

# 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: \_\_\_\_\_  
(Last) (First) (Middle)

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: \_\_\_\_\_

**Prior Work History (Continued)**

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.)

Name of Institution (High School, Technical School, College)	Type of Studies	Dates 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.)

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**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?

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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?

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

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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?

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**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.

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**Applicant's Certification and Agreement (Continued)**

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

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 anytime 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.

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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.

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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 U.S.A. in accordance with the IRCA of 1986.

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5. \_\_\_\_\_ Yes \_\_\_\_\_ No      I understand that this form is not an employment contract.

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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**

**Oklahoma State Department of Health • Nurse Aide Registry Tracking Form**

1000 N.E. 10<sup>th</sup> Street • Oklahoma City, OK 73117-1299 • Telephone: (405) 271-4085

**Submit this form to the Nurse Aide Registry, within 30 days of applicant's employment start date.**

**Personal Information**

Name: \_\_\_\_\_  
(Last) (First) (Middle) (Maiden or Any Other)

Address: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
(Street or P.O. Box) (City) (State) (Zip)

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ M \_\_\_\_\_ F Race: \_\_\_\_\_ Daytime Phone Number: \_\_\_\_\_

**Previous CNA Training - Complete this section only if you will require training at this place of employment.**

If you have had CNA Training in the past for any of the categories of LTC, HHA, ADA, RCA or DDA, please fill out the following:

Category: \_\_\_\_\_ Employer Name: \_\_\_\_\_ Number of Training Days: \_\_\_\_\_  
Category: \_\_\_\_\_ Employer Name: \_\_\_\_\_ Number of Training Days: \_\_\_\_\_  
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**Criminal Arrest Check List**

Employment at this employer shall **not be** considered if the below signed individual has been convicted of one of the following crimes as stated by Oklahoma Statute, Section 1-1950.1 (F) (1) Title 63 (A through P of the list in this section):

- A. Assault, battery or assault and battery with a dangerous weapon
- B. Aggravated assault and battery
- C. Murder or attempted murder
- D. Manslaughter except involuntary manslaughter
- E. Rape, incest or sodomy
- F. Indecent exposure and Indecent exhibition
- G. Pandering
- H. Child abuse
- I. Abuse, neglect or financial exploitation of any person entrusted to his care or possession
- J. Burglary in the first or second degree
- K. Robbery in the first or second degree
- L. Robbery or attempted robbery with a dangerous weapon, or imitation firearm
- M. Arson in the first or second degree
- N. Unlawful possession or distribution, or intent to distribute unlawfully, Schedule I through V drugs as defined by the Uniform Controlled Dangerous Substance Act.
- O. Grand larceny, or
- P. Petit larceny or shoplifting within the past seven (7) years.

It is further understood that if I am hired, it will be as a temporary employee until my criminal background check is received by the employer. If I have no criminal record in accordance with state law, I may be considered for employment, subject to training requirements and other requirements of the job for which I am applying with this employer.

I hereby certify that I have no previous convictions as listed in the Oklahoma Statute, Section 1-1950.1 (F) (1) Title 63 (A through P of the list in this section). My signature below authorizes the employer to run a check with the Nurse Aide Registry of the Oklahoma State Department of Health for notations of abuse, neglect or misappropriation of resident's property. I hereby give the Oklahoma State Department of Health and the Oklahoma State Bureau of Investigations authority to proceed with criminal record history checks as required by law.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date of Signature

**This section to be completed by the employer. Please do not detach this section, submit the whole page to the department.**

**Employer/Applicant Information**

Employment Start Date: \_\_\_\_\_

- The applicant is:  A Certified Nurse Aide in the state of Oklahoma  
 Providing services as a Personal Care Assistant in a Medicaid-certified home health agency.  
 Enrolled in a training program – Training Start Date: \_\_\_\_\_  
 (The training date must be supplied unless applicant is certified or a PCA)

Employer Name: \_\_\_\_\_ Employer Type: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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Date of Application \_\_\_\_\_

Date Available to Start Work \_\_\_\_\_

## Personal Information

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
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Phone Number: \_\_\_\_\_ Emergency Contact Person: \_\_\_\_\_  
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## Employment Desired

Position applied for: \_\_\_\_\_ Salary required: \_\_\_\_\_

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May we contact your present employer?  Yes  No  Not applicable

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

Name of Institution (High School, Technical School, College)	Type of Studies	Dates Attended & Diplomas, etc.

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5. \_\_\_\_\_ Yes \_\_\_\_\_ No

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**Signature of Applicant**

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**Date of Signature**

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Personal Information

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Address: (Street or P.O. Box) (City) (State) (Zip) Social Security Number:

Date of Birth: Sex: M F Race: Daytime Phone Number:

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P. Petit larceny or shoplifting within the past seven (7) years.

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Signature of Applicant

Date of Signature

This section to be completed by the employer. Please do not detach this section, submit the whole page to the department.

Employer/Applicant Information

Employment Start Date:

- The applicant is: [ ] A Certified Nurse Aide in the state of Oklahoma
[ ] Providing services as a Personal Care Assistant in a Medicaid-certified home health agency.
[ ] Enrolled in a training program -- Training Start Date:
(The training date must be supplied unless applicant is certified or a PCA)

Employer Name: Employer Type:

Employer Address: Phone Number: