"/> Yes <input type="checkbox"/> No – IF NO, WHY?
REASON FOR LEAVING	ARE YOUR EMPLOYMENT RECORDS UNDER ANOTHER NAME? <input type="checkbox"/> Yes <input type="checkbox"/> No – IF YES, WHAT NAME:
SUPERVISORY EXPERIENCE	DID YOU HAVE ANY PROMOTIONS? EXPLAIN

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Please list any other work related information you think would be helpful to us in considering you for employment, such as specialized training, certifications, additional work experience, etc.



In signing this application, I certify that I have read and fully understand the questions asked in this application and that all answers given by me are true, accurate, and complete. I also understand that the omission, concealment, or misrepresentation of any fact on this application or during an interview for employment may jeopardize my chances for employment and may be cause for my immediate dismissal from employment.

I give Avalon Home Health and Hospice permission to use any information in this application to enable it and its agents to verify the information contained in this application. I also authorize present and former employers, educational institutions I have attended, credit agencies, all references, and any other persons to answer all questions asked by Avalon Home Health and Hospice with regard to any of the subjects covered by this application. I also understand that in connection with my application for employment or my employment, Avalon Home Health and Hospice may conduct a federal background check and that my employment may be contingent upon the results of such investigation. I release Avalon Home Health and Hospice, its agents, and all affiliated entities, as well as any person, or situation that provides any information about me, from any and all liability whatsoever resulting from any such investigation or the disclosure of such information.

I am willing to submit to a physical examination, including the analysis for the detection of the use of unlawful drugs or substances in accordance with the applicable laws. If I receive an offer of employment I agree that my continued employment may be contingent on the results.

I have read and fully understand the above statement

Applicant Signature: _____

Date: _____

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