NATIONAL® Healthcare Staffing
an AMN Healthcare company

TRAVELER APPLICATION

Name _____ _____ _____
Last First Middle initial

Current address _____ _____ _____ _____
Street address City State Zip code

Home phone _____ _____ Work phone _____
At this location until

Permanent address _____ _____ _____ _____
Street address City State Zip code

Phone _____ _____
Best time/day to reach you

Professional discipline _____ Specialty _____

Social Security number _____ Date available to travel _____

Desired city/state Assignments _____ Email address _____

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

State: License # State: License # State: License #
Expiration date: Expiration date: Expiration date:

CERTIFICATION *(Include photocopies of certification held.)*

○ RN ○ CNA ○ PA ○ RR/PARU ○ CEN ○ PTA/COTA ○ Other: _____
○ LPN ○ CRNA ○ PSCU ○ RRT ○ CCRN ○ CST/ST

Certificate: Registration / Registration number: _____ Expiration date: _____

Has your professional license or certification ever been investigated or suspended? ○ Yes ○ No
If yes, attach separate sheet with explination.

Have you ever been convicted of a crime other than a minor traffic violation? ○ Yes ○ No
If yes, attach separate sheet with explination.

Have you ever been named as a defendant in a professional liability action? ○ Yes ○ No

Are you authorized to work in the U.S.? ○ Yes ○ No

_____

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

Person to notify in case of emergency: _____ _____
Name Relationship

_____
Street address City State Zip code Phone

EMPLOYMENT PROFILE

_____
Applicant's name:

Please indicate all of your employment for the past ten (10) years, beginning with your most recent employer.

Are you employed now? ○ Yes ○ No If so, may we contact your present employer? ○ Yes ○ No

Facility/employer _____ Dept. _____

Street address _____ City _____ State _____ Zip code _____

Dates employed: From _____ To _____ Reason for leaving _____

Position held _____ Specialty _____

Supervisor's name and title _____ Phone _____

Other supervisor? _____ Phone _____

Travel assignment? ○ Yes ○ No Local staff agency? ○ Yes ○ No

Facility/employer _____ Dept. _____

Street address _____ City _____ State _____ Zip code _____

Dates employed: From _____ To _____ Reason for leaving _____

Position held _____ Specialty _____

Supervisor's name and title _____ Phone _____

Other supervisor? _____ Phone _____

Travel assignment? ○ Yes ○ No Local staff agency? ○ Yes ○ No

Facility/employer _____ Dept. _____

Street address _____ City _____ State _____ Zip code _____

Dates employed: From _____ To _____ Reason for leaving _____

Position held _____ Specialty _____

Supervisor's name and title _____ Phone _____

Other supervisor? _____ Phone _____

Travel assignment? ○ Yes ○ No Local staff agency? ○ Yes ○ No

Other names under which you have been employed _____

Please document reasons for periods you were not employed.

I attest that the information provided within this application represents a full and complete disclosure of information about my current and previous employers, and is true and correct to the best of my knowledge and belief. I understand and acknowledge that failure to provide a full and complete disclosure of my employment information is a violation of the law, and could result in civil penalties. I acknowledge that any misstatement or omission of fact on this application may result in my disqualification from participation in the National Healthcare Staffing (NHS) program. I authorize a full release for NHS to obtain information from my current and previous employers. I authorize NHS to release this application and reference information to NHS affiliates, and NHS Client institutions, only after receiving my express written or verbal consent for each assignment opportunity. I understand that by giving NHS permission to submit my application for assignment opportunities, I am also agreeing to background searches that may be required by NHS, certain states or Client institutions. Prior to conducting any background searches that qualify as "consumer" or "investigative consumer" reports, applicant will be provided separate disclosure and acknowledgement forms.

Signature _____ Date _____

EMPLOYMENT PROFILE

_____
Applicant's name:

Complete for any other positions you have held for the past ten (10) years.

Facility/employer _____ Dept. _____
Street address _____ City _____ State _____ Zip code _____
Dates employed: From _____ To _____ Reason for leaving _____
Position held _____ Specialty _____
Supervisor's name and title _____ Phone _____
Other supervisor? _____ Phone _____
Travel assignment? ○ Yes ○ No Local staff agency? ○ Yes ○ No

Facility/employer _____ Dept. _____
Street address _____ City _____ State _____ Zip code _____
Dates employed: From _____ To _____ Reason for leaving _____
Position held _____ Specialty _____
Supervisor's name and title _____ Phone _____
Other supervisor? _____ Phone _____
Travel assignment? ○ Yes ○ No Local staff agency? ○ Yes ○ No

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Supervisor's name and title _____ Phone _____
Other supervisor? _____ Phone _____
Travel assignment? ○ Yes ○ No Local staff agency? ○ Yes ○ No

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Facility/employer _____ Dept. _____

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Dates employed: From _____ To _____ Reason for leaving _____

Position held _____ Specialty _____

Supervisor's name and title _____ Phone _____

Other supervisor? _____ Phone _____

Travel assignment? ○ Yes ○ No Local staff agency? ○ Yes ○ No

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Position held _____ Specialty _____

Supervisor's name and title _____ Phone _____

Other supervisor? _____ Phone _____

Travel assignment? ○ Yes ○ No Local staff agency? ○ Yes ○ No

PROFESSIONAL REFERENCES

(manager, head nurse, supervisor, department head)

Name/Title _____ _____

Facility Name and Telephone _____

Name/Title _____ _____

Facility Name and Telephone _____

Name/Title _____ _____

Facility Name and Telephone _____

Revised 11/20/02 RS