

# EMPLOYMENT APPLICATION

## *ISLAND TEMPORARY NURSING*

1314 South King Street, Suite 616  
Honolulu, Hawaii 96814  
Phone (808) 791-5825 Fax (808) 791-5839

The information you provide will be used to determine whether you meet employment requirements and the minimum qualification requirements specified in the vacancy announcement. **It is Island Temporary Nursing's policy to provide equal opportunity in all areas of the employment practices and to assure that there is no discrimination against its employees or applicants** on the basis of race, sex, sexual orientation, age, religion, color, ancestry, disability, marital status, arrest and court record or other protected status.

*Please type or print legibly in blue or black ink*

**Date of Application:**

<b>1. Title Of Job Applying For:</b>	<b>2. Phone Numbers:</b> Home: _____ Cell: _____
<b>3. Name (last, first, middle):</b>	<b>Email:</b> _____
<b>4. Mailing Address:</b>  Number, Street _____  City _____ State _____ Zip Code _____	<b>5. Social Security Number:</b> _____
<b>6. Emergency Contact Info:</b> Phone: _____ Name _____	
<b>I will accept job which is:</b> A. <input type="checkbox"/> Permanent, Full-Time B. <input type="checkbox"/> Permanent, Part-Time C. <input type="checkbox"/> Temporary, Full-Time D. <input type="checkbox"/> Temporary, Part-Time	
<b>How did you hear about this position?</b> <input type="checkbox"/> ITN Website <input type="checkbox"/> Family/Friends <input type="checkbox"/> Newspaper specify: _____ <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Journal/Magazine, specify _____ <input type="checkbox"/> Internet, specify _____	
<b>7. Work Authorization</b>  I understand that if I am offered employment, I will be required to submit proof of U.S. citizenship or immigration documentation establishing authorization to work in the United States.	<b>8. Residence Status.</b> Check the appropriate block below. Are you a resident of Hawaii? <input type="checkbox"/> Yes <input type="checkbox"/> No Month/Year Hawaii residence began _____

**9. EDUCATION: Please submit proof or evidence of having completed the course(s) of study.**

Name and location of last grade attended:(elementary, intermediate or high school)	Highest Grade Completed:
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**In-Service Training, Business, Trade, Armed Forces, College or University, Graduate or Professional Schools**

Name & Address	From Mo. Yr.	To Mo. Yr.	Course Or Major Field Of Study	Number Of Credits Or Hours Completed Sem'tr Quarter	Kind Of Degree, Diploma Or Certificate Received

**10. OTHER QUALIFICATIONS:**

LICENSE OR CERTIFICATE: Please indicate the kind, registration number, and the State or other licensing authority.  
**If proof or evidence is required as indicated in the vacancy announcement, please submit a copy or present for verification.**

1) PROFESSIONAL LICENSE:	2) OTHER (DRIVER'S LICENSE, etc.):
Identification Number:	
Expiration Date:	
Type:	
3) OTHER LICENSE OR CERTIFICATION:	4) OTHER LICENSE OR CERTIFICATION:
Identification Number:	
Expiration Date:	
Type:	

**11. EXPERIENCE.** Please begin with your present or last employment and work backward showing all of your employment for the past 7 years. In addition, describe all training, including military service and volunteer work, which you have received and which you believe to be relevant to the position for which you are applying. To receive full credit for your experiences, use separate blocks if your duties and responsibilities changed while working for the same employer describing in detail the tasks you were assigned. If you supervised others, explain your duties as a supervisor and indicate the number and types of employees you supervised. If more space is needed use a blank sheet and attach it to this form. Your answers may be verified with former employers. **Please complete even if attaching a resume.**

PRESENT OR LAST POSITION	Employer		From (mm/yy):		To (mm/yy):		DO NOT WRITE IN THIS SPACE	
	Employer's Address		Phone Nbr:		Average Hrs per week:			
	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Vol	Starting Salary:		Per:	Ending Salary:			Per:
	Name & Title of Your Supervisor			Your Title				
	Duties & Responsibilities							
Reasons for Leaving:				May we contact your present employer?: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Employer		From (mm/yy):		To (mm/yy):				
Employer's Address		Phone Nbr:		Average Hrs per week:				
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Vol	Starting Salary:		Per:	Ending Salary:		Per:		
Name & Title of Your Supervisor			Your Title					
Duties & Responsibilities								
Reasons for Leaving:								
Employer		From (mm/yy):		To (mm/yy):				
Employer's Address		Phone Nbr:		Average Hrs per week:				
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Vol	Starting Salary:		Per:	Ending Salary:		Per:		
Name & Title of Your Supervisor			Your Title					
Duties & Responsibilities								
Reasons for Leaving:								
Employer		From (mm/yy):		To (mm/yy):				
Employer's Address		Phone Nbr:		Average Hrs per week:				
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Vol	Starting Salary:		Per:	Ending Salary:		Per:		
Name & Title of Your Supervisor			Your Title					
Duties & Responsibilities								
Reasons for Leaving:								
Employer		From (mm/yy):		To (mm/yy):				
Employer's Address		Phone Nbr:		Average Hrs per week:				
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Vol	Starting Salary:		Per:	Ending Salary:		Per:		
Name & Title of Your Supervisor			Your Title					
Duties & Responsibilities								
Reasons for Leaving:								



**Experience Continued:** Please check each area in which you have experience and indicate the number of years experience.

