



## EMPLOYMENT APPLICATION

*Please Print Clearly and Use Black Ink Only*

Today's Date \_\_\_\_\_ Date Available for Work \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last \_\_\_\_\_

Email Address \_\_\_\_\_

Current Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Address #2 (If you possess a PO Box for your main address, please provide another non-PO Box address)

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Current Phone Number \_\_\_\_\_ Permanent Phone Number \_\_\_\_\_

Other Phone Number (Cellular, Pager, etc.): Type \_\_\_\_\_ # \_\_\_\_\_

Permanent Address (If different from current address) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ Birth Date (MM/DD/YY) \_\_\_\_\_

Can you provide proof of eligibility to work in the United States?  Yes  No

Emergency Contact (not living with you) \_\_\_\_\_ Phone \_\_\_\_\_

**Type of Qualification:**  RN  LPN/LVN  Respiratory Therapist  Radiology Tech  
 Certified Surgical Tech/OR Tech  Other (please specify) \_\_\_\_\_

**Shift Preference:** Days \_\_\_\_\_ Evenings \_\_\_\_\_ Nights \_\_\_\_\_

Have you spoken to a Nurses in Partnership, Inc. Recruiter?  Yes  No Name: \_\_\_\_\_  
(If you have spoken to a recruiter, please be sure to place their name above.)

I understand that in processing my application with Nurses in Partnership, Inc. an investigation may be made in which information is obtained through personal interviews, and a review of information held by law enforcement or other government agencies. I authorize you to verify my past employment and education, criminal records, motor vehicle records, personal references, and other job related data provided on this application, or via the interview process. I authorize appropriate individuals, companies, institutions or agencies to release information, and I release them from any liability as a result of such inquires or disclosures. A consumer report may be generated summarizing this information.

I further understand and waive my right of privacy in this investigation and release and hold harmless Nurses in Partnership from any liability.

I agree that any decision to hire me is contingent upon the results of my report and certify that all statements and answers on my application, resume, or interview are true and complete to the best of my knowledge. I understand that if any statements are false or that if information has been omitted, this will be cause for disqualification and immediate termination of my employment. If employed, I further authorize Nurses in Partnership, Inc. to check my conviction records, as needed, on a continuous basis as it relates to my employment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## EDUCATION

Name and Location of School(s)	Graduated (Date)	Type of Degree
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## LICENSURE

*(Please list all including expired)*

Professional License/ Technical Certificate	# _____	State _____	Exp. Date _____
	# _____	State _____	Exp. Date _____
	# _____	State _____	Exp. Date _____
	# _____	State _____	Exp. Date _____

Which of these licenses is your original state of licensure? \_\_\_\_\_

Has your license or certification ever been under investigation?  Yes  No

If YES, please explain \_\_\_\_\_

Has your license or certification ever been revoked or under suspension?  Yes  No

If YES, please explain \_\_\_\_\_

## PROFESSIONAL CERTIFICATIONS

*(Please list all certifications. Ex., CCRN, CNOR, OCN, CRRN, CEN)*

Type _____	Exp. Date _____
Type _____	Exp. Date _____
Type _____	Exp. Date _____
Type _____	Exp. Date _____

## RESUSCITATION CREDENTIALS

Please indicate your resuscitation credential(s) by placing the expiration date next to the appropriate credential in the table below.

Resuscitation Credential	Expiration Date	Resuscitation Credential	Expiration Date
ACLS		NRP	
BCLS		PALS	
ENPC		TNCC	

## PROFESSIONAL EDUCATION

Course Name	Date	CEUs Earned
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Previous Employment

Please Complete This Section COMPLETELY even if you are attaching your resume. Please List the most recent employer first and please print clearly.

Name: \_\_\_\_\_

Are you employed now?  Yes  No      May we contact your present employer?  Yes  No  
May we contact your previous employer?  Yes  No

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).

Hospital \_\_\_\_\_  
Phone \_\_\_\_\_  
Position Held \_\_\_\_\_  
Specialty \_\_\_\_\_  
Average Patient Ratio \_\_\_\_\_  
Number of Beds: in Unit \_\_\_\_\_ in Hospital \_\_\_\_\_  
Type of Nursing  Primary  Team  Modified Primary  
 Modified Team  Other \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_  
Immediate Supervisor \_\_\_\_\_  
Date Employed: From \_\_\_\_\_ to \_\_\_\_\_  
Reason for Leaving \_\_\_\_\_  
Was this a Travel Assignment?  Yes  No  
With what agency? \_\_\_\_\_  
Charge Experience?  Yes  No How often?  
Hourly Salary \_\_\_\_\_

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Phone \_\_\_\_\_  
Position Held \_\_\_\_\_  
Specialty \_\_\_\_\_  
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