Personal Information

First Name

Last Name

Middle Initial

Social Security #

Date of Birth

Street Address

City

State

Zip Code

Phone Number

Cell

Email Address

Emergency Contact

Relationship

Phone

Employment History

Are you eligible for employment in the USA?

- [ ] Yes
- [ ] No

Position applied for

Hourly Rate Agreed?

Current Employer

Employer Name

Title/Position

Supervisor Name

Address

Contact #

May we contact your supervisor for a reference

- [ ] Yes
- [ ]

Start Date

Employment History

Employer Name

Title/Position

Supervisor Name

Address

Contact #

May we contact your supervisor for a reference

- [ ] Yes
- [ ] No

Start Date

Employment History

Employer Name

Title/Position

Supervisor Name

Address

Contact #

May we contact your supervisor for reference

- [ ] Yes
- [ ] No

Start Date

Educational Information

High School Education

High School Attended

Addresss

Dates Attended

Highest Grade Completed

- [ ] 9
- [ ] 10
- [ ] 11
- [ ] 12

Achieved

- [ ] Diploma
- [ ] GED

College/University

Institution

College Education

Additional College

Address College Education

Additional College

Dates Attended
College Education

Additional College

Degree
College Education

Additional College

Major

College Education

Additional College

Additional Training/Education

Education Type

-

-

-

Address

-

-

-

Certification

-

-

-

Professional Information

Discipline

License

State

Expiration Date

PLEASE INDICATE WHICH OF THE FOLLOWING CREDENTIALS YOU CURRENTLY HOLD

Credential

- [ ] BCLS
- [ ] ACLS
- [ ] PICC
- [ ] IV

Other

Pending Certification(s)

Are you aware of any investigation or restrictions against your licenses in any other state or jurisdiction?

- [ ] Yes
- [ ] No

Have you ever been convicted of a crime?

- [ ] Yes
- [ ] No

If yes, please explain

A conviction may not disqualify an applicant from being hired.

Any information will be utilized to the fullest extent permitted by law.

Do not include any convictions or other information that has been expunged or sealed.

Date

Signature

Attestation

Please read thoroughly prior to signing.

I, _____ hereby voluntarily agree to submit any lawful drug screen, education, employment, references, criminal background, social security checks, and other testing requested and conducted by Bond Health Staffing which deems, in its sole discretion, to reasonably necessary to provide its workers with a safe environment, I authorize that the results of any test be communicated and discloses to third parties. Because of any prohibited result obtained by said test, I understand that I may not be offered a job with Bond Health Staffing Resources or may be disciplined leading up to or including immediate discharge if currently employed Bond Health Staffing I hereby indemnify, release and forever discharge and hold Bond Health Staffing and its subsidiaries, affiliates, agents, and employees harmless from any or all claims, demands, judgments and legal fees arising out of or in connection with such tests, the results, or any lawful use of the results.

Bond Health Staffing may obtain information about you from employment purposes (including contract or volunteer services) from a consumer reporting agency. Thus, you may be the subject of a consumer report which may include but not limited to, public record information, employment, education, license verification, criminal background, social security trace etc. In addition, investigative consumer reports, as defined by the federal Fair Credit Reporting Act, may be obtained which are gathered from personal Interviews with employers, and other current or past associates, which may include information about your character, general reputation, personal characteristics, and /or mode of living. These reports may be obtained at any time after receipt of your authorization and, if you are hired, throughout your employment, you have the right upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative report.

Upon Bond Health Staffing being made aware of the client’s interest in you when placed on a certain position, you may be required to take a Medical Physical examination prior to being hired for the position for which you applied. If accepted and hired, the cost of the Physical. If done mainly through our Affiliated Health Center(s) will be deducted from your weekly wages until repaid in full.

I understand and will comply with the statements made above.

Name

Signature

Full Address

Other Name(s) Used

Social Security #

Contact #

Email

Please select and provide one of the following

Driver License/State ID/Passport Number

State of Driver License/State ID

Issue Date

Exp. Date

Date

Signature

Bond Health Staffing is a staffing company. You will be considered an employee of Bond Health Staffing while actively working on assignments for the company. When the assignment ends, please notify Bond Health Staffing. While waiting for another assignment, you are not considered an employee of Bond Health Staffing. You will remain inactive until working on another assignment for the Company.

