

# Employment Application

Your Personal Information			
Name _____ <small>First Last Middle Initial</small>			Date Available _____
Nickname _____		Social Security # _____	
Current Mailing Address _____ <small>Good Until Street Apt. #</small>			Employment Desired: <input type="checkbox"/> Travel Assignment <input type="checkbox"/> Per Diem
_____	_____	_____	_____
<small>City</small>	<small>State / Province</small>	<small>Zip</small>	<small>Country</small>
Current Phone ( ) _____		Cell Phone ( ) _____	
Email _____			
Permanent Address _____			
_____			<small>Apt. #</small>
_____	_____	_____	_____
<small>City</small>	<small>State / Province</small>	<small>Zip</small>	<small>Country</small>
Permanent Phone ( ) _____		Are you currently eligible for employment in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No	
In Case of Emergency Contact _____		Relationship _____	
Phone ( ) _____			
Address _____			<small>Apt. #</small>
_____	_____	_____	_____
<small>City</small>	<small>State / Province</small>	<small>Zip</small>	<small>Country</small>
Were you referred by anyone? If so, whom? _____			

Professional Credentials	
Specialty (List most current experience first)	
1. _____	Years of Experience _____ As of (indicate date) _____
2. _____	Years of Experience _____ As of (indicate date) _____
3. _____	Years of Experience _____ As of (indicate date) _____
<b>PLEASE INDICATE WHICH OF THE FOLLOWING CREDENTIALS YOU CURRENTLY HOLD.</b>	
<small>(Please attach appropriate copies. Use paper clips only. Do not staple form.)</small>	
<input type="checkbox"/> ACLS <input type="checkbox"/> NRP <input type="checkbox"/> CNOR <input type="checkbox"/> CHEMO <input type="checkbox"/> PALS <input type="checkbox"/> CRRN <input type="checkbox"/> BCLS/CPR <input type="checkbox"/> CEN <input type="checkbox"/> CRITICAL CARE COURSE <input type="checkbox"/> OCN <input type="checkbox"/> TNCC <input type="checkbox"/> CERTIFIED FIRST ASSIST	Related Courses _____ _____ _____ <i>Attaching copies of current credentials will help expedite the application process.</i>

Education	
<b>VOCATIONAL/NURSING SCHOOL:</b> _____	
City _____	State _____
Date Passed Boards/Certification _____	Degree/Certification Earned _____
<small>Month / Year</small>	
<b>COLLEGE/UNIVERSITY:</b> _____	
City _____	State _____
Date Passed Boards _____	Degree Earned _____
<small>Month / Year</small>	
<b>COLLEGE/UNIVERSITY:</b> _____	
City _____	State _____
Date Passed Boards _____	Degree Earned _____
<small>Month / Year</small>	

## Legal Questions

1. At any time before or after becoming a healthcare professional, have you ever been charged with a crime or been convicted or pled guilty or no contest (nolo contendere) to any criminal charge (whether disciplined or cleared)?

Yes  No *If yes, please indicate dates, conviction, final outcome and attach a separate sheet with full particulars.*

Date \_\_\_\_\_ Conviction \_\_\_\_\_

Outcome \_\_\_\_\_

2. Are you aware of any circumstances, which may result in a malpractice claim or suit being made or brought against you?

Yes  No *If yes, please indicate dates, circumstances and attach a separate sheet with full particulars.*

Date \_\_\_\_\_ Circumstances \_\_\_\_\_

Outcome \_\_\_\_\_

3. Has any medical malpractice claim or suit ever been brought or threatened against you or your employer for your acts?

Yes  No *If yes, please provide detail of the suit and its current status and attach a separate sheet with full particulars.*

Date \_\_\_\_\_ Circumstances \_\_\_\_\_

Outcome \_\_\_\_\_

4. Have you ever been the subject of a reprimand or disciplinary action or refused employment or admission to a professional society or had professional privileges suspended by any court or administrative agency, regulatory board, or State Board of Nursing, or ever been the subject of any ethics investigation at local, state or national level (whether disciplined or cleared)?

Yes  No *If yes, please indicate dates, circumstances, final outcome and attach a separate sheet with full particulars.*

Date \_\_\_\_\_ Circumstances \_\_\_\_\_

Outcome \_\_\_\_\_

### Current Employment

Are you currently employed?  Yes  No

Hospital Name \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_

Dates employed \_\_\_\_\_ - \_\_\_\_\_

Hospital Type:  Teaching  Non-teaching

Reason for leaving? \_\_\_\_\_

Position Held \_\_\_\_\_ Hourly wage \_\_\_\_\_

Unit Specialty \_\_\_\_\_

Part Time (Hours per week? \_\_\_\_\_)  Full Time

Avg. Patient Ratio \_\_\_\_\_ Hospital Beds \_\_\_\_\_

Unit Beds \_\_\_\_\_ Type of Nursing  Primary  Team

Computerized Charting  Yes  No Type \_\_\_\_\_

Charge Experience:  Yes (How often? \_\_\_\_\_)  No

Supervisor \_\_\_\_\_

Phone ( ) \_\_\_\_\_ ext. \_\_\_\_\_

Is this a travel assignment?  Yes  No

If so, what travel company? \_\_\_\_\_

May we contact your current employer?  Yes  No

### Previous Employment

Hospital Name \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_

Dates employed \_\_\_\_\_ - \_\_\_\_\_

Hospital Type:  Teaching  Non-teaching

Reason for leaving? \_\_\_\_\_

Position Held \_\_\_\_\_ Hourly wage \_\_\_\_\_

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Avg. Patient Ratio \_\_\_\_\_ Hospital Beds \_\_\_\_\_

Unit Beds \_\_\_\_\_ Type of Nursing  Primary  Team

Computerized Charting  Yes  No Type \_\_\_\_\_

Charge Experience:  Yes (How often? \_\_\_\_\_)  No

Supervisor \_\_\_\_\_

Phone ( ) \_\_\_\_\_ ext. \_\_\_\_\_

Is this a travel assignment?  Yes  No

If so, what travel company? \_\_\_\_\_

May we contact employer?  Yes  No

*The statements made in this application are true to the best of my knowledge. I understand that any falsification will be the basis for disqualification of employment or termination of services. I authorize MedStaff to verify the information I have provided and to contact past employers and references concerning my ability, character and employment records. I release all such persons from liability for furnishing said information. I authorize MedStaff and my employer, to release a copy of this employment application and all information which may be relevant to an assignment with their client facilities, including any required healthcare information. By applying to MedStaff, I authorize release of this information to all other affiliates of MedStaff and I acknowledge and agree that they may contact me using facsimile or any other means. I understand that MedStaff will be providing my profile to facilities and that any opportunity I may have to arrange and schedule an interview with such facility is a result of MedStaff for my benefit. Accordingly, I agree that any interview such facility schedules or arranges with me may not be redirected to another agency. Nothing contained in this employment application, or in the granting of an interview, is intended to create an employment contract between MedStaff and the applicant for either employment or for providing of any benefit. All offers of employment are made conditional upon the applicant's providing employment authorization and identity in accordance with the Immigration Reform and Control Act of 1986.*

X \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please complete all information for each hospital. If any of the employers listed below are day agencies, please provide the name of the agency as well as the name of the hospital where you provided per diem care (i.e., list each hospital you worked at separately and include the agency name as well). List the most recent employer first.

Previous Employment	
<p>Hospital Name _____</p> <p>City _____ State/Province _____</p> <p>Dates employed _____ - _____</p> <p>Hospital Type: <input type="checkbox"/> Teaching <input type="checkbox"/> Non-teaching</p> <p>Reason for leaving? _____</p> <p>Position Held _____ Hourly wage _____</p> <p>Unit Specialty _____</p> <p><input type="checkbox"/> Part Time (Hours per week? _____) <input type="checkbox"/> Full Time</p> <p>Avg. Patient Ratio _____ Hospital Beds _____</p> <p>Unit Beds _____ Type of Nursing <input type="checkbox"/> Primary <input type="checkbox"/> Team</p> <p>Computerized Charting <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____</p> <p>Charge Experience: <input type="checkbox"/> Yes (How often? _____) <input type="checkbox"/> No</p> <p>Supervisor _____</p> <p>Phone ( ) _____ ext. _____</p> <p>Is this a travel assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If so, what travel company? _____</p> <p>May we contact employer? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Hospital Name _____</p> <p>City _____ State/Province _____</p> <p>Dates employed _____ - _____</p> <p>Hospital Type: <input type="checkbox"/> Teaching <input type="checkbox"/> Non-teaching</p> <p>Reason for leaving? _____</p> <p>Position Held _____ Hourly wage _____</p> <p>Unit Specialty _____</p> <p><input type="checkbox"/> Part Time (Hours per week? _____) <input type="checkbox"/> Full Time</p> <p>Avg. Patient Ratio _____ Hospital Beds _____</p> <p>Unit Beds _____ Type of Nursing <input type="checkbox"/> Primary <input type="checkbox"/> Team</p> <p>Computerized Charting <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____</p> <p>Charge Experience: <input type="checkbox"/> Yes (How often? _____) <input type="checkbox"/> No</p> <p>Supervisor _____</p> <p>Phone ( ) _____ ext. _____</p> <p>Is this a travel assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If so, what travel company? _____</p> <p>May we contact employer? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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## Previous Employment

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 Unit Specialty \_\_\_\_\_  
 Part Time (Hours per week? \_\_\_\_\_)  Full Time  
 Avg. Patient Ratio \_\_\_\_\_ Hospital Beds \_\_\_\_\_  
 Unit Beds \_\_\_\_\_ Type of Nursing  Primary  Team  
 Computerized Charting  Yes  No Type \_\_\_\_\_  
 Charge Experience:  Yes (How often? \_\_\_\_\_)  No  
 Supervisor \_\_\_\_\_  
 Phone ( ) \_\_\_\_\_ ext. \_\_\_\_\_  
 Is this a travel assignment?  Yes  No  
 If so, what travel company? \_\_\_\_\_  
 May we contact employer?  Yes  No

Hospital Name \_\_\_\_\_  
 City \_\_\_\_\_ State/Province \_\_\_\_\_  
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