



EMPLOYMENT APPLICATION SUN MEDICAL STAFFING

Name _____ Home Tel. () _____
Street Address _____ Cellular () _____
City, State, Zip _____ Beeper/Pager () _____
Social Security No. _____ E-Mail _____
Position Applying For: _____ Other (Specify): _____

WORK HISTORY:

Current or Last Employer _____ Tel () _____
Street Address _____ Supervisor _____
City, State, Zip _____ Job Title _____
Salary _____ Dates Worked – From _____ To _____ Name Used While Employed _____
Reason for Leaving _____ Duties _____

May We Contact This Employer To Obtain Reference? Yes No

Prior Employer _____ Tel. () _____
Street Address _____ Supervisor _____
City, State, Zip _____ Job Title _____
Salary _____ Dates Worked – From _____ To _____ Name Used While Employed _____
Reason for Leaving _____ Duties _____

EDUCATION:

Name of College or Nursing School _____ Name Used While Attending _____
Street Address _____ Degree/Course/Certificate _____
City, State, Zip _____ Date Received _____

Were You Ever Convicted Of A Crime? Yes No
If Yes, Please
Explain _____

* Criminal conviction (s) will not automatically disqualify an applicant from employment with SUN MEDICAL STAFFING, INC.



PLEASE READ AND SIGN

I hereby authorize Sun Medical Staffing, Inc. and also authorize and request each former employer and person, firm or corporation given as a reference to answer all questions that may be asked and give all information that may be sought in connection with this application specifically concerning my work, skill or my professional action in any transaction. My employment with Sun Medical Staffing, Inc. will not begin until such references are received.

I agree, in consideration of your employing me that I will not seek or accept employment from any client of Sun Medical Staffing, Inc. without first obtaining permission from Sun Medical Staffing, Inc. and I agree to remain on the Sun Medical Staffing, Inc. payroll for an additional 350 hours or the terms agreed upon by all parties. I understand that if I am in violation of this agreement, I am subject to legal action and monetary damages.

I understand that this employment application is not a contract and that if hired, my employment with Sun Medical Staffing, Inc. can be terminated with or without cause, and with or without notice, at any time, at the option of Sun Medical Staffing, Inc. I also understand that any and all benefits received pursuant to employment with Sun Medical Staffing, Inc. may be changed or eliminated at will without prior notice.

I consent to having a background check done on my history, including a social security number verification, and I understand that my employment might hinge on this check, including termination if after I am hired, Sun Medical Staffing, Inc. acquires information that precluded my hire.

I understand that all applicants are required to undergo screening for the presence of illegal drugs or alcohol as a condition of employment at Sun Medical Staffing, Inc. I will be required to voluntarily submit to a urinalysis test at a laboratory chosen by the company and by signing this consent agreement I release Sun Medical Staffing, Inc. from liability. I understand that with positive test results I will be denied employment at this time, but I may initiate another inquiry with Sun Medical Staffing, Inc. after 6 months. Sun Medical Staffing, Inc. will not discriminate against applicants for employment because of past abuse of alcohol/drugs. Neither will Sun Medical Staffing, Inc. tolerate the current abuse of alcohol/drugs. I may also be asked to voluntarily submit to urinalysis tests for Cause/Post Incident Screening, Post Accident Screening and at the request of any client prior to starting an assignment.

I authorize Sun Medical Staffing, Inc. to copy and forward my personnel file contents to any and all agencies which require this of Sun Medical Staffing, Inc. I hereby certify that all of the above information is true and correct. I understand that any misrepresentation or false information given on this application will result in rejection or termination of employment.

Applicants Signature: _____ Date: _____

FOR OFFICE USE ONLY – DO NOT WRITE BELOW

INTERVIEW COMMENTS

Interviewed By: _____ Position: _____ Office: _____

Interviewer's Signature: _____ Date: _____

Multiple horizontal lines for writing interview comments.



