



Thank you for choosing California Nursing Care Services, Inc. We look forward to working together with you. Our company is very flexible, and works hard to get you the hours you desire at the facilities you request. In addition to completing the hiring packet we will need copies of the following forms to complete your employee file:

- Driver's License and SS Card (for I-9)
- Current License (if applicable)
- Current BLS
- Current ACLS/PALS/NRP (If applicable)
- Copy of Immunization record (Proof of MMR)
- Copy of TB (PPD Skin test) within one year

The application process can seem overwhelming at first, but all of the documents required are the same that are needed for hospital employment. We have built a good reputation for our meticulous record keeping and meeting stringent nurse hiring requirements which has allowed us to gain more hospital contracts and offer more shifts with fewer cancellations. We are honored that you have decided to join our team and allowing us to represent you in the healthcare industry. If you have any questions please feel free to contact our office at 909-989-7700.

Sincerely,

Margaret Aiyetiwa, RN, BSN, Administrator

California Nursing Care Services, Inc

11010 Arrow Route Suite 109

Rancho Cucamonga, CA 91730

Phone: 909-989-7700

Fax: 909-989-7744

Website: www.cnchealthcare.com



Application for Employment

Thank you for applying for a position with California Nursing Care Services, Inc. We appreciate the time you are giving to complete this application. It is important that you fully and accurately complete this form yourself and indicate the position(s) for which you wish to be considered. The following must be filled out completely for your application to be considered.

Name: _____
Last First Middle

Have you ever used another name? Yes No If yes, what: _____

Home Telephone: (____) _____ Other Telephone: (____) _____

Date of Birth: _____ Social Security #: _____

Have you ever used another Social Security Number? Yes No

Present Address: _____
No. Street City State Zip

Mailing Address: _____
(If different) No. Street City State Zip

Emergency Contact: _____ Phone: _____

Employment Desired:

Position applying for: _____

If hired, on what date can you start work? _____ Salary desired? _____

References:

How did you hear about our company? _____

List below three persons not related to you who have knowledge of your work performance within the last three years. If this does not apply to you, then provide three school or personal references that are not related to you.

Name	Address	Phone	Years Known
1.) _____	_____	_____	_____
2.) _____	_____	_____	_____



3.) _____

Education and Training

Name and State	Degree Obtained	Date Graduated
High School: _____	_____	_____
College/University: _____	_____	_____
Vocational/Business: _____	_____	_____

Employment History:

List below all present and past employment, starting with your most recent employer:

Are You Employed Now? Yes No May we contact your present employer? Yes No

Name of Employer: _____

Address: _____

No.	Street	City	State	Zip
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Telephone: (____) _____ Your Supervisor's Name: _____

Position Held: _____

Date of Employment: From: _____ To: _____

Earnings: Starting: _____ / Ending: _____

Exact Reason for Leaving: _____

Name of Employer: _____

Address: _____

No.	Street	City	State	Zip
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Telephone: (____) _____ Your Supervisor's Name: _____

Position Held: _____

Date of Employment: From: _____ To: _____

Earnings: Starting: _____ / Ending: _____

Exact Reason for Leaving: _____

Name of Employer: _____

Address: _____

No.	Street	City	State	Zip
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Telephone: (____) _____ Your Supervisor's Name: _____

Position Held: _____

Date of Employment: From: _____ To: _____

Earnings: Starting: _____ / Ending: _____

Exact Reason for Leaving: _____



License Information

Answer the following questions if applying for a professional position:

Are you licensed for the job applied for? Yes No Type of license (RN/LVN/CNA): _____
Issuing state: _____ License/certification number: _____ Has your license ever
lapsed, been revoked or suspended? Yes No If yes, state reason(s), date of lapse,
revocation or suspension and date of reinstatement: _____

Have you ever, under your name or another name, been convicted of (or pleaded guilty or nolo
contendere to) a Felony or Misdemeanor? Yes No

Have you ever, under your name or another name, been convicted of a crime, which resulted
with your being in prison and released from prison or paroled? Yes No

(Do not identify convictions for marijuana-related offenses that are more than two years old; or
convictions for which the criminal record has been expunged, sealed or eradicated by the court;
or, misdemeanor convictions for which any probation has been completed and the case
dismissed by the court.)

