

May 1, 2014

# ROCK BUSINESS STRATEGIES & SOLUTIONS



Vendor Application – Independent Contractor

FOR: STATE TESTED NURSES ASSISTANT (STNA) CONTRACTOR ONLY

## VENDOR INFORMATION

Last Name				First			M.I.	Date		
Street Address							Apartment/Unit #			
City				State			ZIP			
Phone				E-mail Address						
Date Available				Social Security #			Driver's License #			
Position Applied for	<b>STATE TESTED NURSES ASSISTANT (STNA) – INDEPENDENT CONTRACTOR</b>									
Is your Driver's License Valid?	YES <input type="checkbox"/>		NO <input type="checkbox"/>		Do you have Valid Car Insurance?			YES <input type="checkbox"/>		NO <input type="checkbox"/>
What State is your license in?					Name of Insurance Carrier?					
Have you ever worked for this company?	YES <input type="checkbox"/>		NO <input type="checkbox"/>		If so, when?					
Have you ever been convicted of a felony?	YES <input type="checkbox"/>		NO <input type="checkbox"/>		If yes, explain					

## EDUCATION

High School				Address						
From	To	Did you graduate?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	Degree				
College				Address						
From	To	Did you graduate?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	Degree				
Other/Trade				Address						
From	To	Did you graduate?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	Degree				

## REFERENCES

Please list three professional references.

Full Name				Relationship						
Email				Phone						
Full Name				Relationship						
Email				Phone						

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Full Name		Relationship	
Email		Phone	

**WHAT DAY(S) & TIMES ARE YOU AVAILABLE TO WORK?**

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

**HOW FAR ARE YOU WILLING TO TRAVEL?**

10-15 MILES	15-20 MILES	20-25 MILES	25-30 MILES	30-40 MILES	40 + MILES
<input type="checkbox"/>					

**ARE YOU CURRENTLY WORKING NOW?**

YES  NO

**IF YES, LIST CURRENT EMPLOYER/COMPANY?** \_\_\_\_\_

**ARE YOU STATE TESTED NURSES ASSISTANT (STNA)?**

YES  NO

**WHERE DID YOU RECEIVE YOUR CERTIFICATION FROM?** \_\_\_\_\_

**CAN YOU PERFORM STNA NURSING SERVICES INDEPENDENTLY?**

YES  NO

**ARE YOU CURRENTLY ENROLLED IN A STNA PROGRAM?**

YES  NO

**NAME OF SCHOOL?** \_\_\_\_\_

**DO YOU HAVE A DATE TO TAKE/SIT FOR AN EXAM?**

YES  NO

**IF SO, WHEN DO YOU EXPECT TO HAVE YOUR CERTIFICATION?** \_\_\_\_\_

**HOW MANY YEARS OF EXPERIENCE DO YOU HAVE AS A STNA?**

1-2 YRS	2-3 YRS	3-4 YRS	4+ YRS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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<b>PREVIOUS EMPLOYMENT</b>			
Company		Phone	
Address		Supervisor	
Job Title	Starting Salary	\$	Ending Salary \$
Responsibilities			
From	To	Reason for Leaving	
May we contact your previous supervisor for a reference?    YES <input type="checkbox"/> NO <input type="checkbox"/>			
Company		Phone	
Address		Supervisor	
Job Title	Starting Salary	\$	Ending Salary \$
Responsibilities			
From	To	Reason for Leaving	
May we contact your previous supervisor for a reference?    YES <input type="checkbox"/> NO <input type="checkbox"/>			
Company		Phone	
Address		Supervisor	
Job Title	Starting Salary	\$	Ending Salary \$
Responsibilities			
From	To	Reason for Leaving	
May we contact your previous supervisor for a reference?    YES <input type="checkbox"/> NO <input type="checkbox"/>			

<b>LIST (5) QUALITIES THAT YOU HAVE WHICH WOULD BE AN ASSET TO RBSS AND THE PATIENTS THAT WE SERVICE.</b>	
<b>(1)</b>	<b>(2)</b>
<b>(3)</b>	<b>(4)</b>
<b>(5)</b>	

<b>DISCLAIMER AND SIGNATURE</b>	
I certify that my answers are true and complete to the best of my knowledge.	
I understand that false or misleading information in my vendor application or interview may result in termination of my contract.	
Signature of STNA	Date

**Signature of Team Lead**
**Date**