

JOB APPLICATION

In order to qualify, you must have one year of acute care experience within the last two years and your license must be in good standing.

First Name _____

Middle name _____

Last Name _____

Email Address _____

Home Address _____

Apt/Suite etc. _____

City _____

State _____

Zip Code _____

Current Phone Number _____

Permanent Phone Number _____

SSN _____

Birth Date
(MM/DD/YY) Required upon
employment. _____

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

Emergency Contact
(not living with you) Name _____ Phone _____

Type of Profession

<input type="checkbox"/> RN	<input type="checkbox"/> CRNA	<input type="checkbox"/> LPN/LVN
<input type="checkbox"/> Respiratory Therapist	<input type="checkbox"/> Radiology Tech	<input type="checkbox"/> Certified Surgical Tech or Tech

If other, please specify. _____

Personal Referral
Name of Referrer _____

Have you spoken to a
Recruiter or Branch
Director? If you have spoken to a recruiter or branch director please be sure to
enter their name.

Yes Recruiter Name _____

Education

Please list the schools that you have attended below.

a. Name _____ Location _____
Graduated (Date) _____ Type of Degree _____

b. Name _____ Location _____
Graduated (Date) _____ Type of Degree _____

c. Name _____ Location _____
Graduated (Date) _____ Type of Degree _____

d. Name _____ Location _____
Graduated (Date) _____ Type of Degree _____

Licensure

Please list any Professional Licenses and/or Technical Certificates you have below.

a. State _____ Exp. Date _____

b. State _____ Exp. Date _____

c. State _____ Exp. Date _____

d. State _____ Exp. Date _____

Which of these licenses is your original state of licensure? _____

Type Of 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Has your license or certification ever been revoked or under suspension?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, RNC-NICU, OCN, CRRN)

a. Type _____ Exp. Date _____

b. Type _____ Exp. Date _____

c. Type _____ Exp. Date _____

d. Type _____ Exp. Date _____

Resuscitation Credentials

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

ACLS _____

BLS _____

ENPC _____

NRP _____

PALS _____

TNCC _____

Professional Continuing Education

a.
Course Name _____ Date _____ CEUs Earned _____

b.
Course Name _____ Date _____ CEUs Earned _____

c.
Course Name _____ Date _____ CEUs Earned _____

Specialties and Unit Experience

Please indicate the amount of experience - **IN YEARS** - you have worked in the following specialties/units.

