



SUPPORT STAFF, INC

Healthcare Services

3020 Pickett Road • Suite 112 • Durham, NC 27705

(877) 206-4800 • (919) 490-0520

Fax (919) 490-0625

www.supportstaffhealth.com

Application for Employment

Federal and State laws prohibit discrimination in employment because of sex, race, color, religion, national origin, age, handicap, veteran status, and citizenship status. We are an equal opportunity employer.

Personal

Date _____

Name Last _____ First _____ M.I. _____ Social Security # _____

Address _____
Street Address

City _____ State _____ Zip Code _____

Home Phone Number _____ Alternate Phone Number _____

Do you have the legal right to work in the United States? yes no

Classification: RN LPN License Number _____ Renewal Number _____

NA Certificate Number _____

State Issued _____ Expiration Date _____

Date Available for Employment _____

Health Condition: Excellent _____ Good _____ Fair _____ Poor _____

Date of Last TB Test or chest X-ray _____

Do you have any chronic illness or disability which would prevent you from performing the job in a reasonable manner? yes no

If yes, please explain _____

Have you ever applied for/received worker's compensation: yes no

If yes, please explain _____

Have you ever been convicted of a crime, excluding misdemeanors? yes no

If yes, please explain _____

In case of emergency, notify _____

How did you learn about SSI? _____

Education

School of Nursing	Name and Address	Graduated	Course or Major
University/Other		<input type="checkbox"/> Yes <input type="checkbox"/> No	
High School (or equiv.)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Graduate Courses		<input type="checkbox"/> Yes <input type="checkbox"/> No	

CPR CERTIFIED yes no Date _____ Source of Training _____

Do you have malpractice insurance? yes no Policy name and number _____

Have you ever been bonded? yes no

Work History (List in order, last or present employer first)

1. Name							Phone
Street Address					City, State, Zip		
Job Title	Salary	Dates Worked	From	To	Nature of Work	Supervisor	
Reason for Leaving							
2. Name							Phone
Street Address					City, State, Zip		
Job Title	Salary	Dates	From	To	Nature of Work	Supervisor	
Reason for Leaving							
3. Name							Phone
Street Address					City, State, Zip		
Job Title	Salary	Dates	From	To	Nature of Work	Supervisor	
Reason for Leaving							

May we contact the employers listed above? _____ If not, indicate which one(s) you do not wish us to contact and why.

Professional References:

Please list the names of two licensed nurses.
(Excluding former employers or relatives)

Name and Classification	Address	Phone Number

The statements made in this application are true to the best of my knowledge. I understand that any falsification will be basis for disqualification of employment or termination of services.

Signature _____ Date _____

Experience Please list areas in which you have actual work skills/experience. Indicate by checking and entering dates.

Work Skills & Experience	From	To	Work Skills & Experience	From	To	Work Skills & Experience	From	To
Breathing Exercises			QR			Ortho		
Burns			Male Cath. insert			Ostomy Care		
Chest Physiotherapy			Medical			Peds		
Dialysis (Monitor)			Med Nurse			Post Partum		
Dr. Office			Meds - Unit Dose			Private Duty		
EENT			Newborn			Psych		
Enternal			Neuro			Public Health		
Geriatrics			Charge Responsibilities			Rehab		
Gyn			Occupational			Surgical		
Isolation			Oncology			Urology		
IV Insertion			QR			Trach		

Written documentation received _____

Experience High-tech				Experience Pediatrics			
Work Skills & Experience	From	To	Where	Work Skills & Experience	From	To	Facility
<input type="checkbox"/> ICU <input type="checkbox"/> CCU				<input type="checkbox"/> Pedi. ICU			
Advanced EKG				<input type="checkbox"/> Neonatal ICU			
Central Lines				Apnea Monitor			
Chemotherapy				Calc. Ped. Dosages			
Chest Tubes				Central Lines			
IV Insertion				Colostomy/Ileostomy			
Porta Cath.				CPR - Children			
Swan Ganz				CPR - Infants			
TPN				Gastro Tube Feed			
Ventilators				Hospice			
Blood Gases				IV Pumps			
Balloon Pump				IV Start			
Dialysis				IV Therapy			
E.R.				Nasal/Pharin Suction			
Telemetry				Gavage Tube			
Recovery Room				Meds Admin.			
Cardiac drug admin.				Trach. Care			
Vasoactive drug admin.				Trach. Suction			
				Ventilators			
				Premature			

Please explain any additional skills/experience you have with special equipment, tests, examination and specialty areas you have worked in: _____

ACLS certified Yes No Date _____ Source of Training _____

Hours available for assignment: 7-3 3-11 11-7 Shift Preferred _____

Available for less than 8 hour shifts: Yes No If Yes, indicate which hours _____

Days available for assignment: Sat. Sun. Mon. Tues. Wed. Thurs. Fri.

Available for Weekends or occasional Weekends? Yes No If Yes, how often _____

Assignments willing and qualified to perform:

PREFERENCES

Hospital Staff _____ Yes _____ No _____
 Hospital Private Duty _____ Yes _____ No _____
 Nursing Home Staff _____ Yes _____ No _____
 Nursing Home Private Duty _____ Yes _____ No _____
 Home Care _____ Yes _____ No _____