

TRINITY HOMECARE & NURSING SERVICES

APPLICATION FORM

Tel: (609)207-7012 •
6 Maltby Court, Egg Harbor Township, NJ 08234

Today's Date: _____

Personal Data

Last Name	First Name	Soc. Sec. No.	Date of Birth	Home Phone #
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Street Address	City	County	State	Zip	Country	Cell Phone #
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Previous Street Address	City	County	State	Zip	Country	Best Time to Call
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Name of Emergency Contact	Relation	Emergency Phone No.
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Job Information

Position (Job Class) Applying for: CNA LPN RN Other _____ Date Available to Work: ____/____/____

Work Experience/Skills

Please List the number of years you have experience in each area (minimum 1 yr exp.) and are clinically competent to work:

____ Burn	____ ENT	____ Pediatrics	____ Detox/Drug Rehab
____ L&D	____ Rehab	____ Telemetry	____ Post Partum
____ NICU	____ Nursery	____ Psychiatry	____ Orthopedics
____ NICU	____ Dialysis	____ Stepdown	____ Mother/Baby
____ PACU	____ Geriatric	____ Oncology	____ Recovery Room
____ SICU	____ Pedi ICU	____ Neurology	____ Operating Room
____ CCU	____ Med/Surg	____ Open Heart	____ Emergency Room

Other Specialty: _____

Type of Work Desired: Check all that apply

Hospital Nursing Home Assisted Living Other: _____

Language Skills: Other than English, please check any other language you speak:

Spanish French German Other: _____

Check the days of the week you are available to work:

____ Monday ____ Tuesday ____ Wednesday ____ Thursday ____ Friday ____ Saturday ____ Sunday

Check the shift(s) you prefer below:

____ 7AM-3PM ____ 3PM-11PM ____ 11PM-7AM ____ 7AM-7PM ____ 7PM-7AM ____ Other

Education and Training (please list all schools attended, beginning with High Schools, then list all Colleges, Vocational/Military Service Schools).

High School Name	Street Address	City	State	Zip	Country	Grade Completed
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College/Vocational School	Street Address	City	State	Zip	Country
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Major Emphasis	Degree Completed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Level and type
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Graduate School Name	Street Address	City	State	Zip	Country
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Major Emphasis	Degree Completed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Level and type
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License/Certification:

/ /		
License Type	License/Certification No.	State
		Expiration Date
/ /		
License Type	License/Certification No.	State
		Expiration Date
/ /		
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		Expiration Date

Has your Professional License ever been suspended, revoked or under investigation? Yes No

If Yes, please explain: _____

Certifications: Check all applicable certifications and enter expiration date

ACLS _____ Exp. Date ____/____/____	Other _____ Exp. Date ____/____/____
BCLS _____ Exp. Date ____/____/____	IV _____ Exp. Date ____/____/____
CPR _____ Exp. Date ____/____/____	NALS _____ Exp. Date ____/____/____
PALS _____ Exp. Date ____/____/____	AANA _____ Exp. Date ____/____/____

Work Experience: List all of your work experience beginning with your most recent job. You will be asked to explain all gaps in employment. Attach additional sheet(s) if necessary.

Facility/Employer Name	Dates Employed From: Mo Yr To: Mo Yr
Company Street Address	Title
City State Zip Country	Unit
Number of beds in Unit: _____ In Hospital: _____	Name of Current Immediate Supervisor
Describe Duties and Specialty Areas:	Tel. No. (include country code if outside U.S.)
Pay Rate/Salary: <input type="checkbox"/> Yearly <input type="checkbox"/> Hourly \$ _____	May we Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No – If no, why not?
Reason for leaving:	If this was a travel assignment, name of agency:
Are your employment records listed under another name? <input type="checkbox"/> No <input type="checkbox"/> Yes – If yes, what name?	Charge Experience: <input type="checkbox"/> Yes <input type="checkbox"/> No How Often? _____

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Reason for leaving:	If this was a travel assignment, name of agency:
Are your employment records listed under another name? <input type="checkbox"/> No <input type="checkbox"/> Yes – If yes, what name?	Charge Experience: <input type="checkbox"/> Yes <input type="checkbox"/> No How Often? _____

Please list any other work related information you think would be helpful to us in considering you for employment, such as specialized training, certifications, additional work experience, etc.

References (please list three individuals with whom you have worked who were in a position to evaluate your performance)

Name	Title	Street Address	City	Sate	Zip	Telephone No.
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Name	Title	Street Address	City	Sate	Zip	Telephone No.
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Additional Information

1. Are you legally authorized to work in the U.S.? Yes No

(Should you become employed by LifeSavers Healthcare Services, you will be required to provide the documentation proving your eligibility to work in the U.S.).

2. Have you ever been convicted of a felony or misdemeanor crime? Yes No

***PLEASE BE SURE TO READ AND SIGN THE ACKNOWLEDGEMENT
ON THE NEXT PAGE OF THIS APPLICATION***

