

Application for Employment



14225 University Ave
Suite # 130
Waukee, IA 50263

Phone: (515) 252-0000
Toll Free: 1-800-518-1460
Fax: (515) 276-5506

13304 W Center Rd
Suite # 106
Omaha, NE 68144

Phone: (402) 934-4554
Fax: (402) 934-4504

Website: www.mysighealth.com

Find us on Facebook: <http://www.facebook.com/pages/Signature-Healthcare-Nurse-Staffing-and-CNA-Education/121477574566009>

Notice To Applicant:

Please Provide All Information Requested

Applications are only accepted for positions which are currently available.

Please feel free to contact a recruiter for additional job information 1.800.518.1460, or visit our website at www.mysighealth.com for more information regarding current positions.

EQUAL OPPORTUNITY EMPLOYER



Application for Employment

Date Available for Work _____

First Name _____ Middle Name _____ Last Name _____

Email Address _____

Current Address _____

City _____ State _____ Zip _____

Address #2 _____

City _____ State _____ Zip _____

Current Phone Number_(_____) _____ Permanent Phone Number_(_____) _____

Other Phone Number (Cell, Pager, Other)_____(_____) _____

Permanent Address _____

City _____ State _____ Zip _____

Social Security Number _____ Birth Date ____/____/____(MM/DD/YY)

Required upon employment

Emergency Contact (not living with you) _____ Phone_(_____) _____

Can you provide proof of eligibility to work in the US? _____ Yes _____ No

For which discipline are you applying?

RN / LPN: ER _____ Med/Surg _____ ICU/CCU _____ Labor/Delivery _____

Mother/Baby _____ OR _____ PACU/Recovery Room _____ Cath Lab _____ Telemetry _____

Clinic _____ LTC _____ Psych _____ Occ. Health _____ Corrections _____ Other _____

CNA: LTC: _____ Hospital: _____ Hospice: _____

EMT: Intermediate _____ Paramedic _____ Paramedic Specialist _____ Other _____

Dentistry: Dental Assistant _____ Dental Hygienist _____ Other _____

Pharmaceutical: Pharmacy Technician _____ Pharmacist _____

Therapists: Physical _____ Occupational _____ Speech _____ Respiratory _____ Other _____

Employment Type: Full Time: _____ Part Time: _____ Per-diem: _____

(Check all that apply) Contract: _____ Permanent Placement: _____ Travel: _____

How were you referred to us:

Internet: Web Page _____ Search Engine _____ Other _____
Newspaper (specify which paper please) _____
Nursing Seminar (specify location) _____
Personal Referral (Name of referrer) _____
Direct Mail _____
Other (please specify) _____

EDUCATION

Please include all colleges, universities and trade schools that you attended.
Start with the most current.

Name and location	Dates Attended	Degree Received
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PROFESSIONAL LICENSE INFORMATION

Original State of License _____ License Number _____ Exp. Date _____

Please list all other States you are licensed in _____

Has your license(s) or certification ever been under investigation? _____ Yes _____ No

If Yes, please explain _____

Has your license(s) or certification ever been revoked or under suspension? _____ Yes _____ No

If Yes, please explain _____

*Verifications and professional license investigations are completed before an offer of employment is made.

CREDENTIALS

Please indicate your credential(s) including expiration dates

BLS _____ Exp. Date _____ ACLS _____ Exp. Date _____

NRP _____ Exp. Date _____ PALS _____ Exp. Date _____

TNCC _____ Exp. Date _____ ENPC _____ Exp. Date _____

Please specify any other credentials _____

CONTINUING / PROFESSIONAL EDUCATION

Course Name	Date Attended	CEU's Earned
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENT EXPERIENCE

Fill out the following information for all jobs that you have been employed.
Please start with your present or current job.

Employer _____ Full Time _____ Part Time _____
Address _____ City _____ State _____ Zip _____
Supervisor _____ May we contact this employer? ___ Yes ___ No
Unit _____ Did you Float? _____ Where _____
Dates of Employment ____/____/____ (MM/DD/YY) To ____/____/____ (MM/DD/YY)
Reason for leaving _____

Employer _____ Full Time _____ Part Time _____
Address _____ City _____ State _____ Zip _____
Supervisor _____ May we contact this employer? ___ Yes ___ No
Unit _____ Did you Float? _____ Where _____
Dates of Employment ____/____/____ (MM/DD/YY) To ____/____/____ (MM/DD/YY)
Reason for leaving _____

**EMPLOYMENT EXPERIENCE
CONTINUED**

Employer _____ Full Time _____ Part Time _____
Address _____ City _____ State _____ Zip _____
Supervisor _____ May we contact this employer? ____ Yes ____ No
Unit _____ Did you Float? _____ Where _____
Dates of Employment ____/____/____ (MM/DD/YY) To ____/____/____ (MM/DD/YY)
Reason for leaving _____

Employer _____ Full Time _____ Part Time _____
Address _____ City _____ State _____ Zip _____
Supervisor _____ May we contact this employer? ____ Yes ____ No
Unit _____ Did you Float? _____ Where _____
Dates of Employment ____/____/____ (MM/DD/YY) To ____/____/____ (MM/DD/YY)
Reason for leaving _____

Employer _____ Full Time _____ Part Time _____
Address _____ City _____ State _____ Zip _____
Supervisor _____ May we contact this employer? ____ Yes ____ No
Unit _____ Did you Float? _____ Where _____
Dates of Employment ____/____/____ (MM/DD/YY) To ____/____/____ (MM/DD/YY)
Reason for leaving _____

ADDITIONAL INFORMATION

Have you ever been convicted of a felony that would prohibit your employment in a healthcare facility?

Yes _____ No _____

Have you ever been convicted of any law violation? (Do not include minor traffic violations) _____

If yes explain _____

Do you have any physical or mental conditions that would inhibit your ability to perform the essential functions of your job? _____ Yes _____ No If Yes, will you need accommodations to aid you in fulfilling the essential duties of your job? _____

Would you like to be considered for assignments where a labor dispute may exist? _____ Yes _____ No

I certify that the answers given in this application are true and complete and I authorize Signature Healthcare to investigate any or all statements herein. I understand that any falsification or omission of information will result in rejection and/or immediate termination. I understand that my employment, and the terms and conditions therefore, may be modified or terminated at any time, at the discretion of my employer. I agree as a condition of employment to conform to Signature Healthcare's policies and procedures.

I understand that employment is contingent upon favorable results of a drug screen analysis for substance abuse, successful completion of a physical examination, receipt of acceptable references from previous employers, acceptable findings from criminal registry and the adult and child abuse registry and meet the employability requirements to satisfy the I-9.

Applicant Signature _____ Date _____



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