Visiting Nurse

5910 Homestead Road, Fort Wayne, IN 46814 (260) 435-3222

AN EQUAL OPPORTUNITY EMPLOYER

It is the policy of our organization to provide employment, training and development, compensation, promotion, and all other conditions of employment without regard to race, color, religion, national origin, sex, sexual orientation, age, marital status, physical or mental disability or status as a disabled veteran. You may request any needed accommodation in order to complete this form. This application will be retained for one year.

- ☐ Did you complete all 5 pages of the application?
- ☐ Did you complete and sign the Criminal History request?
- ☐ Did you complete the Reference page?
- ☐ Is the application signed?

"Visiting Nurse Staff are not permitted to smoke on VN property or grounds"

PLEASE PRINT CLEARLY

Position(s) Applied For _____Date of Application_____/_____/_____

Referral Source ☐ Advertisement ☐ Employee ☐ Relative ☐ Website

☐ Other _____

E-mail address _____

Last Name	First Name		Middle Name
Address Number Street	City	State	Zip Code
Telephone Number(s)	Social Security Number		

Have you ever been employed with us? ..... ☐ Yes ☐ No

If yes, under what name? ..... _____

If yes, dates of employment? ..... From _____/_____ To _____/_____

Are you currently employed? ..... ☐ Yes ☐ No

Can you, with or without accommodation, perform the duties of the job for which you have applied? ..... ☐ Yes ☐ No

Are you legally eligible for employment in this country? ..... ☐ Yes ☐ No

(Proof of U.S. citizenship or immigration status will be required upon employment.)

On what date would you be available for work? ..... _____

Type of employment desired: ☐ Full Time ☐ Part Time ☐ Weekends ☐ Evenings ☐ Nights

Are you currently on "lay-off" status and subject to recall? ..... ☐ Yes ☐ No

Can you travel if a job requires it? ..... ☐ Yes ☐ No

Have you ever been convicted of a felony or misdemeanor other than a traffic violation? (Prior to hiring we must obtain a criminal history report by Indiana State Law)..... ☐ Yes ☐ No
Conviction will not necessarily disqualify an applicant from employment.

If yes, please explain _____

Do you have a valid driver's license? ..... ☐ Yes ☐ No

Driver's license number _____ State_____
(Upon hiring, we will run a Motor Vehicle Report (MVR) check to verify license and driving record.)

GENERAL SKILLS

Please check (☑) the items that are applicable to the position for which you are applying. Unrelated items may be checked (☑) at your discretion.

____ Filing
____ Switchboard
____Copy Machine
____Computer Skills
____Calculator
____Data Entry
____Medical Terminology
____Typing
____WPM
____Fax Machine

HOME HEALTH AIDE TASKS INVENTORY - Please indicate experience level in each of the following areas

SKILL	SOME EXP.	NO EXP.	SKILL	SOME EXP.	NO EXP.	SKILL	SOME EXP.	NO EXP.
Admin/Assist with Bed Bath			Perform Catheter Care - Female			Count Pulse Rate		
Admin/Assist with Tub/Shower			Perform Catheter Care - Male			Take Blood Pressure		
Perform Oral Hygiene-Conscious Patient			Apply Male External Catheter			Compute & Record Intake & Output		
Perform Oral Hygiene-Unconscious Patient			Empty Catheter Drainage Bag			Care of Patient in Isolation		
Give Back Rub			Collect Voided Urine Specimen			Care of Terminally Ill Patient		
Bedmaking - Unoccupied			Collect Urine Specimen from Catheter			Care of Psychiatric Patient		
Bedmaking - Occupied			Collect Stool Specimen			Care of the Mentally Retarded		
Transfer Patient Bed to Wheelchair & Return			Collect Sputum Specimen			Care of the Geriatric Patient		
Transfer Patient Bed to Commode & Return			Change Ostomy Appliance			Care of Newborns & Infants		
Assist with ROM Exercise			Prepare Regular Diets			Care of Children		
Assist Patient to Walk with Crutches/ Walker/Cane			Prepare Special Diets			Care of the Physically Handicapped		
Assist Patient with Bedpan or Urinal			Take Oral Temperature			Care of Stroke Patient		
			Take Auxiliary Temperature			Use of Hoyer Lift		

REGISTERED NURSE/LICENSED PRACTICAL NURSE SKILLS CHECK LIST - Please indicate experience level

