

## Your Personal Information

Name \_\_\_\_\_  
Full Legal First Name Last Middle Initial

Nickname \_\_\_\_\_ Social Security # \_\_\_\_\_

Current Mailing Address / / \_\_\_\_\_  
Good Until Street Apt. #

\_\_\_\_\_  
City State / Province Zip Country

Current Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Email \_\_\_\_\_

Permanent Address \_\_\_\_\_  
Street Apt. #

\_\_\_\_\_  
City State / Province Zip Country

Permanent Phone ( ) \_\_\_\_\_ Are you currently eligible for employment in the U.S.?  Yes  No

In Case of Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Address \_\_\_\_\_  
Street Apt. #

\_\_\_\_\_  
City State / Province Zip Country

Were you referred by anyone? If so, whom? \_\_\_\_\_

## Professional Credentials

Nursing Specialty (List most current experience first)

1. \_\_\_\_\_ Years of Experience \_\_\_\_\_ As of (indicate date) \_\_\_\_\_
2. \_\_\_\_\_ Years of Experience \_\_\_\_\_ As of (indicate date) \_\_\_\_\_
3. \_\_\_\_\_ Years of Experience \_\_\_\_\_ As of (indicate date) \_\_\_\_\_

**PLEASE INDICATE WHICH OF THE FOLLOWING CREDENTIALS YOU CURRENTLY HOLD.**  
 (Please attach appropriate copies. Use paper clips only. Do not staple form.)

- |                                |                                   |   |
|--------------------------------|-----------------------------------|---|
| <input type="checkbox"/> ACLS  | <input type="checkbox"/> BCLS/CPR | <input type="checkbox"/> CNOR                 |
| <input type="checkbox"/> CHEMO | <input type="checkbox"/> PALS     | <input type="checkbox"/> CRITICAL CARE COURSE |

Related Courses/Certifications (i.e. Chemotherapy, EKG, Balloon Pump, etc.)  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you Applied for VisaScreen?  Yes  No

**Professional Memberships**

Name of Organization:	Registration Number:	Date of Registration:
_____	_____	_____
_____	_____	_____

List any additional education, skills, experience, or relevant qualifications on a separate sheet and attach to application.  
 \_\_\_\_\_  
 \_\_\_\_\_

### Education (Excluding Nursing)

**HIGH/SECONDARY SCHOOL:** \_\_\_\_\_

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

Number of Years Attended \_\_\_\_\_ Degree Earned \_\_\_\_\_

**COLLEGE/UNIVERSITY:** \_\_\_\_\_

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

Date of Graduation \_\_\_\_\_ Degree Earned \_\_\_\_\_  
Month / Year

### Nursing Education

**VOCATIONAL/NURSING SCHOOL:** \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

Date Passed Boards/Certification \_\_\_\_\_ Degree/Certification Earned \_\_\_\_\_  
Month / Year

**COLLEGE/UNIVERSITY:** \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

Date Passed Boards/Certification \_\_\_\_\_ Degree/Certification Earned \_\_\_\_\_  
Month / Year

**ADDITIONAL NURSING/CERTIFICATE PROGRAMS:** \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

Date Passed Boards/Certification \_\_\_\_\_ Degree/Certification Earned \_\_\_\_\_  
Month / Year

### Nursing Education

Do you hold a US RN License?  Yes  No If yes, please provide the following information:

State	Date of Exam (Mo/Day/Yr)	License Number, if granted	Expiration Date of License (Mo/Day/Yr)

Have you taken any of the following examinations?

Exam	Date of Exam (Mo/Day/Yr)	Score
CGFNS Exam		
CGFNS Credentials Evaluation		Not applicable for credential evaluation
TOEFL		
TSE		
TWE		
IELTS ACADEMIC		

### Legal Questions

1. At any time before or after becoming a healthcare professional, have you ever been charged with a crime or been convicted or pled guilty or no contest (nolo contendere) to any criminal charge (whether disciplined or cleared)?

Yes  No *If yes, please indicate dates, conviction, final outcome and attach a separate sheet with full particulars.*

Date \_\_\_\_\_ Conviction \_\_\_\_\_

Outcome \_\_\_\_\_

2. Are you aware of any circumstances, which may result in a malpractice claim or suit being made or brought against you?

Yes  No *If yes, please indicate dates, circumstances and attach a separate sheet with full particulars.*

Date \_\_\_\_\_ Circumstances \_\_\_\_\_

Outcome \_\_\_\_\_

3. Has any medical malpractice claim or suit ever been brought or threatened against you or your employer for your acts?

Yes  No *If yes, please provide detail of the suit and its current status and attach a separate sheet with full particulars.*

Date \_\_\_\_\_ Circumstances \_\_\_\_\_

Outcome \_\_\_\_\_

4. Have you ever been the subject of a reprimand or disciplinary action or refused employment or admission to a professional society or had professional privileges suspended by any court or administrative agency, regulatory board, or State Board of Nursing, or ever been the subject of any ethics investigation at local, state or national level (whether disciplined or cleared)?

