



EMPLOYMENT APPLICATION
Please Print Clearly and Use Black Ink Only

Please print, complete as much as possible, and return to Nurses in Partnership, Inc.
Fax: (800) 978-8556 or Mail: River Oaks Plaza, 28118 Agoura Road, Suite 100, Agoura Hills, CA 91301

JOB NUMBER THAT YOU ARE APPLYING FOR: _____

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 _____
Average Patient Ratio _____
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