EMPLOYMENT APPLICATION
RN

APPLICANT INFORMATION

Last Name		First		M.I.	Date	
Street Address				Apartment/Unit #		
City		State		ZIP		
Phone		E-mail Address				
Position Applied For		Date Available		Desired Salary		
Social Security #		Date of Birth				

Are you a citizen of the United States?	YES ☐	NO ☐	If no, are you authorized to work in the U.S.?	YES ☐	NO ☐
Have you ever worked for this company?	YES ☐	NO ☐	If so, when?		
Have you ever been convicted of a felony?	YES ☐	NO ☐	If yes, explain		

EDUCATION

High School				Address			
From		To		Did you graduate?	YES ☐	NO ☐	Degree
College				Address			
From		To		Did you graduate?	YES ☐	NO ☐	Degree
Other				Address			
From		To		Did you graduate?	YES ☐	NO ☐	Degree

PREVIOUS EMPLOYMENT

Company		Phone
Address		Supervisor
Job Title	Starting Salary $	Ending Salary $
Responsibilities		
From To	Reason for Leaving	
May we contact your previous supervisor for a reference? YES ☐ NO ☐		
Company		Phone
Address		Supervisor
Job Title	Starting Salary $	Ending Salary $
Responsibilities		
From To	Reason for Leaving	
May we contact your previous supervisor for a reference? YES ☐ NO ☐		

Company			Phone
Address			Supervisor
Job Title	Starting Salary $		Ending Salary $
Responsibilities			
From To	Reason for Leaving		
May we contact your previous supervisor for a reference? YES ☐ NO ☐			

MILITARY SERVICE

Branch	From To
Rank at Discharge	Type of Discharge
If other than honorable, explain	

DISCLAIMER AND SIGNATURE

"I CERTIFY THAT ALL THE INFORMATION SUBMITTED BY ME ON THIS APPLICATION IS TRUE AND COMPLETE, AND I UNDERSTAND THAT IF ANY FALSE INFORMATION, OMISSIONS, OR MISREPRESENTATIONS ARE DISCOVERED, MY APPLICATION MAY BE REJECTED AND, IF I AM EMPLOYED. MY EMPLOYMENT MAY BE TERMINATED AT ANY TIME. IN CONSIDERATION OF MY EMPLOYMENT, I AGREE TO CONFORM TO THE COMPANY'S RULES AND REGULATIONS, AND I AGREE THAT MY EMPLOYMENT AND COMPENSATION CAN BE TERMINATED, WITH OR WITHOUT CAUSE. AND WITH OR WITHOUT NOTICE, AT ANY TIME, AT EITHER MY OR THE COMPANY'S OPTION. I ALSO UNDERSTAND AND AGREE THAT THE TERMS AND CONDITIONS OF MY EMPLOYMENT MAY BE CHANGED, WITH OR WITHOUT CAUSE, AND WITH OR WITHOUT NOTICE, AT ANY TIME BY THE COMPANY. I UNDERSTAND THAT NO COMPANY REPRESENTATIVE, OTHER THAN IT'S PRESIDENT, AND THEN ONLY WHEN IN WRONG AND SIGNED BY THE PRESIDENT, HAS ANY AUTHORITY TO ENTER INTO ANY AGREEMENT FOR EMPLOYMENT FOR ANY SPECIFIC PERIOD OF TIME, OR TO MAKE ANY AGREEMENT CONTRARY TO THE FOREGOING. "

Signature	Date

Reference Check 1

Applicant Name: ____ Date: __________

Last *First* *M.I.*

Position Applied for: ____

Contact Information- TO BE COMPLETED BY APPLICANT

Name of Contact: ____

Title: ______________________________ Phone: ____________________

Company: ____

Address: ____

Street Address *Suite #*

____

City *State* *ZIP Code*

Reference Comments –TO BE COMPLETED BY OFFICE

Was the applicant an employee of your company? YES ☐ NO ☐

When? START DATE: __________ END DATE: __________

What was the applicant's position on the last day of employment? ____________________

What were the applicant's job responsibilities?

What are the applicant's strengths? Weaknesses?

How would you characterize the applicant's technical skills?

What was the applicant's reason for leaving your employ?

