# VisionQwest Healthcare

Dear LVN/LPN

Thank you for choosing VisionQwest Healthcare. 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 (for I-9)
- Current License (if applicable)
- Current BLS
- Current ACLS/PALS/NRP (If applicable)
- Copy of Immunization record (Proof of MMR)
- Copy of TB (PPD Skin test) within one year

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 feel free to contact our office at 818.547.0497 Ext 2.

Sincerely,

Michael Lodge
VisionQwest Healthcare

# VisionQwest Healthcare

## Application for Employment

Thank you for applying for a position with our Company. 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.) ________________________________________________________________

# VisionQwest Healthcare

**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
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: ____________________________________________

# VisionQwest Healthcare

**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: ________________ / expiration date_________. 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 California**
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:
________________________________________________________________________________
________________________________________________________________________________

VisionQwest
Resource Group, Inc.

# VisionQwest Healthcare

**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: ____________________________________________ SSN _____-_____-_____

# VisionQwest Healthcare

## 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. VisionQwest Healthcare 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: _______________

# VisionQwest Healthcare

## Education Acknowledgment Form

This is to acknowledge that I have received training on and a copy of VisionQwest Healthcare'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: ______________________________

# VisionQwest Healthcare

## Licensed Vocational/Practical Nurse Job Description

**Summary**

Assume responsibilities for direct nursing care of assigned patients under the supervision of a registered nurse or physician in patient care area. Provides nursing services to patients and families in accordance with the scope of the LPN as defined by the Illinois Board of Nursing

**Duties and Responsibilities**

- Provide and document direct nursing care of assigned patients under the supervision of a registered nurse or physician. Nursing care is guided by the physician orders and the nursing plan of care. Patient response to care is reported to a registered nurse for evaluation, intervention and modification of the plan of care. Assist other health care personnel in the delivery of patient care.

- Participate in maintaining the environment of care including equipment and other material resources.

- Participate in own professional development by maintaining required competencies and attending educational offerings. Supports the development of other staff and formal learners.

- Perform other related duties incidental to the work described herein.

**Education**

Graduation from an accredited Practical Nurse program

**Experience**

A minimum of one year of current experience

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

Current LPN license from the state of Illinois

**Knowledge, Skills, and Abilities:**

- Knowledge of scope of licensed practical nurse, ability to delegate to the CNA

- Considerable knowledge of the care and treatment of patients and special procedures that apply to practical nursing

- Able to independently seek out resources and work collaboratively
- Able to communicate clearly with patients, families, visitors, healthcare team, physicians, administrators and others

# VisionQwest Healthcare

- Able to teach patients and families in accordance with the nursing plan of care
- Able to use sensory and cognitive functions to process and prioritize information, treatment, and follow-up
- Competent in BLS and/or other specialized life support requirements designated by work area or unit assigned
- Able to use fine motor skills
- Able to record activities and document interventions
- Able to withstand prolonged standing and walking with the ability to move or lift at least fifty pounds
- Able to remain focused and organized
- Working knowledge of sterile techniques and special procedures that are applicable to work performed
- Working knowledge of sanitation, personal hygiene and basic health and safety precautions applicable to work in a hospital or Long Term Care (LTC) facility
- Working knowledge of infection control procedures and safety precautions
- Ability to understand English and follow oral and written instructions

Signature: ____________________________________________ Date: _________________

# VisionQwest Healthcare

## Employment Verification Form

I, _______________________________ (Print Name) Voluntarily and knowingly authorize VisionQwest Healthcare 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 VisionQwest Healthcare 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:<br>Good<br>Fair<br>Poor | Attendance:<br>Good<br>Fair<br>Poor | Attendance:<br>Good<br>Fair<br>Poor |
| Eligible for Re-hire<br>Yes<br>No | Eligible for Re-hire<br>Yes<br>No | Eligible for Re-hire<br>Yes<br>No |
| Contact /Title | Contact /Title | Contact /Title |
| Info Verified by: | Info Verified by: | Info Verified by: |

