



For All Your Nursing Needs.

E Q U A L O P P O R T U N I T Y E M P L O Y E R

4311 Wilshire Blvd., Suite 400, Los Angeles, California 90010
Toll free 800-422-0121 Fax (323) 931-5344

Application for Employment



PERSONAL DATA

Name: _____
Last Name
First Name
Middle Initial

Current Address: _____
Street
City
State
Zip code

Permanent Address: _____
 (if different) Street
City
State
Zip code

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____ **Ext:** _____

Emergency Contact Person: _____
Name
Contact No.
Relationship

Address: _____
Street
City
State
Zip code

Social Security No.: _____ **Email Address:** _____

Discipline: _____ **Specialty:** _____ **Other Specialty:** _____

How did you know about Nurse Connection, Inc.? _____ **Date available to Start:** _____

Geographical Preferences: (1) _____ (2) _____ (3) _____

Preferred Clinical Setting: (1) _____ (2) _____ (3) _____

LICENSURE *(Include copies of all licenses held.)*

State	License No.	Exp. Date	State	License No.	Exp. Date
State	License No.	Exp. Date	State	License No.	Exp. Date

CERTIFICATION *(Include copies of all certifications held.)*

Select Appropriate certification(s):

<input type="checkbox"/> ACLS	Exp. Date: _____	<input type="checkbox"/> CEN	Exp. Date: _____	<input type="checkbox"/> MAB	
<input type="checkbox"/> BCLS	Exp. Date: _____	<input type="checkbox"/> NRP	Exp. Date: _____	Exp. Date: _____	
<input type="checkbox"/> CCRN	Exp. Date: _____	<input type="checkbox"/> FHM	Exp. Date: _____	<input type="checkbox"/> OTHER	_____
<input type="checkbox"/> PALS	Exp. Date: _____	<input type="checkbox"/> MICN	Exp. Date: _____	Exp. Date: _____	

EDUCATION	Name and Location of School	Month / Year Graduated	Diplomas, Degrees received
College	_____ _____	_____ _____	_____ _____
Graduate School	_____ _____	_____ _____	_____ _____
Other School (if applicable)	_____ _____	_____ _____	_____ _____

EMPLOYMENT HISTORY

Hospital/Employer: _____		Dept./Unit/Floor: _____	
Address: _____			
Street		City	
State		Zip code	
Employed From: _____	To: _____	Reason for Leaving: _____	
Position Title: _____	Shift Worked: _____	Charge: <input type="radio"/> Yes <input type="radio"/> No	
Supervisor's Name/Title: _____		Phone: _____	Extension: _____
Other Supervisor? _____		Phone: _____	Extension: _____
Travel Assignment? <input type="radio"/> Yes <input type="radio"/> No	-- OR --	Local Staff Agency? <input type="radio"/> Yes <input type="radio"/> No	

Hospital/Employer: _____		Dept./Unit/Floor: _____	
Address: _____			
Street		City	
State		Zip code	
Employed From: _____	To: _____	Reason for Leaving: _____	
Position Title: _____	Shift Worked: _____	Charge: <input type="radio"/> Yes <input type="radio"/> No	
Supervisor's Name/Title: _____		Phone: _____	Extension: _____
Other Supervisor? _____		Phone: _____	Extension: _____
Travel Assignment? <input type="radio"/> Yes <input type="radio"/> No	-- OR --	Local Staff Agency? <input type="radio"/> Yes <input type="radio"/> No	

Other Names under which you have been employed: _____

Please read and answer the following questions carefully. I understand that prior to employment I must show proof of eligibility for employment within the United States.

Are you an American citizen?

Yes No Place of Birth: _____ Languages other than English in which you are proficient: _____

Alien registration #A: _____ H1.A. Visa #: _____ Expiration: _____

I understand that prior to employment I must show proof of a physical examination by a licensed physician within the last year. The medical exam is to determine whether or not I am able to perform all essential functions of the job without restriction or limitation. Furthermore, I must show proof of inoculation/immunization to include VDRL, Rubella, Varicella, Hepatitis B, TB Tine or Chest X Ray which may additionally be requested by our client hospital. I understand that prior to employment I must show proof of current CPR/ACLS if required and that I must maintain documentation current during my employment. I understand that Nurse Connection, Inc., certain states and/or Client institutions may require criminal background check, drug screening, and I consent to such checks. Prior to conducting any background checks that qualify as a consumer or investigative consumer reports, I will be provided, and will return, separate disclosure and acknowledgement forms as required by Nurse Connection, Inc. I understand that prior to employment if required by client hospital I must be prepared to test and to pass the test before I can begin assignment at the client hospital.

Has your Professional license ever been suspended or denied? Yes No

Have you ever been convicted of a crime? Yes No

Are there any physical, medical or psychological limitations that would effect your ability to perform your job duties, or limitations that may endanger yourself or other? Yes No

Have you ever been eligible or received benefits from medicare or disability from any State? Yes No

Workmens Compensation or Private insurance? Yes No If yes, explain separately.

I authorize investigation of statements made in this application for employment by Nurse Connection, Inc. or appointed representative. I understand that any misrepresentation, omission, or margin of false statement is sufficient cause for dismissal.

In affixing my signature I am certifying that the statements contained herein are true and correct to the best of my knowledge.

Signature: _____

Date: _____