Would you rehire this applicant? YES ☐ NO ☐

Is there anything else you would like to add?

Completed by: ______________________________ *Date:* ____________________

Reference Check 2

Applicant Name: ______________________________ Date: __________

Last *First* *M.I.*

Position Applied for: ______________________________

Contact Information- TO BE COMPLETED BY APPLICANT

Name of Contact: ______________________________

Title: ______________________ Phone: ______________

Company: ______________________________

Address: ______________________________

Street Address *Suite #*

____

City *State* *ZIP Code*

Reference Comments –TO BE COMPLETED BY OFFICE

Was the applicant an employee of your company? YES ☐ NO ☐

When? START DATE: ____________ END DATE: ____________

What was the applicant's position on the last day of employment? ______________

What were the applicant's job responsibilities?

What are the applicant's strengths? Weaknesses?

How would you characterize the applicant's technical skills?

What was the applicant's reason for leaving your employ?

Would you rehire this applicant? YES ☐ NO ☐

Is there anything else you would like to add?

Completed by: ______________________________ *Date:* ______________

Reference Check 3

Applicant Name: ______________________________ Date: __________

Last *First* *M.I.*

Position Applied for: ______________________________

Contact Information- TO BE COMPLETED BY APPLICANT

Name of Contact: ______________________________

Title: ______________________________ Phone: __________

Company: ______________________________

Address: ______________________________

Street Address *Suite #*

____

City *State* *ZIP Code*

Reference Comments –TO BE COMPLETED BY OFFICE

Was the applicant an employee of your company? YES ☐ NO ☐

When? START DATE: __________ END DATE: __________

What was the applicant's position on the last day of employment? __________

What were the applicant's job responsibilities?

What are the applicant's strengths? Weaknesses?

How would you characterize the applicant's technical skills?

What was the applicant's reason for leaving your employ?

Would you rehire this applicant? YES ☐ NO ☐

Is there anything else you would like to add?

Completed by: ______________________________ *Date:* __________

CONDITIONS OF EMPLOYMENT

PLEASE INITIAL EACH LINE

______ Reporting to work with impaired abilities; or the possession, consumption or distribution of drugs or alcohol on company premises and/or worksites, shall be grounds for disciplinary action, including discharge. A condition of employment includes willingness on the part of the applicant or employee to agree to physical examination, polygraph and/or substance testing, if required by the company. We are committed to operating a drug free workplace. Violations of our drug and alcohol policy w result in dismissal.

_____ It is understood and agreed upon that any misrepresentation by me in this application will be sufficient cause for cancellation of this application and/or separation from the employer's service if I have been employed. Furthermore, I understand that just as I am free to resign anytime, the Employer reserves the right to terminate my employment at any time, with or without cause and without prior notice. I understand that no representative of the Employer has the authority to make any assurances to the contrary.

_____ I give the employer the right to investigate all police, driving, and personal, DHHS, professional license verifications, and references listed, if job related. I hereby release from liability the Employer and its representatives for seeking such information and all other persons, corporations or organizations for furnishing such information.

______ The Employer is an Equal Opportunity Employer. The Employer does not discriminate in employment and no question on this application is used for the purpose of limiting or excusing any applicant's consideration for employment on a basis prohibited by local, State or Federal law.

______ Any controversy of any kind arising between the parties under this agreement or otherwise (or any agent, officer, director or affiliate of any party), including but not limited to common law, statutory, tort or contract claims, will be submitted to mediation and failing settlement in mediation, to binding arbitration. Unless otherwise agreed a mediation and arbitration designated by staff professionals will govern any mediation and arbitration. The parties will select the mediator or arbitrator from the designated company panel of mediators and will notify the designated company, in writing, to initiate the selection process. The arbitration will be subject to and governed by the provisions of the Federal Arbitration Act. 9 U.S.C. Section 1-et seq. The parties hereto stipulate that this agreement involves matters affecting interstate commerce.

______ This application is current for 60 days. At the conclusion of this time if I have not heard from the Employer and still wish to be considered for employment, it will be necessary to fill out a new application.

Signature: ____ **Date:** ________________________________

Witness: ____ **Date:** ________________________________

MOTOR VEHICLE CHECK FORM

APPLICANT INFORMATION

Applicant Name: ____

Last First M.I.

