

VNA/HOSPICE of Monroe County



PERSONAL/CONTACT INFORMATION:

Date of Application:

First Name:	MI:	Last Name:
Mailing Address:		
City:	State:	Zip Code:
Email Address:	Primary Phone Number:	
Social Security Number:	Secondary Phone Number:	

EMPLOYMENT PREFERENCES/INFORMATION:

Position Applying For:				
Primary Schedule Desired (circle one selection):	Full Time	Part Time	Per Diem	
I would also like to be considered for?	Full Time	Part Time	Per Diem	None
Shift Preferred (circle one):	First	Second	Third	Weekend Only
I would also like to be considered for?	First	Second	Third	Weekend Only
When are you available to begin work?				
How did you find out about this position (please list specific media source if applic.)?				
If referred by a current VNA/Hospice Employee please enter their name:				
If you are under 18, can you provide certification of your eligibility to work?				
Can you perform the essential functions of the position for which you are applying for with or without reasonable accommodations?				
Have you previously worked for the VNA/Hospice of Monroe County?				
Have you previously applied for employment with the VNA/Hospice of Monroe County?				
Have you ever been discharged for a job? If YES please provide details of circumstances surrounding your discharge.				
Have you ever been convicted of a felony or misdemeanor? If YES, describe the criminal conviction(s) and when they occurred.				

Visiting Nurse Association/Hospice of Monroe County
502 VNA Road
East Stroudsburg PA 18301
(P) 570-421-5390 (F) 570-421-7423
www.vnahospiceofmc.org

EDUCATION:

High School: Course of Study:	Did you Graduate?	Location: If NO, do you have a GED?
College/Undergraduate School: Course of Study/Degree:		Location: Did you Graduate?
College/Graduate School: Course of Study/Degree:		Location: Did you Graduate?
Vocational or Trade School: Course of Study/Degree:		Location: Did you Graduate?

LICENSURE AND/OR CERTIFICATIONS:

Professional License (current): NP RN LPN CNA PT OT ST Other _____	Issuing State:	License Number:	Expires:
Certifications (current):			Expires:
Certifications (current):			Expires:
CPR Certification?	Issued By:		Expires:
Have your professional licenses or certifications ever been suspended, placed on probation or revoked? If YES, please provide the date and explain the reason:			

PRIOR WORK EXPERIENCE: check all that apply

Homecare	<input type="checkbox"/>	IV Therapy	<input type="checkbox"/>	Physical Therapy	<input type="checkbox"/>	Billing	<input type="checkbox"/>
Hospice	<input type="checkbox"/>	Venipuncture	<input type="checkbox"/>	Occ. Therapy	<input type="checkbox"/>	Collections	<input type="checkbox"/>
Med Surg	<input type="checkbox"/>	OASIS	<input type="checkbox"/>	Respiratory Therapy	<input type="checkbox"/>	Payroll	<input type="checkbox"/>
Oncology	<input type="checkbox"/>	Nursing Supervision	<input type="checkbox"/>	Orthopedics	<input type="checkbox"/>	Medical Terminology	<input type="checkbox"/>
ICU/CCU	<input type="checkbox"/>						

PROFESSIONAL REFERENCES: *Please do not list family members*

Name:	Phone Number:
Address:	Email:
	Relationship (How you know this person):
Name:	Phone Number:
Address:	Email:
	Relationship (How you know this person):
Name:	Phone Number:
Address:	Email:
	Relationship (How you know this person):

EMPLOYMENT:**Please list Current or Most Recent Employer First**

Company Name:		Job Title:
Mailing Address:		City/State/Zip:
Phone:	Fax:	
Supervisor's Name:		Supervisor's Title:
Date Hired: Date Left (if applic):	Starting Salary: Current/Ending Salary:	Previous Name (if changed):
Job Duties and Responsibilities:		
Reason for Leaving:		
May we contact this employer (If NO, please explain)?		

Company Name:		Job Title:
Mailing Address:		City/State/Zip:
Phone:	Fax:	
Supervisor's Name:		Supervisor's Title:
Date Hired: Date Left (if applic):	Starting Salary: Current/Ending Salary:	Previous Name (if changed):
Job Duties and Responsibilities:		
Reason for Leaving:		

Company Name:		Job Title:
Mailing Address:		City/State/Zip:
Phone:	Fax:	
Supervisor's Name:		Supervisor's Title:
Date Hired: Date Left (if applic):	Starting Salary: Current/Ending Salary:	Previous Name (if changed):
Job Duties and Responsibilities:		
Reason for Leaving:		

EMPLOYMENT Continued:

Company Name:		Job Title:	
Mailing Address:		City/State/Zip:	
Phone:		Fax:	
Supervisor's Name:		Supervisor's Title:	
Date Hired:	Starting Salary:	Previous Name (if changed):	
Date Left (if applic):	Current/Ending Salary:		
Job Duties and Responsibilities:			
Reason for Leaving:			

APPLICANT'S STATEMENT:

All phases of employment at the Visiting Nurse Association/Hospice of Monroe County are based on the qualifications of the individual as related to the requirements of the position. All employment decisions are without regard to sex, sexual orientation, color, religion, national origin, age, race, political belief, disability or history of disability or any other non-job related factor.

I certify to the best of my knowledge that the information contained in the application is true and complete. I understand and agree that any false information, misrepresentation or concealment of fact is sufficient grounds for the Visiting Nurse Association/Hospice of Monroe County to terminate my employment or disqualify me from further consideration of employment.

I hereby understand and acknowledge that my employment relationship with the Visiting Nurse Association/Hospice of Monroe County is of an "at will" nature, which means that I may resign at any time and/or the Visiting Nurse Association/Hospice of Monroe County may discharge me at any time with or without cause. It is further understood that this "at will" employment relationship may not be changed by a written document or by conduct unless such a change is specifically acknowledged in writing by an authorized executive of the organization.

I also understand that employment is conditioned upon satisfactory results of reference checks, criminal background checks and medical examination (if applicable). I understand and agree that all information furnished in this application may be verified by the Visiting Nurse Association/Hospice of Monroe County.

I hereby authorize all individuals and organizations named or referred to in this application and any law enforcement organization to give the Visiting Nurse Association/Hospice of Monroe County all information relative to employment, work habits, and character and hereby release such individuals, organizations and the Visiting Nurse Association/Hospice of Monroe County from any liability for any damages which may result.

Signature

Date

Print Name: