



PO Box 432 • North Conway • New Hampshire 03860

EMPLOYMENT APPLICATION

An Equal Opportunity Employer

Federal and State Laws prohibit discrimination in employment on the basis of race, color, religion, sex, age, national origin, citizenship, sexual orientation, marital status or disability (mental or physical)

Sandra Ruka, MS RN
Executive Director

603-356-7006
800-499-4171
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www.vnhch.org

PLEASE PRINT • ANSWER ALL QUESTIONS • USE BALLPOINT PEN

Last Name	First	Middle Initial	Today's Date
Mailing Address:	Town	State	Zip
Physical Address (if different):	Home Phone #:		Cell Phone #:
Social Security #		Have you ever worked for us before? If yes, dates of employment:	
Position Desired		<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> PER DIEM <input type="checkbox"/> OTHER: _____	
Date available to start work	What days can you work?		What hours can you work?
Have you been convicted of a crime within the past five years? ___Yes ___NO If YES, please describe in full:			
CIRCLE HIGHEST YEAR OF EDUCATION COMPLETED 8 9 10 11 12 13 14 15 16 17 18			
NAME OF SCHOOL	ADDRESS OF SCHOOL	COURSE/MAJOR SUBJECT	DIPLOMA, DEGREE OR CERTIFICATE
High School			
College			
Post Graduate			
Commercial or Technical			
TYPING SKILLS ___NO ___YES OFFICE MACHINES USED:			
THIS SECTION TO BE COMPLETED BY RN OR THERAPIST			
Please check areas in which you have experience or special interest: ___ICU ___ER ___RR ___MED/SURG ___NURSING COORDINATION			
___CCU ___OR ___OB ___LTC ___OTHER – Please Specify _____			
___REHAB ___HOMECARE ___HOSPICE			
Are you registered/licensed in NH? ___YES ___NO IF NOT, STATE IN WHICH YOU ARE CURRENTLY LICENSED: _____			
If not, have you applied ___YES ___NO LICENSE NUMBER _____ EXP. DATE: _____			
WHERE DID YOU LEARN OF THE JOB OPENING? <input type="checkbox"/> FRIEND _____ <input type="checkbox"/> JUST STOPPED IN			
<input type="checkbox"/> NEWSPAPER: WHICH ONE? _____ <input type="checkbox"/> ONLINE: WHERE? _____			

EMPLOYMENT RECORD (BEGINNING WITH THE MOST RECENT)	
<div>FROM:_____TO:_____YOUR POSITION_____SALARY \$_____</div> <div>NAME OF EMPLOYER_____ADDRESS_____</div> <div>NAME & TITLE OF SUPERVISOR_____EMPLOYER PHONE #_____</div> <div>REASON FOR LEAVING_____</div>	
<div>FROM:_____TO:_____YOUR POSITION_____SALARY \$_____</div> <div>NAME OF EMPLOYER_____ADDRESS_____</div> <div>NAME & TITLE OF SUPERVISOR_____EMPLOYER PHONE #_____</div> <div>REASON FOR LEAVING_____</div>	
<div>FROM:_____TO:_____YOUR POSITION_____SALARY \$_____</div> <div>NAME OF EMPLOYER_____ADDRESS_____</div> <div>NAME & TITLE OF SUPERVISOR_____EMPLOYER PHONE #_____</div> <div>REASON FOR LEAVING_____</div>	
<div>HAVE YOU EVER BEEN INVOLUNTARILY DISCHARGED BY AN EMPLOYER? ___YES___NO___IF YES, PLEASE EXPLAIN: _____ _____ _____ _____</div>	
<div>PERSONAL REFERENCES (DO NOT INCLUDE FORMER EMPLOYERS OR RELATIVES)</div> <div>NAME_____ADDRESS_____</div> <div>OCCUPATION_____PHONE NUMBER_____</div> <div>NAME_____ADDRESS_____</div> <div>OCCUPATION_____PHONE NUMBER_____</div> <div>NAME_____ADDRESS_____</div> <div>OCCUPATION_____PHONE NUMBER_____</div>	

PATIENT ABUSE AND CERTIFICATION INFORMATION

1. Have you ever been convicted an/or been found guilty by a court of competent jurisdiction or state agency, or had a finding by the Long Term Care Ombudsman, of abusing, neglecting or mistreating patients/residents or misappropriating patient/resident property in this state or in any other state? If so, please describe the offense, the date and place of the conviction or finding and the underlying circumstances or other information to help us evaluate your current fitness for employment.

___YES ___NO

2. Within the past five years, have you been convicted of:

- A felony
- Cruelty to person or
- Assault of a victim sixty years of age or older?

If so, please describe the offense, the date of conviction, and the underlying circumstances or other information to help us evaluate your current fitness for employment. ____YES ____NO

3. Have you ever been subject to disciplinary action by a healthcare licensing agency in this or any other state, or in any other United States or foreign jurisdiction? If so, please identify the nature and date of the action, the licensing agency involved, and the underlying circumstances or other information to help us evaluate your current fitness for employment. ____YES ____NO
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4. I hereby certify that I have not been convicted and/or been found guilty, or had a finding by the Long Term Care Ombudsman, of patient/resident abuse, neglect, or mistreatment, or of misappropriation of patient/residential property in this state or any other state and that I am not listed in any resident patient abuse registry in this state or any other state. I understand that any offer of employment that is extended to me by Visiting Nurse Home Care & Hospice of Carroll County is conditional upon the verification of this information provided.

Signature

Date

READ CAREFULLY BEFORE SIGNING:

I certify that the statements contained on this application are true. I understand that false or misleading statements on this or any resume are grounds for immediate dismissal. I agree that a thorough investigation of my background may be made and I authorize my former employers and other persons or organizations to provide any information they have about my background and I release all concerned from any liability in connection therewith. I understand that my being hired is contingent upon receipt of satisfactory reference.

Signature: _____

Date: _____