CONFIDENTIAL
Detach and Retain in a confidential File
(conviction of a violation of law or ordinance is not necessarily a bar to employment)
Where you ever convicted of a violation of any law or ordinance or have a current court Proceeding in New York or elsewhere?

- ☐ Yes
- ☐ No

(convictions for juvenile delinquency, youth offender, or wayward minor need not be reported)

If YES, please explain each conviction, or proceeding setting forth the date, charge, court and

Action taken below:

Has your professional License/Registration certificate (for example: RN/LPN/LMSW/License or other)

Ever been suspended or revoked in the state of New York, or any other State?

- [ ] Yes
- [ ] No

If YES, please explain your License suspension/Revocation stating the data, state, charge, court Proceedings

and action took below:

CERTIFICATION I hereby certify that all the facts set forth above to the best of my knowledge are true,

Complete and accurate. I understand that all information shall be subject to investigation and

That false information will be grounds for non-employment or dismissal after employment.

Date

Signature

Education Degree Verification

Section A

Applicant Name

Job Title

Social Security #

Name Used During Attendance

Date of Graduation

Degree Completed

Name Used During Attendance

Phone #

Fax #

Email Address

I hereby give my permission to release the information required on this form to Bond Health Staffing

Date

Signature

Section B

Educational Institute Registrar's Office

It is our hiring policy to verify educational background prior to an employment commitment. Please complete the information below and fax the number shown so that we may consider the applicant for a position with our company.

We would appreciate a response at your earliest convenience. If you have any questions concerning this matter, please feel free to contact us. Thank you for your cooperation.

Information verified by:

Name

Title

Date

Signature

Is the above information correct? If no, please explain.

Acknowledgment Form

Annual Mandated Topics

I hereby acknowledge understanding of the following Mandated Topics from Bond Health Staffing

Topics include:

Fire Safety

Domestic Violence

Electrical Safety Restraints

Workplace Safety / Drug Free Workplace Incident Reporting

OSHA – Infection control / Drug Free Workplace Blood Glucose Monitoring & Management

OSHA Occupational Exposure

HIV Confidentiality Testing and Related Information Advance Directives

Age specific Care Agency administrative Policies and Procedures

Sexual Harassment Emergency Preparedness

Pain Management Prevention of Medical errors

Patient Abuse Hepatitis C

Multi-Cultural Aspects of Patient Care Hepatitis B

HIPPA Privacy Regulations Fair Work Environment

National Patient Safety Goal

Patient Rights

I understand that as an employee of Bond Health Staffing, it is my responsibility to protect the confidentiality of the patient's medical information, Failure to maintain patient confidentially may lead to discharge or other disciplinary action.

I have read and understood the above policy.

Name

Discipline

Date

Signature

Acknowledgement Of Receipt Of Company
Drug -Free Workplace Policy

Signing this form acknowledge that the employee and /or applicant has received a copy of the Company's Drug- Free Policy, has had the opportunity to discuss the Policy and have Questions answered, and understands all the provisions in the Policy. Although it reflects the Company's current policy regarding substance use, it may be necessary to Make changes from time to time at the Company's sole discretion, to best serve the needs of our organization. However, any changes deemed necessary will be made in writing, and modified Policy will be shared with every Employee and /or applicant. By my signature below, I acknowledge that I have received a copy of the Drug-Free Policy of the Company. I understand that it is my obligation to read, understand and comply with the procedures and provisions contained within this policy. As an employee and /or applicant of the Company I hearby acknowledge that the Company's Policy requires me to submit drug testing and / or breathe alcohol testing to rule out the presence of nonprescribed or prohibited dangerous controlled substances in my system. I hearby freely and voluntarily consent to this request for a drug test and /or alcohol test, and agree to participate in the testing program. I hearby and herewith release the company, its employees, agents and contractors from any and all liability whatsoever arising from this request from the actual testing, from the actual testing procedures, and from analysis. I hearby agree to cooperate in all aspects of the testing program. I hearby authorize the release of my drug and/or alcohol test results to the designated Medical Review Officer (MRO), and/or to the Company's examining physician as provided by the Company's Policy.

Employees/Applicants Name

Employee/Applicants Signature

Annual TB Questionnaire

The Annual Tuberculosis Questionnaire is used to evaluate your current TB status. We cannot utilize the Tuberculin skin test (PPD or Mantoux), because you have a positive reaction to the test. A positive skin test means that sometime during your life you came into contact with tuberculosis or have had a vaccination to prevent you from counteracting tuberculosis. It does not mean that you have TB mow.

