



Today's Date: _____ Date Available for Work: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Discipline (RN, LPN, Rad Tech, etc.): _____ Email Address: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Permanent Address: _____

City: _____ State: _____ Zip: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Date of Birth: _____

How did you hear about Alliant Medical Staffing? _____

Emergency Contact _____ Number: _____ Relationship: _____

Interested in: Travel Local Contract Perm Placement Shift Preference: AM PM Either

REFERENCES:

Facility Name: _____ Dept/Unit/Floor: _____

City: _____ State: _____ Dates of Employment: From _____ To _____

Supervisor: _____ Title: _____ Phone Number: _____

Facility Name: _____ Dept/Unit/Floor: _____

City: _____ State: _____ Dates of Employment: From _____ To _____

Supervisor: _____ Title: _____ Phone Number: _____

Facility Name: _____ Dept/Unit/Floor: _____

City: _____ State: _____ Dates of Employment: From _____ To _____

Supervisor: _____ Title: _____ Phone Number: _____

EMPLOYMENT APPLICATION *(continued)*

LICENSURE			
State	License #	Active Y/N	Expiration Date

SPECIALTIES AND UNIT EXPERIENCE		
Department:	Years Experience:	Charge: Y / N
Department:	Years Experience:	Charge: Y / N
Department:	Years Experience:	Charge: Y / N
Department:	Years Experience:	Charge: Y / N

EDUCATION			
Name of School	Location	Graduation Date	Degree

CERTIFICATIONS / CREDENTIALS			
Type	Expiration Date	Type	Expiration Date
CPR		CCRN	
ACLS		CHEMO	
PALS		Critical Care Course	
BCLS		OTHER: _____	
NALS		OTHER: _____	
CRRN		OTHER: _____	

1. Have you ever had any disciplinary action taken against any of your licenses or certifications? Y / N
2. Are your professional licenses or certifications now under review, probation, suspension, or are you working under a consent order from any licensing authority? Y / N
3. Have you ever been named as a defendant in a malpractice claim? Y / N
4. Are you either a U.S. citizen or can you submit verification of your legal right to work in the U.S.? Y / N

**If you answered yes to any of questions 1-3, please attach a separate sheet of paper with a full explanation, including dates and current status.*

EMPLOYMENT HISTORY

Facility Name:	_____	Dept/Unit/Floor:	_____		
Address:	_____				
City:	_____	State:	_____	Zip:	_____
Dates of Employment:	From _____	To _____	Number of Beds:	_____	
Immediate Supervisor:	_____	Telephone Number:	_____		
Name of Staffing Agency (if applicable):	_____				
Reason for Leaving:	_____				

Facility Name:	_____	Dept/Unit/Floor:	_____		
Address:	_____				
City:	_____	State:	_____	Zip:	_____
Dates of Employment:	From _____	To _____	Number of Beds:	_____	
Immediate Supervisor:	_____	Telephone Number:	_____		
Name of Staffing Agency (if applicable):	_____				
Reason for Leaving:	_____				

Facility Name:	_____	Dept/Unit/Floor:	_____		
Address:	_____				
City:	_____	State:	_____	Zip:	_____
Dates of Employment:	From _____	To _____	Number of Beds:	_____	
Immediate Supervisor:	_____	Telephone Number:	_____		
Name of Staffing Agency (if applicable):	_____				
Reason for Leaving:	_____				

EMPLOYMENT HISTORY *(continued)*

Facility Name: _____ Dept/Unit/Floor: _____
Address: _____
City: _____ State: _____ Zip: _____
Dates of Employment: From _____ To _____ Number of Beds: _____
Immediate Supervisor: _____ Telephone Number: _____
Name of Staffing Agency (if applicable): _____
Reason for Leaving: _____

Facility Name: _____ Dept/Unit/Floor: _____
Address: _____
City: _____ State: _____ Zip: _____
Dates of Employment: From _____ To _____ Number of Beds: _____
Immediate Supervisor: _____ Telephone Number: _____
Name of Staffing Agency (if applicable): _____
Reason for Leaving: _____

Facility Name: _____ Dept/Unit/Floor: _____
Address: _____
City: _____ State: _____ Zip: _____
Dates of Employment: From _____ To _____ Number of Beds: _____
Immediate Supervisor: _____ Telephone Number: _____
Name of Staffing Agency (if applicable): _____
Reason for Leaving: _____

AGE SPECIFIC / PERFORMANCE SPECIFIC SKILLS ASSESSMENT

In the spaces below, please indicate the number of years experience you have with each age group.

