



EMPLOYMENT APPLICATION

An Equal Opportunity Employer

NAME AND ADDRESS

Name: (Last, First, M.I.) _____ Social Security Number: _____

Mailing Address: _____ Home Phone: (____) _____

City: _____ State / Zip: _____ Work Phone: (____) _____

Email: _____ Cell Phone: (____) _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Relation: _____ Phone: (____) _____

ADDITIONAL INFORMATION

Ever been dismissed or fired from a position for any reason? _____ No _____ Yes

If yes, please explain: _____

Any discipline action taken against your professional license? _____ No _____ Yes

If yes, please explain: _____

Have you ever been convicted by any court for a felony? _____ No _____ Yes

If yes, please explain: _____

EDUCATION / TRAINING HISTORY

Do you have a high school diploma or a GED certificate? _____ Diploma _____ GED

High School / College / Universtiy	Course of Study	Graduate	Degree / Certificate
A.			
B.			
C.			

LICENSE / REGISTRATION / CERTIFICATE

Description	State	License Number	Expiration
A.			
B.			
C.			

WORK HISTORY

Job Number 1

Name of Employer: _____ Employer Address: _____
Type of Business: _____ Supervisor Name: _____
Position Held: _____ Supervisor Phone: _____
From _____ to _____ Total Time in Position: _____ Hours per Week: _____

List all duties performed:

Job Number 2

Name of Employer: _____ Employer Address: _____
Type of Business: _____ Supervisor Name: _____
Position Held: _____ Supervisor Phone: _____
From _____ to _____ Total Time in Position: _____ Hours per Week: _____

List all duties performed:

Job Number 3

Name of Employer: _____ Employer Address: _____
Type of Business: _____ Supervisor Name: _____
Position Held: _____ Supervisor Phone: _____
From _____ to _____ Total Time in Position: _____ Hours per Week: _____

List all duties performed:

FITNESS FOR POSITION

1. The essential function of a health care provider is to provide a standard of care that is acceptable within his/her specialty.

Are you capable of performing this function with or without reasonable accommodation? ___ Yes ___ No

2. Are you authorized to work in the United States? ___ Yes ___ No

3. Are you currently abusing alcohol, using any illegal drugs, or failing to take legally prescribed drugs in the manner prescribed? ___ Yes ___ No

4. Have you ever abused alcohol, used illegal drugs, or failed to take legally prescribed drugs in the manner prescribed in the past? ___ Yes ___ No

If yes, what drugs and how recently have you used these illegal drugs? _____

PROFESSIONAL LIABILITY

1. Have any malpractice claims, suits, settlements or arbitration proceedings been made against you? ___ Yes ___ No

2. Are there any claims, suits or settlements pending against you or against any professional entity in which you are a member? ___ Yes ___ No

If you answered YES to any of these questions, please include a personal summary on each case to include year occurred, status, settlement amount, details on the case and malpractice carrier.

DISCIPLINARY ACTIONS

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS PLEASE PROVIDE EXPLANATION ON SEPARATE SHEET.

1. Have you ever been convicted of a felony or misdemeanor? ___ Yes ___ No

2. Have you ever been convicted of any violation of state or federal law relating to controlled substances? ___ Yes ___ No

3. Have you ever been denied or surrendered a state or federal controlled substances certificate? ___ Yes ___ No

4. Has your license to practice in your profession in any state been reprimanded, sanctioned, placed on probation, curtailed, suspended, revoked, restricted, denied or voluntarily surrendered? ___ Yes ___ No

5. Have you ever been denied a certificate by, or the privilege of taking an examination before any state board? ___ Yes ___ No

6. Have your staff/clinic privileges at any hospital, healthcare facility, or clinic been denied, revoked, suspended, curtailed, limited or placed under conditions restricting your practice? ___ Yes ___ No

7. Have you ever been terminated from employment? ___ Yes ___ No

8. Have you ever been disciplined by any state board for any violation of the Medical Practice Act or unethical conduct? ___ Yes ___ No

9. Have you ever been denied provider participation in any state or federal Medicare/Medicaid programs? ___ Yes ___ No

10. Have you ever been terminated, sanctioned, penalized or had to repay money to any state or federal Medicare/Medicaid programs? ___ Yes ___ No

11. Have you ever been the subject of any investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency? ___ Yes ___ No

12. Have you ever been convicted of a violation of any federal or state narcotic laws? ___ Yes ___ No

13. Have you ever been disciplined by a hospital staff or training program? ___ Yes ___ No

14. Is there any other issue that should be disclosed that may have an adverse impact on your ability to deliver effective care? ___ Yes ___ No

MILITARY SERVICE

Branch:

Date of Service:

CERTIFICATION AND SIGNATURE

Notice of Drug Testing: Supplemental Nursing Services, herein referred to as the "Company" may conduct drug testing of the job applicants. Should you be considered for employment by this Company, you may be contacted regarding the time and location of the pre-employment drug test. Refusal to take the drug test or failing the drug test will disqualify you from further consideration for a position.

Authorization and Understanding: I certify that the information given herein is true and complete without qualification. I understand the Company may investigate my work and personal history and verify all data given on this application, on related papers and in interviews and I authorize Company, to do the same. The inquiry may include information as to my character, general reputation and personal characteristics, and I consent to the conduct of this inquiry and to the consideration of any statements of references of former employers that are given in response to the inquiry. I authorize all individual, schools and employers names therein, except as specifically limited on this application, to provide information requested about me, and I release them from liability for damages in providing this information. I understand and acknowledge that Company will terminate my employment if I have provided incomplete, inaccurate, untrue or misleading information in this application or on any other document or form at anytime during my employment.

If terminated, I authorize Company to use any information in its possession concerning me for reference purposes and/or if legally required to furnish any information including disclosure of information to a third party, future employer or prospective employer, without receiving any prior notice, and I release company from any liability in connection with such use of disclosure.

In consideration of my employment, I agree to conform to the rules and regulations of Company and the direction of its supervisors, I understand and acknowledge that if employed, unless my employment become subject to a collective bargaining agreement, my employment and compensation will be at the will of the Company and can be terminated with or without cause, and with or without notice, at any time at the option of either Company or myself. I further understand and agree that no manager, representative, agent or employee of Company other than the owners, has now or had in the past any authority to enter into any agreement for employees for any specified period of time or to make any agreement which is contrary to or a modification of the above described employment relationship, and that any such agreement or representation must be in writing and signed by both myself and the owners of Company in order to be effective.

I further understand that my employment is conditional until such time as the results of any pre-employment drug testing if any is required, are known. I also understand and acknowledge that, as a part of the hiring process and throughout my employment, if hired, I may be required to submit to medical/physical examination at the employer's discretion.

All original documents are property of Company:

1. I certify that all statements contained herein are true and complete whether made by me or at my request.
2. I understand that if hired, I must prove that I am legally authorized to work in the United States.
3. I authorize the state of Michigan to check employment references and verify education information provided on this employment application and as disclosed in the interview process.
4. I authorize the Company to check my driving record if the position for which I am applying requires driving.
5. You may be asked to submit to a pre-employment drug test, a credit history check and/or criminal background check as a condition of employment.
6. I release the Company and all providers of information from any liability as a result of furnishing and receiving any information related to the Company's hiring process.

I agree to the conditions stated in the Certification and Signature section.

Signature

Date

THANK YOU FOR YOUR INTEREST IN SUPPLEMENTAL NURSING SERVICES, INC.