

# Med-Link Nursing Services

## Employment Application

Name (First, Middle, Last)

Social Security No:

Address (Street No., City, State, Postal Code, Country, Telephone, Email Address)

Home Tel: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_  
Position Applying For \_\_\_\_\_ Other Positions You May Be Interested In \_\_\_\_\_ Salary Requirements \_\_\_\_\_

### Hours Desired

- 40/Wk
- < 40/Wk
- On Call
- Any

### Shifts Available

- Days
- Evenings
- Nights
- Any

### Days Available

- Sun  Th
- Mon  Fr
- Tue  Sat
- Wed

Preferred locations/site(hospitals, nursing homes, clinics, etc) of interest to work , Make a list. (City, State)

|  |
|--|
|  |
|  |
|  |

### Professional Licensure

| Type       | Number         | Type       | Type           |
|------------|----------------|------------|----------------|
| Expiration | Current States | Expiration | Current States |

### Applicant Declaration

Are you 16 or older?

- Yes  No

Are you eligible to work in the United States legally?

- Yes  No

Have you ever been convicted, pled guilty or no contest to a crime? This includes misdemeanors (except parking violations), gross misdemeanors and felonies. A conviction, guilty plea or no contest will not necessarily disqualify you for employment consideration.

- Yes  No If yes, gives dates and explanation (where, when, etc): \_\_\_\_\_

Have you ever been excluded from the Medicare or Medicaid program for conduct that would constitute a misdemeanor, gross misdemeanor or a felony under the law?  Yes  No.

If yes, please explain: \_\_\_\_\_

Have you ever been disciplined by professional or state ethics or licensing board?  Yes  No

If yes, please explain: \_\_\_\_\_

How did you find out about our company, positions? \_\_\_\_\_

Did anybody refer you to our company?  Yes  No. If yes, who? \_\_\_\_\_

**Educational Information**

|  |       |  |  |        |             |
|--|-------|--|--|--------|-------------|
| <b>High School</b>   |       |  | <b>Diploma Program, Commercial or Technical</b>                            |        |             |
| Address  |       |  | Address  |        |             |
| City   | State | Postal Code  | City   | State  | Postal Code |
| Did You Graduate? <input type="checkbox"/> Yes <input type="checkbox"/> No |       | Did You Graduate? <input type="checkbox"/> Yes <input type="checkbox"/> No |  | Degree |             |
| <b>College or University</b>   |       |  | <b>Graduate School</b>   |        |             |
| Address  |       |  | Address  |        |             |
| City   |       |  | City   |        |             |
| Country  |       |  | Country  |        |             |
| Major  |       |  | Major  |        |             |
| Did You Graduate? <input type="checkbox"/> Yes <input type="checkbox"/> No |       | Degree   | Did You Graduate? <input type="checkbox"/> Yes <input type="checkbox"/> No |        | Degree      |

**Employment Information**

|                                  |  |                        |  |                           |  |                        |  |
|----------------------------------|--|------------------------|--|---------------------------|--|------------------------|--|
| <b>1. Employer (Most Recent)</b> |  |                        |  | <b>2. Employer</b>        |  |                        |  |
| Address                          |  |                        |  | Address                   |  |                        |  |
| City/State/Postal Code           |  |                        |  | City/State/Postal Code    |  |                        |  |
| Supervisor Name/Phone No.        |  |                        |  | Supervisor Name/Phone No. |  |                        |  |
| Start Date                       |  | End Date               |  | Start Date                |  | End Date               |  |
| Position                         |  | Average Hours Per Week |  | Position                  |  | Average Hours Per Week |  |
| Starting Salary                  |  | Ending Salary          |  | Starting Salary           |  | Ending Salary          |  |
| Reason For Leaving               |  |                        |  | Reason For Leaving        |  |                        |  |
| <b>3. Employer</b>               |  |                        |  | <b>4. Employer</b>        |  |                        |  |
| Address                          |  |                        |  | Address                   |  |                        |  |
| City/State/Postal Code           |  |                        |  | City/State/Postal Code    |  |                        |  |
| Supervisor Name/Phone No         |  |                        |  | Supervisor Name/Phone No  |  |                        |  |
| Start Date                       |  | End Date               |  | Start Date                |  | End Date               |  |
| Position                         |  | Average Hours Per Week |  | Position                  |  | Average Hours Per Week |  |
| Starting Salary                  |  | Ending Salary          |  | Starting Salary           |  | Ending Salary          |  |
| Reason For Leaving               |  |                        |  | Reason For Leaving        |  |                        |  |

