



Sun Healthcare Group, Inc.

Dear Applicant,

Thank you for your interest in a position with a subsidiary of Sun Healthcare Group, Inc.

An employment application is attached. Please keep the following in mind as you are completing the application:

- ✓ Print clearly.
- ✓ Read each section carefully and answer each question completely and honestly. If you are not clear about a particular question or section, please ask the hiring manager to clarify for you.
- ✓ **Sun Healthcare Group, Inc. and its subsidiaries are committed to the ethical care and quality of life for our patients, residents, and employees. We conduct a comprehensive background screening on all applicants who receive a conditional offer of employment. The offer is conditioned upon the successful completion of the background screening.**
 - **Misstatements or omissions in the application shall be grounds for rejection of the application and in the event you are hired, grounds for employment termination.**
 - **Criminal convictions from any time period must be disclosed.** This includes any misdemeanors, felonies, and traffic offenses that are not considered minor traffic violations. Please be aware that circumstances involving fines, restitution, guilty pleas, probation, etc. can be considered convictions (e.g. bad check offenses, open container violations, DUI, DWI, etc.) If you are unsure about a particular circumstance, please disclose the information. This information is not an absolute bar to employment, but will be considered when making employment eligibility determinations.
 - Some states require that the applicant submit fingerprints for criminal background screening purposes. If applicable, the hiring manager will notify you of this requirement.
 - This hiring location is a drug-free workplace. If offered a position, all prospective employees are required to submit to a pre-employment drug test.
 - Motor vehicle record and/or credit checks may be required for certain job positions.
 - If you are a licensed or certified applicant, be prepared to present your credentials for verification purposes.
- ✓ If hired, you will also be responsible for providing documentation as proof of your identity and eligibility to work in the United States.
- ✓ Sign and date the application where indicated.

If you have additional questions, feel free to ask the hiring manager.



EMPLOYMENT APPLICATION

Sun Healthcare Group, Inc. offers Equal Employment Opportunities to all persons without regard to race, religion, age, sex, gender identity, color, national origin, citizenship, marital status, sexual orientation, or disability. No question on this application is intended to secure information to be used for such discrimination. The use of this form does not mean there are positions open and does not obligate us in any manner. Your employment application is held for 6 months. You must reapply if you wish to be considered for employment beyond this period. Should you require reasonable accommodation to participate in the completion of this application, please notify us at the time of the application or when an appointment to complete the application is made.

Personal Information

Form fields for Personal Information: Last Name, First Name, Middle Initial, Social Security Number, Today's Date, Date available to start work, Telephone Number (Daytime), Telephone Number (Evenings), Message Telephone Number, Mailing Address (Number, Street, Apartment number), City, State, Zip, List any other names you have worked under:

Form fields for employment history: Were you previously employed by Sun Healthcare Group, Inc or a subsidiary (including CareerStaff Unlimited)? Yes No, If YES, Date: To: If NO, how were you referred? Advertisement, Employment agency, Employee referral, School, Convention, Direct Mail, Other (specify):

Form fields for relatives: List names and departments of relatives employed by Sun Healthcare Group, Inc. or its subsidiaries (including CareerStaff Unlimited). If additional space is needed, please list on another sheet. Name: Relationship: Department:

Form field: Do you have the legal right to remain and work in the United States? Yes No

Form field: Are you over the age of 18 years? Yes No IF NO, employment is subject to verification that you are of minimum age.

Form fields for criminal record: Have you ever been convicted of a crime (felony or misdemeanor) other than a minor traffic violation? Yes No, Minor traffic violations include speeding tickets, parking citations, seatbelt violations, vehicle inspection violations, etc. DUI, DWI, vehicular homicide, etc. are not considered minor traffic violations and must be disclosed. If your answer to the question above is YES, please list ALL convictions and related dates. (Include major traffic offenses such as DUI, DWI, vehicular homicide, etc.) Please use separate page if necessary. Offense Conviction Date, Felony Misdemeanor

Name: Please note: Conviction of a crime is not an absolute bar to employment; factors such as the nature of the offense and how long ago the offense occurred will be considered to determine employment eligibility. Sun Healthcare Group Inc. and its subsidiaries conduct criminal background checks on all applicants as a condition of employment. Falsification of this information will be cause for denial of employment or termination.

Have you ever been convicted of any offense involving the abuse, neglect, endangerment, or mistreatment of an elder or dependent adult, or any offense involving embezzlement from an elder or dependent adult?

Yes No If YES, please explain.

Have you ever been excluded, debarred, suspended or otherwise determined ineligible for participation in federal or state health care programs?

Yes No If YES, please explain.

Can you perform the functions of the job for which you are applying with or without reasonable accommodation? Yes No

JOB INTEREST

Position(s) for which you are applying:

Check preferred work schedule:

- 1. _____
- 2. _____

- Full-time
- On Call
- Per Diem
- Part-time
- Temporary

AN EQUAL OPPORTUNITY EMPLOYER

EDUCATION INFORMATION

If your school records are under a different name(s), please list those names: _____

Type of School	Name and Location	Years Completed	Major Course of Study	Graduated? (Yes or No)	Degree
High School					
College/University					
Graduate School					
Technical/Business					

Please list any job-related professional, trade, business or civic activities, organizations, fellowships and associations in which you participated or of which you are a member. (You may omit those that indicate race, color, religion, political affiliations, national origin, ancestry, disability, sex or age.)

LICENSURE FOR PROFESSIONAL POSITION

Are you now licensed or certified in your profession or occupation? Yes No In which state(s)? _____

If not licensed in this state, have you applied? Yes No

Professional license, certificate or registration number: _____ Expiration Date: _____

Other Licensure/Certifications: _____ Expiration Date: _____

Has your professional license or certification ever been investigated?

Yes No If YES, please explain.

Has your professional license or certification ever been restricted, limited, or suspended?

Yes No If YES, please explain.

Are you currently involved in any proceeding that could affect your license or certification?

Yes No If YES, please explain.

EMPLOYMENT HISTORY

THE FOLLOWING SECTION MUST BE COMPLETED, EVEN IF ACCOMPANIED BY A RESUME. Starting with your most recent job, accurately list ALL jobs you have held in the past ten (10) years. Give correct address and telephone numbers. Include volunteer experience. If additional space is needed, please list on another sheet of paper.

1.

Name of current/most recent employer

Employer's address (number/street)

City

State

Zip

Dates employed: From _____ To _____

Title (starting): _____

Title (final): _____

Job duties: _____

Starting salary: \$ _____

Ending salary: \$ _____

Hourly Weekly Monthly Annually

May we contact this employer? Yes No

Reason for leaving: _____

Telephone number: (_____) _____

Supervisor (name and title): _____

2.

Name of employer

Employer's address (number/street)

City

State

Zip

Dates employed: From _____ To _____

Title (starting): _____

Title (final): _____

Job duties: _____

Starting salary: \$ _____

Ending salary: \$ _____

Hourly Weekly Monthly Annually

May we contact this employer? Yes No

Reason for leaving: _____

Telephone number: (_____) _____

Supervisor (name and title): _____

3.

Name of employer

Employer's address (number/street)

City

State

Zip

Dates employed: From _____ To _____

Title (starting): _____

Title (final): _____

EMPLOYMENT HISTORY (CONTINUED)

Job duties: _____ Starting salary: \$_____ Ending salary: \$_____

_____ Hourly Weekly Monthly Annually
_____ May we contact this employer? Yes No
Reason for leaving: _____ Telephone number: (_____)_____
_____ Supervisor (name and title): _____

4.

Name of employer _____

Employer's address (number/street) _____ City _____ State _____ Zip _____
Dates employed: From _____ To _____ Title (starting): _____ Title (final): _____
Job duties: _____ Starting salary: \$_____ Ending salary: \$_____

_____ Hourly Weekly Monthly Annually
_____ May we contact this employer? Yes No
Reason for leaving: _____ Telephone number: (_____)_____
_____ Supervisor (name and title): _____

OTHER JOB-RELATED TRAINING/EXPERIENCE

Have you received any specialized training which would qualify you for the position for which you are applying that you have not already listed on this application? If so, please state what training or experience you have had.

