

APPLICATION FOR EMPLOYMENT

Today's Date: _____ Social Security Number: _____

Name (Last, First, Middle): _____

Address, City, State, Zip: _____

CONTACT INFORMATION:

Home Ph: _____ Cell Ph: _____ E-mail: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Ph: _____

HOW DID YOU HEAR ABOUT US? Internet _____ Referral: _____ Other: _____

POSITION APPLYING FOR: RN LPN CNA Office Staff Date Available to Start: _____

EDUCATION:

High School: _____ City, State: _____ Grad. Date: _____ Degree: _____

College: _____ City, State: _____ Grad. Date: _____ Degree: _____

Grad. School: _____ City, State: _____ Grad. Date: _____ Degree: _____

Other: _____ City, State: _____ Grad. Date: _____ Degree: _____

LICENSURE:

License Type: _____ License #: _____ State: _____ Exp. Date: _____

License Type: _____ License #: _____ State: _____ Exp. Date: _____

License Type: _____ License #: _____ State: _____ Exp. Date: _____

SPECIALTY:

Please check the Specialty Area(s) that best match your education, experience and interest.

- | | | | | |
|------------------------------------|---|---|---|---|
| <input type="checkbox"/> Burn Unit | <input type="checkbox"/> Home Health | <input type="checkbox"/> Med/Surg | <input type="checkbox"/> Ortho | <input type="checkbox"/> PCU |
| <input type="checkbox"/> Cath Lab | <input type="checkbox"/> Hospice | <input type="checkbox"/> MICU | <input type="checkbox"/> PACU/Recovery | <input type="checkbox"/> Psych |
| <input type="checkbox"/> CCU | <input type="checkbox"/> ICU | <input type="checkbox"/> Neuro ICU | <input type="checkbox"/> Pediatrics | <input type="checkbox"/> SICU |
| <input type="checkbox"/> Clinics | <input type="checkbox"/> IV Therapy | <input type="checkbox"/> NICU | <input type="checkbox"/> Pediatric ER | <input type="checkbox"/> Step Down Unit |
| <input type="checkbox"/> CVICU | <input type="checkbox"/> Labor & Delivery | <input type="checkbox"/> Oncology | <input type="checkbox"/> Pediatric OR | <input type="checkbox"/> Telemetry |
| <input type="checkbox"/> CVOR | <input type="checkbox"/> Long Term Care | <input type="checkbox"/> OR | <input type="checkbox"/> Peds Step Down | <input type="checkbox"/> Trauma Unit |
| <input type="checkbox"/> ER | <input type="checkbox"/> Management | <input type="checkbox"/> OR – Scrub | <input type="checkbox"/> PICU | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> GI Lab | <input type="checkbox"/> Med/Surg | <input type="checkbox"/> OR – Circulate | <input type="checkbox"/> Post Partum | <input type="checkbox"/> Other _____ |

CERTIFICATION:

- | | | |
|--|---|--|
| <input type="checkbox"/> ACLS Exp. Date: _____ | <input type="checkbox"/> CNOR Exp. Date: _____ | <input type="checkbox"/> LCCE Exp. Date: _____ |
| <input type="checkbox"/> AWOHNN Exp. Date: _____ | <input type="checkbox"/> CPI Exp. Date: _____ | <input type="checkbox"/> OCN Exp. Date: _____ |
| <input type="checkbox"/> BLS Exp. Date: _____ | <input type="checkbox"/> CPN Exp. Date: _____ | <input type="checkbox"/> ONC Exp. Date: _____ |
| <input type="checkbox"/> CCRN Exp. Date: _____ | <input type="checkbox"/> CRNFA Exp. Date: _____ | <input type="checkbox"/> RNC Exp. Date: _____ |
| <input type="checkbox"/> CEN Exp. Date: _____ | <input type="checkbox"/> ECRN Exp. Date: _____ | <input type="checkbox"/> TNCC Exp. Date: _____ |
| <input type="checkbox"/> CGRN Exp. Date: _____ | <input type="checkbox"/> ENPC Exp. Date: _____ | <input type="checkbox"/> TNS Exp. Date: _____ |
| <input type="checkbox"/> Chemo Exp. Date: _____ | | |

PLEASE CHECK THE DAYS OF THE WEEK AND SHIFTS YOU ARE AVAILABLE TO WORK:

- Full-Time Part-Time Travel Contract
 7AM – 3PM 3PM – 11PM 11PM – 7AM 7AM – 7PM 7PM – 7AM Other: _____
 Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Time/Distance willing to travel: _____

EMPLOYMENT HISTORY:

Employer: _____ Unit/Floor/ Dept: _____

Address, City, State, Zip: _____

Dates of Employment: From: _____ To: _____ Salary: _____

Position Held: _____ Discipline: _____ Unit Specialty: _____

Supervisor's Name: _____ Title: _____ Phone: _____

May we contact this employer: Yes No

Reason for Leaving: _____

Employer: _____ Unit/Floor/ Dept: _____

Address, City, State, Zip: _____

Dates of Employment: From: _____ To: _____ Salary: _____

Position Held: _____ Discipline: _____ Unit Specialty: _____

Supervisor's Name: _____ Title: _____ Phone: _____

May we contact this employer: Yes No

Reason for Leaving: _____

Employer: _____ Unit/Floor/ Dept: _____

Address, City, State, Zip: _____

Dates of Employment: From: _____ To: _____ Salary: _____

Position Held: _____ Discipline: _____ Unit Specialty: _____

Supervisor's Name: _____ Title: _____ Phone: _____

May we contact this employer: Yes No

Reason for Leaving: _____

AGENCY WORK EXPERIENCE:

Have you worked for other agencies prior to Pro Med Staffing? Yes No

Agency Name: _____

Dates of Employment: From: _____ To: _____

Hospitals/Units Worked: _____

Agency Name: _____

Dates of Employment: From: _____ To: _____

Hospitals/Units Worked: _____

Agency Name: _____

Dates of Employment: From: _____ To: _____

Hospitals/Units Worked: _____

PROFESSIONAL REFERENCES:

Please list 3 references, of which at least 2 individuals are former supervisors, with whom you have worked in a professional setting.

Name: _____ Employer: _____
Title: _____
Home Phone: _____ Work Phone: _____
Address: _____

Name: _____ Employer: _____
Title: _____
Home Phone: _____ Work Phone: _____
Address: _____

Name: _____ Employer: _____
Title: _____
Home Phone: _____ Work Phone: _____
Address: _____

ADDITIONAL INFORMATION:

Has any professional license held by you in any state been investigated, suspended or non-renewed? Yes No
Have you ever been convicted of a crime other than a minor traffic violation? Yes No
Has any malpractice suit ever been brought against you? Yes No

Are you aware of any circumstance which may result in a malpractice claim or suit being made or brought against you? Yes No

Has any professional liability insurance for you ever been denied, cancelled or non-renewed? Yes No

If you responded "yes" to any of the above, please give full details on a separate sheet.

Are you either a U.S. citizen or can you submit verification of your legal right to work in the U.S.? Yes No

Have you been asked to not return to a hospital, whether directly by the hospital, or through another agency? Yes No

If Yes, what agency and hospital? _____

Why: _____

ACKNOWLEDGEMENT:

I certify that all information provided in this application is true and correct. I understand that providing false, incomplete or misleading responses will result in the termination of my employment. I authorize Pro Med Staffing, Inc., to verify the information I have provided and to contact past employers and references. I expressly release all such persons from liability for providing information requested by Pro Med Staffing, Inc. I further authorize Pro Med Staffing, Inc. to use this application and any additional information obtained for the purpose of evaluating my eligibility for employment or assignment. I also expressly authorize Pro Med Staffing, Inc. to share such information with any Pro Med Staffing, Inc. client at any time that I seek or maintain employment or assignment with such client and I expressly release Pro Med Staffing, Inc. from any liability which may result from obtaining, releasing and making an employment decision based upon, such information. I agree that Pro Med Staffing, Inc. may send me employment opportunity and related information via fax, e-mail or any other means.

Applicant's Signature

Date