# VisionQwest Healthcare

## Work Experience Checklist

| Nursing Specialty | | Dates of Experience (mm/YYYY)<br>i.e. 01/2000 – 06/2005 |
|---|---|---|
| | | |
| Adult ICU | ☐ Yes ☐ No | |
| Neuro ICU | ☐ Yes ☐ No | |
| CVICU | ☐ Yes ☐ No | |
| Dialysis | ☐ Yes ☐ No | |
| ER | ☐ Yes ☐ No | |
| Tele Med | ☐ Yes ☐ No | |
| Tele Cardiac | ☐ Yes ☐ No | |
| Med/Surg | ☐ Yes ☐ No | |
| Rehab | ☐ Yes ☐ No | |
| Psych | ☐ Yes ☐ No | |
| Burn Unit | ☐ Yes ☐ No | |
| OR | ☐ Yes ☐ No | |
| Oncology | ☐ Yes ☐ No | |
| PICU | ☐ Yes ☐ No | |
| NICU | ☐ Yes ☐ No | |
| Pediatrics | ☐ Yes ☐ No | |
| Psych Peds | ☐ Yes ☐ No | |
| OB | ☐ Yes ☐ No | |
| Nursery | ☐ Yes ☐ No | |
| L&D | ☐ Yes ☐ No | |
| Level II Nursery | ☐ Yes ☐ No | |
| Ventilators | ☐ Yes ☐ No | |
| PACU | ☐ Yes ☐ No | |
| Hospice | ☐ Yes ☐ No | |
| LTC | ☐ Yes ☐ No | |
| Private Duty | ☐ Yes ☐ No | |
| Home Health | ☐ Yes ☐ No | |
| H/H Infusion | ☐ Yes ☐ No | |
| Intermittent Skill Visit | ☐ Yes ☐ No | |
| Computer Charting | ☐ Yes ☐ No | |
| Balloon Pumps | ☐ Yes ☐ No | |
| Epidurals | ☐ Yes ☐ No | |

| | |
|---|---|
| Recognition of EKG Arrhythmias Yes ☐ No ☐ | Use of Emergency Equipment Yes ☐ No ☐ |
| Blood Glucose Monitor Type: AccuCheck | OSHA TB Fit Mask Type: 3M N95 |

Employee Signature: ________________________________________ Date: _______________

# VisionQwest Healthcare

## Reference Inquiry Form

To: ______________________________
______________________________
______________________________

I have applied for employment at VisionQwest Healthcare. I authorize you to release all information requested below by VisionQwest Healthcare, 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: | |

# VisionQwest Healthcare

## Reference Inquiry Form

To: ______________________________
______________________________
______________________________

I have applied for employment at VisionQwest Healthcare. I authorize you to release all information requested below by VisionQwest Healthcare, 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: | |

# VisionQwest Healthcare

## Reference Inquiry Form

To: ______________________________
______________________________
______________________________

I have applied for employment at VisionQwest Healthcare. I authorize you to release all information requested below by VisionQwest Healthcare, 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: | |

# VisionQwest Healthcare

## Medical Release

________________________________________ LPN______________
Applicant Name 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:

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

| | Date Taken | | :Results |
|---|---|---|---|
| Mumps | ________________ | | :______________________ |
| Rubella | ________________ | | :______________________ |
| Rubeola | ________________ | | :______________________ |
| Varicella | ________________ | | ;______________________ |
| Hepatitis-B | ________________ | | :______________________ |
| TB Test | ________________ | Read On__________ | :______________________ |
| Chest X-Ray | _______________ | | :______________________ |

Signature of Physician: ______________________________ Date: ________________

Printed Name of Physician: ________________________________________________

# VisionQwest Healthcare

## AUTHORIZATION AGREEMENT FOR AUTOMATIC DIRECT DEPOSIT

Employee Name: ____________________________________________

Address: ____________________________________________

City:____________________ State:__________Zip:_________

SS Number: ___________--________--__________ Date: __________

I hereby authorize VisionQwest Healthcare Services, 500 N. Central, Suite 740, Glendale, CA 91203, to initiate electronic entries to the below designated account each payday and to send my salary / wages to the financial institution ("BANK") names below which is authorized to deposit my salary/wages into the named account(s).