If yes, explain each conviction fully, when, where and of what you were convicted and
disposition of the case(s):

Are you currently under arrest, or released on bond or your own recognizance, pending trial for
a criminal offense? Yes No

If yes, state the nature of the crime charged, and when and where trial is pending:

The following section is for employment within the healthcare industry in California

Please answer the following only if:

1. The position for which you are applying will provide you access to patients. Have you ever
been arrested for a sex related crime? Yes No If Yes, Please Explain:

2. The position for which you are applying will provide you access to drugs or medications.
Have you ever been arrested for a drug related crime? Yes No Please Explain:



Authorization

Personally completed this form honestly and accurately

By my signature below, I promise that I have personally completed this application. I declare under penalty of perjury that the information provided in this employment application (and accompanying resume, if any) is true and complete, and I understand that any false information or significant omissions may disqualify me from further consideration for employment, and may be justification for my dismissal from employment if discovered at a later date. I understand that any job offer is conditional based on the satisfactory review of my qualifications including any and all background or drug screening which may be required.

Drug and Alcohol screening

I give permission for a pre-employment drug/alcohol screening exam, and, if the company makes a conditional job offer, I give permission for a complete employment physical and mental examination. I also consent to the appropriate release of any and all medical information, as may be deemed necessary. (See separate Agreement)

Authorization to obtain information

I voluntarily and knowingly authorize any present or past employer; supervisor; administrator; educational institution; law enforcement agency; state, local, or federal agency; credit bureau; collection agency; private business; military branch; the national personnel records center; personal reference; and/or other persons; to give records or information they may have concerning my criminal history, motor vehicle report, educational history, licensing, employment (including character, earnings history and reasons for termination) or any other information requested by the company requested to determine my eligibility for employment.

Release

I voluntarily waive all recourse and release any company, individual or organization from liability for complying with any request from the company or agents of the company (including any consumer reporting agency) to obtain any information from any source whatsoever relating to my application for employment. I further release the company or any individual within the company regarding the use any information received which may have bearing on my application for employment.

Notification and compliance with rules

I agree to immediately notify the company if I should be convicted of a crime while my job application is pending, or during my employment if hired. If I become employed, in consideration of my employment, I agree to comply with the rules, regulations, policies and procedures of the company.

I certify that all of the information provided by me on this Application is true and accurate.

Signature: _____

Date: _____

Print Name: _____



Hepatitis B Vaccine

OSHA requires all health care workers at risk to have the opportunity to have the Hepatitis B Vaccination offered to them by their employer.

1. If you have completed the vaccination series, please indicate such at the appropriate statement, date and sign the bottom of this letter.
2. If you are in the process of receiving the series, please indicate, date and sign at the bottom of this letter. Please indicate if you require a dose of the vaccine while working on this contract. Omega Healthcare Staffing, Inc will provide it to you at no cost.
3. If you decline to have the Hepatitis B Vaccine indicate this at the bottom of this letter, sign and date.

*****Please Choose Only One*****

I understand the OSHA guidelines and have completed the Hepatitis B Vaccine series

Signed: _____ Date: _____

I understand the OSHA guidelines and need #____ or booster, in the series. Please make arrangements with us to receive this dose of the vaccine.

Signed: _____ Date: _____

I understand the OSHA guidelines and DECLINE the Hepatitis B Vaccination.

