NURSING & HEALTH SERVICES TRAINING CONSULTANTS, INC.
APPLICATION- RN/LPN

POSITION APPLYING FOR: _____ CLASSIFICATION: ❒ R.N. ❒ L.P.N ❒ OTHER: _____

SPECIALTY: _____ Do you have 2 or more years in your specialty? ❒ YES ❒ NO
(I.E.: med surge, ICU, CCU, ER, Psych)

What is your primary interest? ❒ DDA ❒ Pediatric Private Duty* ❒ Training/Consulting ❒ Administrative
❒ Hospital Staffing ❒ Corrections ❒ Long-Term Care

*If you are interested in the Pediatric Division: Do you have at least 1 year clinical experience which includes pediatric direct patient care within the last 2 years? *(Please provide at least one professional reference)* ❒ YES ❒ NO

---Please Make Sure to Provide Verifiable References That Demonstrates Your Experience in Your Specialty/Interest---

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Have you ever applied at NHSTC, Inc.? ❒ YES ❒ NO (If yes, when) _____

Have you ever worked with NHSTC, INC.? ❒ YES ❒ NO (If yes, please provide dates of service) _____to_____

LAST NAME_____FIRST NAME_____ MIDDLE NAME_____

ADDRESS_____CITY _____STATE_____ZIP CODE_____

HOME# _____CELL#_____EMAIL ADDRESS_____

D O B _____/_____/_____ SOCIAL SECURITY# _____

DRIVER'S LICENSE #:_____ EXPIRATION DATE: _____ ISSUING STATE: _____

HOW DID YOU HEAR ABOUT US: (PLEASE SPECIFY)

❒ ADVERTISEMENT: _____ ❒ FACEBOOK/TWITTER ❒ FAMILY/FRIEND: _____

❒ EMAIL/NEWSLETTER: _____ ❒ WEBSITE/ SEARCH ENGINE ❒ OTHER: _____

MILITARY SERVICE:

DATE OF VETERAN'S SERVICE: FROM _____ TO _____ ARE YOU CURRENTLY ON ACTIVE DUTY? ❒ YES ❒ NO

ADMINISTRATIVE SKILLS:

CAN YOU TYPE? ❒ YES ❒ NO DO YOU HAVE EXPERIENCE WITH MICROSOFT OFFICE SOFTWARE? ❒ YES ❒ NO

ADDITIONAL LANGUAGES SPOKEN: ❒ SPANISH ❒ FRENCH ❒ ASL (SIGN LANGUAGE) ❒ OTHER: _____

ARE YOU LEGALLY ELIGIBLE TO WORK IN THE UNITED STATES? ❒ YES ❒ NO

HAVE YOU HAD ANY CONVICTIONS OTHER THAN MINOR TRAFFIC VIOLATIONS? ❒ YES ❒ NO
IF YES, GIVE COMPLETED DETAILS ON A SEPARATE SHEET. *CONVICTION IS NOT AN AUTOMATIC BAR T0 EMPLOYMENT. EACH CASE IS CONSIDERED ON ITS OWN MERITS. PERSONS WITH RECORDS OF CONVICTION ARE **EMPLOYED IN** THE STATE SERVICE.*

Please answer the questions below by marking the appropriate boxes: ***(optional)***

A. ARE YOU? ❒ MALE ❒ FEMALE B. ARE YOU HANDICAPPED? ❒ YES ❒ NO

C. RACE / ETHNIC IDENTIFICATION - PLEASE CHECK ONLY ONE.

❒ White / Caucasian ❒ Black/ African American ❒ Asian or Pacific Islanders ❒ American Indian or Alaskan Native
❒ Hispanic ❒ Bi-racial/ Multi-racial ❒ Unable to Determine

NHSTC, Inc. is an Equal Opportunity Employer, and is committed to providing fair and equal employment opportunity for all associates and job applicants regardless of race, color, religion, national origin, gender, sexual orientation, age, marital status or disability. NHSTC, Inc. hires and promotes individuals solely on the basis of their qualifications for the job to be filled.

