

FIDELITY PLUS CARE APPLICATION FORM

Tel: (609) 382 5352

Today's Date: _____

Personal Data

| | | | | |
|------------------|-------------------|----------------------|----------------------|---------------------|
| Last Name | First Name | Soc. Sec. No. | Date of Birth | Home Phone # |
|------------------|-------------------|----------------------|----------------------|---------------------|

| | | | | | | |
|-----------------------|-------------|---------------|--------------|------------|----------------|---------------------|
| Street Address | City | County | State | Zip | Country | Cell Phone # |
|-----------------------|-------------|---------------|--------------|------------|----------------|---------------------|

Work Experience/Skills

Please List the number of years you have experience in each area (minimum 1 yr exp.) and are clinically competent to work:

| | | | |
|----------------------|------------------------|-------------------------|-------------------------------|
| _____ Burn | _____ ENT | _____ Pediatrics | _____ Detox/Drug Rehab |
| _____ L&D | _____ Rehab | _____ Telemetry | _____ Post Partum |
| _____ NICU | _____ Nursery | _____ Psychiatry | _____ Orthopedics |
| _____ NICU | _____ Dialysis | _____ Step Down | _____ Mother/Baby |
| _____ PACU | _____ Geriatric | _____ Oncology | _____ Recovery Room |
| _____ SICU | _____ Pedi ICU | _____ Neurology | _____ Operating Room |
| _____ CCU | _____ Med/Surg | _____ Open Heart | _____ Emergency Room |

Other Specialty: _____

Type of Work Desired: Check all that apply

Hospital
 Nursing Home
 Assisted Living
 Other: _____

Type of Position desired :Check all that apply

Registered Nurse
 Certified Home Health Aide
 Certified Nursing Assistant

Language Skills: Other than English, please check any other language you speak:

Spanish
 French
 Other: _____

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

___ Monday ___ Tuesday ___ Wednesday ___ Thursday ___ Friday ___ Saturday ___ Sunday

Check the shift(s) you prefer below:

___ 7AM-3PM ___ 3PM-11PM ___ 11PM-7AM ___ 7AM-7PM ___ 7PM-7AM ___ Other

Education and Training (please list all schools attended, beginning with High Schools, then list all Colleges, Vocational/Military Service Schools).

| | | | | | | |
|------------------|----------------|------|-------|-----|---------|-----------------|
| High School Name | Street Address | City | State | Zip | Country | Grade Completed |
|------------------|----------------|------|-------|-----|---------|-----------------|

| | | | | | |
|---------------------------|----------------|------|-------|-----|---------|
| College/Vocational School | Street Address | City | State | Zip | Country |
|---------------------------|----------------|------|-------|-----|---------|

| | | | |
|----------------|------------------|------------------------------|-----------------------------|
| Major Emphasis | Degree Completed | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|----------------|------------------|------------------------------|-----------------------------|

| | | | | | |
|----------------------|----------------|------|-------|-----|---------|
| Graduate School Name | Street Address | City | State | Zip | Country |
|----------------------|----------------|------|-------|-----|---------|

| | | | |
|----------------|------------------|------------------------------|-----------------------------|
| Major Emphasis | Degree Completed | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|----------------|------------------|------------------------------|-----------------------------|

License/Certification:

| | | | |
|--------------|---------------------------|-------|-----------------|
| | / / | | |
| License Type | License/Certification No. | State | Expiration Date |
| | | | |
| License Type | License/Certification No. | State | Expiration Date |
| | | | |
| License Type | License/Certification No. | State | Expiration Date |
| | | | |

Has your Professional License ever been suspended, revoked or under investigation? Yes No

If Yes, please explain: _____

Certifications: Check all applicable certifications and enter expiration date

| | |
|-------------------------------------|--------------------------------------|
| ACLS _____ Exp. Date ____/____/____ | Other _____ Exp. Date ____/____/____ |
| BCLS _____ Exp. Date ____/____/____ | IV _____ Exp. Date ____/____/____ |
| CPR _____ Exp. Date ____/____/____ | NALS _____ Exp. Date ____/____/____ |
| PALS _____ Exp. Date ____/____/____ | AANA _____ Exp. Date ____/____/____ |

