

Health Professionals Employment Application

CHECK ONE:

Nursing

- Registered Nurse
- Licensed Practical/Vocational Nurse
- Certified Nursing Assistant
- Advanced Practice Nurse

Surgery

- Certified Surgical Technician
- Surgical Technician

Allied Health

- Radiologic Technologist
- Respiratory Therapist
- Other _____
- Other _____
- Other _____

TRAVEL LOCAL

DATE AVAILABLE: _____ GEOGRAPHIC PREFERENCE: _____

PERSONAL PROFILE: (Please Print)

Name: _____ Maiden Name: _____
First Middle Initial Last
Social Security # (U.S): _____ E Mail Address: _____
Hospital Preference: _____
Shift Preference (Rank in order of preference) Days Evenings Nights
Referred By: (Journal, Individual, Other) _____
(If referred by a healthcare professional, a name must be included for referring HCP to receive referral bonus)

Current Address: (Please Print)

City: _____ State: _____ Zip: _____
Phone Number: _____ Pager/Cell: _____
From: _____
Best Time to Reach You: _____
In Case of Emergency, Contact: (Please Print) _____
Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____

II. PHYSICAL RECORD: (Please Print)

All positions available through MEDStaff include the full range of responsibilities standard to the industry. Are there any reasons why you would be unable to perform any of the essential functions of the position for which you are applying? Yes No

If Yes, please explain: _____

Date of Last Physical: _____ Evidence of a physical exam within 1 year is required.

III. EDUCATION: (Please Print)

Name/Location of School

Month/Year
Graduated

Type of
Degree

High School

Vocational/Technical

College/University

College/University

Other

IV. LICENSURE: (Please Print and Enclose Copies)

Current License: State: _____ Active: Yes [] No [] License #: _____

Registered: State: _____ Active: Yes [] No [] License #: _____

State of Original Licensure: _____ Active: Yes [] No [] License#: _____

Additional Licensure: _____ Active: Yes [] No [] License#: _____

Additional Licensure: _____ Active: Yes [] No [] License#: _____

Additional Licensure: _____ Active: Yes [] No [] License#: _____

Has license ever been investigated or suspended? Yes [] No []

(If yes, attach separate sheet with dates and explanation.)

Do you have malpractice insurance? Yes [] No []

If yes,

Carrier

Number

Expiration Date

V. CERTIFICATIONS: (Please Print and Enclose Copies)

CPR: (Healthcare Provider/Adult & Peds) Yes [] No [] Expires: _____

ACLS: Yes [] No [] Expires: _____

PALS Yes [] No [] Expires: _____

NRP: Yes [] No [] Expires: _____

OTHER: Yes [] No [] Expires: _____

OTHER: Yes [] No [] Expires: _____

OTHER: Yes [] No [] Expires: _____

OTHER: Yes [] No [] Expires: _____

Approved Course Certification (Enclose Copies)

Course Name: _____ Cert. Date: _____

Course Name: _____ Cert. Date: _____

Total years of health care experience within an acute care hospital setting? _____

Please list any additional education, skills, experience or other relevant qualifications (i.e., foreign language) in the space provided below. If more space is necessary, please print on separate sheet and attach to application.



3805 WEST CHESTER PIKE, SUITE 200, NEWTOWN SQUARE, PA 19073

TOLL FREE: (800) 732-9992 • FAX: (610) 353-7850

www.medstaffinc.com

8/26/2008

VI. EMPLOYMENT PROFILE: (Please Print)

LIST ALL EMPLOYMENT BEGINNING FROM THE TIME OF GRADUATION FROM YOUR HEALTH CARE PROGRAM.

All information must be completed, most recent employment first. Your employers will be contacted for verification. (Please list additional employers on a separate sheet of paper should you run out of space).

Include all requested information for each gap in employment longer than 30 days including dates, reasons, and employer information if applicable.

