



DEVON GABLES HEALTH CARE CENTER

An Equal Opportunity Employer Application for Employment

Applicants will receive consideration for employment without regard to race, color, national origin, creed or religion, sex, marital status, age, handicap or any other personal characteristic protected by federal, state or local law. We encourage the employment of veterans of the United States Armed Forces and all other qualified applicants.

Applications are kept on file for a minimum of one year. You may update you application upon request. False statements or omission of requested information on this application form shall be considered sufficient cause for rejection during the hiring process. If false statements or omissions are discovered after hire, they shall be considered sufficient cause for termination of employment. Applications will be considered at the time of receipt. If you wish to update your application or request additional consideration, you must contact the facility.

Please Print In Ink

PERSONAL	Name _____ Date _____	
	Last	First Middle
	Address _____	
	Street	City State Zip Code
	Phone(s) _____ Social Security Number _____	
	Are you authorized to work for wages in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If you answered "Yes," you will be required to present documentation showing your employment authorization and identity.	
	If you answered "No," you are not eligible for employment.	
	Age is not used as a hiring criteria unless required by law. If you are under 18 , you may be required to prove your age for some jobs where state safety standards make restrictions. In some states, you may be required to present a work permit.	
	Have you been convicted of a criminal offense in the last seven (7) years? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," state nature of conviction: _____	
WORK DESIRED	Date of Conviction: _____ Status of Probation: _____	
	Name of Probation Officer, if applicable: _____	
	Address: _____ Phone Number _____	
	<i>Note: A conviction does not mean automatic rejection for employment. However, if you are on probation, we will contact your Probation Officer for a reference.</i>	
	Referral Source <input type="checkbox"/> State Job Service <input type="checkbox"/> Ad _____ <input type="checkbox"/> Current Staff Member _____	
	Name of publication List Employee's name	
	<input type="checkbox"/> None - walk-in <input type="checkbox"/> Other _____	
	Please List	
	Type of work or position(s) desired _____ Date available _____	
	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time (____ hrs./week) <input type="checkbox"/> Temporary: From _____ to _____	
Scheduling: Normal office hours are maintained Monday through Friday. <i>The nursing facility must be staffed 7 days a week, 24 hours a day.</i> Work schedules are varied and require flexibility. Based on our staffing needs, we may not always be able to accommodate your scheduling preferences. Therefore, please consider carefully <i>all</i> of your personal time commitments before responding to the following questions.		
Check shift preference: <input type="checkbox"/> Day <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> No preference, I can work any shift		
2nd choice: <input type="checkbox"/> None <input type="checkbox"/> Day <input type="checkbox"/> Evening <input type="checkbox"/> Night		
Can you rotate shifts? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Indicate all days you would be available for work:		
<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday		

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List all Education you would like considered in the evaluation of your application.

1. School / Location _____
 _____ Type of Degree _____

Relevant courses _____

2. School / Location _____
 _____ Type of Degree _____

Relevant courses _____

3. School / Location _____
 _____ Type of Degree _____

Relevant courses _____

Other Education (seminars, military schools, etc.)

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Review *each* column and check *all* items in which you have training (T) and / or experience (E).

T E
 Supervision of employees
 Teaching

Accounts payable
 Accounts receivable
 Payroll
 Full charge bookkeeping
 Financial statements
 Cost reporting
 Auditing
 Taxes
 Budgeting

Blood pressure
 T.P.R.
 Feeding disabled patient
 Transfer techniques
 Ambulation techniques
 Alignment & positioning
 Range of motion
 B & B training
 Catheterization

T E
 Medicare/Medicaid reimbursement
 Medical records
 Insurance billing

Typing _____ wpm
 Shorthand/Speedwriting _____ wpm
 Dictating equipment
 10-key adding machine
 Calculator
 Key punch machine
 Switchboard
 Copy machines

*** Long-Term Care / Rehabilitation Nursing Techniques ***

Admin. of medicines
 Isolation technique
 Sterile technique
 Reality Orientation
 Therapeutic activity programs
 Use of P.T. in long term care
 Use of O.T. in long term care
 Charting
 Patient care plans

T E
 Data Processing
 Word Processor
 Computers

List any additional skills you consider important: _____

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Have you ever worked for Devon Gables Health Care Center? Yes No

If yes, when _____
From To

Position Held _____ Immediate Supervisor _____

Reason for leaving _____

List any relatives who currently work at Devon Gables _____

We will not employ relatives in positions where a direct supervisory relationship will exist.

List most recent employer first. Include military service if among last four jobs. You may list volunteer experience if you do not have paid work experience with four employers. (Write "V" in salary column.)

1.	Employer	Address (street, city, state, zip code)	Phone
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Dates Employed	Job Title	Supervisor's Name/Job Title
From _____ To _____		

Primary Job Duties _____

Final Salary	Reason for Leaving
\$ _____	

May we contact for a reference? Yes No If No, explain _____

2.	Employer	Address (street, city, state, zip code)	Phone
----	----------	---	-------

Dates Employed	Job Title	Supervisor's Name/Job Title
From _____ To _____		

Primary Job Duties _____

Final Salary	Reason for Leaving
\$ _____	

May we contact for a reference? Yes No If No, explain _____

3.	Employer	Address (street, city, state, zip code)	Phone
----	----------	---	-------

Dates Employed	Job Title	Supervisor's Name/Job Title
From _____ To _____		

Primary Job Duties _____

Final Salary	Reason for Leaving
\$ _____	

May we contact for a reference? Yes No If No, explain _____

4.	Employer	Address (street, city, state, zip code)	Phone
----	----------	---	-------

Dates Employed	Job Title	Supervisor's Name/Job Title
From _____ To _____		

Primary Job Duties _____

Final Salary	Reason for Leaving
\$ _____	

May we contact for a reference? Yes No If No, explain _____

List any other references we may contact: _____

Explain any circumstance(s) that may affect reference received: _____

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Complete this section if a license is required to perform the duties of the job for which you are applying.

Type License/Certification	State	Number	Expiration Date	Leave Blank
Driver's License				
LPN/LVN				
RN				
Administrator				
RPT/LPT				
Other				

If you don't have required license, have you applied? Yes No

If exam is required, give scheduled date: _____

If not licensed in this state, have you applied for reciprocity? Yes No

If you will be driving on the job, name insurance company and type of coverage: _____

In the interest of safety and health of our residents and employees, employment is subject to a successful health screening and/or physical if required by law or dictated by the physical demands of the specific job.

I have read all sections of this application and authorize verification of my statements. I understand that misrepresentations may be considered cause for rejection in the hiring process or termination of employment. I further understand my employment may be subject to a physical examination, favorable references and documentation of my right to work in the U.S. In consideration of my employment, I agree to conform to the rules, procedures and regulations of Devon Gables Health Care Center.

Signature

Date

Do Not Write Below This Line

Interviewed by:

Name

Job Title

Date

Name

Job Title

Date

Name

Job Title

Date