Nursing & Health Services Training Consultants, Inc.
EMPLOYMENT PROFILE

PRINT NAME:	**SOCIAL SECURITY NUMBER:**

M.D. PROFESSIONAL LICENSE NUMBER_____ EXPIRATION DATE_____ISSUING STATE_____

D.C. PROFESSIONAL LICENSE NUMBER_____ EXPIRATION DATE_____ISSUING STATE_____

CPR/CERT/EXP. DATE_____

PLEASE BEGIN WITH MOST RECENT WORK EXPERIENCE AND INCLUDE AT LEAST FIVE (5) YEARS OF WORK HISTORY

❶**Please check the type(s)of experience gained from this employer** *(if applicable)*: ❒ PEDIATRIC ❒CLINICAL ❒N/A NAME OF EMPLOYER: ADDRESS CONTACT PERSON & # DATE STARTED: DATE ENDED:	LIST IN DETAIL SPECIFIC DUTIES FOR EACH POSITION HELD

❷**Please check the type(s)of experience gained from this employer** *(if applicable)*: ❒ PEDIATRIC ❒CLINICAL ❒N/A NAME OF EMPLOYER: ADDRESS CONTACT PERSON & # DATE STARTED: DATE ENDED:	LIST IN DETAIL SPECIFIC DUTIES FOR EACH POSITION HELD

❸**Please check the type(s)of experience gained from this employer** *(if applicable)*: ❒ PEDIATRIC ❒CLINICAL ❒N/A **NAME OF EMPLOYER:** ADDRESS CONTACT PERSON & # DATE STARTED: DATE ENDED:	LIST IN DETAIL SPECIFIC DUTIES FOR EACH POSITION HELD

❹**Please check the type(s)of experience gained from this employer** *(if applicable)*: ❒ PEDIATRIC ❒CLINICAL ❒N/A **NAME OF EMPLOYER:** ADDRESS CONTACT PERSON & # DATE STARTED: DATE ENDED:	LIST IN DETAIL SPECIFIC DUTIES FOR EACH POSITION HELD

❺**Please check the type(s)of experience gained from this employer** *(if applicable)*: ❒ PEDIATRIC ❒CLINICAL ❒N/A **NAME OF EMPLOYER:** ADDRESS CONTACT PERSON & # DATE STARTED: DATE ENDED:	LIST IN DETAIL SPECIFIC DUTIES FOR EACH POSITION HELD

THIS FORM MUST INCLUDE AT LEAST FIVE (5) YEARS OF WORK HISTORY

Nursing & Health Services Training Consultants, Inc.
EMPLOYMENT PROFILE

Please indicate the highest level of education you have achieved:

❒ Some High School ❒ Some College ❒ Bachelor's Degree ❒ Advanced Degree
❒ High School Diploma / G.E. D. ❒ Associate's Degree ❒ Master's Degree ❒ Other: _____

SCHOOL NAME & LOCATION	EDUCATIONAL BACKGROUND GRADUATION DATE	LENGTH OF PROGRAM	DEGREE

COURSES	CONTINUING EDUCATION DATE	PLACE	CREDITS

APPLICANT'S STATEMENT

I certify that the answers given herein are true and complete to the best of my knowledge. I authorize NHSTC, INC. to investigate all matters contained in the application and hereby give NHSTC, Inc. permission to contact and discuss the information in this application with former and current educational, employment and medical organizations for the purpose of credentialing and work verification. I understand that misrepresentations, omissions of facts or incomplete information requested in the application may remove me from further consideration for employment. In addition, if employed, any misrepresentations or omissions of facts called for in this application will be cause for dismissal at any time without any previous notice.

_____ _____
(Applicant's Printed Name) *(Date)*

_____
(Applicant's Signature)

Nursing & Health Services Training Consultants, Inc.

FACE-TO-FACE INTERVIEWER SHEET

I met face-to-face with: _____
(Applicant's Name)

on _____to discuss the positions of _____.
(Date)

Name of Interviewer: _____

*(Applicant's Signature)*_____

FOR OFFICE USE ONLY

ASSESSMENT

	PUNCTUALITY	**APPEARANCE**	**DEMEANOR**	**COMMUNICATION**
EXCELLENT				
GOOD				
FAIR				
POOR				

Pediatric Experience: _____

Comments:

Interview Results: ❒ Recommended for Hire ❒ Not Recommended for Hire

NHSTC, INC.
Nursing & Health Services Training Consultants, Inc.