1. Facility: Number of Beds:

City: State: Zip:

Teaching Facility: Yes No Trauma Facility: Yes No Staff Employee: Yes No

Charge: Yes No Manager/Supervisor: Yes No Educator: Yes No

Specialty Experience: Unit/Dept: #Cases/Day: Nurse Pt. Ratio:

1. Years: # Beds:

2. Years: # Beds:

3. Years: # Beds:

Manager/Supervisor: Shift:

Phone: Extension:

Dates of Employment:

Reason for leaving:

Dates of Employment Gap: Education Personal/Family Vacation/Time Off

Non Clinical Work Experience Employer: Role:

City: State: Supervisor: Phone:

2. Facility: Number of Beds:

City: State: Zip:

Teaching Facility: Yes No Trauma Facility: Yes No Staff Employee: Yes No

Charge: Yes No Manager/Supervisor: Yes No Educator: Yes No

Specialty Experience: Unit/Dept: #Cases/Day: Nurse Pt. Ratio:

1. Years: # Beds:

2. Years: # Beds:

3. Years: # Beds:

Manager/Supervisor: Shift:

Phone: Extension:

Dates of Employment:

Reason for leaving:

Dates of Employment Gap: Education Personal/Family Vacation/Time Off

Non Clinical Work Experience Employer: Role:

City: State: Supervisor: Phone:

3. Facility: Number of Beds:

City: State: Zip:

Teaching Facility: Yes No Trauma Facility: Yes No Staff Employee: Yes No

Charge: Yes No Manager/Supervisor: Yes No Educator: Yes No

Specialty Experience: Unit/Dept: #Cases/Day: Nurse Pt. Ratio:

1. Years: # Beds:

2. Years: # Beds:

3. Years: # Beds:

Manager/Supervisor: Shift:

Phone: Extension:

Dates of Employment:

Reason for leaving:

Dates of Employment Gap: Education Personal/Family Vacation/Time Off

Non Clinical Work Experience Employer: Role:

City: State: Supervisor: Phone:



3805 WEST CHESTER PIKE, SUITE 200, NEWTOWN SQUARE, PA 19073

TOLL FREE: (800) 732-9992 • FAX: (610) 353-7850

www.medstaffinc.com

8/26/2008

4. Facility:

Number of Beds:

City:		State:		Zip:	
Teaching Facility: Yes [] No []		Trauma Facility: Yes [] No []		Staff Employee: Yes [] No []	
Charge: Yes [] No []		Manager/Supervisor: Yes [] No []		Educator: Yes [] No []	
Specialty Experience:	Unit/Dept:	#Cases/Day:	Nurse Pt. Ratio:		
1.		Years:	# Beds:		
2.		Years:	# Beds:		
3.		Years:	# Beds:		
Manager/Supervisor:			Shift:		
Phone:			Extension:		
Dates of Employment:					
Reason for leaving:					
Dates of Employment Gap:		<input type="checkbox"/> Education	<input type="checkbox"/> Personal/Family	<input type="checkbox"/> Vacation/Time Off	
<input type="checkbox"/> Non Clinical Work Experience	Employer:			Role:	
City:	State:	Supervisor:	Phone:		

5. Facility:

Number of Beds:

City:		State:		Zip:	
Teaching Facility: Yes [] No []		Trauma Facility: Yes [] No []		Staff Employee: Yes [] No []	
Charge: Yes [] No []		Manager/Supervisor: Yes [] No []		Educator: Yes [] No []	
Specialty Experience:	Unit/Dept:	#Cases/Day:	Nurse Pt. Ratio:		
1.		Years:	# Beds:		
2.		Years:	# Beds:		
3.		Years:	# Beds:		
Manager/Supervisor:			Shift:		
Phone:			Extension:		
Dates of Employment:					
Reason for leaving:					
Dates of Employment Gap:		<input type="checkbox"/> Education	<input type="checkbox"/> Personal/Family	<input type="checkbox"/> Vacation/Time Off	
<input type="checkbox"/> Non Clinical Work Experience	Employer:			Role:	
City:	State:	Supervisor:	Phone:		

6. Facility:

of Beds:

City:		State:		Zip:	
Teaching Facility: Yes [] No []		Trauma Facility: Yes [] No []		Staff Employee: Yes [] No []	
Charge: Yes [] No []		Manager/Supervisor: Yes [] No []		Educator: Yes [] No []	
Specialty Experience:	Unit/Dept:	#Cases/Day:	Nurse Pt. Ratio:		
1.		Years:	# Beds:		
2.		Years:	# Beds:		
3.		Years:	# Beds:		
Manager/Supervisor:			Shift:		
Phone:			Extension:		
Dates of Employment:					
Reason for leaving:					
Dates of Employment Gap:		<input type="checkbox"/> Education	<input type="checkbox"/> Personal/Family	<input type="checkbox"/> Vacation/Time Off	
<input type="checkbox"/> Non Clinical Work Experience	Employer:			Role:	
City:	State:	Supervisor:	Phone:		

PLEASE REVIEW AND SIGN WHERE INDICATED.

The statements made in this application are true to the best of my knowledge. I understand that any falsification will be the basis for disqualification of employment or termination of services. I authorize Medstaff, Inc. to verify the information I have provided and to contact current and past employers and references concerning my ability, character and employment record on a pre-employment and ongoing basis. I release all such persons from liability for furnishing said information. I authorized MedStaff Inc, as my employer, to release any medical information which may be relevant to my employment to their client facilities. By submitting this application to MedStaff Inc., I authorize release of this information to all other affiliates of the Company and I acknowledge and agree that they may contact me using facsimile or any other means. Nothing contained in this employment application, or in the granting of an interview, is intended to create an employment contract between MedStaff and the applicant for either employment or for providing of any benefit. I understand that my employment, and eligibility for continued employment, may be dependent upon my passing a periodic physical examination, criminal background investigation, clinical competency examination, and urine drug screen. If reasonable suspicion exists, or where warranted by circumstances, workplace conditions or contractual requirements, an additional drug screen may be performed at the discretion of MedStaff, Inc. or the medical facility to which I have been assigned. All offers of employment are made conditional upon the applicant's proving employment authorization and identity in accordance with the Immigration Reform and Control Act of 1986.

RELEASE:

I hereby authorize any prior employers to provide such information concerning my employment with them as may be requested, and also authorize the Registrar/Placement Office of all educational institutions attended to release an official copy of my transcript and, if available, faculty appraisals. I authorize any appropriate licensing board to release full information concerning my licensure status and my licensure history. I authorize MedStaff, Inc. to release this application along with other information to prospective client facilities for an employment decision through Medstaff Inc. I hereby release MedStaff, Inc., its employees, and any individual or entity providing information to MedStaff, Inc. from all liability from any damages from the disclosure of this information.

1. If you are not a U.S. citizen, have you the legal right to work in the U.S.? Yes No
2. Have you ever been convicted of or pled guilty or no contest (nolocontendere) to any felony or misdemeanor charge?
 Yes No

If yes, please indicate dates, conviction, final outcome and attach a separate sheet with full particulars.

Date _____ Conviction _____

Outcome _____

3. Have you ever been the subject of a reprimand or disciplinary action or refused employment or admission to a professional society or had professional privileges (in any jurisdiction in which you are licensed) investigated, suspended or revoked by any court or administrative agency or ever been the subject of any ethics investigation at local, state or national level? Yes No
- If yes, please indicate dates, conviction, final outcome and attach a separate sheet with full particulars.

Date _____ Conviction _____

Outcome _____

4. Has any malpractice claim or suit ever been brought against you? Yes No
- If yes, please indicate dates, conviction, final outcome and attach a separate sheet with full particulars.

Date _____ Conviction _____

Outcome _____

5. Are you aware of any circumstances, which may result in a malpractice claim or suit being made or brought against you?
 Yes No

If yes, please indicate dates, conviction, final outcome and attach a separate sheet with full particulars.

Date _____ Conviction _____

Outcome _____

Signature: _____ Date: _____

MedStaff, Inc. and its affiliated subsidiaries are equal opportunity employers. We do not discriminate on the basis of sex, race, color, religion, national origin, handicapped status or veteran's status.



EMPLOYMENT REFERENCE

APPLICANT: PLEASE COMPLETE THIS BLOCK ONLY.