Driver's License #: ____

Date of Birth: ____

IT IS THE POLICY OF SPECTRUM STAFFING SOLUTIONS, LLC TO PREFORM DRIVING RECORDS CHECKS ON ALL NEW HIRES.

In the past 3 years, have you had any traffic violations or accidents? ***YES*** ☐ *If yes, please explain below* NO ☐

Have you ever had your driver's license suspended or revoked? ***YES*** ☐ If yes, please explain below NO ☐

Have you ever been convicted of:

1) Driving under the influence of drugs or alcohol? ***YES*** ☐ If yes, please explain below NO ☐
2) Leaving the scene of an accident? ***YES*** ☐ If yes, please explain below NO ☐
3) Reckless or Careless driving? ***YES*** ☐ If yes, please explain below NO ☐

Explanation:

RELEASE OF INFORMATION

I attest that I have answered the above questions honestly and to the best of my ability. I understand that Spectrum Staffing Solutions, LLC will perform a driving record check as required by state regulations. I also understand that employment is contingent on satisfactory receipt of this information.

Signature: ______________________________ **Date:** ______________________________

Witness: ______________________________ **Date:** ______________________________

CRIMINAL HISTORY SEARCH CONSENT FORM

APPLICANT INFORMATION

Applicant Name: ____

Last First M.I.

I, ________________________________, have had no prior convictions of an offense described in the **Health and Safety Code** which would bar or potentially bar employment as listed below.

CRIMINAL HOMICIDE

KIDNAPPING & FALSE IMPRISONMENT

INDECENCY WITH A CHILD

AGREEMENT TO ABDUCT FROM CUSTODY

SOLICITATION OF A CHILD

SALE OR PURCHASE OF A CHILD

ARSON

ROBBERY

AGGRAVATED ROBBERY

ASSAULTIVE OFFENSES

BURGLARY & CRIMINAL TRESPASS

THEFT

WEAPONS

FRAUD

PUBLIC LEWDNESS

INDECENT EXPOSURE

PUBLIC INDECENCY

I UNDERSTAND THAT THE HOME HEALTH AGENCY IS REQUIRED TO CONDUCT A CRIMINAL HISTORY CHECK BEFORE OFFERING ME EMPLOYMENT. I, THE UNDERSIGNING, HEREBY AUTHORIZE THIS AGENCY TO CONDUCT AND VERIFY MY CRIMINAL HISTORY BY PERFORMING A CRIMINAL HISTORY CHECK.

Signature: ______________________________ **Date:** ______________________

Witness: ______________________________ **Date:** ______________________

DOE Fingerprinting Registration Form

Applicant Information

Applicant Name: ______________________________

Last *First* *M.I.*

Alias or Maiden Name: ______________________________

Last *First* *M.I.*

Street Address: ______________________________

City: ____________ State: ____________ Zip: ____________

Phone: ____________ Cell □ Home □

Email: ____________ SS Number: ____ - ____ - ____

DOB: ____________ Gender: ____________ Height: ____________ Weight: ____________

Hair Color: ____________ Eye Color: ____________ Race: ____________

Place of Birth: ____________ Citizenship: ____________

For Office Use

Location: ____________ Date/Time: ____________

DOE Application Completed: Yes □ No □ Date Sent: ____________ Check Number: ____________

Approved: Yes □ No □ Expiration Date: ____________

MAINE DEPARTMENT OF EDUCATION
APPLICATION FOR INITIAL EDUCATIONAL APPROVAL

W Z

1. NAME (First, MI, Last, and optional suffix such as Jr., III)	2. Social Security Number - -	3. Other name(s) under which Your records are filed	DATE

4. Mailing Address	5. EMAIL Address	6. City or Town	7. State	8. Zip Code

9. Home Phone	10. Sex ____ Male ____ Female	11. Date of Birth / / mo. day yr.	**RETURN TO:** DEPARTMENT OF EDUCATION CERTIFICATION OFFICE 23 STATE HOUSE STATION, AUGUSTA, ME O4333-0023

THE FOLLOWING QUESTIONS MUST BE ANSWERED:

Have you ever been convicted of **ANY** crime? ____ YES ____ NO

Have you ever had any occupational or professional license or credential suspended or revoked in any state, or voluntarily surrendered an occupational or professional license or credential? ____ YES ____ NO

Have you ever resigned following allegations of physical or sexual abuse? ____ YES ____ NO

If the answer is yes to any of the above, please attach a detailed explanation with required court documents. (See enclosed instructions.)