PHYSICAL EXAMINATION FORM

The Licensure Division for the State of Maryland requires that all employees and contractors have a physical examination completed prior to employment commencement. The regulation stipulates that persons must be free of communicable diseases (including Hepatitis B and Tuberculosis) and have undergone a complete physical examination.

Applicant's Release

I, _____ give the noted below physician permission to release the information requested byNHSTC,INC.
(*Applicant's Printed Name)*

_____ _____
(Applicant's Signature) (*Date)*

Physician Verification

I certify that _____ was physically examined on _____
(Patient's Name) *(Date)*

And is able to: (Please check all that applies)

- ❒ Function without restriction as a health care worker,
- ❒ Free of communicable diseases, including but not limited to Tuberculosis and Hepatitis B in their communicable form.
- ❒ In good physical and mental health

The following tests were done with results being:

Tuberculin test: (Please Check One) ❒TB Skin Test (PPD) ❒ Tine Test ❒Chest X-Ray

Date: _____ Date Read/Result: _____

Chest X-Ray Date & Result: _____

Remarks: _____

_____ _____
(Printed Physician Name) *(Date)*

_____ _____
(Physician's Signature) *(Office Number)*

Physician's Address:
(Please Use Office Stamper)

Please mail or fax this completed form to:
NHSTC, INC. (Main Office)
311 North Charles Street
Baltimore, MD 21201
Office: 410.528.5430 Fax: 410.528.5436

NHSTC, INC.
Nursing Health Services Training Consultants, Inc.

Consent/Decline Form for Hepatitis B Vaccination

NHSTC, INC., the agency I contract with has provided me education about the Hepatitis B. Vaccine. I understand the effectiveness of the vaccine, the risk of contracting Hepatitis B due to exposure to blood and other potential infectious materials while working at the various sites that NHSTC, INC. is currently under contract to service with staffing needs and the importance of taking active steps to reduce the risk.

I currently choose of my own free will to hereby: (Please check the appropriate box)

☐ **CONSENT** to being given the Hepatitis B vaccine.

☐ **DECLINE** to being given the Hepatitis B vaccine.
I do understand that if I decline the vaccination, I may receive it in the future.

_____ _____

(Applicant's Printed Name) *(Applicant's Signature)* *(Date)*

NOTE: Maintain this record for duration of employment plus 30 years

Nursing & Health Services Training Consultants, Inc.
INDEPENDENT CONTRACTOR AGREEMENT

The undersigned consultant acknowledges attainment for one or several of the following contractual services for the NHSTC, INC. agency:

❒ Nursing Care Provider ❒ Nursing Assessment Consultant ❒ Nursing Trainer

It is further acknowledged that:

1. The undersigned shall be deemed an Independent Contractor and is not bonded for any length of time with NHSTC, INC. for employment, partnership, joint venture or other agency associations.

2. The relationship between the undersigned Independent Contractor and NHSTC, INC. is based on the Independent Contractor's decision to work at his/her own discretion with regards to self-scheduling on the available cases/positions.

3. Consistent with the foregoing, NHSTC, INC. will not be responsible or held liable for the following: FICA, Medicare, Federal, State and any other required tax deductions. The undersigned Independent Contractor acknowledges his/her responsibility to pay all of the above mentioned tax liabilities.

4. The undersigned Independent Contractor further acknowledges that he/she is not entitled to any benefits bestowed on an employee of NHSTC, INC., including, pension, profit sharing, unemployment insurance, professional liabilities, overtime, pay bonuses, sick leave, vacation leave, family leave, tuition reimbursement and travel reimbursement.

5. The undersigned Independent Contractor accepts the above mentioned terms for referral of services by NHSTC, INC. and payment strictly for hours worked at the rate of **$_____ per hour.**

Signed on this *(day)* _____ of *(month)* _____ of 20____

_____ _____

Applicant's Printed Name *NHSTC, INC. Representative Print Name*

_____ _____

Applicant's Signature *NHSTC, INC. Representative Signature*

NHSTC, INC.
311 North Charles Street
Baltimore, Maryland 21201
Office: 410.528.5430
Fax: 410.528.5436

Nursing & Health Services Training Consultants, Inc.

