

INSTRUCTIONS:

This form is a professional document. It must be complete, true, and accurate. Falsification of professional documents by omission or false statements is an offense reportable to the State Board (s).

Referred By: _____

Phone: _____

NAME: _____

Maiden Name AND/OR Other Practiced Under: _____

CURRENT ADDRESS: _____

CITY/STATE/ZIP: _____

Permanent Address: _____

City/State/Zip: _____

Current Phone: _____ Cell Phone: _____

Permanent Phone: _____ FAX: _____

You must have a minimum of 1 year's current RN experience, in the clinical area you are submitted to.

E Mail Address: _____

SS#: _____ Date of Birth: _____ U.S. Citizen? _____

Marital Status: _____ # Dependents? _____ Ages: _____

EMERGENCY CONTACT (EC): List information of nearest relative not living with you, for emergency notification.

Name: _____

Address: _____

City/State/Zip: _____

EC Phone 1: _____ EC Phone 2: _____

Clinical Areas Preferred: _____ TRANSPORTATION: Car? _____ Other _____

Date Available For Travel or Cap RN Position: _____ SHIFT PREFERENCES, IN ORDER: 1) _____ 2) _____ 3) _____

MALPRACTICE Insurance Policy #: _____ **Company:** _____ **Policy Exp. Date** (Enclose copy of policy): _____

RN EDUCATION (Include graduate hours)			
School name	City/State	Mo/Yr Graduated	Degree

Clinical Area Worked	Years Exp	Clinical Area Worked	Years Exp	Clinical Area Worked	Years Exp	Clinical Area Worked	Years Exp

RN LICENSURE: List original first, then all others:						CERTIFICATIONS/CEs: Enclose copies.					
State	Number	Expires	State	Number	Expires	Name	Date Taken	Expires	Name	Date Taken	Expires
						BCLS			CCRN		
						ACLS			PALS		
						NALS/NRP					

HAVE YOU EVER HAD DISCIPLINARY ACTION taken against any of your nursing licenses, or are you currently the subject of a report or investigation? _____ (Y/N) *If the answer is yes please give details on a *Privacy Page, together with the name and phone number of the official who can verify the information.* Are you eligible for rehire at all previous and current RN positions? _____ (Y/N) *If the answer is NO please give details on a *Privacy Page.*

Have you ever worked as a travel RN? _____ (Y/N) did you successfully complete your travel assignments? _____ (Y/N) *if not please give details on a *Privacy Page. (*Sensitive data you include on a separate page)*

RN EMPLOYMENT HISTORY (Continues on next page).

List most recent employment first. You must account for all time from the present to the month/year you passed the State Boards and received your RN license. Use additional sheets as necessary. Do not omit any RN position. If there was a problem, explain on a separate sheet. Enter Agency if you worked PRN or Travel positions. Explain all breaks in employment and provide verification information. Please make sure that the contact names and phone numbers are current and accurate. **Please give first and last names.**

Passed State Boards: MONTH _____ YEAR _____ STATE _____

Current Hospital _____ City _____ State _____ From (Mo/Day/Yr.) _____ to _____

(AGENCY _____ Travel _____ PRN _____ Contact _____ Phone _____)

Eligible for Rehire? (Y/N) _____ Fulltime? _____ Position _____ Unit Type _____ # of Beds worked _____ Your Shift _____ N/P Ratio _____ Charge Experience?: _____

Charge Nurse _____ FIRST NAME _____ LAST NAME _____ Supervisor _____ FIRST NAME _____ LAST NAME _____ Unit Phone _____

List Areas/Diagnoses/Equipment: (Example: Ortho, Neuro, CHF, diabetes, COPD, vents, a-lines, ect.) _____

Previous Hospital _____ City _____ State _____ From (Mo/Day/Yr.) _____ to _____

(AGENCY _____ Travel _____ PRN _____ Contact _____ Phone _____)

Eligible for Rehire? (Y/N) _____ Fulltime? _____ Position _____ Unit Type _____ # of Beds worked _____ Your Shift _____ N/P Ratio _____ Charge Experience?: _____

Charge Nurse _____ FIRST NAME _____ LAST NAME _____ Supervisor _____ FIRST NAME _____ LAST NAME _____ Unit Phone _____

List Areas/Diagnoses/Equipment: (Example: Ortho, Neuro, CHF, diabetes, COPD, vents, a-lines, ect.) _____

RN EMPLOYMENT HISTORY (Continued)

RN's Name: _____

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Previous Hospital _____ City _____ State _____ From (Mo/Day/Yr.) _____ to _____

(AGENCY _____ Travel _____ PRN _____ Contact _____ Phone _____)