Have you had your fingerprints taken as required by the Criminal History Record Check? (See enclosed instructions.)

_____ YES _____ NO

If yes, where ____ Date: _______________________

I authorize the Dept. of Education to charge the applicable fees for this application:

M/C ___ VISA ___ EXPIRATION DATE _____ CREDIT CARD NUMBER _________________________

I hereby declare or affirm under penalty in the law for unsworn falsification that this application, and any supporting documentation provided in support of this application, contains no willful misrepresentations or falsifications and that the information given by me is true, accurate, and complete to the best of my knowledge and belief, and so far as based on information and belief, I believe the information to be true. I understand that my answers may be verified and that I may be declared ineligible for certification and subject to civil or criminal penalties if there are any misrepresentations.

SIGNATURE OF APPLICANT ____DATE _____________

DEPT. USE ONLY				C									

Unless you receive an exception, you will be approved to be employed in the schools of Maine in a position for which you are otherwise qualified. The local school unit is responsible for determining whether you are otherwise qualified for a job category.

EFC-300-C
REV 12/12

AVAILABILITY FORM

APPLICANT INFORMATION

Applicant Name: ____

Last | First | M.I.

List any foreign language(s) and check the box that best describes your skill level.

Language	Read and write	Read and speak	Speak only

Are you willing to work in homes with clients who smoke?
YES ☐ NO ☐

Are you willing to work in homes with dogs?
YES ☐ NO ☐

Are you willing to work in homes with cats?
YES ☐ NO ☐

Are you willing to work with male clients?
YES ☐ NO ☐

Are you willing to work with female clients?
YES ☐ NO ☐

Days of the week/shifts that I am available to work:

	Sun	Mon	Tues	Wed	Thur	Fri	Sat
11-7							
7-3							
3-11							
Other: Please specify availability							

Signature: ______________________________ **Date:** ______________________

SPECTRUM STAFFING SOLUTIONS LLC

RN SKILLS CHECKLIST

APPLICANT INFORMATION

Applicant Name: ____

Last First M.I.

Please place a check-mark in the appropriate box using the Self-Rating Key below:

0-No experience
1- Clinicals Only
2- Experienced
3- Can Perform Task Independently

NEUROLOGICAL SYSTEM	#
Neuro Assessment/Neuro Vitals	
Halo Traction	
Seizure Precautions	
Caring for Patient with:	
Spinal Cord Injury	
Head Injury	
Rehabilitation of the Neuro Patient	
Pre / Post Neurological Surgery	
CNS Infections	
Parkinson's	
Alzheimer's	
Autonomic Dysreflexia	
Chronic C.V.A / T.I.A	
Using Glasgow Coma Scale	
CARDIOVASCULAR	**#**
Assessment:	
Capillary Refill	
Edema	
Heart Tones	
Pulses	
Angina (**Acute** and Chronic)	
Assessing and Treating Orthostatic BP	
Assessing Abnormal Heart Tones	
Anti-embolic Devices	
RESPIRATORY	**#**
Assessing the Respiratory System including:	
Breath Sounds	
Breathing Pattern / Effort	
Cough Effort	

Skin and Nail Bed Color	
Sputum (Color/Character)	
Care and Maintenance of:	
Acute Airway	
Nasopharyngeal Airway	
Oropharyngeal Airway	
Administering and Monitoring O2 including:	
Nasal Cannula	
Mask	
O2 Sats	
Care of Ventilator Dependent Patient:	
Suctioning: Length of time suctioning	
Hyperventilation	
Ventilator Settings	
Documentation	
Caring for a Patient with:	
Respiratory Failure	
Respiratory Infections	
Status Asthmatics	
Respiratory Distress Syndrome	
Pulmonary Edema	
Pulmonary Emboli	
Tension Pneumothorax	
Tracheostomy	
Demonstrating proper use of Ambu Bag	
Use of Incentive Spirometer	
GASTROINTESTINAL	**#**
Assessing Bowel Sounds	
Identifying Abnormalities	
Caring for Patient on Total Parenteral Nutrition	

