Best Nurses, Inc.

Application for Employment

Qualified applicants receive consideration for employment without discrimination because of sex, marital status, race, color, creed, national origin, age, veteran status or disability that can be reasonably accommodated without an undue hardship.

This application form was designed for use by applicants for various positions. All questions must be answered carefully and completely, regardless of attached resume or referral. If any section does not apply to the position for which you are applying, please indicate "Not Applicable" (N/A).

PERSONAL DATA

Date: _____

Name: _____
First *Middle* *Last*

Please list any other names you may have worked under _____

Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home _____ Work: _____ Cell: _____

Position Desired: _____ Date Available:_____

Check (√) type of employment desired: □ Full-Time □ Part-Time □ Per Diem

Check (√) days available: □ Mon. □ Tues. □ Wed. □ Thurs. □ Fri. □ Sat. □ Sun.

Hours Available: □ 7-3 □ 3-11 □ 11-7 □ 7a-7p □ 7p-7a □ Other Hours: _____

Are you legally authorized to work in the United States? □ Yes □ No

Are you above the age of 18? □ Yes □ No

Can you perform the essential functions of the job for which you are applying with or without reasonable accommodation?
□ Yes □ No

Have you ever been convicted of a criminal offense? □ Yes □ No If yes, explain:

_____

_____

(An affirmative answer will not automatically disqualify you from being considered as a candidate for employment)

Have you previously been employed by this company or one of its subsidiaries? □ Yes □ No If yes, When?

_____

Place a check (√) to indicate source of referral:

□ Advertisement- Name of Publication _____ □ Employee- Name of Employee_____

□ Web Site_____ □ Other _____

EDUCATION	NAME and LOCATION of SCHOOL	GRADUATION Month/Year	DIPLOMA/DEGREE
High School			
College or University			
Other			

PROFESSIONAL SKILLS

Licensure

License/Certification: #_____ State:_____ Exp. Date: _____

Has your license (in any jurisdiction that you may have been licensed in) ever been investigated, suspended or revoked?

□ **Yes** □ **No**

If yes, please detail the circumstances and the final outcome:_____

_____

(An affirmative answer will not disqualify you from being considered as a candidate for employment.)

Health Care Specialty

Area: _____ Years Experience: _____

Area: _____ Years Experience: _____

Area: _____ Years Experience: _____

Area: _____ Years Experience: _____

Please indicate which of the following credentials you currently hold:

CPR □ Exp. Date _____ OCN □ Exp. Date _____ ACLS □ Exp. Date _____

CNOR □ Exp. Date _____ PALS □ Exp. Date _____ CRRN □ Exp. Date _____

NALS □ Exp. Date _____ CCRN □ Exp. Date _____ CEN □ Exp. Date _____

IV Therapy Course □ Date Completed _____ EKG Course □ Date Completed _____

Critical Care Course □ Date Completed _____ Other □ _____

EMPLOYMENT HISTORY

(List most recent employment first)

All employments must be recorded; use additional sheets as necessary.

Employer: ______________________________

Address: ______________________ City/State: ______________

Position Held: ______________________________

Duties: ______________________________

Immediate Supervisor: ______________________ Phone: ______________

Dates Employed: From ____________ To ____________ May we contact? ____________

Reason for Leaving: ______________________________

____

Employer: ______________________________

Address: ______________________ City/State: ______________

Position Held: ______________________________

Duties: ______________________________

Immediate Supervisor: ______________________ Phone: ______________

Dates Employed: From ____________ To ____________ May we contact? ____________

Reason for Leaving: ______________________________

____

Employer: ______________________________

Address: ______________________ City/State: ______________

Position Held: ______________________________

Duties: ______________________________

Immediate Supervisor: ______________________ Phone: ______________

Dates Employed: From ____________ To ____________ May we contact? ____________

Reason for Leaving: ______________________________

____

Employer: ______________________________

Address: ______________________ City/State: ______________

Position Held: ______________________________

Duties: ______________________________

Immediate Supervisor: ______________________ Phone: ______________

Dates Employed: From ____________ To ____________ May we contact? ____________

Reason for Leaving: ______________________________

____

REFERENCES

List three business or professional persons, not related to you, whom you have known at least one year.

1. Name: _____ Occupation: _____
   Address: _____ Phone: _____

2. Name: _____ Occupation: _____
   Address: _____ Phone: _____

3. Name: _____ Occupation: _____
   Address: _____ Phone: _____

Please include any other information you think would be helpful to us in considering your application, such as publications, activities, awards, etc.

_____

_____

_____

In case of emergency notify:

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

AGREEMENT

Please read the following statements carefully.

I hereby affirm that the information provided on this application (and accompanying resume, if any) is true and complete to the best of my knowledge. I also agree that falsified information or significant omissions may disqualify me from further consideration for employment and may be considered justification for dismissal if discovered at a later date.

I hereby authorize the release of any information regarding any criminal convictions that may exist against me for all pre- and post-employment purposes. My signature below indicates my agreement to release Best Nurses, Inc. and all persons and entities from any liability arising out of such investigation.

Signature: _____ Date: _____