Eligible for Rehire? (Y/N) _____ Fulltime? _____ Position _____ Unit Type _____ # of Beds worked _____ Your Shift _____ N/P Ratio _____ Charge Experience?: _____

Charge Nurse _____ FIRST NAME _____ LAST NAME _____ Supervisor _____ FIRST NAME _____ LAST NAME _____ Unit Phone _____

List Areas/Diagnoses/Equipment: (Example: Ortho, Neuro, CHF, diabetes, COPD, vents, a-lines, ect.) _____

Previous Hospital _____ City _____ State _____ From (Mo/Day/Yr.) _____ to _____

(AGENCY _____ Travel _____ PRN _____ Contact _____ Phone _____)

Eligible for Rehire? (Y/N) _____ Fulltime? _____ Position _____ Unit Type _____ # of Beds worked _____ Your Shift _____ N/P Ratio _____ Charge Experience?: _____

Charge Nurse _____ FIRST NAME _____ LAST NAME _____ Supervisor _____ FIRST NAME _____ LAST NAME _____ Unit Phone _____

List Areas/Diagnoses/Equipment: (Example: Ortho, Neuro, CHF, diabetes, COPD, vents, a-lines, ect.) _____

Previous Hospital _____ City _____ State _____ From (Mo/Day/Yr.) _____ to _____

Supervisor _____ FIRST NAME _____ LAST NAME _____ Phone _____ Eligible for Rehire? (Y/N) _____ Fulltime? _____ Unit Type _____

(AGENCY _____ Travel _____ PRN _____ Contact _____ Phone _____)

Previous Hospital _____ City _____ State _____ From (Mo/Day/Yr.) _____ to _____

Supervisor _____ FIRST NAME _____ LAST NAME _____ Phone _____ Eligible for Rehire? (Y/N) _____ Fulltime? _____ Unit Type _____

(AGENCY _____ Travel _____ PRN _____ Contact _____ Phone _____)

Previous Hospital _____ City _____ State _____ From (Mo/Day/Yr.) _____ to _____

Supervisor _____ FIRST NAME _____ LAST NAME _____ Phone _____ Eligible for Rehire? (Y/N) _____ Fulltime? _____ Unit Type _____

(AGENCY _____ Travel _____ PRN _____ Contact _____ Phone _____)

Previous Hospital _____ City _____ State _____ From (Mo/Day/Yr.) _____ to _____

Supervisor _____ FIRST NAME _____ LAST NAME _____ Phone _____ Eligible for Rehire? (Y/N) _____ Fulltime? _____ Unit Type _____

(AGENCY _____ Travel _____ PRN _____ Contact _____ Phone _____)

EXPLAIN ALL BREAKS:

PERSONAL PROFESSIONAL REFERENCES To help us process your application as quickly as possible, please list an **additional** SUPERVISORY RN with direct personal knowledge of your professional skills for each of your RN POSITIONS FOR THE LAST 3 YEARS (after contacting them and making sure that these RNs are willing to provide personal references for you).

Name	Phone	Hospital	Dates you worked	Unit
FIRST NAME _____ LAST NAME _____	_____	_____	_____	_____
FIRST NAME _____ LAST NAME _____	_____	_____	_____	_____
FIRST NAME _____ LAST NAME _____	_____	_____	_____	_____

CONDITION OF HEALTH/PRACTICE CERTIFICATION (Requires separate signature):

____ Excellent ____ Good ____ Fair Height _____ Weight _____ Date last physical _____ I, the undersigned RN, do hereby certify by my signature on this document that I am able without limitation to practice and perform all of the duties of an RN, that I am licensable without limitation, and that no complaints or investigations are pending against my license(s). If previously impaired, I have successfully completed an approved program and my State Board has released me to perform as an RN without limitation. I understand and agree that prior to starting an assignment with CMSI, I must provide a list of all medications I currently take, provide a Physician's Statement, lab work, and do Drug/Alcohol Screens.

1 SIGNATURE: _____ **DATE:** _____

The statements herein are true and complete to the best of my knowledge. I understand that falsification will be basis for disqualification or termination of contract and report to the State Board(s). I, the undersigned RN, do hereby request, direct, and give permission to any and all physicians, RNs, contractors, employers, and their employees, agents, designated or authorized representatives to release any and all information concerning my performance, conduct, and nursing practice known to them, and I agree to hold harmless from liability for any cause, except wilful falsification of data, arising from the release and use of said information those who provide said information and those to whom this information is provided. I authorize the retention of information relating to my previous, current, and future RN positions in the Quality Assurance Database, and the use of this information in QA activities. I understand that refusal by any party to provide said information may result in denial of a professional position.

2 SIGNATURE: _____ **DATE:** _____