



EMPLOYMENT APPLICATION

Please Print Clearly and Use Black Ink Only

Today's Date (DD/MM/YY) _____ Date Available for Work (DD/MM/YY) _____

First Name _____ Middle Initial _____ Last _____

Email Address _____

Current Address _____

City _____ Province _____ Postal Code _____

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

City _____ Province _____ Postal Code _____

Current Phone Number _____ Permanent Phone Number _____

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

Permanent Address (If different from current address) _____

City _____ Province _____ Postal Code _____

Social Security Number _____ Birth Date (DD/MM/YY) _____

Are you a Canadian citizen? Yes No

Emergency Contact (not living with you) _____ Phone _____

Type of Qualification: RN 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.)

By signing this application, I certify: That this application is complete and accurate to the best of my knowledge and that I have not made any attempt to conceal information, and that falsification could be cause for dismissal. Further, Nurses in Partnership, Inc. or its agents may request employment information from my previous employers and persons or corporations who provide information related to my previous employment and will be released from any liability or damage.

Signature _____

Date (DD/MM/YY) _____

Please fax your completed application to: [888] 879-9719

OR mail it to our Head Office: 28118 Agoura Road, Suite 100, Agoura Hills, CA 91301 USA

EDUCATION

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

LICENSURE

(Please list all including expired)

Professional License / Technical Certificate	Province/State	Expiry Date (DD/MM/YY)

Which of these licenses is your original provincial license? _____

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Has your license or certification ever been revoked or under suspension?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	CEU's Earned
_____	_____	_____
_____	_____	_____
_____	_____	_____

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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 _____	City/Province/Postal Code _____
Phone _____	Immediate Supervisor _____
Position Held _____	Date Employed: From _____ to _____
Specialty _____	Reason for Leaving _____
Number of Beds: in Unit _____ in Hospital _____	Average Patient Ratio _____
Type of Nursing <input type="checkbox"/> Primary <input type="checkbox"/> Team <input type="checkbox"/> Modified Primary	Charge Experience? <input type="checkbox"/> Yes <input type="checkbox"/> No How often? _____
<input type="checkbox"/> Modified Team <input type="checkbox"/> Other _____	Hourly Salary _____

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