ENROLLEMENT FORM
ANNUAL MANDATED TOPICS

I hereby acknowledge receipt and understanding of the following Mandated Topics from **Sun Medical Staffing, Inc.**

Topics Included:

- ❖ Fire Safety
- ❖ Electrical Safety
- ❖ Infection Control/Universal Precautions
- ❖ Hepatitis C
- ❖ Hepatitis B
- ❖ HIV Testing and Related Information
- ❖ Age Specific Care
- ❖ Sexual Harassment
- ❖ Pain Management
- ❖ Patient Abuse
- ❖ Multi-Cultural Aspects and Spiritual Diversity of Patient Care
- ❖ HIPAA Privacy Regulations
- ❖ National Patient Safety Goals
- ❖ Patient Rights
- ❖ Domestic Violence
- ❖ Restraints
- ❖ Blood Glucose Monitoring & Management
- ❖ Advance Directives
- ❖ Agency Administrative Policies and Procedures
- ❖ Emergency Preparedness Plan
- ❖ Prevention of Medical Errors
- ❖ Back Safety
- ❖ Workplace Violence

I understand that as an employee of *Sun Medical Staffing*, at any client facility, it is my responsibility to protect the confidentiality of the patients' medical information. Failure to maintain patient confidentiality may lead to discharge or other disciplinary action. I have read and understand the above policy.

Print Name

Title

Signature

Date



AGE SPECIFIC EXPERIENCE

AGES	NO EXP.	LESS THAN 1 YEAR	1-4 YEARS	5-10 YEARS	10-15 YEARS	15+ YEARS
0-5						
6-10						
11-15						
16-20						
21-25						
26-34						
35-44						
45-54						
55-64						
65+						



REFERENCE REQUEST

The following employment information must be provided to Sun Medical Staffing, Inc. in accordance with there stringent pre-employment requirements. I hereby authorize the release of my employment and performance records.

I respectfully request your prompt response to this request for my employment information, as my future employment is dependent on your contribution.

EMPLOYER CONTACT INFORMATION

Facility Name: _____ Unit: _____

Address: _____

Contact Name: _____ Title: _____

Phone: _____ Fax: _____ E-Mail: _____

EMPLOYEE INFORMATION

Name of Applicant (printed): _____

Name Used while employed: _____ Position: _____

Social Security #: _____ Dates of Employment: From: _____ to _____

Signature of Applicant: _____ Date: _____

THIS PORTION IS TO BE COMPLETED BY THE EMPLOYER

	EXCELLENT	GOOD	AVERAGE	POOR
Quality of Work / Competency				
Attendance / Punctuality				
Professional Conduct				
Cooperation /Relationships				

Comments: _____

Eligible for Rehire: _____ YES _____ NO Still Currently Employed: _____ YES _____ NO

Name (printed): _____ Date: _____

Title: _____ Contact Phone Number: _____

Signature: _____

The staff of Sun Medical Staffing, Inc, recognizes the many tasks you must accomplish daily. We appreciate the moments you spent completing this request. Your comments directly impact our ability to achieve our goal to continuously provide qualified healthcare professionals to facilities such as yours. Please return this document to our offices via mail or fax to: Sun Medical Staffing, Inc 4500 New Brunswick Ave Piscataway, NJ 08854 Phone: 732-529-5865 Fax: 732-529-5870



PHYSICAL EXAMINATION

Name: _____ Date: _____

Date of Birth: _____ Gender: _____

PPD, Mantoux, TB Tine Test

Step 1 Date Placed _____ Date Read _____ Result _____

Step 2 Date Placed _____ Date Read _____ Result _____

If result is positive please attach the Chest X- Ray Report

Titre / Immunization Records

*Please specify immunity status as well as the source used to verify this status.
Immunization records and or Titre results must be attached.*

	<i>Immune Status</i>	<i>Titre</i>	<i>Vaccination Record</i>
Measles	_____	_____	_____
Mumps	_____	_____	_____
Rubella	_____	_____	_____
Varicella	_____	_____	_____
Rubeola	_____	_____	_____

**Rubeola Immunity must be verified if patient DOB is after 11/1/57*

Hepatitis B Vaccination Dates

1. _____ 2. _____ 3. _____

Diphtheria Tetanus Vaccination Date _____ (if applicable)

Statement of Health

The above named is free from a health impairment which is of potential risk to the patient or which might interfere with the performance of his/her duties, including the habituation of addiction to depressants, stimulants, narcotics, alcohol or other drugs or substances which may alter the individual's behavior.