Yes  No *If yes, please indicate dates, circumstances, final outcome and attach a separate sheet with full particulars.*

Date \_\_\_\_\_ Circumstances \_\_\_\_\_

Outcome \_\_\_\_\_

### Traveling Details

Do you hold a valid passport?

Yes  No

What is your passport's expiration date? \_\_\_\_\_

Do you hold a valid driver's license?

Yes  No

What is your driver's license expiration date? \_\_\_\_\_

Do you hold a valid US driver's license?

Yes  No

What is your US driver's license expiration date? \_\_\_\_\_

Do you plan to travel with family?

Yes  No

Number of people: \_\_\_\_\_ Spouse: \_\_\_\_\_ Children: \_\_\_\_\_

List ages of children: \_\_\_\_\_

Do you have a US location preference? If yes, please list three choices in order of preference: (This is not a guarantee of assignment).

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Will you be taking any pets with you to the US?  Yes  No *If yes, please tell us how many, type of pet(s) and weight(s)?*

\_\_\_\_\_

### Emergency Contacts

In case of an emergency, whom should we notify? (please list one contact who does not live at your address)

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

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). List the most recent employer first and at least 7 years of employment.

Current Employment	Previous Employment
Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Hospital Name _____ City _____ State/Province _____ Dates employed _____ - _____ Hospital Type: <input type="checkbox"/> Teaching <input type="checkbox"/> Non-teaching Reason for leaving? _____ Position Held _____ Hourly wage _____ Unit Specialty _____ <input type="checkbox"/> Part Time (Hours per week? _____) <input type="checkbox"/> Full Time Avg. Patient Ratio _____ Hospital Beds _____ Unit Beds _____ Type of Nursing <input type="checkbox"/> Primary <input type="checkbox"/> Team Computerized Charting <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Charge Experience: <input type="checkbox"/> Yes (How often? _____) <input type="checkbox"/> No Supervisor _____ Phone ( ) _____ ext. _____ Is this a travel assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what travel company? _____ May we contact your <u>current</u> employer? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe the unit(s) worked in & include any particular skills brought to the position/unit(s), types of patients, equipment used: _____ _____ _____ _____	Hospital Name _____ City _____ State/Province _____ Dates employed _____ - _____ Hospital Type: <input type="checkbox"/> Teaching <input type="checkbox"/> Non-teaching Reason for leaving? _____ Position Held _____ Hourly wage _____ Unit Specialty _____ <input type="checkbox"/> Part Time (Hours per week? _____) <input type="checkbox"/> Full Time Avg. Patient Ratio _____ Hospital Beds _____ Unit Beds _____ Type of Nursing <input type="checkbox"/> Primary <input type="checkbox"/> Team Computerized Charting <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Charge Experience: <input type="checkbox"/> Yes (How often? _____) <input type="checkbox"/> No Supervisor _____ Phone ( ) _____ ext. _____ Is this a travel assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what travel company? _____ May we contact employer? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe the unit(s) worked in & include any particular skills brought to the position/unit(s), types of patients, equipment used: _____ _____ _____ _____

*The statements made in this application are true to the best of my knowledge. I understand that any falsification will be the basis for disqualification of employment or termination of services. I authorize Assignment America to verify the information I have provided and to contact past employers and references concerning my ability, character and employment records. I release all such persons from liability for furnishing said information. I authorize Assignment America and my employer, to release a copy of this employment application and all information which may be relevant to an assignment with their client facilities, including any required healthcare information. By applying to Assignment America, I authorize release of this information to all other affiliates of Assignment America and I acknowledge and agree that they may contact me using facsimile or any other means. I understand that Assignment America will be providing my profile to facilities and that any opportunity I may have to arrange and schedule an interview with such facility is a result of Assignment America for my benefit. Accordingly, I agree that any interview such facility schedules or arranges with me may not be redirected to another agency. Nothing contained in this employment application, or in the granting of an interview, is intended to create an employment contract between Assignment America and the applicant for either employment or for providing of any benefit. All offers of employment are made conditional upon the applicant's providing employment authorization and identity in accordance with the Immigration Reform and Control Act of 1986.*

X \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Previous Employment

Hospital Name \_\_\_\_\_  
 City \_\_\_\_\_ State/Province \_\_\_\_\_  
 Dates employed \_\_\_\_\_ - \_\_\_\_\_  
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 Reason for leaving? \_\_\_\_\_  
 Position Held \_\_\_\_\_ Hourly wage \_\_\_\_\_  
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 Part Time (Hours per week? \_\_\_\_\_)  Full Time  
 Avg. Patient Ratio \_\_\_\_\_ Hospital Beds \_\_\_\_\_  
 Unit Beds \_\_\_\_\_ Type of Nursing  Primary  Team  
 Computerized Charting  Yes  No Type \_\_\_\_\_  
 Charge Experience:  Yes (How often? \_\_\_\_\_)  No  
 Supervisor \_\_\_\_\_  
 Phone ( ) \_\_\_\_\_ ext. \_\_\_\_\_  
 Is this a travel assignment?  Yes  No  
 If so, what travel company? \_\_\_\_\_  
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