VNA Visiting Nurse Association

A Tradition of Caring and Quality Since 1949

Employment Application

The VNA is an equal opportunity employer, and all matters relating to employment will be considered without regard to race, color, age, religion, sex, marital status, national origin or ethnicity, gender identity, sexual orientation, sexual preference, or disability/health status, or any consideration made unlawful by federal, state, or local laws; except, where a bona fide occupational requirement may necessitate otherwise.

PART I - APPLICANT INFORMATION (Please print)

_____

Last Name First MI

Social Security Number: _____

Complete Address: _____

_____

Home phone #:_____Alternate phone #:_____

E-mail Address:_____

Position(s) applying for: _____

How did you hear about the position you are applying for? _____

I prefer to work: ___auxiliary ("as needed") ___ part time ___ full time

Have you ever worked for or applied with the VNA? ___Yes ___No

If yes, what position and when? _____

Do you have any family members or relatives currently employed by the VNA? ___Yes ___No Who? _____

Are you at least 18 years of age? ____Yes ____ No

Are you eligible to be lawfully employed in the United States? __Yes __ No

(Proof of citizenship or immigration status is required upon employment)

Do you have reliable transportation for visits? ___Yes ___No ___ NA

Is liability insurance in the amount required by the state carried on the vehicle you would be using for visits? ___Yes ___No ___ NA

Do you have a valid driver's license? ___Yes____ No ___ NA

Date available for employment: _____Salary Expectation: _____

Have you ever been convicted of a crime? ___ Yes ___ No (stating yes may not necessarily hinder employment) Please explain:

_____
_____
_____

Have you ever been excluded from the participation of Medicare and/or Medicaid programs? _____ Yes _____ No (please list dates and explain)

_____
_____
_____

Do you have current licenses and/or professional certifications necessary to perform the job(s) for which you are applying? _____Yes_____ No (Example: CNA, RN, LPN, PT etc license)

License number: _____ Expiration Date: _____

Are you currently under investigation, or have you ever received any disciplinary action from your professional board including, but not limited to, suspension, revocation and/or probation in any state you have worked?

____Yes ____No If yes, please explain:

_____
_____

PART II– EDUCATION

SCHOOL ATTENDED (include city and state)	**DEGREE EARNED**
High School:	
Higher Education:	Degree:_____ Year graduated: _____ Name as it appears on diploma: _____ Check here if you did not graduate: ____
Other:	Degree:_____ Year graduated: _____ Name as it appears on diploma: _____ Check here if you did not graduate: ____

PART III – EMPLOYMENT HISTORY

If you have worked under a different name(s), please specify:

_____

PLEASE COMPLETE THE FOLLOWING. "SEE ATTACHED RESUME"IS NOT SUFFICIENT. PLEASE EXPLAIN ALL GAPS BETWEEN EMPLOYMENT.

COMPANY NAME: _____ JOB TITLE: _____

ADDRESS: _____ DATES EMPLOYED: _____

SUPERVISOR (NAME AND PHONE NUMBER):_____

WORK PERFORMED: _____

_____

SALARY: _____

REASON FOR LEAVING: _____

MAY WE CONTACT YOUR CURRENT SUPERVISOR? YES NO

If yes, please list name and phone number: _____

COMPANY NAME: _____ JOB TITLE: _____

ADDRESS: _____ DATES EMPLOYED: _____

SUPERVISOR (NAME AND PHONE NUMBER):_____

WORK PERFORMED: _____

_____

SALARY: _____

REASON FOR LEAVING: _____

COMPANY NAME: _____ JOB TITLE: _____

ADDRESS: _____ DATES EMPLOYED: _____

SUPERVISOR (NAME AND PHONE NUMBER):_____

WORK PERFORMED: _____

_____

SALARY: _____

REASON FOR LEAVING: _____

PART IV – REFERENCES: please list three professional references.

