Offer of Employment

Applicant: _____ Date of Offer: _____

Position: _____ Offer Accepted: Yes □ No □

Offer Made By: _____ Rate of Pay: _____

Probationary Period: ___ Hours Status: Active □ Inactive □

Following section to be completed only if offer of employment is accepted.

Date of birth: ____ / ____ / 19 ____ SS #: _____
Day Month Year

Marital Status: Single □ Married □ Separated □ Divorced □ Widowed □

Do you have any physical or mental condition that may limit your ability to perform certain kinds of work?

Yes □ No □ If YES please describe the condition and any work limitations it may impose on you.

_____

_____

Persons to be notified in case of accident or emergency:

Name	_____	_____
Relationship	_____	_____
Address	_____	_____
	_____	_____
Home Phone	_____	_____
Work Phone	_____	_____
Cell Phone	_____	_____

_____ _____

Manager/Supervisor Signature Date

I, _____, understand that to remain as an independent contractor with 1st Nurse Registry, I must ensure completion of my file every 3 months with updated documents or as required by regulations governing the agency and its contractors.

_____ _____

Caregiver Signature Date

1st Nurse Registry
2215 N. Military Trail, Suite O, West Palm Beach, FL 33409
Phone: 561-948-2010 Fax: 561-948-2012
Email: Office@1stNurseRegistry.com
www:1stNurseRegistry.com