FNI Healthcare, Inc.
Job Application

Today's Date: _____

Personal Data

Email Address: _____

Last Name	First Name	Middle	SSN

Home Address	City	State	Zip

Home Phone	Cell Phone	Pager

Emergency Contact Information

Name of Emergency Contact	Relation	Emergency Telephone Number

Job Information

Position (Job Class) Applying for:

☐ RN ☐ PT ☐ LP/VN ☐ CNA ☐ OT ☐ PTA ☐ Clerical ☐Other _____ Date Available: _____

Work Experience/Skills
Please list the number of years you have experience in each area (min 1 year exp.) and are clinically competent to work:

☐ Burn	☐ ENT	☐ Pediatrics	☐ Detox/Drug Rehab
☐ L & D	☐ Rehab	☐ Telemetry	☐ Post Partum
☐ MICU	☐ Nursery	☐ Psychiatry	☐ Orthopedics
☐ NICU	☐ Dialysis	☐ Stepdown	☐ Mother/Baby
☐ PACU	☐ Geriatric	☐ Oncology	☐ Recovery Room
☐ SICU	☐ Pedi ICU	☐ Neurology	☐ Operating Room
☐ CCU	☐ Med/Surg	☐ Open Heart	☐ Emergency Room
☐ Other	☐ Other	☐ Other	☐ Other
_____	_____	_____	_____

Previous Facility Types Worked: Check All That Apply –

☐ Hospital ☐ Hospice ☐ Nursing Home ☐ Rehab ☐ Private Duty ☐ Assisted Living / Residential Treatment

Language Skills: **Other than English, please check any other languages you speak –**	**Check the type of assignment you are available for:**
☐ Spanish ☐ French ☐ German ☐ Other: _____	☐ Full-time ☐ Part-time ☐ Contract ☐ Travel

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Check the days of the week you are available to work:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

☐ Holidays available to work: _____

License Type	License/Certification #	State	Expiration Date
License Type	License/Certification #	State	Expiration Date
License Type	License/Certification #	State	Expiration Date

Has your professional license ever been suspended, revoked or under investigation? ☐ Yes ☐ No
If Yes, Please explain: _____

Certifications: Check all applicable certifications and enter expiration date:

☐ **ACLS** **Expiration Date:** _____

☐ **BCLS** **Expiration Date:** _____

☐ **CPR** **Expiration Date:** _____

☐ **PALS** **Expiration Date:** _____

☐ **Other** **Expiration Date:** _____

☐ **IV** **Expiration Date:** _____

☐ **NALS** **Expiration Date:** _____

Work Experience: List all of your work experience beginning with your most recent job. You will be asked to explain all gaps in employment. Attach additional sheet(s) if necessary.

Facility/Employer Name	**Date Employed** **From:** _____ **To:** _____
Address	**Title**
City/State/Zip **Country**	**Unit**
Number of Beds in Unit: _____ **In Hospital:** _____	**Name of Current Immediate Supervisor**
Describe duties and specialty areas:	**Telephone #:**
Pay Rate/Salary: Hourly _____ **Yearly** _____	**May We Contact:** ☐ **Yes** ☐ **No – If no, why?**
Reason for leaving:	**If this was a travel assignment, name of agency:**
Are your employment records listed under another name? ☐ **No** ☐ **Yes If yes, what name?**	**Supervisory Experience:** ☐ **Yes** ☐ **No – How often?**