HONOR CODE

POSITION APPLIED FOR: _____

NHSTC, INC. HONOR CODE:

1. I will represent NHSTC, INC. to the best of my ability on each and every assignment.

2. I understand that NHSTC, INC. is my contractor and assigns me to various clients whenever services are requested.

3. I understand that NHSTC, INC. will pay me at the rate agreed upon for each assignment.

4. In consideration of NHSTC, INC. introducing me to and providing me work with one or more of its' clients I agree:

    - Not to work directly or indirectly with any NHSTC, INC. client through another agency for **75 days** after the last day that I work with the client through NHSTC, INC.

    - To forfeit all cost related to breach of this agreement.

5. I will not give my contact information (i.e.; home phone number, cell phone number, email address, home address, etc.) to any NHSTC, INC. client.

6. I understand that it is to my advantage to notify NHSTC, INC. immediately when any of their clients contact me.

I hereby certify that the information given on this application is true, correct and complete in every respect.

_____ _____

Applicant's Printed Name *Applicant's Signature* *Date*

_____ _____

Interviewer's Signature *Date*

Nursing & Health Services Training Consultants, Inc.
AUTHORIZATION FOR RELEASE OF INFORMATION

PINKERTON®
CONSULTING & INVESTIGATIONS

DISCLOSURE AND AUTHORIZATION

[IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

Nursing and Health Services Training Consultants, Inc. ("The Company") may obtain information about you for employment purposes from a third party consumer reporting agency. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. Credit history will only be requested where such information is substantially related to the duties and responsibilities of the position for which you are applying. You have the right, upon written request made within a reasonable time, to request whether a consumer report has been run about you and disclosure of the nature and scope of any investigative consumer report and to request a copy of your report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by Pinkerton Consulting and Investigations, 11019 McCormick Road, Suite 120, Hunt Valley, MD, 800-635-1649, or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

New York and Maine applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by **Nursing and Health Services Training Consultants, Inc.** by contacting the consumer reporting agency identified above directly. You may also contact the Company to request the name, address and telephone number of the nearest unit of the consumer reporting agency designated to handle inquiries, which the Company shall provide within 5 days.
New York applicants or employees only: Upon request, you will be informed whether or not a consumer report was requested by **Nursing and Health Services Training Consultants, Inc.**, and if such report was requested, informed of the name and address of the consumer reporting agency that furnished the report. By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.
Oregon applicants or employees only: Information describing your rights under federal and Oregon law regarding consumer identity theft protection, the storage and disposal of your credit information, and remedies available should you suspect or find that the Company has not maintained secured records is available to you upon request.
Washington State applicants or employees only: You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Pinkerton Consulting and Investigations, 11019 McCormick Road, Suite 120, Hunt Valley, MD, 800-635-1649, another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

New York applicants or employees only: By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.
Minnesota and Oklahoma applicants or employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. ☐
California applicants or employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. ☐

Print Name: _____

Signature: _____ Date: _____

Nursing & Health Services Training Consultants, Inc.
BACKGROUND INFORMATION FORM

PLEASE CLEARLY AND COMPLETELY PRINT THE INFORMATION IN THIS FORM.

Last Name _____ First _____ Middle _____

Other Names/Alias _____

Social Security* # _____ Date of Birth* _____

Driver's License # _____ State of Driver's License _____

Present Address _____ Phone Number _____

City/State/Zip _____

Previous Address _____

City/State/Zip _____

Previous Address _____

City/State/Zip _____

Previous Address _____

City/State/Zip _____

Previous Address _____

City/State/Zip _____

Former Employer _____ Position _____ Dates of Employment _____

*This information will be used for background screening purposes only and will not be used as hiring criteria.

[Note: If you do business in Utah, you cannot ask for DOB, driver's license, or SSN until either a confidential offer of employment or at the time the background report will be run.]

Reference Instructions **(please read carefully before completing reference forms)**

NHSTC, Inc. requires three (3) verifiable references: (2) Professional References and (1) Personal Reference- *usually in the form of a Letter of Recommendation.*

The application includes (2) professional reference forms. Please ask Human Resources, if you need additional forms; and if you would prefer to use a Letter of Recommendation Form.

