AC Nursing & Health Services Inc.

APPLICATION FOR EMPLOYMENT

Position Applying For: ***(Please Check)*** **PSW ☐ RPN ☐ RN ☐ ICU ☐ CCU ☐ ER ☐ Other: _____**

EMAR ☐ SURGONC ☐ L&D ☐ NICU ☐ MENTAL HEALTH ☐ PEDS ☐ OTHER:

PERSONAL INFORMATION *(Please PRINT)*

LAST OR FAMILY NAME	**FIRST NAME**	**INITIALS**

STREET ADDRESS	**APT#**	**CITY**	**POSTAL CODE**

HOME TELEPHONE NUMBER	**CELL NUMBER**	**CELL PHONE PROVIDER**

******IMPORTANT:*** Cell phone provider must be filled in so that text messages can be sent automatically from our email to your phone***

EMAIL ADDRESS	**SIN NUMBER**	**DATE OF BIRTH**

MAIN INTERSECTION:

Are you legally entitled to obtain employment in Canada? **YES** ☐ **NO** ☐

Have you had a **VULNERABLE SECTOR SCREENING** done in the last 12 months? **YES** ☐ **NO** ☐

Police or security checks are commonly done in health agencies and facilities. Do not take it personally.
This check is done to prevent the hire of the rare individual who may have a criminal history that could put the client at risk

COMMUNICATION: *(Please check or name the languages you can communicate in the most fluently.)*

	Read	Write	Speak
English	☐	☐	☐
French	☐	☐	☐

Other: _____

CERTIFICATION:

Do you have a current certificate in (last 24 months) Please check appropriate box.

FIRST AID **YES** ☐ **NO** ☐ BCSL ☐ Specialty Certificates ☐

CPR **YES** ☐ **NO** ☐ ACLS ☐ Please Specify_____

INFORMATION:

Means of Travel: Car □ Public Transit □

Have you worked with clients in: Home Care □ Facilities: Long Term Care □ Acute Care □

What type of clients do you like to take care of? _____

_____

Have you cared for clients who have special needs (example: Alzheimer's, Palliative Care, AIDS, Paralyzed, Brain injury or other)?

_____

Are you comfortable being assigned to clients who have pets? Yes____No_____

Please tell us anything else about yourself which will help us to assign you to cases which **BEST** suit your skills and experience.

_____

_____

AVAILABILITY:

I wish to begin work on: *(Date)*_____PREFER: DAYS_____NIGHTS_____

EDUCATION: *(Highest level completed in CANADA)*

_____ _____

Name of Course Institution

_____ _____ Finished Program: YES □ NO □

Length of Course Year Completed

EXTRA CERTIFICATIONS/TRAINING:

CERTIFICATE/TRAINING	Certificate Obtained Yes/No		Months/Years of Experience	Describe Experience
ICU				
CCU				
ER				
MENTAL HEALTH				
POST PARTUM				
REHABILITATION				
OTHER:				

OTHER EDUCATION: *(include courses/programs from other Provinces or Countries where applicable)*

Name of Course:_____ Year of Completion: _____

Name of Course:_____ Year of Completion: _____

EMPLOYMENT: ***(Present or most recent employer)***
PLEASE ENSURE THAT WE CAN CONTACT YOUR 2 PROFESSIONAL REFERENCES.

1. MANAGER OR DIRECT SUPERVISOR

Name of Employer	Address	Telephone Number
Position Held	Dates Employed	Supervisor

Rate of Pay_____

Have you notified your reference that we will be contacting them? **YES ☐ NO ☐**

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2. DIRECT SUPERVISOR OR PRECEPTOR

Name of Employer	Address	Telephone Number
Position Held	Dates Employed	Supervisor

Rate of Pay_____

Have you notified your reference that we will be contacting them? **YES ☐ NO ☐**

PERSONAL REFERENCES: ***(example: Pastor, Doctor, Colleague, Priest, NO Family members or Friends may be used)***

NAME OF RERERENCE	ADDRESS	TELEPHONE NUMBER

I certify that the statements made by me in this application are true and complete to the best of my knowledge.
This written consent below allows AC Nursing & Health Services Inc. to contact the individuals identified as references on this candidates application form.
The purpose of this information is to request an appraisal of the candidates work performance, areas of strength and areas for improvement, from the individuals identified as employment references.
Personal references are asked to identify the personal strengths and characteristics, which would make this candidate a successful employee.
AC Nursing & Health Services Inc. will adhere to the Freedom of Information Act, and will maintain the confidentiality of the employee information gained from the reference check process.

I hereby give AC Nursing & Health Services Inc. my permission to request information
1. Regarding previous work performance from the work references indicated on my application form.
2. Personal references I have identified may also be contacted, for the purposes stated in the consent above.

Employee Signature _____ Date _____

EMPLOYEE CONFIDENTIALITY AGREEMENT

The confidentiality of information concerning a client's physical, psychological, financial and social health is fundamental to the security of the clients we serve.

As an employee of AC Nursing & Health Services Inc you will have information given to you about the personal matters of clients and their families. This information may come to you from different sources, an electronic form, in written form or spoken. This private client information is to be used for the client's benefit. All information about a client from any source belongs to the client and is not be repeated to any one outside the health care team caring for the client.
AC Nursing & Health Services Inc, will not release any personal information concerning the client, without the permission of a person(s) designated by the AC Nursing & Health Services Inc Chief Executive Officer or delegate. This person(s) has been delegated to access and disclose client health information and act as a representative of AC Nursing & Health Services Inc when dealing with referring health care client information.

I hereby acknowledge that I understand the content and the performance expectations placed on me, by the AC Nursing & Health Services Inc policy regarding client confidentiality and agree to abide by the terms and conditions.

I also understand that failure to comply with the client confidentiality policy is grounds for my immediate dismissal without notice.

_____
Employee Name (Please PRINT)

_____ _____
Employee Signature Date Signed

_____
All-Care Personnel Signature

EMPLOYEE EMERGENCY CONTACT FORM

We need each employee to identify the person(s) they wish AC Nursing & Health Services Inc. to contact should you become involved in an emergency. Please complete the following information for your employee file.

Please print the following information

Employee Full Name: _____

Name of person (s) you wish AC Nursing & Health Services Inc. to contact in case of an emergency:

Contact # 1

Full Name:_____ Home #_____

Relationship:_____ Cell # _____

Contact # 2

Full Name:_____ Home #_____

Relationship:_____ Cell # _____