**Equal Employment Opportunity Questionnaire**

To All Applicants

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Name \_\_\_\_\_ Date \_\_\_\_\_

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Position Applied For \_\_\_\_\_ Sex  Male  Female

**What Racial/Ethnic Category Do You Consider Yourself**

- American Indian or Alaskan Native      All persons having origins in any of the original people of North America.
- Asian or Pacific Islander      All persons having origins in any of the original people of East, Southeast Asia, the Pacific Islands or Indian subcontinent. This area includes for example China, Japan, The Philippines Island, and Samoa.
- Black      Not of Hispanic Origin. All persons having origins in any of the Black racial groups.
- Hispanic      All persons of Mexican, Puerto Rican, Cuban, Central or South America, or other Spanish culture or origin.

**Vietnam Veteran**

Did you serve active duty in the armed services (for a period of more than 180 days) between August 5, 1964 and May 7, 1975?  
 Yes  No

**Disabled Veteran**

Are you entitled to disability compensation under laws administered by the Veterans Administration for disability rates at 30% or more, or are you a person whose discharge or release from active duty was for a disability incurred or aggravated in the line of duty.

Yes  No    If yes, list disability \_\_\_\_\_

**Handicapped**

Do you (1) have a physical or mental impairment which substantially limits one or more major life activities, (2) have a secure record of such impairment, (3) are regarded as having such an impairment, or (4) have experienced difficulty, retaining or advancement in employment because of your handicapped?     Yes  No

Our company is committed to respectful and equal treatment for all employees. This commitment includes non-discrimination towards applicants and employees on the grounds of race, color, creed, religion, age, sex, disability, national origin, ancestry, sexual orientation, marital status, or with regard to public assistance, or union or non-union status. This prevails throughout the employment relationship, including, but not limited to recruitment, selection, training, transfer, compensation, promotion, demotion, layoff and termination.

**Work Related References (No family members, relatives, or personal friends)**

|  |                              |
|--|------------------------------|
| <b>Most Recent Supervisor Name</b>   | <b>Reference One</b>         |
| Company  | Company                      |
| Telephone Number   | Telephone Number             |
| Position You Held  | How Do You Know This Person? |
| May We Contact This Person For A Reference<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                              |
| <b>Reference Two</b>   | <b>Reference Three</b>       |
| Company  | Company                      |
| Telephone Number   | Telephone Number             |
| How Do You Know This Person?   | How Do You Know This Person? |

**Applicant Release, Please read and sign below**

I authorize the investigation of my background including all information contained in this application and information provided in the interview. I understand that misrepresentation or omission of information in connection with my application and interview will be sufficient cause, in and of itself, for rejection or dismissal whenever discovered. I understand and agree that any offer of employment is contingent upon satisfactory completion of \_\_\_\_\_ pre-employment investigation which includes but is not limited to health assessment, criminal history check, educational and work verification, reference checks, consumer report and any investigation required by local, state, or federal laws. I understand that if I am hired by \_\_\_\_\_, my employment will be for an indefinite period of time and will be "at will" which means that either \_\_\_\_\_ or I may terminate the employment relationship at anytime and for any reason or no reason.

I further understand that, if hired, my at-will employment status may only be changed in written contract signed by the management of \_\_\_\_\_, and that no representative of \_\_\_\_\_ has the authority to make oral promise to me concerning my employment. Finally, I also understand that \_\_\_\_\_ may adopt, from time to time, policies or handbooks dealing with benefits and other terms or conditions of employment. These policies or handbooks do not constitute a contract of employment between \_\_\_\_\_ and me. \_\_\_\_\_ reserves the right to change or discontinue these policies and/or handbooks at any time with or without notice to me.

\_\_\_\_\_ strives to provide a safe, healthy and productive work environment and supports a smoke free, alcohol-free work environment.

Signature of Applicant \_\_\_\_\_

Date \_\_\_\_\_

# BACKGROUND CONSENT FORM

## REQUEST, AUTHORIZATION, CONSENT & RELEASE FOR INVESTIGATIVE BACKGROUND INFORMATION

I understand that in processing my application, **Med-Link Nursing Services** may procure an investigative background report on me. Information for this report may be obtained through personal interview(s), a review of information held by law enforcement or governmental agencies, present or former employer(s), school(s), financial institution(s), or other persons having personal knowledge about me.