- **References must all be from different individuals, organizations and non-family. (We will not accept 2 or more of the same reference from the same individual and/or organization)**

Professional References

- Complete top numbered section only on the Professional Reference Forms.
- Professional References in most cases should only be from organizations to which you have provided direct care/ services and that can verify your dates of employment, position, and experience. **(Personal contacts/numbers are acceptable in some cases only)**
- Personal contacts/numbers are acceptable only, if the individual is someone you have provided direct care/ services to- such as a private duty case; or if the individual has a very small-run organization (run by several individuals)

(Please check with Human Resources if your Professional References do not fit the criteria above)

Personal Reference / Letter of Recommendation

- May be handwritten or typed and must include contact information (name and number/ or email).
- May be written by a work colleague, supervisor, professor, or anyone else who can attest to your work ethic and character.
- May not be written by someone who is also a Professional Reference.

Specialty/Interest

- If you are interested in the Pediatric Division, please make sure to include at least one verifiable reference that demonstrates your pediatric experience (**pediatric direct patient care within the last two (2) years**).
- Also, if you have a specialty/interest, please provide a reference that demonstrates your experience in your specialty/interest.

Nursing & Health Services Training Consultants, Inc.

PROFESSIONAL REFERENCE FORM

Applicant, please clearly and completely fill out all information in the numbered sections only.

1 Company: _____

Address: _____

_____

Phone #:_____

Fax #: _____

2 A. My position with this employer was:

❒RN ❒LPN ❒CNA ❒Other_____

B. I was employed from: _____to:_____

C. This reference serves as verification of my:
❒Pediatric Experience ❒Clinical Experience ❒N/A

3 **AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize NHSTC, Inc. to investigate and obtain any information relating to my employment and any pertinent information regarding my work performance and history, whether such information is favorable or unfavorable to me. I hereby, release the above mentioned company (listed in box 1) and its agent from any and all liability and claims with respect to furnishing such information. I acknowledge that a fax, image, or copy of this authorization is as valid as the original.

_____ _____ _____

Print Applicant Name **Applicant's Signature** **Date**

APPLICANT- DO NOT WRITE BELOW THIS LINE

To be completed by Supervisor or Head of Department:

	Outstanding	Good	Poor	N/A
Knowledge				
Punctually				
Performance				
Cooperation				
Dependability				
Personality				

Position Held: _____

Type of Work Performed: _____

Would You Consider Applicant for Rehire? ❒ Yes ❒ No Reason for Leaving: _____

Dates of Employment: from: _____ to: _____

- COMAR 10.09.53.03 D. requires PDN agencies to "ensure" each nurse rendering services to a pediatric patient has at least 1 year of clinical experience which includes pediatric direct patient care within the last 2 years. Any consideration of placement with NHSTC, Inc. is dependent upon verification of the following:
- Did the Applicant have any Pediatric experience within the Past 2 Years? ❒ Yes ❒ No

Person Completing this Form Signature **Title**

Print Name **Date**

Office Use Only: ❒ Via Verbal: *(*Complete information above and write name of person and title providing information)*

HR Representative Signature: _____ **Date:** _____

Nursing & Health Services Training Consultants, Inc.

PROFESSIONAL REFERENCE FORM

Applicant, please clearly and completely fill out all information in the numbered sections only.

1 Company: _____

Address: _____

_____

Phone #:_____

Fax #: _____

2 A. My position with this employer was:

❒RN ❒LPN ❒CNA ❒Other_____

B. I was employed from: _____to:_____

C. This reference serves as verification of my:
❒Pediatric Experience ❒Clinical Experience ❒N/A

3 **AUTHORIZATION FOR RELEASE OF INFORMATION**

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_____ _____ _____

Print Applicant Name **Applicant's Signature** **Date**

APPLICANT- DO NOT WRITE BELOW THIS LINE

To be completed by Supervisor or Head of Department:

	Outstanding	Good	Poor	N/A
Knowledge				
Punctually				
Performance				
Cooperation				
Dependability				
Personality				

Position Held: _____

Type of Work Performed: _____

Would You Consider Applicant for Rehire? ❒ Yes ❒ No Reason for Leaving: _____

Dates of Employment: from: _____ to: _____

- COMAR 10.09.53.03 D. requires PDN agencies to "ensure" each nurse rendering services to a pediatric patient has at least 1 year of clinical experience which includes pediatric direct patient care within the last 2 years. Any consideration of placement with NHSTC, Inc. is dependent upon verification of the following:
- Did the Applicant have any Pediatric experience within the Past 2 Years? ❒ Yes ❒ No

Person Completing this Form Signature **Title**

Print Name **Date**

Office Use Only: ❒ Via Verbal: *(*Complete information above and write name of person and title providing information)*

HR Representative Signature: _____ **Date:** _____

Personnel Payroll Form / Change Form

OFFICE USE ONLY

Contractor # _____

Pay Rate: $_____

Date of Hire: _____

Date: _____

RE: ❒NEW ENTRY ❒INFORMATION CHANGE

PLEASE CLEARLY AND COMPLETELY PRINT THE INFORMATION IN THIS FORM.