Date: _____ Physician Name: _____
Please Print

Address: _____ Phone: _____

Physicians Signature _____

THIS FORM MUST BE COMPLETED AND RETURNED WITH REQUIRED ATTACHMENTS PRIOR TO ACTIVE EMPLOYMENT!

Sun Medical Staffing, Inc. 4500 New Brunswick Ave Piscataway, NJ 08854 Phone: 732-529-5865 Fax: 732-529-5870



HEPATITIS B STATUS DECLARATION

Do not sign both the Acceptance and Declination portions of this form. If you have any uncertainty regarding your current status, please contact your **Sun Medical Staffing, Inc.** representative for clarification. If you are unable to provide the required Vaccination Information at this time, please sign the Declination Portion of this document.

Hepatitis B Declination

I understand that my occupation may result in exposure to blood or other potentially infectious materials and that I may be at risk of acquiring Hepatitis B virus (HBV) infection. I understand that my failure to receive this vaccine may subject me to the risk of acquiring Hepatitis B disease or, I am in the process of receiving inoculations for Hepatitis, but I have not completed them yet. Therefore, for now I decline and I will furnish you proof of my inoculations when they are completed.

Print Name

Date

Signature

Hepatitis B Acceptance

I have already received 3 (three) vaccinations required for Hepatitis B Vaccination Series and I am able to provide the vaccination records as proof of these inoculations at this time.

Print Name

Date

Signature



TB Questionnaire

EMPLOYEE NAME: _____ SPECIALTY: _____

STEP I

If you have had a positive PPD in the past, go to step II. If you receive PPD's on an annual basis, complete **Step I ONLY**.

DATE OF LAST PPD: _____ RESULTS OF LAST PPD IN MM: _____

STEP II

Since you have had a positive/sensitive PPD and are no longer required to have an annual chest x-ray, the following is to be completed annually and maintained in the personnel file. However, you must have the results of at least one XRAY on File.

DATE OF LAST XRAY: _____

Please read and put a checkmark in the correct Yes/No space if you are experiencing any of the following symptoms or if any of the following apply to you:

	YES	NO
1. Unplanned loss of weight (>10% of body weight)	___	___
2. Night sweats	___	___
3. Fever lasting several weeks	___	___
4. Frequent coughing in the absence of a cold or flu	___	___
5. Coughing blood-streaked sputum	___	___
6. Unusual tiredness or weakness lasting weeks	___	___
7. Pain in chest when taking a breath	___	___
8. Have you been recently diagnosed with diabetes, silicosis, HIV disease, renal disease or liver disease?	___	___
9. Have you been recently been exposed to a family member or others with active TB?	___	___

If you checked YES to any of the above question, are you currently treating with a physician?
(Circle one) YES NO Please explain: _____

IF YOU DEVELOP ANY OF THE SYMPTOMS LISTED ABOVE, PLEASE CONTACT YOUR PHYSICIAN AND AGENCY **IMMEDIATELY**. A CHEST X-RAY **MUST** BE PERFORMED PRIOR TO WORKING AGAIN.

SIGNATURE: _____ DATE: _____

PHYSICIAN: _____ DATE: _____



TUBERCULOSIS EDUCATION

Please circle one:

TB is caused by Mycobacterium tuberculosis	TRUE	FALSE
TB is most commonly found in the kidneys	TRUE	FALSE
TB is spread through contact with blood and body fluids	TRUE	FALSE
Common signs of pulmonary TB are diarrhea, increased urination and weight loss	TRUE	FALSE
PPD skin tests must be read within 48-72 hours of placement	TRUE	FALSE
A positive PPD skin test indicates that a person has active TB disease	TRUE	FALSE
A person infected with HIV is more likely to have a false positive skin test due to immunosuppression	TRUE	FALSE
PPD skin testing is contraindicated during pregnancy	TRUE	FALSE
Preventative therapy consists of the daily administration of INH for 3 months	TRUE	FALSE
TB exposure is defined as having known contact with a confirmed case of TB, having a positive PPD skin test and a normal physical exam and chest x-ray	TRUE	FALSE

Signature/Print Name