



Thank you for choosing Seniorhearts Nurse Registry. We look forward to working together with you. Our company is very flexible, and works hard to get you the hours you desire at the facilities you request. In addition to completing the hiring packet we will need copies of the following forms to complete your employee file:

- Driver's License and SS Card
- Current RN / LPN / CNA License (if applicable)
- Current HHA Certificate
- Car Insurance
- Background Check Level 1 & Level 2
- HIPPA Training (APD ONLY) / Infection Control
- CPR / First Aid card
  
- **CEU's**
- HIV 4 HR
- HIV/AIDS (UPDATE)
- DOMESTIC VIOLENCE
- ALZHEIMER'S
  
- PHYSICAL
- Copy of TB (PPD Skin test) or CHEST X-RAY within one year
- Copy of Immunization record (Proof of MMR)
- Current ACLS/PALS/NRP (If applicable)
- MEDICAL RECORD DOCUMENTATION
- LEGAL ASPECTS/RULES & REGULATON
  
- PREVENTION OF MEDICAL ERRORS
- RESIDENT/PATIENT RIGHTS
- ASSISTING WITH MEDICATION
- AFFADAVIT OF GOOD MORAL CHARACTER

The application process can seem overwhelming at first, but all of the documents required are the same that are needed for hospital employment. We have built a good reputation for our meticulous record keeping and meeting stringent nurse hiring requirements which has allowed us to gain more hospital contracts and offer more shifts with fewer cancellations. We are honored that you have decided to join our team and allowing us to represent you in the healthcare industry. If you have any questions please contact our office at **(855) 775-7070**.

Sincerely,

**SENIORHEARTS NURSE REGISTRY**

4400 North Federal Highway # 33

Boca Raton, Florida 33431

Phone:(855) 775-7070

Email: [info@myseniorhearts.com](mailto:info@myseniorhearts.com)

Website: <http://www.myseniorhearts.com>



## Application for Employment

Thank you for applying for a position with **Seniorhearts Nurse Registry**. We appreciate the time you are giving to complete this application. It is important that you fully and accurately complete this form yourself and indicate the position(s) for which you wish to be considered. The following must be filled out completely for your application to be considered.

Name: \_\_\_\_\_  
Last First Middle

Have you ever used another name?  Yes  No If yes, what: \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_\_ Other Telephone: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Have you ever used another Social Security Number?  Yes  No

Present Address: \_\_\_\_\_  
No. Street City State Zip

Mailing Address: \_\_\_\_\_  
(If different) No. Street City State Zip

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### Employment Desired:

Position applying for: \_\_\_\_\_

If hired, on what date can you start work? \_\_\_\_\_ Salary desired? \_\_\_\_\_

### References:

How did you hear about our company? \_\_\_\_\_

List below three persons not related to you who have knowledge of your work performance within the last three years. If this does not apply to you, then provide three school or personal references that are not related to you.

Name	Address	Phone	Years Known
1.) _____	_____	_____	_____
2.) _____	_____	_____	_____
3.) _____	_____	_____	_____



**Education and Training**

Name and State	Degree Obtained	Date Graduated
High School: _____	_____	_____
College/University: _____	_____	_____
Vocational/Business: _____	_____	_____

**Employment History:**

List below all present and past employment, starting with your most recent employer:

Are You Employed Now?  Yes  No    May we contact your present employer?  Yes  No

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

No.	Street	City	State	Zip
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Telephone: (\_\_\_\_) \_\_\_\_\_ Your Supervisor's Name: \_\_\_\_\_

Position Held: \_\_\_\_\_

Date of Employment: From: \_\_\_\_\_ To: \_\_\_\_\_

Earnings: Starting: \_\_\_\_\_ / Ending: \_\_\_\_\_

Exact Reason for Leaving: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

No.	Street	City	State	Zip
-----	--------	------	-------	-----

Telephone: (\_\_\_\_) \_\_\_\_\_ Your Supervisor's Name: \_\_\_\_\_

Position Held: \_\_\_\_\_

Date of Employment: From: \_\_\_\_\_ To: \_\_\_\_\_

Earnings: Starting: \_\_\_\_\_ / Ending: \_\_\_\_\_

Exact Reason for Leaving: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_

No.	Street	City	State	Zip
-----	--------	------	-------	-----

Telephone: (\_\_\_\_) \_\_\_\_\_ Your Supervisor's Name: \_\_\_\_\_

Position Held: \_\_\_\_\_

Date of Employment: From: \_\_\_\_\_ To: \_\_\_\_\_

Earnings: Starting: \_\_\_\_\_ / Ending: \_\_\_\_\_

Exact Reason for Leaving: \_\_\_\_\_



### License Information

Answer the following questions if applying for a professional position:

