



INITIAL APPLICATION

Thank you for taking the time to come in to Family Care Visiting Nurse and Home Care Agency, LLC. All of us at FCVN are dedicated to providing each patient with quality services and programs based on their individual needs. To continue this level of dedication, we strive to recruit and hire the best-qualified candidate.

As part of the application process, please complete the following information:

Name: _____
 Address: _____
 City: _____ State _____ Zip Code _____
 Telephone # _____ Cell Phone # _____

POSITION APPLYING FOR:

Nursing: _____ RN _____ Full Time _____ Per Diem _____ P/T
 _____ LPN _____ Full Time _____ Per Diem _____ P/T

License #: _____ Expiration Date: _____

Other Position: _____

Salary Range: _____ per _____ hour _____ week _____ annual

Have you ever been employed at FCVN? _____ Yes _____ No

If yes, From _____ To _____ Position _____

How did you hear about FCVN? Advertisement in _____
 Referral by _____
 Other _____

In order to continue the application process, and expedite your candidacy, please complete the following request for references and background check. Please note, if/when you become an employee of FCVN, a more in-depth Employment Application will need to be completed.

We look forward to having you participate in our pro-active and growing environment.

Applicant's Signature: _____ Date: _____



FAMILY CARE
VISITING NURSE
and Home Care Agency, LLC

EMPLOYMENT HISTORY

Applicant's Name: _____

Position Applied For: _____

Date of Application: _____

Please list most current employment first.

Employer: _____	Position Held: _____
Address: _____	Dates Employed: From: _____ To: _____
City/State: _____	Supervisor: _____
Telephone #: _____	
Reason(s) for Leaving: _____	
May we contact for reference: Yes: <input type="checkbox"/> No: <input type="checkbox"/> Later: <input type="checkbox"/> When? _____	

Employer: _____	Position Held: _____
Address: _____	Dates Employed: From: _____ To: _____
City/State: _____	Supervisor: _____
Telephone #: _____	
Reason(s) for Leaving: _____	
May we contact for reference: Yes: <input type="checkbox"/> No: <input type="checkbox"/> Later: <input type="checkbox"/> When? _____	

Employer: _____	Position Held: _____
Address: _____	Dates Employed: From: _____ To: _____
City/State: _____	Supervisor: _____
Telephone #: _____	
Reason(s) for Leaving: _____	
May we contact for reference: Yes: <input type="checkbox"/> No: <input type="checkbox"/> Later: <input type="checkbox"/> When? _____	

Educational Background:

School Name/Address	Program Completed	Certificate/Degree	Certificate #	From	To



INITIAL APPLICATION

References For: _____

Please list the name and telephone number of three (3) business/professional references who are not related to you. If not applicable, please list three (3) school or personal references who are not related to you:

Name	Telephone	Type of Reference (Professional or Personal)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you currently employed? Yes No

If yes, please list employer's name and address: _____

May we contact your current employer: Yes No

If No, may we contact your employer when an offer of employment is made?

Applicant's Authorization:

I request and authorize that my references listed above furnish Family Care Visiting Nurse and Home Care Agency, LLC with information pertaining to my employment record, work performance, abilities and other qualities pertinent to my qualification for employment. I hereby release both my references and Family Care Visiting Nurse and Home Care Agency, LLC from all liability and responsibilities ensuing from any information provided:

Applicant's Signature: _____ Date: _____



FAMILY CARE
VISITING NURSE
and Home Care Agency, LLC

Date: _____

Name: _____

Position applied for: _____

The above person has applied with Family Care Visiting Nurse and Home Care Agency, LLC. Please answer the appropriate section and return to us as soon as possible - the candidates employment depends on your response. Thank you for your cooperation.

PROFESSIONAL WORK REFERENCE:

Company Name:
Address:
Phone #:
Reference:
Position:

Dates of Employment: From: _____ To: _____

Position Held: _____

Criteria	Exceeds Objectives	Meets Objectives	Satisfactory	Needs Improvement	Comments:
Attendance					
Punctuality					
Cooperation					
Job Knowledge					
Dependability					
Initiative					
Quality of work					

Would you recommend this person for a position? Yes No

Completed By: _____ Position: _____

Please Print Name: _____ Date: _____

Applicants Authorization for Release of Information:

I request and authorize that the individuals I have listed as references furnish Family Care Visiting Nurse and Home Care Agency, LLC with information regarding my employment record, work performance, abilities and qualities pertinent to my qualifications for employment. I hereby release the individual completing the reference and Family Care Visiting Nurse and Home Care Agency, LLC from all liability and responsibilities ensuing from any information provided.