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Facility/Employer Name	**Date Employed** **From: _____ To: _____**
Address	**Title**
City/State/Zip **Country**	**Unit**
Number of Beds in Unit: _____ **In Hospital: _____**	**Name of Current Immediate Supervisor**
Describe duties and specialty areas:	**Telephone #:**
Pay Rate/Salary: Hourly _____ Yearly _____	**May We Contact: ☐ Yes ☐ No – If no, why?**
Reason for leaving:	**If this was a travel assignment, name of agency:**
Are your employment records listed under another name? **☐ No ☐ Yes - If yes, what name?**	**Supervisory Experience: ☐ Yes ☐ No – How often?**
Facility/Employer Name	**Date Employed** **From: _____ To: _____**
Address	**Title**
City/State/Zip **Country**	**Unit**
Number of Beds in Unit: _____ **In Hospital: _____**	**Name of Current Immediate Supervisor**
Describe duties and specialty areas:	**Telephone #:**
Pay Rate/Salary: Hourly _____ Yearly _____	**May We Contact: ☐ Yes ☐ No – If no, why?**
Reason for leaving:	**If this was a travel assignment, name of agency:**
Are your employment records listed under another name? **☐ No ☐ Yes If yes, what name?**	**Supervisory Experience: ☐ Yes ☐ No – How often?**

Please list any other work related information you think would be helpful to us in considering you for employment, such as specialized training, certifications, additional work experience, etc.

Additional Information:

1. Are you legally authorized to work in the USA? ☐ Yes ☐ No
2. Have you ever been convicted of a felony? ☐ Yes ☐ No
3. Can you pass a pre-employment drug test? ☐ Yes ☐ No
4. How were you referred to FNI Healthcare, Inc.?
   ☐ Newspaper ☐ Trade Publication ☐ Job Fair/Open House ☐ Internet Site
   ☐ Company Employee – Name: _____

I understand that **I must** report all accidents to my immediate supervisor **and** to FNI Healthcare, Inc. - - No MATTER HOW SLIGHT.
☐ Yes

I also understand that I must wear all required personal protection equipment (PPE). ☐ Yes
The penalty for not wearing PPE is disciplinary action, up to and including termination.

_____
Signature

ACKNOWLEDGMENT (*Please read carefully and sign*)

In signing this application, I certify that I have read and fully understand the questions asked in this application and that all answers given by me are true, accurate, and complete. I also understand that the omission, concealment, or misrepresentation of any fact on this application or during any interview for employment may jeopardize my chances for employment and be cause for my immediate dismissal from employment.

I give FNI Healthcare, Inc. permission to use any information in this application to enable it and its agents to verify the information contained in this application I also authorize present and former employers, educational institutions I have attended, credit agencies, all references, and any other persons to answer all questions asked by FNI Healthcare, Inc. with regard to any of the subjects covered by this application. I also understand that in connection with my application for employment or my employment, FNI Healthcare, Inc. may conduct a criminal background investigation and that my employment may be contingent on the results of such investigation. I release FNI Healthcare, Inc., its agents, and all affiliated entities, as well as any person or situation that provides any information about me, from any and all liability whatsoever resulting from any such investigation or the disclosure of such information.

In consideration of my employment and of my being considered for employment by FNI Healthcare, Inc., I agree to abide by all rules and regulations, which I understand are subject to change at any time for any reason without prior notice. I also understand that if employed, I will be an employee at will and employed for no definite period of time. I understand that either FNI Healthcare, Inc. or I can terminate my employment at any time, with or without cause and with or without advance notice. I further understand that no communication, whether oral or written, by any representative of FNI Healthcare, Inc., at any time, can constitute a contract of employment. No representative or agent of FNI Healthcare, Inc., has the authority to enter into any agreement for employment for any specific period of time or to make any agreement contrary to the foregoing.

I am willing to submit to a physical examination, including the analysis for the detection of the use of unlawful drugs or substances in accordance with the applicable laws. If I receive an offer of employment I agree that my continued employment may be contingent on the results.

I understand that FNI Healthcare, Inc. is not involved in the day-to-day supervision or decision concerning patient care or dentistry. This remains with the Professional as part of the Professional's practice. The Professional fully indemnifies FNI Healthcare, Inc. against any and all liability and responsibility associated with his or her professional duties. The Professional maintains his or her license as required by law, professional liability coverage and other responsibilities as found under state prime contract law.

I HAVE READ THE ABOVE AND FULLY UNDERSTAND IT.

Applicant Signature _____ Date _____