PLEASE ENSURE THAT YOUR APPLICATION IS COMPLETE. ANY OMISSIONS MAY BE GROUNDS FOR REJECTION.

**PLEASE READ THE FOLLOWING CAREFULLY
BEFORE SIGNING THIS APPLICATION FORM BELOW**

I hereby certify that I have not knowingly withheld any information that might adversely affect my chances for employment and that the answers given by me are true and correct to the best of my knowledge. I hereby certify that I, the undersigned applicant, have personally completed this application, or have noted the name of the individual assisting me in the completion of this application.

I understand that any omission or misstatement of material fact on this application, or on any document used to secure employment, shall be grounds for rejection of this application, or for immediate discharge if I am employed, regardless of the time elapsed before discovery.

I hereby consent and authorize Sun Healthcare Group, Inc. and its subsidiaries to thoroughly investigate my references, work record, education, and other matters related to my suitability for employment. I further authorize my former employers to disclose to Sun Healthcare Group, Inc. and its subsidiaries any and all letters, reports, and other information related to my work records, without giving me prior notice of such disclosures. In addition, I hereby release Sun Healthcare Group, Inc. and its subsidiaries, my former employers, and all other persons, corporations, partnerships, and associations from any and all claims, demands, or liabilities

arising, or that may arise, out of, or in any way related to, such investigation or disclosure.

I acknowledge and agree that this application will be considered by Sun Healthcare Group, Inc. and its subsidiaries for no longer than 6 months from the date it was made. I understand that nothing contained in the application or conveyed during any interview, which may be granted, is intended to create an employment contract between myself and Sun Healthcare Group, Inc. or its subsidiaries. In addition, I understand and agree that if I am employed, my employment is at will and is for no definite or determinable period and may be terminated at any time, with or without prior notice, and for any reason or no reason, at the option of either myself or Sun Healthcare Group, Inc. or its subsidiaries, and that promises or representations contrary to the foregoing, or given at any time in the future, are not binding. If employed, I will comply with all rules, regulations, instructions, policies and procedures.

I understand that such rules, regulations, policies and procedures do not constitute a contract of employment and are subject to change at any time and without advanced notice.

I understand it is the policy of Sun Healthcare Group, Inc. and its subsidiaries to comply with the Drug-Free Workplace Act of 1988.

I understand that some states in which Sun Healthcare Group, Inc. and its subsidiaries conduct business require healthcare professionals to undergo a job-related physical. I agree to undergo a post-offer/pre-employment physical if employed in any state with such requirement.

APPLICANT'S SIGNATURE

DATE

If this application has been completed by an individual other than the above applicant, please print name here:

CareerStaff

Pharmacist/Pharmacy Technician Self Assessment

Name: _____

Date: _____

Registered Pharmacist

Pharmacy Technician

Please complete the following checklist relative to your professional experience. Be assured this checklist will be used in assessing your clinical proficiency in certain areas.

Level of Experience:

A - No Experience

B - Intermittent Experience

C - One Year of Consistent Experience

D - Two Years of Consistent Experience

E - Able to Teach and Supervise

TYPES OF SETTINGS	A	B	C	D	E
Acute Hospitals:					
Inpatient					
Outpatient					
Trauma/Emergency Room					
Critical Care					
Acute Rehabilitation					
Subacute Facility					
Skilled Nursing Facility					
Long Term Care Facility					
Home Health					
Retail					
Medical Practices					
Other:					
PRACTICE SETTINGS					
Pediatrics					
Psychiatric					
Endocrinology					
Diabetes					
Nuclear Medicine					
Pharmaco Therapy					
Oncology					
Nutritional Support					
Other:					

COMPUTER SYSTEMS (list each system):	A	B	C	D	E
1					
2					
3					
4					

ADDITIONAL INFORMATION

Please list any other areas in which you feel you have extensive experience not included in the skills survey:

LICENSES HELD

State:	Number:	Expiration Date:		State:	Number:	Expiration Date:

CERTIFICATIONS

Certification:	Number:	Date Certified:	Expiration Date:

The information I have given is true and accurate to the best of my knowledge. In addition, I hereby authorize CareerStaff Unlimited to release this Skills Checklist to client institutions in relation to my assignment with that institution.

Signature

Date

Name - please print



Pharmacy Software Skill Check List

Name: _____

Date: _____

Please complete the following checklist relative to your professional experience. Be assured this checklist will be used in assessing your clinical proficiency in certain areas.

Level of Experience:

A - No Experience

B - Intermittent Experience

C - One Year of Consistent Experience

D - Two Years of Consistent Experience

E – Able to Teach and Supervise

No	SOFTWARE	A	B	C	D	E
1	ARX					
2	Cerner					
3	Cerner Millennium					
4	CIPS 8.0 / 9.0					
5	Condor					
6	Connexus					
7	Coram dose based system					
8	FSI (Foundation System Inc)					
9	Group Health software					
10	HBOC					
11	HBS (Health Business Systems)					
12	Innovation					
13	McKesson / McKesson Pharmaserve					
14	Megasource					
15	Meditech					
16	NDC					
17	NRx					
18	PCSI (Pharmacy Computer System Inc.)					
19	PDX					
20	Prodigy Software					
21	PSI					
22	QS1					
23	QS1 (GUI version)					
24	QS1's Rx Care Plus					
25	Renlar					
26	RPMS (Resource & Patient Mgmt System)					
27	RX 2000					
28	ZADALL					

If you are familiar with any other system not listed above, please write down the name of the system that you have used before and the experience level.

No	SOFTWARE	A	B	C	D	E
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

This information I have given is true and accurate to the best of my knowledge. In addition, I hereby authorize CareerStaff RX to release this checklist to client institutions in relation to my assignment with that institution.

Signature

Date

Name – Please print



REFERENCE CHECK FORM #1

Attention Applicants: Please answer the questions in the top portion of the form only.

Date: _____
Applicant Name: _____
Reference Name: _____ Phone: _____
Company Name: _____

FOR INTERNAL USE ONLY

Dates of Employment: From _____ To _____

Position/Positions Held: _____

Salary History: _____

Verify the above information with the supervisor and confirm the reason for leaving. _____

Please describe the type of work for which the candidate was responsible. _____

Please rate the applicant's relationships with coworkers, subordinates (if applicable) and supervisors.

[] Favorable [] Satisfactory [] Unsatisfactory

Please rate the applicant's patient service skills.

[] Favorable [] Satisfactory [] Unsatisfactory

Please rate the applicant's work attitude.

[] Favorable [] Satisfactory [] Unsatisfactory

Please rate the quantity and quality of work generated by the applicant.

[] Favorable [] Satisfactory [] Unsatisfactory

Please rate the applicant's work attendance.

[] Favorable [] Satisfactory [] Unsatisfactory

Please rate the applicant's honesty, dependability and forthrightness.

[] Favorable [] Satisfactory [] Unsatisfactory

Please rate your overall assessment of the applicant.

[] Favorable [] Satisfactory [] Unsatisfactory

Would you recommend him or her for this position?

[] Yes [] No

Would this individual be eligible for rehire?

[] Yes [] No

Other comments: _____

Signature: _____ Date: _____

Title: _____



REFERENCE CHECK FORM #2

Attention Applicants: Please answer the questions in the top portion of the form only.

Date: _____
Applicant Name: _____
Reference Name: _____ Phone: _____
Company Name: _____

FOR INTERNAL USE ONLY

Dates of Employment: From _____ To _____

Position/Positions Held: _____

Salary History: _____

Verify the above information with the supervisor and confirm the reason for leaving. _____

Please describe the type of work for which the candidate was responsible. _____

Please rate the applicant's relationships with coworkers, subordinates (if applicable) and supervisors.

[] Favorable [] Satisfactory [] Unsatisfactory

Please rate the applicant's patient service skills.

[] Favorable [] Satisfactory [] Unsatisfactory

Please rate the applicant's work attitude.

[] Favorable [] Satisfactory [] Unsatisfactory

Please rate the quantity and quality of work generated by the applicant.

[] Favorable [] Satisfactory [] Unsatisfactory

Please rate the applicant's work attendance.

