Ellendee Healthcare Agency LLC

EMPLOYMENT APPLICATION

PERSONAL INFORMATION

FIRST NAME: _____ LAST NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

SOCIAL SECURITY NUMBER: _____

DRIVER'S LICENSE NUMBER: _____

EMAIL ADDRESS: _____

ARE YOU ABLE TO LEGALLY WORK IN THE UNITED STATES? YES: _____ NO: _____

HOW DID YOU HEAR ABOUT US? _____

HAVE YOU EVER BEEN CONVICTED OF A CRIMINAL OFFENSE (FELONY OR MISDEMEANOR)? NOTE: An affirmative answer will not necessarily result in disqualification for employment: YES: _____ NO: _____

IF YES, PLEASE EXPLAIN: _____

_____

_____

LIST ANY FRIENDS OR RELATIVES EMPLOYED BY ELLENDEE MEDICAL STAFFING:

_____

_____

EMPLOYMENT

POSITION APLYING FOR: _____

SALARY DESIRED: _____

WHAT DAYS ARE YOU AVAILABLE TO WORK? DAYS, EVE, NOC ETC.

_____

ARE YOU ABLE TO OVER TIME IF NECESSARY? YES: _____ NO: _____

ARE YOU OVER 18 YEARS OF AGE? YES: _____ NO: _____

WHEN CAN YOU BEGIN WORK? _____

ARE YOU ABLE TO PERFORM THE ESSENTIAL FUNCTIONS OF THE JOB, WHICH YOU ARE APPLYING FOR? _____

SKILLS

ARE YOU ABLE TO OPERATE A PERSONAL COMPUTER? YES: _____ NO: _____

WHAT KNOWLEDGE, SPECIAL SKILLS AND/OR INDIVIDUAL CAPABILITIES DO YOU HAVE WHICH ESPECIALLY PREPARE YOU FOR THE POSITION APPLIED FOR?

_____

_____

_____

DO YOU SPEAK ANY OTHER LANGUAGES OTHER THAN ENGLISH? YES: _____ NO: ___

_____

EDUCATION

HIGH SCHOOL OR TRADE SCHOOL
NAME AND CITY:

____

NUMBER OF YEARS COMPLETED: __________ DID YOU GRADUATE? YES: ____ NO: _____

COLLEGE OR UNIVERSITY
NAME AND CITY:

____

NUMBER OF YEARS COMPLETED: _________ DID YOU GRADUATE? YES: _____ NO: _____
DEGREE (S) OR
DIPLOMA(S):____

EMPLOYMENT HISTORY

PLEASSE BEGIN WITH YOUR CURRENT OR MOST RECENT

EMPLOYER: _________________________________ PHONE: _____________________________________
ADDRESS: ___________________________________ MAY WE CONTACT? YES: _______NO: ______
JOB TITLE: __________________________________ SALARY: ____________________________________
DATES EMPLOYED: FROM: ___________________________ TO: ______________________________
JOB DUTIES: ____
REASON FOR LEAVING: ____

EMPLOYER: _________________________________ PHONE: _____________________________________
ADDRESS: ___________________________________ MAY WE CONTACT? YES: _______NO: ______
JOB TITLE: __________________________________ SALARY: ____________________________________
DATES EMPLOYED: FROM: ___________________________ TO: ______________________________
JOB DUTIES: ____
REASON FOR LEAVING: ____

EMPLOYER: _________________________________ PHONE: _____________________________________
ADDRESS: ___________________________________ MAY WE CONTACT? YES: _______NO: ______
JOB TITLE: __________________________________ SALARY: ____________________________________
DATES EMPLOYED: FROM: ___________________________ TO: ______________________________
JOB DUTIES: ____
REASON FOR LEAVING: ____

MILITARY SERVICE

HAVE YOU OBTAINED ANY SPECIAL SKILLS OR ABILITIES AS THE RESULT OF SERVICE IN THE MILITARY? YES: _____ NO: _____
DESCRIBE: _____

PERSONAL REFERENCES

PLEASE LIST AT LEAST THREE (3) PERSONS NOT RELATED TO YOU, WHO YOU HAVE KNOWN FOR ATLEAST FIVE (5) YEARS.

NAME: _____ PHONE: _____
ADRESS: _____ YEARS KNOWN: _____

NAME: _____ PHONE: _____
ADRESS: _____ YEARS KNOWN: _____

NAME: _____ PHONE: _____
ADRESS: _____ YEARS KNOWN: _____

I hereby certify that all the information I have provided to **Ellendee Medical staffing** on this application is true and accurate. I understand and acknowledge that any misrepresentation or omissions may result in disqualification from employment and/or immediate termination.

EMPLOYEE SIGNATURE: _____ DATE: _____

OFFICE STAFF SIGNATURE: _____ DATE: _____

Ellendee Healthcare Agency LLC

CERTIFIED NURSING ASSISTANT JOB RESPONSABILITIES

MULTI-TASKING, MEDICAL TEAMWORK, BEDSIDE MANNER, INFECTION CONTROL, NURSING SKILLS, HEALTH PROMOTION AND MAINTENANCE, CREATING A SAFE AND EFFECTIVE ENVIRONMENT, INFORMING OTHERS, JUDGEMENT, PAIN MANAGEMENT AND ACUTE/CRITICAL CARE.

