

**APPLICATION
CURRICULUM VITAE**



-Quality Professionals According to Need-

PERSONAL INFORMATION

Date _____ Social Security Number _____

Name _____
Last First Middle

Present Address _____
Street City State/Province Zip/Postal Code

Present Phone () _____ Work () _____ Cell Phone () _____ Beeper () _____

Permanent Address _____
Street City State/Province Zip/Postal Code

E-mail Address _____ Best time to reach you: _____ a.m. _____ p.m.

Are you legally eligible for employment in the United States? _____

Have you ever worked or are you currently working with any travel nurse companies? _____
 If so, give name _____

Days preferred: M T W T F S S Shifts: 7-3 3-11 11-7 7a-7p 7p-7a

Desired geographical location: 1) _____ 2) _____ 3) _____

*Have you ever been convicted of a felony? _____ if yes, attach separate sheet with explanation.

Other languages spoken: _____

HOW DID YOU HEAR ABOUT US? Journal _____ Newspaper _____
Name Name

Convention _____ Friend/Associate _____
Name Name

PERSONAL REFERENCES

PLEASE GIVE TWO REFERENCES (EXCLUDING RELATIVES & FORMER EMPLOYEES) WHOM YOU HAVE KNOWN AT LEAST ONE YEAR

NAME	ADDRESS	PHONE	OCCUPATION	YEARS KNOWN
1.		()		
2.		()		

*Conviction of a crime will not result in automatic disqualification.

EMPLOYMENT REFERENCES

TITLE _____ DATE AVAILABLE FOR PLACEMENT _____
 PERMANENT PLACEMENT _____ SHORT TERM ASSIGNMENT _____ NUMBER WEEKS DESIRED _____
 CLINICAL AREA OF NURSING IN WHICH YOU HAVE WORKED (LISTING MOST RECENT FIRST):
 1. _____ EXPERIENCE _____ YEARS
 2. _____ EXPERIENCE _____ YEARS
 3. _____ EXPERIENCE _____ YEARS

LICENSURE

List all states in which you are currently licensed or have been licensed. **Please attach photocopies of all current licenses.**

STATE	LICENSE #	EXP. DATE	STATE	LICENSE #	EXP. DATE
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

HAS YOUR NURSING LICENSE EVER BEEN SUSPENDED, REVOKED, OR INVESTIGATED? _____

OSHA REQUIREMENTS

HAVE YOU BEEN IMMUNIZED FOR HEPATITIS B? _____

DATE OF IMMUNIZATION: 1st _____, 2nd _____, 3rd _____

EDUCATION

EDUCATION	NAME AND ADDRESS OF SCHOOL	YEARS ATTENDED	YEARS COMPLETED	GRADUATE?	DEGREE	GPA
HIGH SCHOOL		FROM		YES	DEGREE	
	CITY, STATE	TO		NO	MAJOR	
COLLEGE / SCHOOL OF NURSING		FROM		YES	DEGREE	
	CITY, STATE	TO		NO	MAJOR	
GRADUATE SCHOOL		FROM		YES	DEGREE	
	CITY, STATE	TO		NO	MAJOR	
OTHER (SPECIFY)		FROM		YES	DEGREE	
	CITY, STATE	TO		NO	MAJOR	

CONTINUING EDUCATION/CERTIFICATION

CONTINUING EDUCATION (PLEASE ENCLOSE COPIES) _____

CRITICAL CARE COURSE _____ EKG COURSE: Yes No

ARE YOU CPR/BCLS CERTIFIED? _____ DATE TAKEN: _____ EXPIRATION DATE _____

ARE YOU ACLS CERTIFIED? _____ DATE TAKEN: _____ EXPIRATION DATE _____

SPECIALTY CERTIFICATIONS (CCRN, CEN, etc.) PLEASE ENCLOSE COPIES _____

PLEASE ENCLOSE COPIES OF CPR CERTIFICATION. YOU MUST HAVE CURRENT CPR PRIOR TO ASSIGNMENT.

ARE YOU IV CERTIFIED? Yes No

EMPLOYMENT HISTORY

List most recent employment first.

All employment must be recorded; use additional sheets as necessary

Any breaks in employment must be explained

Explanations, if necessary:

Employer _____
Immediate Supervisor _____ Dept./Unit/Floor _____
Address _____ Phone () _____
City/State /Province/Zip _____ Dates Employed (Mo./Day/Yr.): From _____ To _____
Position Held _____ Duties _____
Specialty _____ Charge Experience _____
Number of beds _____ Number and Title of Employees Supervised _____
Type of Nursing (Primary, etc.) _____ Reason for Leaving _____
Average No. Hours per week _____ Was this a travel assignment? _____ Can we contact this employer? _____

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Application continues on next page....

Employment history continued....

HAVE YOU EVER BEEN DISCHARGED FROM A JOB OR FORCED TO RESIGN? _____

IF YES, PLEASE EXPLAIN _____

EMERGENCY

Please notify in case of emergency:

1) Name _____ Relationship _____

Address _____ City/State/Zip _____

Phone () _____ Phone () _____

2) Name _____ Relationship _____

Address _____ City/State/Zip _____

Phone () _____ Phone () _____

LIABILITY INSURANCE

DO YOU HAVE PROFESSIONAL LIABILITY INSURANCE? _____

IF YES, ATTACH A COPY OR SUPPLY NAME OF CARRIER _____

I certify that all answers to questions in this application are true. I understand that any false or misleading information or omissions in this application shall result in ineligibility for employment or immediate dismissal. I further understand and agree that Advantage Nursing Services, LLC will require a health assessment prior to my employment and periodically thereafter as a condition of employment. I authorize Advantage Nursing Services, LLC , its agents, servants, and employees to investigate all statements made in this application and to contact former employers, educational institutions licensing and any and all other institutions, persons or agencies, and hereby authorize Advantage Nursing Services, LLC, its agents, servants and employees and said herein before identified organizations and persons to release any and all records, documents and information relative to such inquiries and I further hereby release and all of said parties from any liability or responsibility in connection herewith. I agree that my references and/or a copy of my application may be disclosed to an authorized representative from a client hospital/institution of Advantage Nursing Services, LLC as required by Joint Commission requirements.

The Civil Rights Act of 1964 prohibits discrimination in employment because of race, color, religion, sex or national origin. Federal law also prohibits discrimination on the basis of age with respect to certain individuals. The laws of most states also prohibits some or all of the above types of discrimination as well as some additional types such as discrimination based upon ancestry, marital status or physical or mental handicap or disability

SIGNATURE _____

DATE _____

INTERVIEWER _____

DATE _____

For office use only

Travel _____

Staffing _____

Payroll _____

References _____