Peregrine Hospice and Palliative Care **adheres to a policy of equal employment opportunity and equal treatment of clients. It is a corporation that does not discriminate on the ground of race, color, religion, sex, marital status, age, handicap or national origin in the hiring, retention, or promotion of employees; or in services or accomodations offered or provided to our employees or clients.**

POSITION YOU ARE APPLYING FOR

EMPLOYEE APPLICATION

PERSONAL INFORMATION

If you need more space to answer any item, you may use the back page indicating the number of each item to which it refers.

NAME OF APPLICANT				DATE OF APPLICATION
ADDRESS STREET	CITY		STATE	ZIP CODE
HOME PHONE NUMBER	MOBILE PHONE NUMBER	WORK PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS

HOW DO YOU PREFER TO BE CALLED BY THE COMPANYWHEN THERE IS PATIENT REFERRAL?
☐ HOME PHONE ☐ MOBILE PHONE ☐ WORK PHONE ☐ FAX ☐ EMAIL

OTHER NAMES UNDER WHICH YOU HAVE WORKED

WHERE DID YOU HEAR ABOUT PEREGRINE HOSPICE?

IF YOU ARE UNDER 18 AND WE REQUIRE A WORK PERMIT, CAN YOU FURNISH ONE? IF NO, EXPLAIN.

ARE YOU A CITIZEN OF THE UNITED STATES? ☐ YES ☐ NO
IF NOT, ARE YOU LEGALLY ALLOWED TO WORK IN THE UNITED STATES? ☐ YES ☐ NO

*HAVE YOU EVER BEEN CONVICTED OF ANY CRIME OTHER THAN A MINOR TRAFFIC VIOLATION? ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN AND STATE THE CHARGE, THE COURT, THE DATE, AND DISPOSITION OF THE CASE.

** HAVE YOU EVER BEEN CONVICTED OF A FEDERAL CRIME, AS DEFINED IN 24 USC 1320 A7 (I), OR BEEN EXCLUDED FROM PARTICIPATION IN ANY FEDERAL OR STATE HEALTHCARE PROGRAM? ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN AND STATE THE CHARGE, THE COURT, THE AGENCY THAT EXCLUDED YOU, AND DISPOSITION OF THE MATTER.

*** ARE YOU ABLE TO PERFORM THE ESSENTIAL FUNCTIONS OF THE POSITION FOR WHICH YOU ARE APPLYING, EITHER WITH OR WITHOUT REASONABLE ACCOMMODATIONS? ☐ YES ☐ NO
IF NECESSARY, PLEASE DESCRIBE WHAT TYPE OF REASONABLE ACCOMMODATIONS ARE NEEDED.

EMPLOYMENT DESIRED

POSITION YOU ARE APPLYING FOR	DESIRED RATE or COMPENSATION	DATE AVAILABLE TO START

TYPE OF EMPLOYMENT
☐ FULL TIME ☐ PART TIME ☐ TEMPORARY

ARE YOU ABLE TO WORK OVERTIME?
☐ YES ☐ NO

WHY DO YOU WANT TO WORK IN A HOSPICE SETTING?

HAVE YOU EVER WORKED FOR ANOTHER HOSPICE? ☐ YES ☐ NO

WHICH GEOGRAPHIC AREAS DO YOU PREFER TO VISIT PATIENTS?

WHAT ARE YOUR GOALS AND EXPECTATIONS WORKING FOR HOSPICE?

EMPLOYMENT HISTORY

Please fill out completely. List current or most recent job and all work experiences in reverse chronological order for the past 8 years. In order to verify information, please indicate the name under which you were employed, if different.

DATE FROM: TO:	POSITION HELD	STARTING SALARY: ENDING SALARY:
NAME OF COMPANY	NAME OF CURRENT SUPERVISOR	PHONE NUMBER MAY WE CONTACT? ☐ YES ☐ NO
ADDRESS		
RESPONSIBILITIES		
REASON FOR LEAVING		

DATE FROM: TO:	POSITION HELD	STARTING SALARY: ENDING SALARY:
NAME OF COMPANY	NAME OF CURRENT SUPERVISOR	PHONE NUMBER MAY WE CONTACT? ☐ YES ☐ NO
ADDRESS		
RESPONSIBILITIES		
REASON FOR LEAVING		

DATE FROM: TO:	POSITION HELD	STARTING SALARY: ENDING SALARY:
NAME OF COMPANY	NAME OF CURRENT SUPERVISOR	PHONE NUMBER MAY WE CONTACT? ☐ YES ☐ NO
ADDRESS		
RESPONSIBILITIES		
REASON FOR LEAVING		

DATE FROM: TO:	POSITION HELD	STARTING SALARY: ENDING SALARY:
NAME OF COMPANY	NAME OF CURRENT SUPERVISOR	PHONE NUMBER MAY WE CONTACT? ☐ YES ☐ NO
ADDRESS		
RESPONSIBILITIES		
REASON FOR LEAVING		

EMPLOYMENT HISTORY

Please fill out completely. List current or most recent Job and all work experiences in reverse chronological order for the past 8 years In order to verify information, please indicate the name under which you were employed, if different

DATE FROM: TO:	POSITION HELD	STARTING SALARY: ENDING SALARY:
NAME OF COMPANY	NAME OF CURRENT SUPERVISOR	PHONE NUMBER MAY WE CONTACT? ☐ YES ☐ NO
ADDRESS		
RESPONSIBILITIES		
REASON FOR LEAVING		