Applicant's Signature: _____ Date: _____



**FAMILY CARE
VISITING NURSE**
and Home Care Agency, LLC

Date: _____

Name: _____

Position applied for: _____

The above person has applied with Family Care Visiting Nurse and Home Care Agency, LLC. Please answer the appropriate section and return to us as soon as possible - the candidates employment depends on your response. Thank you for your cooperation.

PROFESSIONAL WORK REFERENCE:

Company Name:
Address:
Phone #:
Reference:
Position:

Dates of Employment: From: _____ To: _____

Position Held: _____

Criteria	Exceeds Objectives	Meets Objectives	Satisfactory	Needs Improvement	Comments:
Attendance					
Punctuality					
Cooperation					
Job Knowledge					
Dependability					
Initiative					
Quality of work					

Would you recommend this person for a position? Yes No

Completed By: _____ Position: _____

Please Print Name: _____ Date: _____

Applicants Authorization for Release of Information:

I request and authorize that the individuals I have listed as references furnish Family Care Visiting Nurse and Home Care Agency, LLC with information regarding my employment record, work performance, abilities and qualities pertinent to my qualifications for employment. I hereby release the individual completing the reference and Family Care Visiting Nurse and Home Care Agency, LLC from all liability and responsibilities ensuing from any information provided.

Applicant's Signature: _____ Date: _____



**FAMILY CARE
VISITING NURSE**
and Home Care Agency, LLC

Date: _____

Name: _____

Position applied for: _____

The above person has applied with Family Care Visiting Nurse and Home Care Agency, LLC. Please answer the appropriate section and return to us as soon as possible - the candidates employment depends on your response. Thank you for your cooperation.

PERSONAL REFERENCE:

Name:
Address:
Phone #
Relationship:

Criteria	Exceeds Objectives	Meets Objectives	Satisfactory	Needs Improvement	Comments:
Responsibility					
Patience					
Cooperation					
Compatibility					
Initiative					
Trustworthiness					
Character					

Would you recommend this person for a position? Yes No

Completed By: _____

Please Print Name: _____ Date: _____

Applicants Authorization for Release of Information:

I request and authorize that the individuals I have listed as references furnish Family Care Visiting Nurse and Home Care Agency, LLC with information regarding my employment record, work performance, abilities and qualities pertinent to my qualifications for employment. I hereby release the individual completing the reference and Family Care Visiting Nurse and Home Care Agency, LLC from all liability and and responsibilities ensuing from any information provided.

Applicant's Signature: _____ Date: _____



FAMILY CARE
VISITING NURSE
and Home Care Agency, LLC

Date: _____

Name: _____

Position applied for: _____

The above person has applied with Family Care Visiting Nurse and Home Care Agency, LLC. Please answer the appropriate section and return to us as soon as possible - the candidates employment depends on your response. Thank you for your cooperation.

PERSONAL REFERENCE:

Name:
Address:
Phone #
Relationship:

Criteria	Exceeds Objectives	Meets Objectives	Satisfactory	Needs Improvement	Comments:
Responsibility					
Patience					
Cooperation					
Compatibility					
Initiative					
Trustworthiness					
Character					

Would you recommend this person for a position? Yes No

Completed By: _____

Please Print Name: _____ Date: _____

Applicants Authorization for Release of Information:

I request and authorize that the individuals I have listed as references furnish Family Care Visiting Nurse and Home Care Agency, LLC with information regarding my employment record, work performance, abilities and qualities pertinent to my qualifications for employment. I hereby release the individual completing the reference and Family Care Visiting Nurse and Home Care Agency, LLC from all liability and responsibilities ensuing from any information provided.

Applicant's Signature: _____ Date: _____



MEDICAL INFORMATION FORM

Prior to employment and/or providing direct patient care, an employee must provide evidence of a current physical examination and PPD or chest X-ray. Please forward this form to your physician for completion. The completed form can be faxed to FCVN Human Resources at 203.380.3595, which is a confidential fax in compliance with HIPAA.

=====

To be completed by your physician:

I examined _____ on _____
Last Name First Name Initial Date

who is applying for the position of: _____

I have found no condition that appears to prevent him/her from performing the duties of the position applied for with the exception of, or the possible exception of the following:

Further, I have found the above individual to be free of communicable disease(s) that could be expected to be transmitted during the course of their work related activities.

<u>Test</u>	<u>Date Performed</u>	<u>Results</u>
PPD	_____	_____
Chest X-ray	_____	_____

Note: Physical examination/chest X-ray to have been done within one (1) year of application.
 PPD to have been done within six (6) months of application.

Physician's Name: _____

Physician's Signature: _____

Date of Signature: _____

Address: _____

Telephone #: _____