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 | Dates Employed From: Mo Yr To: Mo Yr |
| Company Street Address | Title |
| City State Zip Country | Unit |
| Number of beds in Unit: _____ In Hospital: _____ | Name of Current Immediate Supervisor |
| Describe Duties and Specialty Areas: | Tel. No. (include country code if outside U.S.) |
| Pay Rate/Salary: <input type="checkbox"/> Yearly <input type="checkbox"/> Hourly \$ _____ | May we Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No – If no, why not? |
| Reason for leaving: | If this was a travel assignment, name of agency: |
| Are your employment records listed under another name? <input type="checkbox"/> No <input type="checkbox"/> Yes – If yes, what name? | Charge Experience: <input type="checkbox"/> Yes <input type="checkbox"/> No How Often? _____ |

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| City State Zip Country | Unit |
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| Describe Duties and Specialty Areas: | Tel. No. (include country code if outside U.S.) |
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| Reason for leaving: | If this was a travel assignment, name of agency: |
| Are your employment records listed under another name? <input type="checkbox"/> No <input type="checkbox"/> Yes – If yes, what name? | Charge Experience: <input type="checkbox"/> Yes <input type="checkbox"/> No How Often? _____ |

References (please list three individuals with whom you have worked who were in a position to evaluate your performance)

| Name | Title | Street Address | City | Sate | Zip | Telephone No. |
|------|-------|----------------|------|------|-----|---------------|
|------|-------|----------------|------|------|-----|---------------|

| Name | Title | Street Address | City | Sate | Zip | Telephone No. |
|------|-------|----------------|------|------|-----|---------------|
|------|-------|----------------|------|------|-----|---------------|

| Name | Title | Street Address | City | Sate | Zip | Telephone No. |
|------|-------|----------------|------|------|-----|---------------|
|------|-------|----------------|------|------|-----|---------------|

Additional Information

1. Are you legally authorized to work in the U.S.? Yes No

(Should you become employed by Fidelity Plus Care you will be required to provide the documentation proving your eligibility to work in the U.S.).

2. Have you ever been convicted of a felony or misdemeanor crime? Yes No

***PLEASE BE SURE TO READ AND SIGN THE ACKNOWLEDGEMENT
ON THE NEXT PAGE OF THIS APPLICATION***

**NOTICE/AUTHORIZATION FOR RELEASE OF INFORMATION FOR EMPLOYMENT
PURPOSES/INVESTIGATIVE CONSUMER REPORT**

In connection with my application for employment with Fidelity Plus Care. I authorize the agency or its agents to procure a consumer report and/or investigative consumer report about my background, character or reputation, including, but not limited to, information as to my employment, education, consumer credit history (consumer credit history will only be verified if appropriate for certain job descriptions), driving record, social security number verification, criminal record and/or other public records history. I authorize all persons to fully disclose information relevant to this investigation. I release from liability all persons, companies and governmental or other agencies disclosing such information. I further authorize that a photocopy of this authorization may be considered as an original.

I HAVE READ, UNDERSTAND AND AUTHORIZE, ANY PERSON, AGENCY OR OTHER ENTITY CONTACTED BY THE AGENCY OR ITS AGENCY TO FURNISH THE ABOVE MENTIONED INFORMATION.

THIS FORM WILL NOT BE ACCEPTED IF ALTERED, ILLEGIBLE OR INCOMPLETE.

SIGNATURE

DRIVER LICENSE #

STATE

TYPE OR PRINT NAME (last, first, middle initial)

OTHER NAMES USED (alias, maiden, nickname)

YEARS USED

CURRENT ADDRESS

CITY

STATE

ZIP

COUNTY OF RESIDENCE

DATE

Fidelity Plus Care is an Equal Employment Opportunity.