



PHOENIX HEALTH CARE

218 ROUTE 17 NORTH, ROCHELLE PARK, NJ 07662 201-567-4364 FAX 201-567-7232 WWW.PHOENIXHEALTHCARENJ.COM

Dear

Thank you for your interest in applying for work with Phoenix Health Care, Inc.. Enclosed is an application for you to complete. As soon as you receive this application, contact us to set up an interview at your earliest convenience.

As you are probably aware, both the Health Department and JCAHO require evidence of the following items annually:

Current Nursing License

BCLS/ACLS..... ACLS is required of all ER personnel

Malpractice..... 1-2 or 1-3 million.

Physical..... Must include a PPD/Mantoux and Rubella Titre

Fire, Safety, and Infection Control.

In addition, any of the following certifications that you may have are extremely helpful:

IV Certification

ICU/CCU Certification

Chemotherapy administration

Operating Room

CV or Resume

We currently have work available in the following areas:

ICU/CCU/OH

ER/ERH

PACU

OR/RR/PACU

NICU/PICU

PSYCH

MED/SURG

TELEMETRY

LONG TERM CARE/SUB ACUTE

PRIVATE DUTY

ONCOLOGY IN-PATIENT/OUT-PATIENT

If you have any questions, please do not hesitate to telephone us at any time.

Thank you in advance.

Theresa LaFlam, RN

Director of Nursing



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APPLICATION FOR EMPLOYMENT

Name: _____ SS No.: _____
Last First

Street Address: _____

City: _____ State: _____ Zip: _____

County: _____

Home Telephone No.: _____ Work Telephone No.: _____

Email: _____ Beeper #: _____ Cell #: _____

NJ RN License No.: _____ Expiration Date: _____

Area of Expertise: _____

Hospitals: _____

Shifts: _____

MALPRACTICE INSURANCE INFORMATION

Company: _____ Expiration Date: _____

Policy No.: _____ Coverage Limits: _____

EDUCATION

	Institution	From/To	Degree or Certificate
School Nursing/Undergraduate:			
Graduate:			
College:			

-Over-

APPLICATION FOR EMPLOYMENT

Page 2

PROFESSIONAL HISTORY (Start with most recent)

Facility & Address: _____
From/To: _____ Unit(s) Worked: _____
Supervisor: _____ Phone No.: _____

Facility & Address: _____
From/To: _____ Unit(s) Worked: _____
Supervisor: _____ Phone No.: _____

CERTIFICATIONS

B.C.L.S.: _____ Expiration Date: _____ A.C.L.S.: _____ Expiration Date: _____
I.V. Certification Date: _____ Institution: _____
CCRN Date: _____ CCRN #: _____ Expiration: _____
CEN Date: _____ CEN #: _____ Expiration: _____

Please check areas in which you are clinically competent and willing to work (must have 1 yr. current experience in the area checked):

<input type="checkbox"/>	Medical ICU	<input type="checkbox"/>	Emergency/ERH	<input type="checkbox"/>	Private Duty
<input type="checkbox"/>	Coronary ICU	<input type="checkbox"/>	PACU	<input type="checkbox"/>	Well Baby
<input type="checkbox"/>	Surgical ICU	<input type="checkbox"/>	L&D/P.P	<input type="checkbox"/>	CNA
<input type="checkbox"/>	Open Heart	<input type="checkbox"/>	General Peds	<input type="checkbox"/>	Telemetry
<input type="checkbox"/>	Operating Room	<input type="checkbox"/>	Utilization Review	<input type="checkbox"/>	Sub Acute
<input type="checkbox"/>	Neonatal ICU	<input type="checkbox"/>	Oncology	<input type="checkbox"/>	LTC
<input type="checkbox"/>	Pediatrics ICU	<input type="checkbox"/>	Med/Surg	<input type="checkbox"/>	Case Management- D/C Planning

Please list pertinent continuing education / critical care courses completed.
Include ICU Certification, seminars and in-service programs:

Course: _____ Location: _____ Date: _____
Course: _____ Location: _____ Date: _____
Course: _____ Location: _____ Date: _____

I certify the above information to be true and accurate.

Applicant's Signature: _____ Date: _____

Interviewer's Signature: _____

Comments: _____

**PHOENIX HEALTH CARE
CRIMINAL BACKGROUND CHECK
SEARCH REQUEST FORM**

To Be Completed By Applicant: (Please type or print legibly)

Individual's Name: _____

Address: _____

City/State/Zip: _____

Phone #: _____ Social Security No: _____ Date of Birth: _____

Driver's License No: _____ DL State: _____

**APPLICANT CONSENT FOR BACKGROUND
INVESTIGATION**

I hereby authorize Phoenix Health Care and it's affiliates, or its agents to investigate me, my former employment and professional reputation.

I hereby authorize all persons, firms, companies, government agencies, courts, credit agencies, associations or institutions having control of any documents, records or other information to furnish said documents to the above requestor.

I understand that the above information is specifically related to the background investigation process, and that in no way will it be used as a basis for the employment decision.

I hereby release to Phoenix Health Care and it's affiliate, or its agents from any and all liability resulting from such investigation.

Signature: _____ Date: _____



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I HAVE READ AND UNDERSTAND THE INFECTION CONTROL, FIRE AND ELECTRICAL SAFETY, AND HIPPA GUIDELINES IN ACCORDANCE WITH THE STATE AND JCAHO REGULATION.

Print Name _____

Signature _____ Date _____

Authorized Signature _____ Date _____



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PHYSICIAN'S STATEMENT

RE: _____

ADDRESS: _____

DATE OF PHYSICAL EXAM: _____

DATE AND RESULTS OF TWO STEP MANTOUX: _____

(one time requirement)

DATE AND RESULTS OF PPD: _____

(yearly requirement)

IF PPD IS/HAS BEEN POSITIVE, A CHEST X-RAY IS REQUIRED. ANY SYMPTOMS?

DATE OF POSITIVE PPD: _____

DATE AND RESULTS OF CHEST X-RAY: _____

DATE OF MEASLES, MUMPS & RUBELLA (MMR) VACCINATION: _____

DATE AND RESULTS OF RUBELLA TITER: _____

DATE AND RESULTS OF RUBEOLA TITER: _____

DATE OF VARICELLA TITER: _____

DATE OF HEP B VACCINE _____

OR, IF YOU HAVE DECLINED THE HEPATITIS B VACCINE PLEASE SIGN HERE:

NURSES SIGNATURE: _____ DATE: _____

Please sign below, stating that you have examined the above named individual and found her/him to be free from health conditions which would be of potential risk to patients or which might interfere with the performance of the person's duties as a healthcare worker, including, but not limited to the habituation or addiction to substances which may alter the individual's behavior.

PHYSICIAN'S SIGNATURE: _____ DATE: _____

PHYSICIAN'S NAME (PRINT): _____

ADDRESS: _____

EMPLOYEE'S SIGNATURE _____ **DATE** _____



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DRUG SCREEN

This is to ensure that _____ is free from any health impairment that is of potential risk to patients or might interfere with the performance of the work of such person including but not limited to, the habituation of addiction to Depressants, Stimulants, Narcotics, Alcohol or other drugs or substances that might alter the behavior of the nurse.

Physician's signature _____

Physician's Name _____
(print)

Address _____

Date _____



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As a condition of my association with Phoenix Health Care , I understand that the information that I will access through my employment at Phoenix Health Care will include sensitive and confidential patient information. I understand that it is my responsibility to maintain confidentiality of all information, both clinical or financial, that is entrusted to me. This obligation shall exist while I am under contract or associated with Phoenix Health Care and shall continue after my association, contract expiration, or termination regardless of the reason.

I specifically understand that information regarding patients, employees and individuals affiliated with Phoenix Health Care or any of their accounts is to be shared with only those individuals who have an authorized need to know.

If issued a computer password, I agree not to release it to anyone else. I will not post, share or otherwise distribute my password. I will contact the Information Systems Department immediately if I have reason to believe the confidentiality of my password has been broken.

By signing below, I acknowledge that I have read the above and accept the responsibilities associated with these statements. I understand that I will be subject to disciplinary action, suspension and possible immediate termination if I violate any of the above agreed upon statements.

Name (print)

Signature

Date



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Dear

The applicant listed below has applied for assignments through PHOENIX HEALTH CARE, INC. We ask that you verify and complete this form at your earliest convenience. It is understood that any information provided by you will be kept confidential. Thank you for your cooperation in the completion of this form.

Phoenix Health Care

I authorize the above named employer to furnish Phoenix Health Care, Inc. with the information requested on this form.

Applicant Signature

PLEASE PRINT:

Name of Applicant _____

Social Security Number _____ Position _____

Dates Employed _____ to _____ Clinical Area _____

Please Evaluate Application	Acceptable	Unacceptable	Comments
Knowledge of Medication Principles			
Knowledge of Primary Nursing			
Ability to Work Independently			
Cooperation			
Attendance & Punctuality			
Personal Appearance			

Additional Comments _____

If no longer employed:

Reason for leaving: _____

Eligible for re-employment Yes No If not please explain:

Does applicant have any physical disability? _____

Has applicant ever received compensation for injuries ? Yes No

Signature _____ Date _____

Title _____



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