



Pushmataha Hospital

Uniform Employment Application for Nurse Aide Staff

This application form is required by Title 63 O.S. Section 1-1950.4 of state law and by the Oklahoma State Board of Health Rules OAC 310-2-15-3. This uniform application shall be used as the only application for employment of nurse aides in nursing and specialized nursing facilities, residential care homes, assisted living centers, continuum of care facilities, hospice programs, adult day care centers, and home care agencies on and after January 1, 2001.

This employer does not discriminate in its hiring decisions or in any other employment decision on the basis of race, color, sex, religion, citizenship, national origin, veteran status, age or upon a physical or mental disability which is unrelated to the applicant's/employee's ability to perform the essential functions of the position.

Date of Application: _____ Date Available to Start Work: _____

Personal Information

Name: _____ Social Security Number: _____

List any other name(s) you have worked under: _____

Present Address: _____
(Street) (City) (State) (Zip)

Permanent Address (if different than present address): _____
(Street) (City) (State) (Zip)

Phone Number: _____ Emergency Contact Person: _____
(Name) (Address) (Phone Number)

Employment Desired

Position Applied For: _____ Salary Required: _____

Hours Available to Work: _____ Days _____ Evenings _____ Nights _____ Weekends

Will you accept employment of: _____ Full Time? _____ Part Time? _____ Occasional Part Time?

U.S. Military Record

Branch: _____ Date Entered: _____ Date and Type of Discharge: _____

Prior Work History (List your last four (4) jobs beginning with your most recent or current employer.)

Employer's Name and Address: _____

Position Held: _____ Supervisor: _____

Dates Employed: From (month/year) _____ To (month/year) _____ Salary: _____

Reason for Leaving: _____

Employer's Name and Address: _____

Position Held: _____ Supervisor: _____

Dates Employed: From (month/year) _____ To (month/year) _____ Salary: _____

Reason for Leaving: _____

Employer's Name and Address: _____

Position Held: _____ Supervisor: _____

Dates Employed: From (month/year) _____ To (month/year) _____ Salary: _____

Reason for Leaving: _____

Employer's Name and Address: _____

Position Held: _____ Supervisor: _____

Dates Employed: From (month/year) _____ To (month/year) _____ Salary: _____

Reason for Leaving: _____

List name(s) of all other employers for the last five (5) years:

May we contact your present employer? _____ Yes _____ No _____ Not Applicable

Have you ever been terminated or asked to resign from any position? _____ Yes _____ No

Educational Background (List all educational schools attended with degrees, diplomas or certificates received.)

1. Name of Institution: _____ Type of Studies: _____

Date(s) Attended & Diplomas, etc.: _____

2. Name of Institution: _____ Type of Studies: _____

Date(s) Attended & Diplomas, etc.: _____

3. Name of Institution: _____ Type of Studies: _____

Date(s) Attended & Diplomas, etc.: _____

If your school or employment records are under another name(s), indicate that name(s): _____

Certification

If you hold a current certification as a nurse aide (CNA), check the appropriate certification(s) below:

_____ Long Term Care (LTC) _____ Home Health Aide (HHA) _____ Adult Day Care (ADC)

_____ Residential Care Aide (RCA) _____ Developmental Disability Aide (DDA) _____ Certified Medication Aide (CMA)

List all technical special skills or education honors, certificates, licenses, memberships or Medication Administration Technician (MAT) certification not previously listed: _____

If you are a CMA, have you obtained your 8 hours of continuing education for this calendar year? _____ Yes _____ No

References (List name, address and telephone number of three references who are not relatives or former employers.)

- 1. _____
- 2. _____
- 3. _____

Background Information

If you answer YES to any of the questions below, explain in the space after the question. The explanation for a YES answer should include, but not be limited to:

- 1. State and/or jurisdiction
- 2. Nature of Complaint
- 3. Disposition of Complaint; e.g., “dismissed insufficient evidence”
- 4. Date of disposition
- 5. Copies of any correspondence received by applicant with regard to the complaint

1. _____ Yes _____ No Have you ever been arrested, charged with, entered a plea of guilty, no contest, convicted of or been sentenced for any criminal offense in any state or US jurisdiction?

2. _____ Yes _____ No Have you ever been found to have violated any state, US jurisdiction or federal law regulating the practice of a health care profession?

3. _____ Yes _____ No Are any disciplinary actions pending against your CNA certificate or health care professional license in any state or US jurisdiction?

4. _____ Yes _____ No Have you had any certificate, license, registration or other privilege to practice a health care profession denied, revoked, suspended, restricted, reprimanded, censured or placed on probation by a state or US jurisdiction, federal or foreign authority or have you ever surrendered such credential to avoid or in connection with action by such authority?

Applicant’s Certification and Agreement

(PLEASE READ CAREFULLY – If you answer NO to any of the questions below, explain in the space after the question.)

1. _____ Yes _____ No I understand that the employer has the right to proceed with any criminal background check.

Applicant's Certification and Agreement (Continued)

2. _____Yes _____No I understand that as a part of the job selection process, I may be required to take a drug-screening test at the time of employment and if requested in accordance with the state and federal law at any time during my employment. A test result that has been confirmed as positive will eliminate me from employment. If I refuse to sign this form and submit to drug testing the employer will reject my application.

3. _____Yes _____No I understand that I may be required to have a physical examination and I hereby consent to take a physical examination and any future physical examinations as required by the employer.

4. _____Yes _____No I understand that if I am hired I will be required to produce proof that I have a legal right to work in the USA in accordance with the IRCA of 1986.

5. _____Yes _____No I understand that this form is not an employment contract.

I certify that the information provided on this application is true and complete and I understand that false information or omission of facts may disqualify me from employment and may cause termination if discovered at a later date.

Signature of Applicant

Date of Signature