/

VNA/HOSPICE
of Monroe County

Visiting Nurse Association of Monroe County
502 Independence Drive
East Stroudsburg, PA 18301
(570) 421-5390 Phone (570) 421-7423 Fax
www.vnahospiceofmc.org

Date of application:

PERSONAL

First Name: MI: Last Name:

Social Security:

Mailing Address:

City: State: Zip:

Home Phone: Business Phone:

Other Phone: E-mail Address:

Schedule preferred:	☐ full-time	☐ part-time
	☐ per-diem	☐ weekends
Shift preferred:	☐ first shift	☐ second shift
When will you be available to begin work?		
How did you find out about this position?		
If you were referred by a current VNA/Hospice of Monroe County employee, enter their name:		
If you are under 18, can you provide certification of your eligibility to work?	☐ YES	☐ NO
Have you previously applied for employment with the VNA/Hospice of Monroe County within the past year?	☐ YES	☐ NO
Have you previously worked at the VNA/Hospice of Monroe County?	☐ YES	☐ NO
Are you currently employed?	☐ YES	☐ NO
May we contact your current employer?	☐ YES	☐ NO
Can you perform the essential functions of the position for which you are applying with or without reasonable accommodations?	☐ YES	☐ NO
Have you ever been discharged from a job?	☐ YES	☐ NO
	If yes, explain fully	
Have you ever been convicted of a felony or misdemeanor? If yes, describe fully the criminal conviction(s). List the nature of the offense and when offense occurred. Record of conviction does not disqualify applicant from employment consideration.	☐ YES	☐ NO
	If yes, give details	

EDUCATION					
Education Level	Name & Location of School Attended	Course of Study	# of Years	Did You Graduate	Date of Graduation
High School				☐ YES	
Vocational or Trade				☐ YES	
Professional or Diploma				☐ YES	
College				☐ YES	
Graduate				☐ YES	

EXPERIENCE

Check all that apply:

☐ Billing	☐ Medical Terminology	☐ Bookkeeping/Accounting	☐ Collections
☐ I.V. Therapy	☐ Nursing Supervision	☐ Oncology	☐ Geriatric
☐ Switchboard	☐ Pediatrics	☐ ICU-CCU	☐ OASIS
☐ Hospice	☐ Neurology	☐ Physical Therapy	☐ Venipuncture
☐ Med Surg	☐ Orthopedics	☐ Respiratory Therapy	☐ Surgery/Recovery Room
☐ Hospital Admitting			

Typing Speed - WPM:_______________

Word Processing / Computers:_______________

Office Equiptment:_______________

Other Skills (not mentioned above):_______________

LICENSURE AND/OR CERTIFICATIONS

Professional Licensure

Type of License	Issuing State	Registration Number	Issue Date	Expiration Date

Have your professional licenses and/or certifications ever been suspended, revoked or placed on probation? ☐ YES ☐ NO

IF YES, for what reason?_______________

MILITARY

Did you ever serve in the U.S. Armed Forces? ☐ YES ☐ NO

If yes, what branch?_______________

Describe any training received relevant to the position for which you are applying._______________

EMPLOYMENT	
1. Present or Most Current Employer	
Company Name:	Job Title:
City:	State:
Date Hired (month/year):	Date Left (month/year):
Starting Salary:	Ending Salary:
Supervisor's Name:	Supervisor's Title:
Employer's Phone:	Previous name if changed:
Job Duties and Responsibilities:	Reason for Leaving:

2.	
Company Name:	Job Title:
City:	State:
Date Hired (month/year):	Date Left (month/year):
Starting Salary:	Ending Salary:
Supervisor's Name:	Supervisor's Title:
Employer's Phone:	Previous name if changed:
Job Duties and Responsibilities:	Reason for Leaving:

3.	
Company Name:	Job Title:
City:	State:
Date Hired (month/year):	Date Left (month/year):
Starting Salary:	Ending Salary:
Supervisor's Name:	Supervisor's Title:
Employer's Phone:	Previous name if changed:
Job Duties and Responsibilities:	Reason for Leaving:

4.	
Company Name:	Job Title:
City:	State:
Date Hired (month/year):	Date Left (month/year):
Starting Salary:	Ending Salary:
Supervisor's Name:	Supervisor's Title:
Employer's Phone:	Previous name if changed:
Job Duties and Responsibilities:	Reason for Leaving:

DIRECT CARE FIELD STAFF ONLY			
Drivers License Number	**State of Issue**	**Date Issued**	**Date Expired**

PLEASE READ CAREFULLY BEFORE SIGNING

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 this application is true and complete. I understand and agree that any false information, misrepresentation or concealment of fact is sufficient grounds for 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 change is specifically acknowledged in writing by an authorized executive of this organization.

I also understand that employment is conditioned upon satisfactory result 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 organizations 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:____________

REFERENCES	
1.	
Name:	
Address:	
Phone:	
2.	
Name:	
Address:	
Phone:	
3.	
Name	
Address:	
Phone:	