Are you licensed for the job applied for?  Yes  No Type of license (RN/LVN/CNA): \_\_\_\_\_  
Issuing state: \_\_\_\_\_ License/certification number: \_\_\_\_\_ Has your license ever  
lapsed, been revoked or suspended?  Yes  No If yes, state reason(s), date of lapse,  
revocation or suspension and date of reinstatement: \_\_\_\_\_

Have you ever, under your name or another name, been convicted of (or pleaded guilty or nolo  
contendere to) a Felony or Misdemeanor? ....  Yes  No

Have you ever, under your name or another name, been convicted of a crime, which resulted  
with your being in prison and released from prison or paroled? ....  Yes  No

(Do not identify convictions for marijuana-related offenses that are more than two years old; or  
convictions for which the criminal record has been expunged, sealed or eradicated by the court;  
or, misdemeanor convictions for which any probation has been completed and the case  
dismissed by the court.)

If yes, explain each conviction fully, when, where and of what you were convicted and  
disposition of the case(s):

\_\_\_\_\_

Are you currently under arrest, or released on bond or your own recognizance, pending trial for  
a criminal offense? .....  Yes  No

If yes, state the nature of the crime charged, and when and where trial is pending:

\_\_\_\_\_

**The following section is for employment within the healthcare industry in Florida**

Please answer the following only if:

1. The position for which you are applying will provide you access to patients. Have you ever  
been arrested for a sex related crime?  Yes  No If Yes, Please Explain:

\_\_\_\_\_

2. The position for which you are applying will provide you access to drugs or medications.  
Have you ever been arrested for a drug related crime?  Yes  No Please Explain:

\_\_\_\_\_

\_\_\_\_\_



## Authorization

### Personally completed this form honestly and accurately

By my signature below, I promise that I have personally completed this application. I declare under penalty of perjury that the information provided in this employment application (and accompanying resume, if any) is true and complete, and I understand that any false information or significant omissions may disqualify me from further consideration for employment, and may be justification for my dismissal from employment if discovered at a later date. I understand that any job offer is conditional based on the satisfactory review of my qualifications including any and all background or drug screening which may be required.

### Drug and Alcohol screening

I give permission for a pre-employment drug/alcohol screening exam, and, if the company makes a conditional job offer, I give permission for a complete employment physical and mental examination. I also consent to the appropriate release of any and all medical information, as may be deemed necessary. (See separate Agreement)

### Authorization to obtain information

I voluntarily and knowingly authorize any present or past employer; supervisor; administrator; educational institution; law enforcement agency; state, local, or federal agency; credit bureau; collection agency; private business; military branch; the national personnel records center; personal reference; and/or other persons; to give records or information they may have concerning my criminal history, motor vehicle report, educational history, licensing, employment (including character, earnings history and reasons for termination) or any other information requested by the company requested to determine my eligibility for employment.

### Release

I voluntarily waive all recourse and release any company, individual or organization from liability for complying with any request from the company or agents of the company (including any consumer reporting agency) to obtain any information from any source whatsoever relating to my application for employment. I further release the company or any individual within the company regarding the use any information received which may have bearing on my application for employment.

### Notification and compliance with rules

I agree to immediately notify the company if I should be convicted of a crime while my job application is pending, or during my employment if hired. If I become employed, in consideration of my employment, I agree to comply with the rules, regulations, policies and procedures of the company.

**I certify that all of the information provided by me on this Application is true and accurate.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_



## Hepatitis B Vaccine

OSHA requires all health care workers at risk to have the opportunity to have the Hepatitis B Vaccination offered to them by their employer.

1. If you have completed the vaccination series, please indicate such at the appropriate statement, date and sign the bottom of this letter.
2. If you are in the process of receiving the series, please indicate, date and sign at the bottom of this letter. Please indicate if you require a dose of the vaccine while working on this contract. Omega Healthcare Staffing, Inc will provide it to you at no cost.
3. If you decline to have the Hepatitis B Vaccine indicate this at the bottom of this letter, sign and date.

