Employment Application

Please complete this Application Packet and send it back by either Fax (216) 293-8335 pr e-mail at contactus@austerehealthcare.com

To ensure compliance with the standards of both our clients and Austere International Healthcare, we require the following documentation for our records.

REQUIREMENTS:

□ **RESUME**
- Explain **Gaps in Employment**, if any to avoid delays in your Pre-Qualification process
- Please indicate the **City and State** plus **Month and Year** per work history

□ **APPLICATION FOR EMPLOYMENT**
- Austere International Application Form
- Employment History
- Emergency Contact Information
- Legal Questionnaire
- Authorization for Release of Information

□ **EMPLOYMENT REFERENCE #1**

□ **EMPLOYMENT REFERENCE #2**

□ **EMPLOYMENT REFERENCE #3**

□ **CLINICAL SKILLS COMPETENCY (as applicable)**

□ **CLINICAL ASSESSMENTS / EXAMS (as applicable)**

□ **CONTINUING EDUCATION (as applicable)**

□ **CREDENTIALS – Please attach the following:**

1. State Professional License (as applicable)
2. Driver's License
3. BLS / CPR – Front and Back copies with signature. AHA approved.

4. ACLS, PALS, MAB, EKG/ARRYTHMIA Certification as Applicable. Back should be signed, AHA provider.
5. Physician Statement or Physical with MD signature. Must be taken within the last 12 months.
6. 2-Step PPD Test, T-spot, QuantiFERON Gold, or Chest X-ray. Must be administered within the last 12 months.
7. Drug Screen. Must be administered within 30 days of start date at client site.
8. Immunization Records (MMR and Varicella)
    - TB/PPD Test
    - Rubella Titre, Rubeola Titre, Mumps Titre
    - Vaccine Zoster Titre, Immunity by History of Disease as Verified by MD and Vaccination
    - Hepatitis B Declination, Proof of Series, or Titre showing Immunity
    - Influenza Vaccination Record. Within most recent season or Declination
    - COVID Vaccination Record, or Declination

Application for Employment

(Please complete event if attaching a resume)

_______________________________________ _______________________________
Name (Last, First, and Middle) Maiden / Other

_____________________________ _________________ _______________ ________
Street Address City Select State Zip

____ _________________________
Email Address Social Security Number

___________________ _________________ _____________ __________________
DOB (Day, Mo, Year) Driver's License Select State Expiration Date

________________________ _______________________ ________________________
Home Phone # Cell Phone # Preferred Time to Call

Date Available:___________________ Shift Preferred: □ Day □ Night

Type of Position Applying for (check all that applies): □ Per Diem □ Travel

Do you speak any languages other than English? □ Yes □ No If yes, Please list______________

How were you referred? ____

Have you completed a Travel assignment in the past? □ Yes □ No

If yes, which company(s)? ____

Are you able to perform the basic functions of the position for which you are applying without any restrictions? □ Yes □ No

If no, Please explain____

____

Please use the space below to let us know your preferences in terms of Facility, Commute, Restrictions, Pay, etc.

____

____

____

____

Emergency Contact Information

We would like to have the names of two (2) contacts that we could call in the case of an emergency. Please provide that information below for our files and reference.

Primary Contact:______________________ Secondary Contact: _________________________

Relationship: _________________________ Relationship:_______________________________

Address:_____________________________ Address:____________________________________

_____________________________________ ____

Contact Number:_______________________ Contact Number:____________________________

Professional Credentials

Education: ____From:_________ To:_________
College or University & Location

Degree or Certification Earned:____

Education: ____From:_________ To:_________
College or University & Location

Degree or Certification Earned:____

Specialty (Please list most current experience first)

1. ____________________________ Years of Experience _______ as of (Indicate Date) _______

2. ____________________________ Years of Experience _______ as of (Indicate Date) _______

3. ____________________________ Years of Experience _______ as of (Indicate Date) _______

Professional Licenses (Please attach a copy of each including the front and back copies)

1. State ______________________ License #________________ Expiration Date:__________
2. State ______________________ License #________________ Expiration Date:__________
3. State ______________________ License #________________ Expiration Date:__________
4. State ______________________ License #________________ Expiration Date:__________
5. State ______________________ License #________________ Expiration Date:__________

Certifications (Please attach a copy of each including front and back copies)

□ BLS / CPR Expiration Date: __________ □ ACLS Expiration Date: __________

□ PALS Expiration Date: __________ □ NRP / NALS Expiration Date: _________

□ MAB Expiration Date: __________ □ CCRN Expiration Date: __________

□ CNOR Expiration Date: __________ □ TNCC Expiration Date: __________

□ EKG Cert Expiration Date: __________ □ CHEMO Expiration Date: __________

□ Other Expiration Date: ____________ □ Other Expiration Date: ____________

□ Other Expiration Date: ____________ □ Other Expiration Date: ____________

Employment History

Date Employed From:____________ To: ____________ Business Phone:________________

Facility / Hospital:_______________________________ Supervisor Name:_______________

