



18151 West Catawba Avenue • Cornelius, NC 28031
Phone: (844) 866-1866 • Fax: (704) 987-4250

PLEASE PRINT

Date: ___/___/___

Position Applying For:

Registered Nurse

Licensed Practical Nurse

Other/Comments: _____

PERSONAL INFORMATION

Name _____
(Last) (First) (Middle Initial) (Maiden Name)

Address _____
(Street, Route, PO Box)

(City) (State) (Zip Code) (County)

Home Phone () _____ Work Phone () _____

Cell Phone () _____ Email Address _____

Have you been a resident of North Carolina for the past five (5) years? Yes No
(If "No," please list your previous out-of-state address below.)

(Street, Route, PO Box)

(City) (State) (Zip Code) (County)

Person to be notified in case of an emergency _____
(Last Name) (First)

(Address) (Phone #) (Relationship to)

Availability: Full-Time OR Part-Time _____
(Days and Hours Available)

Acceptable Compensation \$ _____ Date Available to Start ___/___/___

Do you have a valid driver's license? Yes _____
 No _____
(Number) (State) (Class)

How did you hear about Zoom Sourcing?
____ Newspaper ad, if so which newspaper? _____
____ Current employee of Zoom Sourcing, if so who? _____
____ Received card in the mail about Zoom Sourcing.
____ Web site (zoomsourcingnc.com)
____ Other _____

EMPLOYMENT HISTORY

Start with present employer and work back. Use additional sheets if necessary.

1.

| EMPLOYER | JOB TITLE | DATES | |
|----------|------------|-------------------------------|-----------|
| | | Starting | Ending |
| ADDRESS | | SALARY | |
| | | \$ Starting | \$ Ending |
| PHONE # | SUPERVISOR | # OF PEOPLE SUPERVISED BY YOU | |
| | | | |
| DUTIES | | REASON FOR LEAVING | |
| | | | |

2.

| EMPLOYER | JOB TITLE | DATES | |
|----------|------------|-------------------------------|-----------|
| | | Starting | Ending |
| ADDRESS | | SALARY | |
| | | \$ Starting | \$ Ending |
| PHONE # | SUPERVISOR | # OF PEOPLE SUPERVISED BY YOU | |
| | | | |
| DUTIES | | REASON FOR LEAVING | |
| | | | |

3.

| EMPLOYER | JOB TITLE | DATES | |
|----------|------------|-------------------------------|-----------|
| | | Starting | Ending |
| ADDRESS | | SALARY | |
| | | \$ Starting | \$ Ending |
| PHONE # | SUPERVISOR | # OF PEOPLE SUPERVISED BY YOU | |
| | | | |
| DUTIES | | REASON FOR LEAVING | |
| | | | |

** May we contact your present employer? Yes No



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RECORD OF EDUCATION

| Name & Address of School | Dates Attended | Did You Graduate? | Degree & Major |
|--------------------------------------|----------------|--|----------------|
| High School | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Will Graduate ___/___/___ | |
| Technical, Business or Trade Schools | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Will Graduate ___/___/___ | |
| College(s) | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Will Graduate ___/___/___ | |
| Graduate School(s) | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Will Graduate ___/___/___ | |

REFERENCES

LIST 3 PEOPLE WHO ARE NOT RELATED TO YOU AND HAVE DEFINITE KNOWLEDGE OF YOUR QUALIFICATIONS AND FITNESS FOR THE POSITION FOR WHICH YOU ARE APPLYING.

- | NAME | OCCUPATION | RELATIONSHIP TO YOU |
|--------------|------------|---------------------|
| | | |
| PHONE NUMBER | ADDRESS | |
| | | |
- | NAME | OCCUPATION | RELATIONSHIP TO YOU |
|--------------|------------|---------------------|
| | | |
| PHONE NUMBER | ADDRESS | |
| | | |
- | NAME | OCCUPATION | RELATIONSHIP TO YOU |
|--------------|------------|---------------------|
| | | |
| PHONE NUMBER | ADDRESS | |
| | | |



IMMIGRATION REFORM AND CONTROL ACT OF 1986

EMPLOYMENT VERIFICATION SYSTEM

Employment with Zoom Sourcing, Inc. will be contingent upon documentation of your identity and eligibility to work for wages in the United States and completion of Immigration and Naturalization Service Form I-9.

PRE-EMPLOYMENT RELEASE STATEMENT

As certified on the attached Employment application, I declare that my answers are true and I, the undersigned do hereby authorize Zoom Sourcing, Inc. (the company) to obtain and/or examine pre-employment information, including references from previous employers, personal and business references, criminal records on file, Department of Motor Vehicle records, and professional licenses, certifications, and registrations.

I do understand I am waiving my right to confidentiality regarding this pre-employment information. I also hereby release the company and its employees, officers, agents and affiliates from any and all claims, rights or actions or liability of any kind or nature that may result from information obtained from the above sources.

I understand that the completion of this application does not assure me of a position with Zoom Sourcing, Inc. and does not obligate Zoom Sourcing, Inc. to me in any way.

I further understand that any misleading or incorrect statements or the failure to complete any part of this application not prohibited by law may render this application void and if employed could be cause for immediate discharge.

Signature

_____/_____
Date

AN EQUAL OPPORTUNITY EMPLOYER

It is the Policy of Zoom Sourcing, Inc. not to discriminate in its employment or the provision of services in regard to race, sex, handicap, age, religion, political affiliation, or national origin, unless a bona fide occupational qualification exists.



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| Skills or Procedure | Have never done | Have done but need review/practice | Feel comfortable doing | Comments |
|---|-----------------|------------------------------------|------------------------|----------|
| Establishing Medication Regimen: | | | | |
| 30) Injections | | | | |
| 31) IM | | | | |
| 32) Sub Q | | | | |
| 33) Intradermal | | | | |
| 34) Z Track | | | | |
| 35) Pain Management | | | | |
| IV Therapy: | | | | |
| 36) Peripheral | | | | |
| 37) Hickman Catheter | | | | |
| 38) Port-A-Cath | | | | |
| 39) Groshong Catheter | | | | |
| 40) Prn Adapters | | | | |
| 41) Venipunctures | | | | |
| 42) Tracheostomy | | | | |
| 43) Trach Tube Change | | | | |
| 44) Suctioning | | | | |
| 45) NG Tube Insertion | | | | |
| 46) Gastrostomy Tube Insertion | | | | |
| 47) Gastrostomy Irrigations | | | | |
| 48) Tube Feedings | | | | |
| Equipment: | | | | |
| 49) Hoyer Lift | | | | |
| 50) Infusion Pump | | | | |
| 51) Oxygen | | | | |
| 52) Humidifier | | | | |
| 53) Ventilator | | | | |
| 54) Suction Machine | | | | |
| 55) Blood Glucose Machine | | | | |
| Category II: | | | | |
| 56) ABG | | | | |
| 57) CPR (Required) | | | | |

Signature

_____/_____/_____
Date



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