



*Please advise us if you need an accomodation to complete this application*

Date of Application \_\_\_\_\_ Social Security # \_\_\_\_\_ Skill \_\_\_\_\_

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

Street Address \_\_\_\_\_ Apt. # \_\_\_\_\_ Home Phone # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Message Phone # \_\_\_\_\_

Are you at least 18 years old?  Yes  No Will you work in a home with a pet?  Yes  No

Do you have access to public transportation?  Yes  No

Do you have access to a car?  Yes  No E mail address: \_\_\_\_\_

Do you have a driver's license?  Yes  No

Driver License # \_\_\_\_\_ State: \_\_\_\_\_ Expiration Date \_\_\_\_\_

Have you been convicted\* of a felony within the last 7 years?  Yes  No If yes, please explain:

\*(Conviction will not necessarily disqualify an applicant from employment)

Professional License # \_\_\_\_\_ State: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Do You Have Professional Liability Insurance?  Yes  No If YES, Who is Carrier? \_\_\_\_\_

What is amount of Coverage \_\_\_\_\_ Have you ever been bonded?  Yes  No

How were you referred to PRN?  Newspaper (Name) \_\_\_\_\_

Friend Name of Friend: \_\_\_\_\_ Other: \_\_\_\_\_

I am fluent in the following languages: \_\_\_\_\_

**Skill Inventory A (Check areas in which you have experience or training)**

	<u>Experience</u>	<u>Training</u>		<u>Experience</u>	<u>Training</u>
Head Nurse .....	<input type="checkbox"/>	<input type="checkbox"/>	Pediatrics.....	<input type="checkbox"/>	<input type="checkbox"/>
Home Care.....	<input type="checkbox"/>	<input type="checkbox"/>	Peds-ICU.....	<input type="checkbox"/>	<input type="checkbox"/>
Staff Relief .....	<input type="checkbox"/>	<input type="checkbox"/>	OB/GYN.....	<input type="checkbox"/>	<input type="checkbox"/>
Private Duty .....	<input type="checkbox"/>	<input type="checkbox"/>	Neonatal-ICU .....	<input type="checkbox"/>	<input type="checkbox"/>
Hospital.....	<input type="checkbox"/>	<input type="checkbox"/>	Med-Surg.....	<input type="checkbox"/>	<input type="checkbox"/>
Nursing Home .....	<input type="checkbox"/>	<input type="checkbox"/>	ICU-CCU .....	<input type="checkbox"/>	<input type="checkbox"/>
Industrial Nurse .....	<input type="checkbox"/>	<input type="checkbox"/>	IV Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Public Health Nurse .....	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric.....	<input type="checkbox"/>	<input type="checkbox"/>
School.....	<input type="checkbox"/>	<input type="checkbox"/>	Oncology .....	<input type="checkbox"/>	<input type="checkbox"/>
Geriatrics .....	<input type="checkbox"/>	<input type="checkbox"/>	Neurology .....	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedics .....	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
Staff Relief .....	<input type="checkbox"/>	<input type="checkbox"/>			

**Skill Inventory B (Check areas in which you are proficient)**

Meds: IV .....	<input type="checkbox"/>	Ztrack .....	<input type="checkbox"/>	Kangaroo Pump .....	<input type="checkbox"/>
PO .....	<input type="checkbox"/>	Interdermal.....	<input type="checkbox"/>	Gastro Tube Feed .....	<input type="checkbox"/>
IM.....	<input type="checkbox"/>	Sub Q .....	<input type="checkbox"/>	Suctioning .....	<input type="checkbox"/>
Heparin Lock .....	<input type="checkbox"/>			Trach Care .....	<input type="checkbox"/>
Subclavian .....	<input type="checkbox"/>			Respirators .....	<input type="checkbox"/>
Dressings: Sterile .....	<input type="checkbox"/>			MA-1 .....	<input type="checkbox"/>
Catheterization ... Male .....	<input type="checkbox"/>			Respiratory Therapy... ..	<input type="checkbox"/>
Female .....	<input type="checkbox"/>			IV's .....	<input type="checkbox"/>
Apnea Monitor .....	<input type="checkbox"/>			IV Pump ..	<input type="checkbox"/>
Cardiac Monitor .....	<input type="checkbox"/>			Ostomy Care .....	<input type="checkbox"/>
Fetal Monitor .....	<input type="checkbox"/>			Hyperalimentation.....	<input type="checkbox"/>
EKG .....	<input type="checkbox"/>			Oxygen Therapy .....	<input type="checkbox"/>
				Other _____	<input type="checkbox"/>

What are your work preferences? \_\_\_\_\_

What Days/Hours Are You NOT Available? \_\_\_\_\_

EDUCATION	HIGH SCHOOL	COLLEGE	OTHER
SCHOOL NAME, CITY, STATE			
GRADUATED?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
DEGREE OR MAJOR			

PREVIOUS EMPLOYMENT: LIST YOUR LAST 3 EMPLOYERS (BOTH PERMANENT AND TEMPORARY):							
DATES FROM	DATES TO	NAME/ADDRESS OF EMPLOYER	PHONE NO.	SUPERVISOR	POSITION	SALARY	REASON FOR LEAVING

PERSONAL REFERENCES (NO FAMILY)				
NAME	ADDRESS	OCCUPATION	PHONE NO.	NUMBER OF YEARS KNOWN

Are you capable of performing in a reasonable manner the activities involved in the job or occupation for which you have applied? A description of the activities involved in such a job is attached. Do not answer this question unless you have been informed about the requirements of the job for which you are applying.  Yes  No

I certify that answers given herein are true and complete to the best of my knowledge.

I understand that, in the event of employment, false or misleading information given in my application or interview may result in discharge.

I authorize investigation of all references and statements contained in the application for employment as may be necessary in arriving at an employment decision.

I understand that after meeting all other job prerequisites, and after I am offered a job, employment will be contingent upon the satisfactory outcome of a medical examination.

I understand that if I am offered employment, I will be working for PRN, on its payroll, at its client's premises.

I understand that my employment may be terminated by PRN at any time, without liability to me for wages and salary except as have been earned by me at the date of such termination.

APPLICANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_