Signed: _____ Date: _____



Education Acknowledgment Form

This is to acknowledge that I have received training on and a copy of California Nursing Care Services, Inc's Annual Education Booklet which contains information and verification of procedures related to the following:

Blood borne Pathogens and Universal Precautions
Latex Allergies
Hospital and Fire Safety
Emergency Preparedness
Security and Workplace Violence
Tuberculosis Education
HIPAA Education
Patient Rights
Risk Management
Age Specific Competency
Use of Restraints
Abuse Reporting
Sexual Harassment
Conscious Sedation
Advance Directives
Organ Donation
Medication Errors
Preventing Workplace Injuries
JCAHO National Patient Safety Goals

I understand that the above mentioned materials provide guidelines and summary information about the company's policies and procedures. I also understand that it is my responsibility to read, understand, become familiar with, and comply with the standards that have been established.

Signature: _____

Print Name: _____

Date: _____



Licensed Vocational/Practical Nurse Job Description

Summary

Assume responsibilities for direct nursing care of assigned patients under the supervision of a registered nurse or physician in patient care area. Provides nursing services to patients and families in accordance with the scope of the LPN as defined by the California Board of Nursing

Duties and Responsibilities

- Provide and document direct nursing care of assigned patients under the supervision of a registered nurse or physician. Nursing care is guided by the physician orders and the nursing plan of care. Patient response to care is reported to a registered nurse for evaluation, intervention and modification of the plan of care. Assist other health care personnel in the delivery of patient care.
- Participate in maintaining the environment of care including equipment and other material resources.
- Participate in own professional development by maintaining required competencies and attending educational offerings. Supports the development of other staff and formal learners.
- Perform other related duties incidental to the work described herein.

Education

Graduation from an accredited Practical Nurse program

Experience

A minimum of one year of current experience

Degrees, Licensure, and/or Certification

Current LPN license from the state of California

Knowledge, Skills, and Abilities:

- Knowledge of scope of licensed practical nurse, ability to delegate to the CNA
- Considerable knowledge of the care and treatment of patients and special procedures that apply to practical nursing
- Able to independently seek out resources and work collaboratively
- Able to communicate clearly with patients, families, visitors, healthcare team, physicians, administrators and others



- Able to teach patients and families in accordance with the nursing plan of care
- Able to use sensory and cognitive functions to process and prioritize information, treatment, and follow-up
- Competent in BLS and/or other specialized life support requirements designated by work area or unit assigned
- Able to use fine motor skills
- Able to record activities and document interventions
- Able to withstand prolonged standing and walking with the ability to move or lift at least fifty pounds
- Able to remain focused and organized
- Working knowledge of sterile techniques and special procedures that are applicable to work performed
- Working knowledge of sanitation, personal hygiene and basic health and safety precautions applicable to work in a hospital or Long Term Care (LTC) facility
- Working knowledge of infection control procedures and safety precautions
- Ability to understand English and follow oral and written instructions

Signature: _____ Date: _____



Employment Verification Form

I, _____ (Print Name) Voluntarily and knowingly authorize California Nursing Care Services, Inc to contact the following employers listed in the "Company" box below to give records or information they may have concerning my present or prior employment (including character, earnings, history and reason for termination) and any other information requested by California Nursing Care Services, Inc to determine my eligibility for employment. **Candidate - please complete the highlighted areas only below.**

Signed: _____

Date: _____

Company: (Print current or prior employer name here)	Company: (Print prior employer name here)	Company: (Print prior employer name here)
Phone:	Phone:	Phone:
Position Held:	Position Held:	Position Held:
Dates of Employment:	Dates of Employment:	Dates of Employment:
Attendance: Good Fair Poor	Attendance: Good Fair Poor	Attendance: Good Fair Poor
Eligible for Re-hire Yes No	Eligible for Re-hire Yes No	Eligible for Re-hire Yes No
Contact /Title	Contact /Title	Contact /Title
Info Verified by:	Info Verified by:	Info Verified by:



Work Experience Checklist

Nursing Specialty		Dates of Experience (mm/YYYY) <i>i.e. 01/2000 – 06/2005</i>
Adult ICU	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Neuro ICU	<input type="checkbox"/> Yes <input type="checkbox"/> No	
CVICU	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ER	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tele Med	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tele Cardiac	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Med/Surg	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rehab	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Psych	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Burn Unit	<input type="checkbox"/> Yes <input type="checkbox"/> No	
OR	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Oncology	<input type="checkbox"/> Yes <input type="checkbox"/> No	
PICU	<input type="checkbox"/> Yes <input type="checkbox"/> No	
NICU	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pediatrics	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Psych Peds	<input type="checkbox"/> Yes <input type="checkbox"/> No	
OB	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nursery	<input type="checkbox"/> Yes <input type="checkbox"/> No	
L&D	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Level II Nursery	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ventilators	<input type="checkbox"/> Yes <input type="checkbox"/> No	
PACU	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hospice	<input type="checkbox"/> Yes <input type="checkbox"/> No	
LTC	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Private Duty	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Home Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	
H/H Infusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Intermittent Skill Visit	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Computer Charting	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Balloon Pumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Epidurals	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Recognition of EKG Arrhythmias Yes <input type="checkbox"/> No <input type="checkbox"/>	Use of Emergency Equipment Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood Glucose Monitor Type: AccuCheck	OSHA TB Fit Mask Type: 3M N95

Employee Signature: _____ Date: _____



Reference Inquiry Form

To: _____

I have applied for employment at California Nursing Care Services, Inc. I authorize you to release all information requested below by California Nursing Care Services, Inc, including information concerning my character, habits, abilities, and reason(s) for leaving your company. The following information may help in identifying my records:

Name:		Social Security Number:	
Position:		Dates of Employment:	
Applicant's Signature:			

	Excellent	Good	Standard	Fair	Poor
Job Performance	(((((
Attendance	(((((
Quality of Work	(((((
Ability to Work with Others	(((((
Comments:					
Signature of person completing this Form				Date:	



Reference Inquiry Form

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Name:		Social Security Number:	
Position:		Dates of Employment:	
Applicant's Signature:			

	Excellent	Good	Standard	Fair	Poor
Job Performance	(((((
Attendance	(((((
Quality of Work	(((((
Ability to Work with Others	(((((

Comments:	
Signature of person completing this Form	Date:



Medical Release

Applicant Name

LPN
Position

Based on qualifications presented on your application form and/or in your job interview, you are hereby, offered a job with our organization conditional upon submitting to our standard medical review and the verification of your answers to the following questions. Your job offer cannot and will not be rescinded unless a medical review reveals that you cannot perform the essential functions of the job (with accommodations if requested), or you present a hazard to yourself or others. False or misleading statements are also grounds for rescinding this offer. This form must be accurate and complete for us to process. This information is considered personal and medical in nature and will be treated as such by handling it confidentially in strict compliance with the American with Disabilities Act.

PHYSICIAN'S STATEMENT

I have examined the individual named above, and to the best of my knowledge, he/she is in good physical and mental health, free of any communicable diseases, and is able to perform in his/her profession at full capacity.

Comments:

Signature of Physician: _____ Date: _____

Printed Name of Physician: _____



What Happens Now?

Thank you for applying with California Nursing Care Services, Inc. Once we get your application, we begin the process of putting together your employee file, and completing a background check. In the meantime, please return to our office the following checked items:

- Proof of MMR
- Proof of Tb (PPD Skin Test)
- Proof of Varicella titer
- Completed Urine Drug Screen
- Completed Competency Exams (Age Related, Universal Precautions, Med Calc, and LPN Exam)
- Completed Skills Checklist
- Two References
- Copy of License
- Copy of CPR / ACLS / PALS / NRP
- Other: _____

Once your chart is complete, we will contact you to determine a start date. You can pre-book up to one year in advance, or call us an hour before a shift and inform us if you would like to work. You can also specify how frequently or infrequently you would like to be contacted by us.

Contact Information:

California Nursing Care Services, Inc.
11010 Arrow Route Suite 109
Rancho Cucamonga, CA 91730
Phone: 909-989-7700
Fax: 909-989-7744
Website: www.cnchealthcare.com

Once again, thank you, and please feel free to contact us at any time and let us know what we can do better to serve you.