



## VisionQwest Healthcare

Dear RN

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
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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: \_\_\_\_\_



# 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/PT): \_\_\_\_\_

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 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 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 a copy of VisionQwest Healthcare's Employee Manual 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: \_\_\_\_\_

**Registered Nurse Job Description**



# VisionQwest Healthcare

## Summary

Responsible for the delivery of patient care through the nursing process of assessment, diagnosing, planning, implementation, and evaluation Responsible for directing and coordinating all nursing care for patients based on established clinical nursing practice standards; Collaborates with other professional disciplines to ensure effective and efficient patient care delivery and the achievement of desired patient outcomes; Serves in the Resource Nurse role when oriented and as directed; Utilizes knowledge of patient's age and cultural diversity into the provision of patient care; Contributes to the provision of quality nursing care through performance improvement techniques that demonstrate positive outcomes in patient care

## Duties and Responsibilities

- Plan, provide, supervise and document professional nursing care utilizing the nursing process for patients in accordance with physician orders and established policies and procedures. Use professional nursing judgment to individualize the plan of care based on assessment of the patient's baseline needs and response to care.
- Delegate tasks and supervises the activities of other licensed and unlicensed care providers.
- Assist other nursing personnel in the delivery of nursing care and act as team leader or charge nurse for a group of patients or an entire unit as assigned.
- Monitor and initiate corrective action to maintain the environment of care including equipment and material resources.
- Participate in own professional development by maintaining required competencies, identifying learning needs and seeking appropriate assistance or educational offerings.
- May participate in the interview process and make hiring recommendations.
- Perform other related duties incidental to the work described herein.

## Education

Graduation from an accredited Bachelor of Science in Nursing, Associate Degree in Nursing or Nursing Diploma program

## Experience

A minimum of one year current experience

## Degrees, Licensure, and/or Certification

Must have current or compact licensure in the state of California

## Knowledge, Skills, and Abilities



## VisionQwest Healthcare

- Knowledge of scope of the registered nurse, licensed practical nurse and CNA
- Knowledge of and appropriate application of the nursing process
- Knowledge of professional theory, practice and procedure
- Ability to assess nursing needs of acute and chronically ill patients and their families
- Able to independently seek out resources and work collaboratively
- Ability to establish and maintain effective working relationships
- Able to communicate clearly with patients, families, visitors, healthcare team, physicians, administrators and others
- 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
- Able to use fine motor skills
- Competent in BLS and/or other specialized life support requirements designated by work area
- Able to record activities, document assessments, plan of care, interventions, evaluation and re-evaluation of patient status
- 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 procedures and techniques involved in administering routine and special treatments to patients
- Working knowledge of infection control procedures and safety precautions

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

### Employment Verification Form



## VisionQwest Healthcare

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: 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:



# VisionQwest Healthcare

## Work Experience Checklist

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

Recognition of EKG Arrhythmias Yes <input type="checkbox"/> No <input type="checkbox"/>	Use of Emergency Equipment Yes <input type="checkbox"/> No <input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to Work with Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					
Signature of person completing this Form				Date:	



# VisionQwest Healthcare

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

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Position:		Dates of Employment:	
Applicant's Signature:			

	Excellent	Good	Standard	Fair	Poor
Job Performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to Work with Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					
Signature of person completing this Form				Date:	



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## Reference Inquiry Form

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

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Position:		Dates of Employment:	
Applicant's Signature:			

	Excellent	Good	Standard	Fair	Poor
Job Performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to Work with Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:					
Signature of person completing this Form				Date:	



# VisionQwest Healthcare

## Medical Release

Applicant Name \_\_\_\_\_ RN \_\_\_\_\_  
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:

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

	<u>Date Taken</u>	<u>:Results</u>
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%):	<input type="checkbox"/> CHECKING	<input type="checkbox"/> SAVINGS	<input type="checkbox"/> OTHER
BANK NAME:	_____	BANK PHONE NUMBER:	_____
ROUTING NUMBER:	_____	ACCOUNT NUMBER:	_____
Dollar amount OR percentage of check to be deposited into this account: _____			

Account #2	<input type="checkbox"/> CHECKING	<input type="checkbox"/> SAVINGS	<input type="checkbox"/> OTHER
BANK NAME:	_____	BANK PHONE NUMBER:	_____
ROUTING NUMBER:	_____	ACCOUNT NUMBER:	_____
Dollar amount OR percentage of check to be deposited into this account: _____			

Account #3	<input type="checkbox"/> CHECKING	<input type="checkbox"/> SAVINGS	<input type="checkbox"/> OTHER
BANK NAME:	_____	BANK PHONE NUMBER:	_____
ROUTING NUMBER:	_____	ACCOUNT NUMBER:	_____
Dollar amount OR percentage of check to be deposited into this account: _____			

Account #4	<input type="checkbox"/> CHECKING	<input type="checkbox"/> SAVINGS	<input type="checkbox"/> 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 its 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 VisionQwest.

With this authorization, I release VisionQwest Healthcare and VisionQwest Resource Group, Inc. of any liability which might result from having my funds 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 on 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 RN 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.