Name: _____
First **MI** **Last**

Address: _____

City, State, Zip Code: _____

SSN: _____

Date of Birth: _____

Home Phone: _____

Mobile Phone: _____

Emergency Contact: _____

Emergency Contact #: _____

Check One: ❒ **1099** *(All Independent Contractors; RNs and LPNs ONLY)*
❒ **W2** *(Office Employee or CNAs ONLY)*

# of Exemptions (If W2): _____

Additional Information:

_____

_____

_____

Nursing & Health Services Training Consultants, Inc.

DOCUMENTATION AGREEMENT

I agree to submit any and all documents required by the agency, NHSTC, Inc. in a timely fashion prior to being placed on any assignments and throughout the duration of my employment at NHSTC, Inc.

I also understand that I am to remain fully credentialed for the duration of my contract with the agency.

I am aware that any wages due to me will be held within the office until all documents are submitted and/or my credentials are in compliance with state and federal regulations and company policy.

I have read and agree to all the terms of this agreement.

_____	_____
Applicant's Printed Name	*Witness Signature*
_____	_____
Applicant's Signature	*Date*

02/2013

NURSING & HEALTH SERVICES TRAINING CONSULTANTS, INC.

Please make sure you have all the required documents on this list before calling to schedule an interview. This is a general list; you may be required to submit further documents depending on job position, your classification and/or specialty.

Documents Needed	RN	LPN	CNA/ GNA	PCT/ Comp.
Original Application *(Original – do not fax)*	✓	✓	✓	✓
Driver's License or Gov't-issued ID *(must submit in person to HR Associate)*	✓	✓	✓	✓
Social Security Card *(must submit in person to HR Associate)*	✓	✓	✓	✓
Permanent Resident Card *(if applicable)* *(must submit in person to HR Associate)*	✓	✓	✓	✓
CPR Card	✓	✓	✓	✓
First Aid Card			✓	✓
Resume	✓	✓	✓	✓
Professional Liability Certificate*	✓	✓	*	
Two (2) Professional References**	✓	✓	✓	✓
One (1) Letter Recommendation**	✓	✓	✓	✓
Physical Exam- (No older than a (1) year) *DC Applicants Only- (No older than 6 months)*	✓	✓	✓	✓
TB Results- Annual PPD or Chest X-Ray Results	✓	✓	✓	✓
Proof of Hepatitis B Series ***(****or you may substitute the declination form in the application packet)*	✓	✓	✓	✓
Proof of immunity to MMR, Varicella, Tetanus (titer) *(Preferred, but not required)*			✓	✓

IMPORTANT INFO---PLEASE READ

***Professional Liability Certificate**

- If you do not have Professional Liability Insurance, you may choose to obtain it from **Nurse Service Organization (NSO); www.nso.com or 1-800-247-1500** or any other company that offers it.
- CNA/ GNA- Professional Liability Certificate is not required upon initial interview and orientation; however it may be required at a later time.

****** Professional References and Letter of Recommendation:

- References must all be from different individuals, organizations and non-family.
- Professional References may only be from an organization or someone to whom you have provided direct care (Not a family/friend).
- If interested in the pediatric division, please include at least one reference that verifies pediatric experience within the past two years.
- If you have a certain specialty/interest, please include at least one verifiable reference that demonstrates your experience in your specialty/interest.

YOU MAY SUBMIT DOCUMENTS TO HUMAN RESOURCES VIA:

FAX: (410) 528-5436
DROP OFF: 311 N. CHARLES ST., BALTIMORE, MD 21201
EMAIL: HUMANRESOURCES@NURSINGANDHEALTH.COM

* If you choose to drop off documents, please remember that all interviews must be scheduled in advance. First gather your documents, and then call (410) 528-5430 to schedule an interview.