[] Favorable [] Satisfactory [] Unsatisfactory

Please rate the applicant's honesty, dependability and forthrightness.

[] Favorable [] Satisfactory [] Unsatisfactory

Please rate your overall assessment of the applicant.

[] Favorable [] Satisfactory [] Unsatisfactory

Would you recommend him or her for this position?

[] Yes [] No

Would this individual be eligible for rehire?

[] Yes [] No

Other comments: _____

Signature: _____ Date: _____

Title: _____

**NOTICE/AUTHORIZATION AND RELEASE TO OBTAIN A CONSUMER REPORT
(PLEASE PRINT OR TYPE)**

In connection with my application for employment with a subsidiary of **Sun Healthcare Group, Inc. ("Sun subsidiary")**, I authorize **Kroll Background America ("KBA")** or its agents to obtain a consumer report about my background, character or reputation. This report will be used to evaluate my eligibility for hire and continued employment with a **Sun subsidiary**. Depending on the position I hold, I understand that this report may include, but is not limited to, information as to my employment, education, driving record, licensure, certification, social security number verification, criminal record and/or other public records history. I authorize all persons to fully disclose information relevant to any investigation. I release from liability the **Sun subsidiary, KBA**, any and all persons, companies and governmental or other agencies disclosing such information from any and all liability, claims, and/or demands by me or my heirs, or other making such claim or demand on my behalf for providing a consumer report on me. I further authorize that a photocopy of this authorization may be considered as an original. I understand that I am entitled to a complete and accurate disclosure of the nature and scope of any consumer report of which I am the subject upon my written request to **KBA**, if such is made within a reasonable time after the date hereof. I also understand that I may receive a written summary of my rights under 15 U.S.C. § 1681 et seq. **A Sun subsidiary will not be obtaining a credit report and your credit history will not be a factor in whether you are eligible for hire or continued employment.**

I HAVE READ, UNDERSTAND AND AUTHORIZE, ANY PERSON, AGENCY OR OTHER ENTITY CONTACTED BY KROLL BACKGROUND AMERICA, OR ITS AGENTS, TO FURNISH THE ABOVE MENTIONED INFORMATION. I FURTHER UNDERSTAND THAT THIS AUTHORIZATION/RELEASE IS VALID THROUGHOUT MY TERM OF EMPLOYMENT WITH A SUN SUBSIDIARY. I CERTIFY THAT THE INFORMATION IS TRUE AND CORRECT.

THIS FORM WILL NOT BE ACCEPTED IF ALTERED, ILLEGIBLE, OR INCOMPLETE.

DATE: _____

SIGNATURE SOCIAL SECURITY # DRIVER'S LIC. # STATE

_____/_____/_____
DATE OF BIRTH* GENDER (M or F)* POSITION

TYPE OR PRINT NAME (last, first, middle initial) OTHER NAMES USED (alias, maiden, nickname) YEARS USED

CURRENT ADDRESS

STREET/P.O. BOX CITY STATE ZIP COUNTY OF RESIDENCE

PLEASE LIST ALL ADDRESSES FOR LAST SEVEN (7) YEARS (If you need additional space please use the back of this form)

STREET/P.O. BOX CITY STATE ZIP COUNTY DATES LIVED HERE

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Have you ever been convicted of any criminal violation of the law (felony or misdemeanor) other than a minor traffic violation or are you now under pending investigation or charges? Yes No **If yes, please attach a complete explanation.**

Have you ever been sanctioned, disciplined, debarred, and/or excluded by a duly authorized regulatory agency or are there any current restrictions or limits on your license (s) or certification (s)? Yes No **If yes, please attach a complete explanation.**

For healthcare professionals, federal regulations require that credentials for all states must be verified. Please list all licenses and certificates regardless of status (e.g. active, inactive, expired, etc.). If you need additional space, please use the back of this form.

PROFESSIONAL LICENSE (S) OR CERTIFICATION (S) LICENSE OR CERTIFICATION # (S) STATE (S) ISSUED

* This information will enable us to properly identify you in the event we find adverse information during the course of our background investigation.