Up to four (4) different accounts may be selected for direct deposit, and either a flat amount or a percentage of wages can go into each account. There is no cost if you want your entire check to go into one account: if desired, only complete the information for Account #1 and enter 100%. Otherwise, a fee of $10 per year will be deducted from your check for each account.

Account #1 (no cost if 100%): (__) CHECKING (__) SAVINGS (__) OTHER
BANK NAME: ____________________________ BANK PHONE NUMBER:______________
ROUTING NUMBER: ______________________ ACCOUNT NUMBER: _________________
Dollar amount OR percentage of check to be deposited into this account: __________________

Account #2 (__) CHECKING (__) SAVINGS (__) OTHER
BANK NAME: ____________________________ BANK PHONE NUMBER:______________
ROUTING NUMBER: ______________________ ACCOUNT NUMBER: _________________
Dollar amount OR percentage of check to be deposited into this account: __________________

Account #3 (__) CHECKING (__) SAVINGS (__) OTHER
BANK NAME: ____________________________ BANK PHONE NUMBER:______________
ROUTING NUMBER: ______________________ ACCOUNT NUMBER: _________________
Dollar amount OR percentage of check to be deposited into this account: __________________

Account #4 (__) CHECKING (__) SAVINGS (__) OTHER
BANK NAME: ____________________________ BANK PHONE NUMBER:______________
ROUTING NUMBER: ______________________ ACCOUNT NUMBER: _________________
Dollar amount OR percentage of check to be deposited into this account: __________________

# VisionQwest Healthcare

**EMPLOYEE AGREEMENT**

This authorization is to remain in full force and effect until VisionQwest Healthcare has received written notification from me of it termination in such time and in such manner as to afford VisionQwest and BANK a reasonable opportunity to act on it, or by my death or legal incapacity, or my ineligibility to receive said salary/wage payment(s). I may revoke this authorization only by notice to VisionQwest Healthcare, but agree to notify BANK of any cancellation. Should BANK notify me of any termination of this Authorization or of my account, I will immediately notify VisionQwest of such termination.

To change BANK to receive such salary/wage payment(s), the EMPLOYEE must complete a new Authorization Agreement with the newly selected BANK and provide VisionQwest with a copy of it. Such change in BANK will not take effect until received by and processed by VsiionQwest.

With this authorization, I release VisionQwest Healthcare and VisionQwest Resource Group, Inc. of any liability which might result from having my fund electronically deposited into an account I designate. I understand that I have the option of having my paycheck on the check date. I am voluntarily choosing to have my funds available through direct deposit and understand this does not guarantee deposit of my funds of the check date.

EMPLOYEE SIGNATURE: _____________________________ DATE:__________________

# VisionQwest Healthcare

## What Happens Now?

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

☐ Proof of MMR
☐ Proof of Tb (PPD Skin Test)
☐ Proof of Varicella titer
☐ Completed Urine Drug Screen
☐ Completed Competency Exams (Age Related, Universal Precautions, Med Calc, and LPN Exam)
☐ Completed Skills Checklist
☐ Two References
☐ Copy of License
☐ Copy of CPR / ACLS / PALS / NRP
☐ Other: ________________________

Once your chart is complete, we will contact you to determine a start date. You can pre-book up to one year in advance, or call us an hour before a shift and inform us if you would like to work. You can also specify how frequently or infrequently you would like to be contacted by us.

Contact Information:

VisionQwest Healthcare
500 N. Central, Suite 740
Glendale, CA  91203
818.547.0497 Ext 2 (office)
310.861.5558 (fax)

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.