I further understand that **Med-Link Nursing Services** will use the services of an approved Investigative Company as an agent to procure this report.

These above mention reports may include but are not limited to information as to my character, general reputation, and personal characteristics, motor vehicle records, criminal records, current and former employers, military records, and education records, professional and personal references. I request, authorize and consent to the release and disclosure of any and all information including but not limited to the above to, **Med-Link Nursing Services** and an approved Investigative Company.

This authorization in original or copy form shall be valid for one year from the date indicated next to my signature. According to the Fair Credit Reporting Act, **Med-Link Nursing Services** will notify me if employment is denied because of information obtained from a Consumer Reporting Agency. Additionally, I understand that upon written request to an Investigative Company within a reasonable amount of time after the date indicated below, I will be given a full and accurate disclosure as to the nature and substance of all information provided to **Med-Link Nursing Services**. I further understand that when requesting a copy of the report, proper identification will be required and I should direct my request to:

This consumer authorization serves as the required, stand alone, consumer notification that a report may be requested and used for the purpose of evaluating me for employment, promotion, reassignment, or retention as an employee.

I understand that any decision to hire me is contingent upon the results of an investigator report. I further understand that misrepresentation or omission of information will be sufficient cause, in and of itself, for rejection or dismissal whenever discovered.

Please provide me with a copy of my background investigation report. Yes No

Print Name: \_\_\_\_\_

List former names under which you have been employed: \_\_\_\_\_

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

## Background Check Consent Form

I hereby authorize **Med-Link Nursing Services** to receive any criminal history on file pertaining to me from any federal, state or local criminal justice agency.

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(Print Full Name)

---

(Signature)

(Date)

---

(Street Address)

---

(City)

(State)

(Zip)

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\*(Sex)  
Number)

\*(Race)

\*(Date of Birth)

\*(Social Security

\* The above information is necessary to retrieve criminal history information.

# MED-LINK NURSING SERVICES

## RESTRAINT TEST

1. Medical restraints are utilized for patients.  
True or False
2. Restraints must be attached to bed frame, not to side rails  
True or False
3. In case of an emergency. A nurse may apply restraints to protect the patient from potential harm but an order must be obtained within 4 hours of application.  
True or False
4. A verbal order for restraint must be signed by a physician within 24/H  
True or False
5. If needs for restraints continues, a complete new order must be written  
True or False
6. Patient in behavioral restraints for out of control behavior should be Observed every 15 minutes  
True or False
7. Assessments and documentation in Nurses notes on restraint flow sheet should include:
  - a. Patient behavior
  - b. Time of application and release
  - c. Skin integrity
  - d. All of the above
8. Side rails are considered to be restraints. True or False
9. Physiology and /or psychological disturbances such as CHF, hemorrhage and shock can lead to acute confusion.  
True or False
10. Reorienting patient to date, time, and place is considered an alternative intervention prior to restraint use. True or False

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Score: \_\_\_\_\_

**OSHA Bloodborne Pathogens Test**

**MED-LINK NURSING SERVICES**

**Applicant Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Branch Location** \_\_\_\_\_

**SHORT ANSWER**

1. Name the two bloodborne diseases most prevalent in the U.S.  
\_\_\_\_\_
2. Name three "infectious materials" that can contain bloodborne pathogens.  
\_\_\_\_\_
3. What is the single most important hygiene activity for preventing infection from bloodborne diseases?  
\_\_\_\_\_
4. Are BIOHAZARD WARNING labels required for any or all linen? If so, what type?  
\_\_\_\_\_
5. Name three types of personal protective equipment that can help guard against infection from bloodborne pathogens.  
\_\_\_\_\_  
\_\_\_\_\_
6. In a procedure likely to involve hand contact with blood, but no splashing, it would be most appropriate to wear which personal protective equipment?  
\_\_\_\_\_
7. List the appropriate steps you should take once exposure occurs.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**TRUE OR FALSE**

- \_\_\_\_\_ 8. Hepatitis B Vaccine is offered free of charge to all employees who have a reasonable expectation of exposure.
- \_\_\_\_\_ 9. If you are exposed, you should report the incident to your supervisor as soon as possible.
- \_\_\_\_\_ 10. Small blood or body-fluid spills do not require the use of gloves when cleaning up the spill.
- \_\_\_\_\_ 11. You don't have to wear any personal protective equipment if it is annoying or uncomfortable.
- \_\_\_\_\_ 12. Universal Precautions means treating the blood and body fluids of only sexually active adults between the ages of 18 and 65 as if they were known to be infected with HIV or HBV.