	Newborn	Pediatric	Adolescent	Adult	Geriatric
Possesses knowledge and skills to perform an assessment and treatment. (Meds., equipment, etc.)					
Knowledge of growth and development.					
Ability to assess age specific data.					
Ability to interpret age specific data.					
Ability to communicate age specific data to other care givers.					
Ability to document age specific criteria regarding patient care.					
Ability to perform age specific patient teaching.					
Ability to evaluate age specific data response to treatments.					
Ability to involve family and or significant other in decision making.					

JCAHO MANDATORY ANNUAL IN-SERVICES

I have read and understand the following booklets, or have had this training at an accredited facility on the date listed below. If it has been longer than one calendar year since your last training on these topics, please check the box provided, and books will be mailed to you.

BOOK TITLE	DATE
FIRE SAFETY IN HEALTHCARE FACILITIES	
ELECTRICAL SAFETY IN HEALTHCARE FACILITIES	
WHAT YOU SHOULD KNOW ABOUT LIFTING AND MOVING OF PATIENTS	
UNIVERSAL PRECAUTIONS IN HEALTHCARE SETTINGS	
WHY YOU SHOULD BE INFORMED ABOUT AIDS	
HAZARDOUS MATERIALS IN HEALTHCARE FACILITIES	
INFECTION CONTROL	
BLOOD BORNE PATHOGENS	
WHAT HEALTHCARE WORKERS SHOULD KNOW ABOUT HEPATITIS B	
CONTINUOUS QUALITY IMPROVEMENT	
COMPETENCY IN PROVIDING AGE APPROPRIATE CARE	

DIVERSITY STATEMENT

If we, as individuals and as an organization, are to thrive in a world of plural cultures, we must learn not only to respect differences but enjoy them, not only to familiarize ourselves with different cultural traditions, but to take advantage of the enrichment gained through our interaction with members of those cultures. As a result of this, we, as an interaction with members will not discriminate on the basis of age, race, sex, religion or sexual orientation. We at Alliant Medical Staffing look forward to servicing the world.

Signature

Date

Print Name

CONSENT/ AGREEMENT AND AUTHORIZATION

I understand and acknowledge that, as a condition of employment, I must submit to a physical examination, including the analysis for the detection of the use of unlawful drugs or substances in accordance with applicable laws. If I receive an offer of employment at the request of Alliant Medical Staffing and if one is given, I agree that my continued employment may be contingent on the results.

I have read and fully understand the questions asked in this application and that all answers given by me are true, accurate, and complete. I also understand that the omission, concealment, or misrepresentation of any fact on this application or during any interview for employment may be cause for my immediate dismissal from employment.

I give Alliant Medical Staffing permission to use any information in this application to enable it and its agents to verify the information contained in this application, and I authorize present and former employers, educational institutions I have attended, credit agencies, all references, and any other persons to answer all questions asked by Alliant Medical Staffing. Alliant Medical Staffing may conduct a criminal background investigation and I understand that my employment with Alliant Medical Staffing may be contingent upon the results of such investigation. I release Alliant Medical Staffing, its agents, and all affiliated entities, as well as any person or institutions that provides Alliant Medical Staffing with any information about me, from any and all liability whatsoever resulting from any such investigation or the disclosure of such information.

In consideration of my employment and of my being considered for employment by Alliant Medical Staffing, I agree to abide by all Company rules and regulations, which I understand are subject to change by Alliant Medical Staffing at any time for any reason without prior notice. I also understand that if employed, I will be an employee at will and employed for no definite period of time. I understand that either the company or I can terminate my employment at any time, with or without cause and with or without advance notice. I further understand that no communication, whether oral or written, by any representative of Alliant Medical Staffing, at any time, can constitute a contract of employment. No representative or agent of the company other than the Director of Human Resources by either written or mutually signed agreement has the authority to enter into any agreement for employment for any specific period of time or to make any agreement contrary to the foregoing.

In addition, I understand that Alliant Medical Staffing and all compensation and benefits plan administrators have the maximum discretion permitted by law to administer, interpret, modify, discontinue, enhance, or otherwise administer, interpret, or change all policies, procedures, benefits, or other terms and conditions of employment.

Alliant Medical Staffing strives to have a safe environment for our employees to work in. In the event you are injured while on an assignment, you must call our office immediately. If you feel unable to call, please ask your supervisor to contact us. You must immediately report any injuries no matter how minor they may seem. Any claims not reported immediately may be subject to denial. Alliant Medical Staffing will work together with both the client and the employee for the proper procedure and treatment of the injury.

I agree, in consideration of your employing me, that I will not seek or accept employment, either directly or indirectly in any capacity from any client of Alliant Medical Staffing to whom I have been assigned, for at least 90 working days after the last day of that assignment. I also agree that I will not solicit these clients on my behalf nor on behalf of any future employer(s). I further understand that I cannot be paid until I present a time slip signed by both the client and me to the Alliant Medical Staffing office.

SIGNED _____ DATE _____

PRINT NAME _____

WITNESS _____ DATE _____