Critical Care - Adult

Bone Marrow Transplant ICU _____ Float
Time (years) _____ Float

Burn ICU _____ Float
Time (years) _____ Float

Cardiac ICU _____ Float
Time (years) _____ Float

Cardiac Catheterization Lab _____ Float
Time (years) _____ Float

Cardiothoracic ICU _____ Float
Time (years) _____ Float

Cardiovascular ICU _____ Float
Time (years) _____ Float

Emergency Room

Time (years) _____ Float

Medical ICU

Time (years) _____ Float

Neuro ICU

Time (years) _____ Float

Neurosurgical ICU

Time (years) _____ Float

Transplant ICU

Time (years) _____ Float

Trauma ICU

Time (years) _____ Float

Surgical ICU

Time (years) _____ Float

Critical Care - Pediatric

Burn ICU - Peds

Time (years) _____ Float

Cardiac Catheterization Lab

Time (years) _____ Float

Emergency Room - Peds

Time (years) _____ Float

Pediatric ICU

Time (years) _____ Float

Pediatric - Transplant ICU

Time (years) _____ Float

Other

Please specify _____

Intermediate Care - Adult

Cardiac SD/Telemetry Unit

Time (years) _____ Float

Endoscopy Lab

Time (years) _____ Float

Surgical Step-down Unit

Time (years) _____ Float

Intermediate Care - Pediatric

Pediatric Step-down Unit

Time (years) _____ Float

Other

Please specify _____

Medical Surgical - Adult

Admitting/Observation Unit

Time (years) _____ Float

Diabetic Unit

Time (years) _____ Float

Gastrointestinal Unit

Time (years) _____ Float

General Surgery Unit

Time (years) _____ Float

Genitourinary Unit

Time (years) _____ Float

Geriatric Unit

Time (years) _____ Float

Gynecology Unit

Time (years) _____ Float

Hematology Unit

Time (years) _____ Float

Hemodialysis Unit

Time (years) _____ Float

Home Health

Time (years) _____ Float

Hospice Unit

Time (years) _____ Float

Med Surg Unit

Time (years) _____ Float

Renal Unit

Time (years) _____ Float

Neurology Unit

Time (years) _____ Float

Oncology Unit

Time (years) _____ Float

Orthopedic Unit

Time (years) _____ Float

Outpatient Clinic

Time (years) _____ Float

Pulmonary Unit

Time (years) _____ Float

Radiology Services

Time (years) _____ Float

Rehabilitation Unit

Time (years) _____ Float

Skilled Nursing Facility

Time (years) _____ Float

Medical Surgical - Pediatric

General Peds Unit

Time (years) _____ Float

Oncology Unit

Time (years) _____ Float

Home Health

Time (years) _____ Float

Hospice Unit

Time (years) _____ Float

Rehabilitation Unit

Time (years) _____ Float

Other

Please specify _____

Perioperative

Pre-op Holding or Monitoring

Time (years) _____ Float

Operating Room

Time (years) _____ Float

Cardiovascular OR

Time (years) _____ Float

Cystoscopy Suite

Time (years) _____ Float

ENT/Ophthalmology OR

Time (years) _____ Float

General Surgery OR

Time (years) _____ Float

Neurosurgical OR

Time (years) _____ Float

Orthopedic OR

Time (years) _____ Float

Transplant OR

Time (years) _____ Float

Post Anesthesia Care Unit/ RR

Time (years) _____ Float

Same Day Surgery

Time (years) _____ Float

Perinatal

Antepartum Unit

Time (years) _____ Float

Labor & Delivery

Time (years) _____ Float

High Risk Labor & Delivery

Time (years) _____ Float

LDRP

Time (years) _____ Float

Mother Baby Unit

Time (years) _____ Float

NICU, Level 2

Time (years) _____ Float

NICU, Level 3

Time (years) _____ Float

Newborn Nursery

Time (years) _____ Float

Postpartum Unit

Time (years) _____ Float

Other

Please specify _____

Psychiatry - Adult

General Psychiatric Unit - Adult

Time (years) _____ Float

Chemical Dependency Unit-Adult

Time (years) _____ Float

Dual Diagnosis Unit - Adult

Time (years) _____ Float

Locked Psychiatric Unit - Adult

Time (years) _____ Float

Other

Please specify _____

Psychiatry - Pediatrics

Adolescent Psychiatric Unit

Time (years) _____ Float

Dual Diagnosis Unit - Adolescent

Time (years) _____ Float

Pediatric Psychiatric Unit

Time (years) _____ Float

Other

Please specify _____

Specialty Skills

Please identify any of the skills listed below for which you have completed an organized training course and which you have at least six months experience.

Skills:

Arrhythmia Interpretation

Intra-Aortic Balloon Pump

- Chemotherapy Administration
- Credentialed
- Circulating OR Skills
- CVVN, CAVH, or CRRT
- ECT
- ECMO
- Fetal Monitoring
- Hemodialysis
- Sheath Removal

- Intracranial Pressure Monitoring
- IV Conscious Sedation
- IV Catheter Insertion
- LVAD
- Mechanical Ventilation
- PICC Line Insertion
- Peritoneal Dialysis
- Scrub OR Skills
- Transport Skills

Additional Information

Have you been convicted of any law violation?
Include any plea of "guilty" or "no contest." Exclude
minor traffic violations.

Yes_____ No_____

If YES please give details. (A conviction will not
necessarily disqualify an applicant from
employment.)

Are you currently employed?

Yes_____ No_____

If YES, may we contact your employer?

Yes_____ No_____

Do you have any physical or mental conditions that
would inhibit or restrict your ability to perform the
essential functions of your job?

Yes_____ No_____

If YES, would you be requesting any accommodations
to aid you in fulfilling the essential duties of your job?

Yes_____ No_____

If YES, what are they?

Do you have one year of acute care experience in the
past two years?

Yes_____ No_____

Please check all that apply

- I would like to be considered for Travel
Nursing positions where I may need to
travel to an assignment.
- I would like to be considered for
positions with U. S. Nursing where a labor
dispute may exist.

Employment Experience

Start with your present or last job.

Employment Dates (mm/dd/yy) From _____ To _____

Salary Beginning _____ Ending _____

Hospital/Facility _____

Agency (if used) _____

Full Time Yes_____ No_____

Part Time Yes_____ No_____

Address _____

City _____

State _____

Zip Code _____

Immediate Supervisor _____

Specialty/Unit _____

Types of Patients _____

Number of Beds _____

Supervisory experience? Yes_____ No_____

Was this a supplemental assignment? Yes_____ No_____

Reason for leaving _____

Employment Dates (mm/dd/yy) From _____ To _____

Salary Beginning _____ Ending _____

Employer _____

Full Time Yes_____ No_____

Part Time Yes_____ No_____

Address _____

City _____

State _____

Zip Code _____

Immediate Supervisor _____

Specialty/Unit _____

Types of Patients _____

Number of Beds _____

Supervisory experience? Yes_____ No_____

Was this a supplemental assignment? Yes_____ No_____

Reason for leaving _____

Employment Dates
(mm/dd/yy)

From _____ To _____

Salary

Beginning _____ Ending _____

Employer

Full Time

Yes_____ No_____

Part Time

Yes_____ No_____

Address

City

State

Zip

Immediate Supervisor

Specialty/Unit

Types of Patients

Number of Beds

Supervisory experience?

Yes_____ No_____

Was this supplemental assignment?

Yes_____ No_____

Reason for leaving

I certify that I have read, understand and intend to comply with the Applicant Agreement and that the facts contained in this application are true and accurate. I understand that any misrepresentation or omission of facts is cause for dismissal. I authorize the employer to investigate any and all statements contained herein and request the persons, firms, and/or corporations named above to answer any and all questions relating to this application. I release all parties from all liability, including but not limited to, the employer and any person, firm or corporation who provides information concerning my prior education, employment or character:

I understand that by selecting "Yes, I accept this agreement" below that I have read, understood and intend to comply with the **Applicant Agreement**

For Corporation:

Advanced Medical Personnel, Inc
10 Mountain View Avenue, Suite 1020
Bay Point, CA 94565

For Applicant:

Applicant Name _____

Applicant Address _____

Do you accept this agreement? YES NO

Today's Date _____

Signature _____