DATE FROM: TO:	POSITION HELD	STARTING SALARY: ENDING SALARY:
NAME OF COMPANY	NAME OF CURRENT SUPERVISOR	PHONE NUMBER MAY WE CONTACT? ☐ YES ☐ NO
ADDRESS		
RESPONSIBILITIES		
REASON FOR LEAVING		

DATE FROM: TO:	POSITION HELD	STARTING SALARY: ENDING SALARY:
NAME OF COMPANY	NAME OF CURRENT SUPERVISOR	PHONE NUMBER MAY WE CONTACT? ☐ YES ☐ NO
ADDRESS		
RESPONSIBILITIES		
REASON FOR LEAVING		

DATE FROM: TO:	POSITION HELD	STARTING SALARY: ENDING SALARY:
NAME OF COMPANY	NAME OF CURRENT SUPERVISOR	PHONE NUMBER MAY WE CONTACT? ☐ YES ☐ NO
ADDRESS		
RESPONSIBILITIES		
REASON FOR LEAVING		

REFERENCES

Please furnish the names, addresses, and telephone numbers of three individuals to whom you are not related and by whom you have not been employed.

NAME	RELATION	PHONE NUMBER
ADDRESS STREET	CITY	STATE ZIP CODE
NAME	RELATION	PHONE NUMBER
ADDRESS STREET	CITY	STATE ZIP CODE
NAME	RELATION	PHONE NUMBER
ADDRESS STREET	CITY	STATE ZIP CODE

EDUCATIONAL BACKGROUND

HIGH SCHOOL	DID YOU GRADUATE?	YEAR OF GRADUATION
ADDRESS STREET	CITY	STATE ZIP CODE
COLLEGE or UNIVERSITY	DEGREE RECEIVED	YEAR OF GRADUATION
ADDRESS STREET	CITY	STATE ZIP CODE
POST GRADUATE	DEGREE RECEIVED	YEAR OF GRADUATION
ADDRESS STREET	CITY	STATE ZIP CODE
VOCATIONAL or TECHNICAL SCHOOL	DEGREE RECEIVED	YEAR OF GRADUATION
ADDRESS STREET	CITY	STATE ZIP CODE

SKILLS INVENTORY

Mark any of the following in which area you are proficient.

- ☐ Focal Point (Visitrack)
- ☐ Word Processing
- ☐ Word Perfect
- ☐ Windows XP
- ☐ Microsoft Word
- ☐ Microsoft Excel
- ☐ Microsoft Powerpoint
- ☐ MapQuest or similar
- ☐ Data Bases
- ☐ Quick Books
- ☐ Quicken
- ☐ Adobe Programs
- ☐ Others: _____

LANGUAGE

- ☐ English
- ☐ Spanish
- ☐ Portuguese
- ☐ Arabic
- ☐ Japanese
- ☐ Chinese
- ☐ Vietnamese
- ☐ Filipino
- ☐ French
- ☐ Italian
- ☐ German
- ☐ Russian
- ☐ Others: _____

PROFESSIONAL BACKGROUND Mark any of the following to indicate your experience.

EXPERIENCE

☐ Cardiac Rehab	☐ Medical	☐ Orthopedics	☐ Respiratory
☐ Education	☐ Med/Surg	☐ Outpatient Clinic	☐ Skilled Nursing Facility
☐ Emergency Department	☐ Neonatology	☐ Pediatric	☐ Surg ICU/Trauma
☐ Home Health	☐ Neurology/Neurosurgery	☐ Ped ICU	☐ Surgery
☐ Hospice	☐ Nursing	☐ Ped Oncology	☐ Telemetry
☐ ICU/CCU	☐ OB/GYN/Nursery	☐ Physician Practice	☐ Urology
☐ Intermediate Care or DOU	☐ Oncology	☐ Psychiatric	☐ Wound Care
☐ Isolation	☐ Operating Room	☐ Rehabilitation	

MEMBERSHIP IN PROFESSIONAL ORGANIZATIONS

* The applicant is required to submit these documents to the employer upon registration.

CERTIFICATION AND LICENSE

DESCRIPTION	DETAILS	EFFECTIVE DATE	EXPIRATION DATE
☐ SOCIAL SECURITY CARD			
☐ **PROFESSIONAL LICENSE**			
☐ MALPRACTICE INSURANCE			
☐ INS AUTHORIZATION			
☐ DRIVER'S LICENSE			
☐ AUTO INSURANCE			
☐ **CPR CERTIFICATION**			
☐ PHYSICAL EXAMINATION			
☐ CHEST X-RAY/TB TEST			
☐ HEPATITIS B			
☐ OTHER			

*** You are required to take these tests if you are:** Please take time to answer the test/s that pertain to your profession. It is part of our screening process	**TOTAL**
☐ BASIC PROFICIENCY (RN/LVN)	
☐ INTRAVENOUS THERAPY (RN)	
☐ SKILLS ASSESSMENT (CHHA)	

I certify that my answers are true and complete to the best of my knowledge. I authorize **Peregrine Hospice** to make such investigations and inquiries of my personal, employment, educational, financial, or medical history and other related matters as may be necessary for an employment decision. I hereby release employers, shcools or persons from all liability in responding to inquiries in connection with my application.

In the event I am employed, I understand that false or misleading information given in my application or interviews may result in termination.

SIGNATURE OF APPLICANT

DATE