All N One Nursing Registry, LLC
Application

Today's Date: ____________

Personal Data

Last Name	First Name	Middle

Home Address	City	State	Zip

Home Phone	Cell Phone	Pager	Email	Fax

Driver's license or State Identification	Social Security	Birthdate

Emergency Contact Information

Name of Emergency Contact	Relation	Emergency Telephone Number

Name of Emergency Contact	Relation	Emergency Telephone Number

Physician	Telephone Number	Address

Hospital	*Telephone Number*	*Address*

Job Information

Position (Job Class) Applying for:

☐ RN ☐ PT ☐ LP/VN ☐ CNA ☐ OT ☐ PTA ☐ Clerical ☐ Other ____________ Date Available: ____________

Work Experience/Skills
Please check the areas you have experience in (min 1 year exp.) and are clinically competent to work:

☐ Burn	☐ ENT	☐ Pediatrics	☐ Detox/Drug Rehab
☐ L & D	☐ Rehab	☐ Telemetry	☐ Post Partum
☐ MICU	☐ Nursery	☐ Psychiatry	☐ Orthopedics
☐ NICU	☐ Dialysis	☐ Stepdown	☐ Mother/Baby
☐ PACU	☐ Geriatric	☐ Oncology	☐ Recovery Room
☐ SICU	☐ Pedi ICU	☐ Neurology	☐ Operating Room
☐ CCU	☐ Med/Surg	☐ Open Heart	☐ Emergency Room
☐ Other	☐ Other	☐ Other	☐ Other
____________	____________	____________	____________

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Previous Facility Types Worked: Check All That Apply –

☐ Hospital ☐ Hospice ☐ Nursing Home ☐ Rehab ☐ Private Duty ☐ Assisted Living / Residential Treatment

Language Skills: **Other than English, please check any other languages you speak –**	**Check the type of assignment you are available for:**
☐ Spanish ☐ French ☐ German ☐ Other: ______	☐ Full-time ☐ Part-time ☐ Contract ☐ Travel

Check the days of the week you are available to work:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Shifts available to work: Days ☐ Evenings ☐ Nights ☐

Do you work Doubles: Day/Evening ☐ Evening/Night ☐

☐ Holidays available to work: ______________________________

License Type	License/Certification #	State	Expiration Date
License Type	License/Certification #	State	Expiration Date

Has your professional license ever been suspended, revoked or under investigation? ☐ Yes ☐ No
If Yes, Please explain: ______________________________

Have you ever been denied a Fingerprinting Clearance Card? ☐ Yes ☐ No
If Yes, Please explain: ______________________________

Certifications: Check all applicable certifications and enter expiration date:

☐ **ACLS** **Expiration Date:** __________

☐ **BCLS** **Expiration Date:** __________

☐ **CPR** **Expiration Date:** __________

☐ **PALS** **Expiration Date:** __________

☐ **Other** **Expiration Date:** __________

☐ **IV** **Expiration Date:** __________

☐ **NALS** **Expiration Date:** __________

Do you have the following items needed to work Registry: Check all applicable and enter expiration date as needed:

☐ **License/Certification** **Expiration Date:** ________ **(Must provide proof)**

☐ **TB Test** **Expiration Date:** __________ **(Must provide proof)**

☐ **CPR** **Expiration Date:** __________ **(Must provide proof)**

☐ **Fingerprint Clearance Card** **Expiration Date:** ______ **(Must provide proof)**

☐ **Drug Test** **Date Performed :** ______ **(Must provide proof**

☐ **Annual Physical** **Date Performed:** ______________ **(Must provide proof)**

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☐ Chicken Pox Verification
I certify I have had the Chicken Pox Date: ______________
Signature:______________________________ Date:__________________

☐ Hepatitis B Declination Form: 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 (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatits B, a serious disease. If in the future I continue to have have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge.
Signature:_____________________________________ Date:______________

Immunization Record:

MMR Vaccination ☐ Immunization ☐ Titer Date:____________________

Varicella (Chicken Pox) ☐ History ☐ Titer Date:____________________

Hepatitis B Vaccination: Date:____________________

Negative TB Test (Annual) Date:____________________

Negative Chest X-Ray (If positive TB Test) Date:____________________

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Work Experience: 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	Date Employed From: ______________ To: ______________ .
Address	Title
City/State/Zip Country	Unit
Number of Beds in Unit: ______________ In Hospital: ______________	Name of Current Immediate Supervisor
Describe duties and specialty areas:	Telephone #:
Pay Rate/Salary: Hourly ________ Yearly __________	May We Contact: ☐ Yes ☐ No – If no, why?
Reason for leaving:	If this was a travel assignment, name of agency:
Are your employment records listed under another name? ☐ No ☐ Yes If yes, what name?	Supervisory Experience: ☐ Yes ☐ No – How often?

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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.

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Additional Information:

1. Are you legally authorized to work in the USA? ☐ Yes ☐ No
2. Have you ever been convicted of a felony? ☐ Yes ☐ No
3. Can you pass a pre-employment drug test? ☐ Yes ☐ No
4.
5. How were you referred to Registry, LLC?
   ☐ Newspaper ☐ Trade Publication ☐ Job Fair/Open House ☐ Internet Site
   ☐ Company Employee – Name: ______________________________

I understand that **I must** report all accidents to my immediate supervisor **and** to All N One Home Health Agency, LLC - - No MATTER HOW SLIGHT. ☐ Yes

I also understand that I must wear all required personal protection equipment (PPE). ☐ Yes
The penalty for not wearing PPE is disciplinary action, up to and including termination.

____
Signature

ACKNOWLEDGMENT (*Please read carefully and sign*)

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 any interview for employment may jeopardize my chances for employment and be cause for my immediate dismissal from employment.

I give All N One Nursing Registry, LLC 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 All N One Nursing Registry, LLC 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, All N One Nursing Registry, LLC may conduct a criminal background investigation and that my employment may be contingent on the results of such investigation. I release All N One Nursing Registry, LLC, 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.

In consideration of my employment and of my being considered for employment by All N One Nursing Registry, LLC, I agree to abide by all rules and regulations, which I understand are subject to change at any time for any reason without prior notice. I also understand that if employed, I will be an Independent Contractor at will and employed for no definite period of time.

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 understand that All N One Nursing Registry, LLC is not involved in the day-to-day supervision or decision concerning patient care or dentistry. This remains with the Professional as part of the Professional's practice. The Professional fully indemnifies All N One Nursing Registry, LLC against any and all liability and responsibility associated with his or her professional duties. The Professional maintains his or her license as required by law, professional liability coverage and other responsibilities as found under state prime contract law.

I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.

Applicant Signature ______________________________ Date ________________