Inserting /Maintaining Feeding Tubes (NG)	
Administering Tube Feedings	
Abdominal Wounds or Infections	
Ileostomy/Colostomy	
Stool Tests	
I&O: Shift volumes and totals including marking and/	
Or measuring amounts of urine, gastric fluid	
NG drainage, emesis, diarrhea	
GENITOURINARY	**#**
Inserting/Maintaining Urinary Drainage Tubes:	
Insertion of Foley	
Managing Urostomy	
Managing Suprapubic Catheter	
Placing Condom Catheter	
Caring for Patients with Chronic Renal Failure	
Caring for Patient receiving Dialysis	
Assessing Fluid and Electrolyte Problems	
Knowledge of UA values	
Collecting Specimens	
ENDOCRINE	**#**
Caring for the Diabetic Patient:	
Checking Capillary Blood Glucose	
Diabetic Teaching	
Treating Hypo/Hyperglycemia	
Caring for the Diabetic Patient: (Cont'd)	
Insulin Administration	
Hormone Therapy	
MUSCULOSKELETAL	**#**
Traction	

Braces	
Casts	
Collars	
Slings/Splints	
Skeletal and Skin Traction	
Beds:	
Clinitron	
Roto Rest	
Circelectric	
Crutch Walking/Walkers	
Arthroscopy	
Caring for Patients with:	
Joint/Bone Disorders	
Total Knee Replacement	
Total Hip Replacement	
Amputation	
VITAL SIGNS & WEIGHTS	**#**
Obtaining and Recording:	
BP, Including Orthostatic	
Pulse, Radial	
Temperature, Oral	
Temperature, Rectal	
Temperature, Axillary	
Temperature, Tympanic	
Respirations	
Weight, Pounds and Kilograms	
Use of Electronic VS equipment:	
Automatic BP Machine	
Electronic Thermometer	
Cardioversion Defibrillation	
Activating Code Term	
Bringing Emergency Equipment to Room	
DNR Status	
Applying Oximetry	
Scale Use:	
Standing	
Chair	
Bed	
Recoding and Reporting Information	
SKIN & HYGINE	**#**
Risk Factors For Skin Breakdown	
Observing, recording and reporting pressure points for redness of breakdown	
Recording and Reporting Hygiene/Skin//Breakdown	
Bathing/Daily Hygiene:	

Bathing (shower/tub/bed)	
Use of Shower Chair	
Use of Bath/Shower Boat	
Oral care including patients who are NPO, Comatose, with dentures	
Bathing/Daily Hygiene: cont'd	
Peri-Care	
Foot care for Patients with Impaired Circulation of Sensation	
Incontinence care	
Shaving and Precautions	
Use of Pressure and Friction Reduction Devices:	
Special Beds/Mattresses	
Heels and Elbow Protection	
Foot Cradles	
NUTRITION	**#**
Estimating Intake	
Setting up for Meals	
Aspiration Precautions	
Nourishments	
Feeding Patients	
Counting Calories	
Fluid Restriction	
NPO	
Recording and Reporting Nutritional Information	
ROUTINE CARE	**#**
New Admissions and Transfers:	
Room Preparation	
VS. Height and Weight	
Inventory and Disposition of Belongings	
Room Orientation, Call Bell	
Basic Comfort Measures	
Preparing for and Explaining Routines to Patient	
Post Mortem Care	
SAFETY/ACTIVITY	**#**
Determining Patient ID	
Identifying/Responding to Safety Hazards	
Determining Need for Additional Help	
Recognizing Abuse:	
Substance	
Physical	
Emotional	