**\*\*\*Please Choose Only One\*\*\***

I understand the OSHA guidelines and have completed the Hepatitis B Vaccine series

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I understand the OSHA guidelines and need #\_\_\_\_ or booster, in the series. Please make arrangements with us to receive this dose of the vaccine.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

I understand the OSHA guidelines and DECLINE the Hepatitis B Vaccination.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



## Education Acknowledgment Form

This is to acknowledge that I have received training on and a copy of Seniorhearts Nurse Registry's Annual Education Booklet which contains information and verification of procedures related to the following:

Blood borne Pathogens and Universal Precautions  
Latex Allergies  
Hospital and Fire Safety  
Emergency Preparedness  
Security and Workplace Violence  
Tuberculosis Education  
HIPAA Education  
Patient Rights  
Risk Management  
Age Specific Competency  
Use of Restraints  
Abuse Reporting  
Sexual Harassment  
Conscious Sedation  
Advance Directives  
Organ Donation  
Medication Errors  
Preventing Workplace Injuries  
JCAHO National Patient Safety Goals

I understand that the above mentioned materials provide guidelines and summary information about the company's policies and procedures. I also understand that it is my responsibility to read, understand, become familiar with, and comply with the standards that have been established.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_



## Certified Nursing Assistant Job Description

### Summary

Perform a variety of nonprofessional nursing duties in the direct care of patients under the direct supervision of an RN/LPN.

### Duties and Responsibilities

- Prepare patients, equipment and supplies for specific procedures and provide manual assistance as required.
- Obtain and record patient data for medical records noting and informing RN/LPN of information collected.
- Administer treatment and personal care procedures to patients including, but not limited to, feeding, bathing, shaving, changing clothing, cleaning bed-making, assisting with ambulation, enemas, skin care, and bowel and bladder elimination; provide such additional care as required to meet the personal needs and comfort of assigned patients.
- Participate in teaching activities by reinforcing teaching instructed by RN and/or physician as needed.
- Assist physician and nurses with physical examinations by helping position patients, changing non-sterile dressing and weighing patients.
- Note and reports any changes in patient's condition to the RN or LPN.
- Take and records vital signs, record I&O, applies ice bags, administer douches and enemas.
- Turn and position patients, set up and feed patients as necessary, provide patients with fresh drinking water.
- Perform finger sticks for blood glucose testing with appropriate training.
- Assist with admission, discharge, and transportation of patients.
- Follow standard precautions and use personal protective equipment as required.
- Perform other related duties incidental to the work described herein.
- Collect, deliver and conduct routine tests on patient specimens.
- Clean assigned area; stock and replenish supplies and equipment as required.





- Participate in own professional development by maintaining required skills validation and attending educational offerings. Supports the development of other staff and formal learners.
- Perform other related duties incidental to the work described herein.

### **Education**

Completion Certified Nurse Aide education program approved by the Florida Board of Nursing with a High School diploma or equivalent preferred.

### **Experience**

A minimum of one year current experience

### **Degrees, Licensure, and/or Certification**

Current Certified Nursing Assistant license in the state of Florida and current BLS

### **Knowledge, Skills, and Abilities**

- Working knowledge of procedures and techniques involved in administering routine and special treatments to patients.
- Working knowledge of sanitation, personal hygiene and basic health and safety precautions applicable to work in a hospital
- Working knowledge of infection control procedures and safety precautions
- Able to withstand prolonged standing and walking with the ability to move or lift at least 50 pounds
- Ability to understand English and follow oral and written instructions
- Ability to document and communicate pertinent information
- Ability to establish and maintain effective working relationships with patients and hospital staff

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Employment Verification Form

I, \_\_\_\_\_ (Print Name) Voluntarily and knowingly authorize Seniorhearts Nurse Registry to contact the following employers listed in the "Company" box below to give records or information they may have concerning my present or prior employment (including character, earnings, history and reason for termination) and any other information requested by Seniorhearts Nurse Registry. to determine my eligibility for employment.  
**Candidate - please complete the highlighted areas only below.**

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Company: (Print current or prior employer name here)	Company: (Print prior employer name here)	Company: (Print prior employer name here)
Phone:	Phone:	Phone:
Position Held:	Position Held:	Position Held:
Dates of Employment:	Dates of Employment:	Dates of Employment:
Attendance: Good Fair Poor	Attendance: Good Fair Poor	Attendance: Good Fair Poor
Eligible for Re-hire Yes No	Eligible for Re-hire Yes No	Eligible for Re-hire Yes No
Contact /Title	Contact /Title	Contact /Title
Info Verified by:	Info Verified by:	Info Verified by:



**Senior Hearts**

Nurse Registry

"We are here because we care!"