CERTIFIED NURSING ASSISTANT JOB DUTIES

PROVIDES PATIENT'S PERSONAL HYGIENE BY GIVING BEDPANS, URINALS, BATHS, BACKRUBS, SHAMPOOS, AND SHAVES. ASSIST WITH TRAVEL TO THE BATHROOM AND HELPING WITH SHOWERS AND BATHS.

PROVIDES FOR ACTIVITIES OF DAILY LIVING BY ASSISTING WITH SERVING MEALS, FEEDING PATIENTS AS NECESSARY ALSO AMBULATING, TURNING AND POSITIONING PATIENTS, AND PROVIDING FRESH WATER AND NOURISHMENT BETWEEN MEALS.

MAINTAINS PATIENTS STABILITY BY CHECKING VITAL SIGNS AND WEIGHT. TESTING URINE AND RECORDING INTAKE AND OUTPUT IMFORMATION.

PROVIDES PATIENTS COMFORT BY UTILIZING RESOURCES AND MATERIALS ANSWERING PATIENTS CALL LIGHTS AND REQUEST AND REPORTING OBSERVATIONS OF THE PATIENT TO NURSING SUPERVISOR.

DOCUMENTS ACTIONS BY COMPLETING FORMS, REPORTS, LOGS, AND RECORDS.

MAINTAINS WORK OPERATIONS BY FOLLOWING POLICIES AND PROCEDURES.

PROTECTS ORGANIZATIONS VALUE BY KEEPING PATIENTS INFORMATION CONFIDENTIAL.

SERVES AND PROTECTS THE FACILLITY COMMUNITY BY ADHERING TO PROFESSIONAL STANDARS, FACILITIES POLICIES AND PROCEDURES, FEDERAL, STATE, AND LOCAL REQUIREMENTS AND JCAHO STANDARDS.

UPDATE JOB KNOWLEDGE BY PARTICIPATIONG IN EDUCATIONAL OPPORTUNITIES, READING PROFESSIONAL PUBLICATIONS, PARTICIPATING IN PROFESSIONAL ORGANIZATIONS AND MAINTAINING LICENSURE.

ENHANCES NURSING DEPARTMENT AND FACILITIES REPUTATION BY ACCEPTING OWNERSHIP ACOMPLISHING NEW AND DIFFERENT REQUEST, EXPLORING OPPORTUNITIES TO ADD VALUE TO JOB ACCOMPLISHMENTS.

EMPLOYEE SIGNATURE: _____ DATE: _____

OFFICE STAFF SIGNATURE: _____DATE: _____

EDUCATION AND EXPERIENCE

HIGH SCHOOL EDUCATION

CURRENT NAC/LPN/RN CERTIFICATION OR LICENSE IN WA STATE

CURRENT CPR CERTIFICATION

WORKING CONDITIONS

EXPOSURE TO SIGNIFICANT WORK PACE/PRESSURE

EXPOSURE TO CHEMICALS AND DISINFECTANTS

EXPOSURE TO BODILY FLUIDS

WORK IN WELL LIGHTED, HEATED, AIR CONDITIONING BUILDING

OTHER CONSIDERATIONS

ALL REQUIREMENTS ARE SUBJECT TO POSSIBLE MODIFICATION TO REASONABLY ACCOMMODATE INDIVIDUALS WITH KNOWN DISABILITIES, UNLESS TO DO SO WOULD IMPOSE A HARDSHIP ON THE OPERATIONS OF THE FACILITY.

I, _____ HAVE READ THIS JOB DESCRIPTION AND I FULLY UNDERSTAND THE CONDITIONS SER FORTH THEREIN, AND WILL PERFORM THESE DUTIES TO THE BEST OF MY KNOWLEDGE AND ABILITY.

EMPLOYEE SIGNATURE: _____ DATE: _____

OFFICE STAFF SIGNATURE: _____ DATE: _____

THE FOLLOWING IS FOR IDENTIFICATION PURPOSES ONLY TO PERFORM THE BACKGROUND CHECK, AND WILL NOT BE USED FOR ANY OTHER PURPOSE

DATE: _____

PRINT NAME: _____

SIGNATURE: _____

SSN: _____

DATE OF BIRTH: _____
(For background purposes only)

DRIVERS LICENSE NUMBER: _____ STATE: _____

CURRENT ADDRESS: _____

PREVIOUS ADDRESS (LAST 7 YEARS): _____

_____

_____

_____

ANY OTHER NAMES I HAVE BEEN KNOWN BY (INCLUDIG MAIDEN NAME)
_____

_____

_____

EMPLOYEE SIGNATURE: _____ DATE: _____

Ellendee Healthcare Agency LLC

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize **Ellendee Medical Staffing LLC** or any other organization or person having any records, data, or information concerning me to furnish such records, data, or information to or its representative in regards to employment information. I understand that **Ellendee Medical Staffing LLC** will keep such information confidential. I agree that a photocopy of this authorization shall be considered as effective and valid as the original

EMPLOYEE SIGNATURE: _____ DATE: _____