SKILL	SOME EXP.	NO EXP.	SKILL	SOME EXP.	NO EXP.	SKILL	SOME EXP.	NO EXP.
Care of the Quadriplegic Patient			Insertion of an Airway			Application of Ostomy Appliance		
Care of the Paraplegic Patient			Perform CPR			Administer Enema or Douche		
Application of Prosthesis			Use of Defibrillator			Perform Colostomy Irrigation		
Use of Hoyer Lift			Perform Venipuncture			Foley Catheter Insertion - Female		
Instruct in Ambulation with walker, cane, crutches			Application of Back, Neck, Leg Brace			Foley Catheter Insertion - Male		
Carry out ROM Exercises			Perform Oral-Pharyngeal Suctioning			Foley Catheter Irrigation		
Care of Patient with Neurological Disease			Assist with Bed, Chair, Tub Transfers			Irrigate Supraupubic Catheter		
Insertion of N/G Tube			Assist with Renal or Peritoneal Dialysis			Perform Trachael Care		
Function as Medication Nurse			Administer N/G Tube Feedings			Administer Tracheostomy Care		
Administer I.M. or S.C. Injection			Administer Gastrostomy Tube Feeding			Perform Shunt or Fistula Care		
Start I.V. Infusion			Assist with Hyperalimentation			Care of Patient on Mechanical Ventilation		
Care of the Pediatric Patient			Administer & Maintain I.V. Infusion			Interpret Cardiac Monitor Readings		

Special Skills and Qualifications

Summarize special job-related skills and qualifications acquired from employment or other experience. Include any foreign languages you speak or sign language capability.

_____

_____

_____

_____

_____

_____

EDUCATION

School	Name and Location of School	Course of Study	No. of Years Completed	Did You Graduate?	Degree or Diploma
Graduate				☐ Yes ☐ No	
College				☐ Yes ☐ No	
Business/Trade/ Technical				☐ Yes ☐ No	
High School				☐ Yes ☐ No	
Elementary				☐ Yes ☐ No	

Have you ever been known by another name? ☐ Yes ☐ No

If yes, by what name(s)? _____

Are you currently under any legal or contractual restrictions that would prevent you from accepting employment with our organization? If yes, please explain_____

List professional, trade, business, or civic associations and any offices held. (Exclude memberships which would reveal sex, race, religion, national origin, age, color, disability or other protected status.)

Organization	Offices Held

LICENSURE

Must be completed by individuals applying for positions that require professional registration or licensure.

Professional Registration	License/Certificate Number (as applicable)	Date of Issue	Expiration Date	State
Professional (RN, LPN, B/MSW)				
Certification (HHA, CNA)				
Other				

EMPLOYMENT

Please give accurate, complete full-time and part-time employment record. Start with your present or most recent employer.

1

Company Name	Telephone ( )
Address	Employed – (State month and year) From To
Name of Supervisor	Weekly pay Beginning Ending
State Job Title and describe your work	Reason for Leaving

2

Company Name	Telephone ( )
Address	Employed – (State month and year) From To
Name of Supervisor	Weekly pay Beginning Ending
State Job Title and describe your work	Reason for Leaving

3

Company Name	Telephone ( )
Address	Employed – (State month and year) From To
Name of Supervisor	Weekly pay Beginning Ending
State Job Title and describe your work	Reason for Leaving

4

Company Name	Telephone ( )
Address	Employed – (State month and year) From To
Name of Supervisor	Weekly pay Beginning Ending
State Job Title and describe your work	Reason for Leaving

We may contact the employers listed above unless you indicate those you do not want us to contact.

DO NOT CONTACT

Employer Number(s) _____ Reason _____

References

List name, address, and telephone number of three references that are not related to you and are not previous employers.

Name	Address	Telephone	Years Known
		( ) -	
		( ) -	
		( ) -	

Applicant Certification and Agreement

I certify that the information provided in this application is true and complete. I authorize Visiting Nurse to investigate all statements contained in my application for employment and understand that any false or misleading statements or material omissions are cause for refusal to hire or cause separation of employment, if employed. I hereby authorize former and present employers, except as I have otherwise indicated in writing, as well as physicians, medical personnel, references and others to provide or verify any information they have regarding me or my employment with them to this organization (hereinafter called the "Agency") or its representatives and release them from any liability arising from the furnishing of any employment history or medical information to the Agency.

I further agree and understand that except as governed by existing federal, state or local law, where applicable, my employment or an offer of employment establishes no guarantee or promise of continued employment or set hours of work or any other obligation on the part of the Agency beyond pay for actual work performed at the agreed upon rate and that the employment relationship may be terminated at any time, by myself or the Agency, at either party's option and will.

I understand that the needs of the Agency may require that I be assigned increased hours, decreased hours, shift work, overtime work, weekend work, rotation shifts or other work schedule arrangements or changes in my work schedule or hours and I hereby agree to accept any such work schedule or hours or any such changes in work schedule or hours as a condition of employment with the Agency.

I agree to accept and abide by the policies of the Agency as may from time to time be established or amended. I understand that only the President of the Agency may amend this Agreement and that such amendment must be in writing.

I also understand that this is an Application for Employment only and that I have not been offered employment by this organization.

_____ _____

Signature of Applicant Date

For Agency Use Only

Interviewed by: _____ Date: _____

Comments:

Notifications:

Phone References:

FTE: _____ Starting Salary: _____