# MED-LINK NURSING SERVICES

## EDUCATION VERIFICATION

Employee Name: \_\_\_\_\_ Class \_\_\_\_\_

SCHOOL ATTENDED: \_\_\_\_\_

YEAR GRADUATED: \_\_\_\_\_

DEGREE: \_\_\_\_\_

Telephone Verification: \_\_\_\_\_

Transcript Visualized : \_\_\_\_\_

Verified By: \_\_\_\_\_

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

Title: \_\_\_\_\_

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

# **Med-Link Nursing Services**

## **Unacceptable Abbreviations Do Not Use List**

I, \_\_\_\_\_ have received in-service and I have been informed about unacceptable abbreviations "Do Not Use" list. I promise to comply and refrain from using these unacceptable abbreviations at any clients' facilities.

\_\_\_\_\_  
Employee Name (Print)

\_\_\_\_\_  
Employee Signature

Date \_\_\_\_\_

# Med-Link Nursing Services

## New Employee Artificial Nail Acknowledgement Statement

I agree to remove my artificial nails prior to commencement of work at all client/hospitals. I understand removal of artificial nails is a condition of employment. Further, I understand and agree to periodic monitoring by my department supervisor/manager for policy compliance.

Employee Name: \_\_\_\_\_

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

Signature \_\_\_\_\_

Witness by: \_\_\_\_\_

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

**Med-Link Nursing Services**  
Employment Verification

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

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

Name: \_\_\_\_\_

SS#: \_\_\_\_\_

Has applied for employment with **Med-Link Nursing Services**, and has given your name as a reference. Please complete and return this form at your earliest convenience. Thank you for your cooperation.

I hereby authorize release of the information below concerning my work experience to **Med-Link Nursing Services**.

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

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**To be filled out by employer**

Position Held: \_\_\_\_\_

Length of Employment:      From: \_\_\_\_\_      To: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Eligible for Re-hire:      Yes: \_\_\_\_\_      No: \_\_\_\_\_

How would you rate the above-named on: (please circle one)

|                     |      |      |           |
|---------------------|------|------|-----------|
| Professional Skills | Poor | Good | Excellent |
| Dependability       | Poor | Good | Excellent |
| Appearance          | Poor | Good | Excellent |
| Patient Care        | Poor | Good | Excellent |
| General Conduct     | Poor | Good | Excellent |

Comment: \_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

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

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

**Med-Link Nursing Services**  
Employment Verification

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

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

Name: \_\_\_\_\_

SS#: \_\_\_\_\_

Has applied for employment with *Med-Link Nursing Services*, and has given your name as a reference. Please complete and return this form at your earliest convenience. Thank you for your cooperation.

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

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**To be filled out by employer**

Position Held: \_\_\_\_\_

Length of Employment:      From: \_\_\_\_\_      To: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Eligible for Re-hire:      Yes: \_\_\_\_\_      No: \_\_\_\_\_

How would you rate the above-named on: (please circle one)

|                     |      |      |           |
|---------------------|------|------|-----------|
| Professional Skills | Poor | Good | Excellent |
| Dependability       | Poor | Good | Excellent |
| Appearance          | Poor | Good | Excellent |
| Patient Care        | Poor | Good | Excellent |
| General Conduct     | Poor | Good | Excellent |

Comment: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

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

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

**Med-Link Nursing Services**  
Employment Verification

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

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Has applied for employment with *Med-Link Nursing Services*, and has given your name as a reference. Please complete and return this form at your earliest convenience. Thank you for your cooperation.

I hereby authorize release of the information below concerning my work experience to *Med-Link Nursing Services*.

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

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**To be filled out by employer**

Position Held: \_\_\_\_\_

Length of Employment: From: \_\_\_\_\_ To: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Eligible for Re-hire: Yes: \_\_\_\_\_ No: \_\_\_\_\_

How would you rate the above-named on: (please circle one)

|                     |      |      |           |
|---------------------|------|------|-----------|
| Professional Skills | Poor | Good | Excellent |
| Dependability       | Poor | Good | Excellent |
| Appearance          | Poor | Good | Excellent |
| Patient Care        | Poor | Good | Excellent |
| General Conduct     | Poor | Good | Excellent |

Comment: \_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

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