



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 4 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.

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Filing | <input type="checkbox"/> Calculator | <input type="checkbox"/> Typing |
| <input type="checkbox"/> Switchboard | <input type="checkbox"/> Data Entry | <input type="checkbox"/> WPM |
| <input type="checkbox"/> Copy Machine | <input type="checkbox"/> Medical Terminology | <input type="checkbox"/> Fax Machine |
| <input type="checkbox"/> Computer Skills | | |

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.

E D U C A T I O N	School	Name and Location of School	Course of Study	No. of Years Completed	Did You Graduate?	Degree or Diploma
	Graduate				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	College				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Business/Trade/ Technical				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	High School				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Elementary				<input type="checkbox"/> Yes <input type="checkbox"/> 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

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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