Name	Address	Phone	Relationship

Please read carefully and sign:

By my signature below, I verify that the information provided in this employment application (and attached resume, if applicable) is true and complete. Furthermore, I understand that any false information or significant omissions may disqualify me from further consideration of employment. I agree to immediately notify the VNA if any information changes while my application is pending or during my period of employment if hired.

Date: _____

Signature: _____

Authorization to Obtain Consumer Reports and

Release of Information for Employment Purposes

Pursuant to the federal Fair Credit Reporting Act, I hereby authorize the VNA and its designated agents and representatives to conduct a comprehensive review of my background through a consumer report and/or an investigative consumer report to be generated for employment, promotion, reassignment or retention as an employee. I understand the scope of the consumer report/investigative consumer report may include, but is not limited to, the following areas: verification of Social Security number; current and previous residences; employment history, including all personnel files; education; references; abuse registries; national sexual predator registry; criminal history, including records from any criminal justice agency in any or all federal, state or county jurisdictions; birth records; motor vehicle records, including traffic citations and registration; and any other public records.

I, _____, authorize the complete release of these records or data pertaining to me which an individual, company, firm, corporation or public agency may have. I understand that I must provide my date of birth to adequately complete said screening and acknowledge that my date of birth will not affect any hiring decisions. I hereby authorize and request any present or former employer, school, police department, financial institution or other persons having personal knowledge of me to furnish the VNA or its designated agents with any and all information in their possession regarding me in connection with an application of employment. I am authorizing that a photocopy of this authorization be accepted with the same authority as the original.

I hereby release the VNA and its agents, officials, representatives or assigned agencies, including officers, employees or related personnel, both individually and collectively, from any and all liability for damages of whatever kind, which may at anytime result to me, my heirs, family or associates because of compliance with this authorization and request to release. I understand that a copy of this authorization may be given at any time, provided I do so in writing.

I understand that, pursuant to the federal Fair Credit Reporting Act, if any adverse action is to be taken based upon the consumer report, a copy of the report and a summary of the consumer's right will be provided to me.

_____

By signing below, you are certifying that the above information is true and correct.

Signature _____

Date _____

IOWA HEALTH CARE FACILITY (135C) RECORD CHECK
FORM C

ACCT #_____

TO: Iowa Department of Criminal Investigation
Bureau of Identification
Wallace State Office Bldg
Des Moines, IA 50319
(515) 281-5138
(515) 242-6876 (fax)

FROM: Visiting Nurse Association
1524 Sycamore Street
Iowa City, IA 52240
Phone #: (319) 337-9686 ext. 1150
Fax #: (319) 351-9061

I AM REQUESTING AN IOWA CRIMINAL HISTORY/DEPENDENT ADULT ABUSE CHECK ON:

(Type/Print Legibly)

REQUEST
Please Print

_____
Last Name Maiden Name First Name Middle Name

_____ _____ _____
Date of Birth Sex Social Security Number

_____ _____
Professional License Number Signature of Requester

There is a separate form "C" required for each last name submitted

(DCI Use Only)

RESULTS

As of _____, a Name and Date of Birth check revealed:

No CCH Record Found ☐
CCH Record Attached ☐

No Record Founded Dependent Adult Abuse ☐
Potential DAAR "hit", send to DHS ☐

DCI initials _____

I hereby give permission for the above requesting official to conduct an Iowa criminal history and dependent adult abuse check with the Division of Criminal Investigation.

_____ _____
Signature Date

Form No. 595-1490 (4/99)

Visiting Nurse Association
MVR Record Check Request Release Form

Name _____

Drivers
License # _____

State of
Issued Drivers
License _____

I hereby give permission for the above requesting official to conduct an Iowa MVR record check with the Iowa Department of Motor Vehicles. Any information maintained by the DMV may be released as allowed by law.

_____ _____
Signature Date

_____ _____
Signature of Requester/Employer Date

CNA/RN/LPN/OT/PT/Speech/Dietician/Social Work's

How does your name appear on your professional license?

_____

Updated and revised: 1/2013, 9/2014, 6/16