Maintaining Clean , Orderly work area	
Handling Hazardous Materials	
Proper Body Mechanics	
ROM Exercises	
Transfer to Bed, WC, Commode with or without device	
Turning and Positioning	
Ambulating with or without Device	
Patient Safety Module	
Reporting Broken Equipment	
Use of Hoyer Lift	
Bed Operation	
Use of Wheel Locks	
Use of Alarms (Bed, Patient, Unit)	
Use of Call Light	
Application and Documentation of Restraints:	
Belt, Including Seat Belt	
Wrist/Ankle	
Vest	
Use of Seizure Pads	
INFECTION CONTROL	**#**
Proper Use of Specific Barrier Methods:	
Gloves	
Gown	
Mask/Goggles	
Protective/Reverse Isolation	
Brody Substance Isolation	
TB Precautions	
MRSA Precautions	
Hand Washing	
Infectious/Hazardous Waste Disposal	
Supply/Equipment Disposal	
Use of Disposable Thermometer	
Use of CPR Mask/Bag	
Disposal of Sharpe	
IV & LINES	**#**
Venipuncture for Specimen	
IV Therapy Including:	
Starting IV	
Changing IV Sites	
Changing IV Dressings	
Changing IV Tubing	
Administering Fluids on Continuous IV Pumps	
Setting Up and Monitoring PCA	
Administering Blood and Blood Products	

Obtaining Central Venous/Peripheral Venous Blood	
Using PICC, Hickman, Triple Lumen Caths	
Set up and Monitoring for TPN	
MEDICATIONS	**#**
Cimetidine (Tagamet)	
Diazepam (Valium)	
Digoxin (Lanoxin)	
Duramorph	
Furosemide (Lasix)	
Heparin	
Insulin	
Lorazepam (Ativan)	
Morphine	
Naloxone (Narcan)	
Nitroglycerine	
Pentobarbital	
Phenytoin (Dilantin)	
Potassium Chloride	
Terbutaline	
Theophylline	
Verapamil (Calan)	
Oral Medications	
Topical Medications	
Suppositories:	
Vaginal	
Rectal	

Ordering Meds	
COMMUNICATION	**#**
Using Appropriate Abbreviations	
Identifying Need for Alternate Communicating Mechanisms	
Communicating to Charge RN:	
Changes in Patient Condition	
Patient Needs, Complaints and Concerns	
Unusual Incidents	
Reinforcing RN Teaching with Patient	
Selecting and Using Forms Appropriately	
Using Alternate Communication Tools/Devices	
MISC SKILLS	**#**
Obtaining Cultures for Septic Work-up (Blood, Sputum, Urine, Catheter Tips)	
Caring for Patient Using Jehovah Witness Protocol	
Overbed Frame Safety	
Specialty Beds (i.e. Kinair)	
Hospital Transport	
Providing Education to Patient Family Related to Medical Condition, Self Care and Health Care Habits	
Communicating Discharge Needs and Arrangements for Support through Appropriate Documentation	
Coordinating Multidisciplinary Plan of care and Initiating Interdisciplinary Referral for	

Patient Needs	
Preparing Patient for Surgery	
Clearly Communicating the Plan of care, Patient Responses and Outcomes in the Patient Record According to Standards	
Assigning or Delegating Tasks to Another for which that Person is Prepared and Qualified to Perform, i.e. LPN's or CNA's	
Using Computerized Tools Effectively	
Knowledge of Serum Lab Values Including:	
Chem 7, Chem 10	
CBC	
Serum drug levels	
Pain Management	
Caring for Drains/Tubes (i.e. Hemovac, Penrose)	
Monitoring and Assessing I & O	
Performing Complex Dressing Changes	
Alert Charting	
Identifying Unusual Incidents on the Unit that Require reporting	
Locating and Using Appropriate Reference Materials	
Charging for Patient Care items	
Completing Risk Management Reports as Needed	
Obtaining Needed Supplies and Equipment	
Using Telephone System	

To the best of my knowledge, the information I have provided on this Registered Nurse Skills Checklist is true and accurate. My signature indicates that I have read this document in its entirety and understand its contents. In addition, I hereby authorize Spectrum Staffing Solutions, LLC to release this Skills Checklist to Facilities in relation to my assignment to that Facility.

Signature: ______________________________ **Date:** ______________________

OFFICE USE ONLY			
INTERVIEWED BY		DATE	
PROFESSIONALISIM		ABILITY	
REMARKS			
HIRED?	YES ☐ NO ☐		
POSITION		WAGE	
ADDITIONAL INFO			
APPROVED	❑ __________ADMINISTRATOR ❑ __________PROGRAM DIRECTOR ❑ ___________OPERATIONS DIRECTOR		