ACUTE CARE	<input checked="" type="checkbox"/> Adult Medical	years	<input type="checkbox"/> Adult Surgical	years	<input type="checkbox"/> Adult Psych	years
SPECIALTY CARE	<input checked="" type="checkbox"/> ICU	years	<input checked="" type="checkbox"/> CCU	years	<input checked="" type="checkbox"/> Telemetry	years
	<input checked="" type="checkbox"/> OB/GYN	years	<input checked="" type="checkbox"/> L & D	years	<input checked="" type="checkbox"/> Postpartum	years
	<input checked="" type="checkbox"/> Nursery	years	<input checked="" type="checkbox"/> NICU	years	<input checked="" type="checkbox"/> Pediatrics	years
	<input checked="" type="checkbox"/> PICU	years				
OTHER	<input checked="" type="checkbox"/> OR	years	<input checked="" type="checkbox"/> PACU	years	<input type="checkbox"/> Dialysis	years
	<input type="checkbox"/> Radiology	years				
LONG TERM CARE	<input checked="" type="checkbox"/> Rehab	years	<input checked="" type="checkbox"/> SNF	years	<input checked="" type="checkbox"/> ICF	years
OUTPATIENT	<input checked="" type="checkbox"/> Medical Clinics	years	<input checked="" type="checkbox"/> Home Care	years	<input checked="" type="checkbox"/> Private Duty	years
	<input checked="" type="checkbox"/> Urgent Care	years				

**12. Knowledge of other languages. Please indicate skill level as (Good, Fair or Slight).**

Language	Read	Write	Speak

Do you have a reliable means of transportation?

Yes  No

**13. PLEASE NOTE:** Information requested in items A, B and C are needed to make determinations on your suitability for employment. Dishonorable separations from military service do not automatically disqualify you from employment; however, certain Federal and State laws allow us to disqualify individuals with convictions for those offenses noted below.

A. DISHONORABLE SEPARATIONS FROM MILITARY SERVICE  YES  NO  
 Within the past 5 years, were you separated from military service under conditions other than honorable?

B. CONVICTION FOR A VIOLATION OF ANY OF THE FOLLOWING:  YES  NO

- 1) Controlled substance-related offense in the three-year period immediately preceding the date of the application.
- 2) State or federal healthcare program-related crimes.
- 3) Patient abuse, neglect or mistreatment.
- 4) Felony conviction after August 21, 1996 of fraud, theft, embezzlement, breach or fiduciary responsibility or other financial misconduct in connection with a healthcare program.
- 5) Felony conviction after August 21, 1996 relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
- 6) Any act, attempt, or conspiracy to overthrow the State or the federal government by force or violence.

C. IF YOU ANSWERED "YES," TO ANY OF THE ABOVE, PLEASE PROVIDE EXPLANATION, INCLUDING DATE AND CIRCUMSTANCES SURROUNDING THE INCIDENT UNDERLYING THE CONVICTION.

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**13. CERTIFICATION (Please read carefully before signing)**

- A. I certify that all statements made on this application for employment are true and complete to the best of my knowledge. I understand and agree that any misrepresentation or omission whenever discovered is grounds for the denial of or immediate separation from employment.
- B. If employed by Island Temporary Nursing (ITN), I agree to conform to the guidelines and policies of ITN. I understand that unless otherwise provided by collective bargaining agreements or law, and if appointed to an exempt position, my exempt employment is "at will" and may be terminated by myself or by ITN with or without cause.
- C. I consent to and authorize ITN to communicate with all my former employers, school officials, government agencies, and persons named as references, and to make any investigation of my employment history. In consideration for ITN's review of this application, I release ITN and any other person or company responding to any reference or information from any claim or liability regarding any information or opinion supplied. I understand that any offer of employment is subject to satisfactory references. In consideration for employment, I further authorize ITN to disclose information about my job performance with ITN to any prospective employer upon request of that prospective employer. I specifically waive any claims against ITN for such disclosure unless it is established by clear and convincing evidence that such information was knowingly false or rendered with malicious purpose and also such disclosure was not otherwise privileged.
- D. I understand that other checks required by ITN to comply with various governmental programs such as Medicare and Medicaid will be conducted and any offer of employment and continued employment will be contingent on the satisfactory return of these checks.
- E. State and Federal criminal history record checks will be conducted. An applicant with a conviction may be denied employment.
- F. Conditions for business purposes include, but are not limited to the following: overtime, shift work, rotating shift work schedule, or a work schedule other than the weekdays. I understand and accept these as conditions of my employment.
- G. I understand and agree that if I am employed by ITN, all of the foregoing terms are continuing conditions of my employment with Island Temporary Nursing.

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Applicant's Signature

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Date

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