In the past yearly chest x-rays were performed; however recent studies show that they are unnecessary. Instead, this health survey will assist Employment Health to monitor possible TB

Symptoms. Chest x-rays are required every 2 years.

TB symptoms can progress slowly and/or mimic other diseases. You can develop symptoms of TB a few weeks after contracting the bacteria- or not until years after the initial infection. This questionnaire targets some of the most common symptoms. Please familiarize yourself with them. You are the first to know when you are not feeling well and may have TB symptoms.

Tuberculosis Health Check Survey

Have you ever experienced any of the following symptoms NOT associated with a specific illness (I.e flu or cold) and lasting 3 weeks or longer?

Cough

- ☐ Yes
- ☐ No

Blood streaked sputum (phlegm)

- ☐ Yes
- ☐ No

Loss of weight (unplanned)

- ☐ Yes
- ☐ No

Night Sweats

- ☐ Yes
- ☐ No

Fever

- ☐ Yes
- ☐ No

Anorexia

- ☐ Yes
- ☐ No

This authorization will expire one year from the dated signature below.

Name

Date

Signature

Hepatitis B Status Declaration

Below you will find a Declination Statement for the Hepatitis B Vaccine Series. If an offer of employment is extended to you by Bond Health Staffing, you will be entitled to receive the vaccine series at no cost to you if you are at risk exposure to HBV through your occupation. You may elect to receive the vaccine at any point during your employment. If you wish to receive the vaccine during your employment, please notify your AMS representative. If you have any uncertainty regarding your status or your exposure potential, please contact your Bond Health Staffing representative for clarification.

Hepatitis B Status Declaration

I understand that my occupation may result in exposure to blood or other potentially infectious material and that I may be at risk of acquiring the Hepatitis B Virus (HBV) Infection, I understand that my failure to receive this vaccine may subject me to risk of acquiring the HBV disease. If I am in the process of receiving the series during my enrollment with AMS, I will furnish Proof of the Inoculation series upon completion.

Name

Date

Signature

Influenza Vaccination

Consent or Declination Form

As a healthcare professional, you may have exposure to the Influenza virus, you can either Consent to or decline the vaccination but you must complete this form to assure that if you remain unvaccinated, you have personally declined the vaccine and agree to wear an N95 respirator or surgical mask for the duration of your shift if required.

Please read the Influenza Information and complete this form with your signature and data.

Consent

- ○ I have been informed about and offered the opportunity to receive the Influenza vaccine, I understand That it is

Date of Vaccination

Type of Vaccination

Signature

Decline

- ○ In declining the Influenza vaccination for non-medical reasons, I am aware that I cannot get the Influenza disea

I have a medical contraindication. Please check:

- ☐ Allergy to eggs, chickens, or chicken feathers
- ☐ Gillian-Barre Syndrome or a persistent neurological Illness
- ☐ Other

If other, please explain.

Based on the requirements of your assignment location or facility:

I understand that If I choose to decline the influenza vaccine, and my job duties may cause me to infect patients or to become infected, I may be required to wear an N95 respirator or surgical mask for the duration of my shift beginning September 1. Failure to wear an N95 respirator or surgical mask during duty will result in disciplinary action up to and including termination.

I understand that I may change my mind at any time and accept the Influenza vaccination if the vaccine is available.

I understand that If I decline the vaccine AND refuse to wear an N95 respirator or surgical mask I am voluntarily resigning my position.

I have read and fully understand the information on this form.

Date

Flu Vaccination Declaration

Due to my occupation, I may transmit Influenza to patients, visitors, and healthcare workers, among others, though I may have no symptoms. This can result in a serious Infection, particularly for those persons at high risk for Influenza-associated complications.

I have been offered the Influenza vaccine at no charge through my employment with Bond Health Staffing, however, I decline to receive the vaccination now. Should I elect to receive the Influenza vaccine in the future, I can receive the vaccine at no charge.

I am declining the Influenza Vaccine at this time for the following reasons:

- ☐ I have already received the flu vaccination this season
- ☐ I plan to obtain the vaccination elsewhere
- ☐ My healthcare provider has advised me not to vaccinate
- ☐ I decline for personal reason
- ☐ I do not believe the vaccine will prevent me from contracting the flu
- ☐ Other

Name

Date

Signature

Please upload specified document images.

Driver’s license

Professional License

Social Security Card

Send application to

If you were referred by someone, please provide their full name, phone number, and email address below.