May we contact? □ Yes □ No Position Held:__________________

□ Full Time □ Part-Time □ Traveler-Agency____

Address:_______________________________________ City and State:__________________

Reason for Leaving:______________________________ Pay / HR:_______________________

Date Employed From:____________ To: ____________ Business Phone:________________

Facility / Hospital:______________________________ Supervisor Name:_______________

May we contact? ◻ Yes ◻ No Position Held:__________________

◻ Full Time ◻ Part-Time ◻ Traveler-Agency_______________________________________

Address:______________________________________ City and State:__________________

Reason for Leaving:______________________________ Pay / HR:______________________

Date Employed From:____________ To: ____________ Business Phone:________________

Facility / Hospital:______________________________ Supervisor Name:_______________

May we contact? ◻ Yes ◻ No Position Held:__________________

◻ Full Time ◻ Part-Time ◻ Traveler-Agency_______________________________________

Address:______________________________________ City and State:__________________

Reason for Leaving:______________________________ Pay / HR:______________________

Employment Reference Check #1

* Clinical references must provide dates of employment, give a rating of work history, state the position or specialty that the candidate worked. State the title of person giving the references such as Charge RN, RN Supervisor, DON, Nurse Manager. The reference MUST be someone who the candidate reported directly to on the floor unit. *

____ ________________________________

Applicant's Name Position Held

________________ ____

Dates of Employment Current / Former Employer

(From month & Year – To month & Year)

_______ ______________ ________________________ ________________________

City State Supervisor's Name / Role Contact Number

□ I hereby give permission to the above-named employer to release information to Austere International Healthcare regarding my performance while employed at the facility / hospital.

____ ______________________________

Applicant's Signature Date

Employment History

* The person above is applying for employment with Austere International Healthcare L.LC. and has listed you as a previous employer. We would appreciate your assistance in verifying employment and evaluating job performance. All information will be treated with the utmost confidentiality. *

Personal Evaluation	Above Average	Satisfactory	Did Not Meet Expectation	Poor
Clinical Competency				
Quality of Work				
Quantity of Work				
Attitude and Cooperation				
Adaptability to Work Situations				
Dependability				
Attendance and Punctuality				
Personal Appearance / Professionalism				

Comments:____

____

Employer's Signature:____________________________ Title:___________________ Date:_________

(Note to staffer – Please indicate if verbal verification occurred)

Employment Reference Check #2

* Clinical references must provide dates of employment, give a rating of work history, state the position or specialty that the candidate worked. State the title of person giving the references such as Charge RN, RN Supervisor, DON, Nurse Manager. The reference MUST be someone who the candidate reported directly to on the floor unit. *

____ _______________________________
Applicant's Name Position Held

________________ ____
Dates of Employment Current / Former Employer
(From month & Year – To month & Year)

_______ ______________ ________________________ ________________________
City State Supervisor's Name / Role Contact Number

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____ ______________________________
Applicant's Signature Date

Employment History

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Clinical Competency				
Quality of Work				
Quantity of Work				
Attitude and Cooperation				
Adaptability to Work Situations				
Dependability				
Attendance and Punctuality				
Personal Appearance / Professionalism				

Comments:____
____

Employer's Signature:____________________________ Title:____________________ Date:_________

(Note to staffer – Please indicate if verbal verification occurred)

Employment Reference Check #3

* Clinical references must provide dates of employment, give a rating of work history, state the position or specialty that the candidate worked. State the title of person giving the references such as Charge RN, RN Supervisor, DON, Nurse Manager. The reference MUST be someone who the candidate reported directly to on the floor unit. *

____ ________________________________

Applicant's Name Position Held

________________ ____

Dates of Employment Current / Former Employer
(From month & Year – To month & Year)

_______ ______________ ________________________ ________________________

City State Supervisor's Name / Role Contact Number

□ I hereby give permission to the above-named employer to release information to Austere International Healthcare regarding my performance while employed at the facility / hospital.

____ _______________________________

Applicant's Signature Date

Employment History

* The person above is applying for employment with Austere International Healthcare L.LC. and has listed you as a previous employer. We would appreciate your assistance in verifying employment and evaluating job performance. All information will be treated with the utmost confidentiality. *

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Clinical Competency				
Quality of Work				
Quantity of Work				
Attitude and Cooperation				
Adaptability to Work Situations				
Dependability				
Attendance and Punctuality				
Personal Appearance / Professionalism				

Comments:____
____

Employer's Signature:____________________________ Title:____________________ Date:_________

(Note to staffer – Please indicate if verbal verification occurred)