## Work Experience Checklist

Clinical Skill		Dates of Experience (mm/YYYY) i.e. 01/2008 – 02/2013
I&O	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Vital Signs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Acute Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Private Duty	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hospice	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nursery	<input type="checkbox"/> Yes <input type="checkbox"/> No	
CPR	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Blood Glucose Monitor	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Reference Inquiry Form

To: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I have applied for employment at Seniorhearts Nurse Registry. I authorize you to release all information requested below by Seniorhearts Nurse Registry, including information concerning my character, habits, abilities, and reason(s) for leaving your company. The following information may help in identifying my records:

Name:		Social Security Number:	
Position:		Dates of Employment:	
Applicant's Signature:			

	Excellent	Good	Standard	Fair	Poor
Job Performance	(	(	(	(	(
Attendance	(	(	(	(	(
Quality of Work	(	(	(	(	(
Ability to Work with Others	(	(	(	(	(

Comments:	
Signature of person completing this Form	Date:



## Reference Inquiry Form

To: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I have applied for employment at Seniorhearts Nurse Registry. I authorize you to release all information requested below by Seniorhearts Nurse Registry, including information concerning my character, habits, abilities, and reason(s) for leaving your company. The following information may help in identifying my records:

Name:		Social Security Number:	
Position:		Dates of Employment:	
Applicant's Signature:			

	Excellent	Good	Standard	Fair	Poor
Job Performance	(	(	(	(	(
Attendance	(	(	(	(	(
Quality of Work	(	(	(	(	(
Ability to Work with Others	(	(	(	(	(
Comments:					
Signature of person completing this Form				Date:	



## Medical Release

\_\_\_\_\_  
Applicant Name

\_\_\_\_\_  
CNA  
Position

Based on qualifications presented on your application form and/or in your job interview, you are hereby, offered a job with our organization conditional upon submitting to our standard medical review and the verification of your answers to the following questions. Your job offer cannot and will not be rescinded unless a medical review reveals that you cannot perform the essential functions of the job (with accommodations if requested), or you present a hazard to yourself or others. False or misleading statements are also grounds for rescinding this offer. This form must be accurate and complete for us to process. This information is considered personal and medical in nature and will be treated as such by handling it confidentially in strict compliance with the American with Disabilities Act.

### PHYSICIAN'S STATEMENT

I have examined the individual named above, and to the best of my knowledge, he/she is in good physical and mental health, free of any communicable diseases, and is able to perform in his/her profession at full capacity.

Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Physician: \_\_\_\_\_



## What Happens Now?

Thank you for applying with Seniorhearts Nurse Registry. Once we get your application, we begin the process of putting together your applicant file, and completing a background check. In the meantime, please return to our office the following checked items:

- Driver's License and SS Card
- Current RN / LPN / CNA License (if applicable)
- Current HHA Certificate
- Car Insurance
- Background Check Level 1 & Level 2
- HIPPA Training (APD ONLY) / Infection Control
- CPR / First Aid card
- CEU's**
- HIV 4 HR
- HIV/AIDS (UPDATE)
- DOMESTIC VIOLENCE
- ALZHEIMER'S
- PHYSICAL
- Copy of TB (PPD Skin test) or CHEST X-RAY within one year
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- PREVENTION OF MEDICAL ERRORS
- RESIDENT/PATIENT RIGHTS
- ASSISTING WITH MEDICATION
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### Contact Information:

SENIORHEARTS NURSE REGISTRY  
4400 North Federal Highway # 33  
Boca Raton, Florida 33431  
Phone:(855) 775-7070  
Email: [info@myseniorhearts.com](mailto:info@myseniorhearts.com)  
Website: <http://www.myseniorhearts.com>

Once again, thank you, and please feel free to contact us at any time and let us know what we can do better to serve you.