Applicant's Name (Please print) _____ SS# _____

I give my permission for the following employer to provide this information to MedStaff, Inc.

Signature _____ Date _____

To Whom It May Concern:

Med Staff, Inc. has a commitment of maintaining high quality standards for our clients. This commitment requires us to employ individuals with demonstrated skills and proficiency levels.

The applicant whose signature appears above has submitted your name as a reference. We would greatly appreciate your assistance in substantiating the qualifications of our applicant. Your responses will be held in strictest confidence.

Thank you in advance for your courtesy and help in this matter.

Previous Employer _____

Address _____

Position(s) Held _____ Unit _____

Supervisor's Name/Title _____

Phone _____

Dates of Employment: _____

Reason for Termination/Departure: _____

Eligible for Rehire? Yes[] No[] If no, explain: _____

Please rate the applicant upon the standards of performance expectations for the unit.

PERSONAL ATTRIBUTES

	Excellent	Very Good	Good	Poor
Punctuality	[]	[]	[]	[]
Appearance	[]	[]	[]	[]
Initiative	[]	[]	[]	[]
Adaptability	[]	[]	[]	[]
Efficiency	[]	[]	[]	[]
Follows Policies/Rules	[]	[]	[]	[]
Team Player	[]	[]	[]	[]
Safety Minded	[]	[]	[]	[]

PATIENT CARE/RELATIONS

	Excellent	Very Good	Good	Poor
Client Rapport	[]	[]	[]	[]
Follows Physician's Orders	[]	[]	[]	[]
Observes/Reports Patient Condition	[]	[]	[]	[]
Charts Accurately	[]	[]	[]	[]
Applies Theory/Skills	[]	[]	[]	[]
Consistent Performance	[]	[]	[]	[]
Performance in Emergencies	[]	[]	[]	[]
Teaches/Directs Relative to Clinical Expertise	[]	[]	[]	[]
Infection Control/Safety Awareness	[]	[]	[]	[]
Universal Precautions	[]	[]	[]	[]

Comments: _____

Evaluator's Signature: _____ Date: _____

Position: _____ Dept./Unit _____

Phone reference: Verified By: _____ Date: _____



3805 WEST CHESTER PIKE, SUITE 200, NEWTOWN SQUARE, PA 19073

TOLL FREE: (800) 732-9992 • FAX: (610) 353-7850

www.medstaffinc.com

8/26/2008

EMPLOYMENT REFERENCE

APPLICANT: PLEASE COMPLETE THIS BLOCK ONLY.

Applicant's Name (Please print) _____ SS# _____

I give my permission for the following employer to provide this information to MedStaff, Inc.

Signature _____ Date _____

To Whom It May Concern:

Med Staff, Inc. has a commitment of maintaining high quality standards for our clients. This commitment requires us to employ individuals with demonstrated skills and proficiency levels.

The applicant whose signature appears above has submitted your name as a reference. We would greatly appreciate your assistance in substantiating the qualifications of our applicant. Your responses will be held in strictest confidence.

Thank you in advance for your courtesy and help in this matter.

Previous Employer _____

Address _____

Position(s) Held _____ Unit _____

Supervisor's Name/Title _____

Phone _____

Dates of Employment: _____

Reason for Termination/Departure: _____

Eligible for Rehire? Yes[] No[] If no, explain: _____

Please rate the applicant upon the standards of performance expectations for the unit.

PERSONAL ATTRIBUTES

	Excellent	Very Good	Good	Poor
Punctuality	[]	[]	[]	[]
Appearance	[]	[]	[]	[]
Initiative	[]	[]	[]	[]
Adaptability	[]	[]	[]	[]
Efficiency	[]	[]	[]	[]
Follows Policies/Rules	[]	[]	[]	[]
Team Player	[]	[]	[]	[]
Safety Minded	[]	[]	[]	[]

PATIENT CARE/RELATIONS

	Excellent	Very Good	Good	Poor
Client Rapport	[]	[]	[]	[]
Follows Physician's Orders	[]	[]	[]	[]
Observes/Reports Patient Condition	[]	[]	[]	[]
Charts Accurately	[]	[]	[]	[]
Applies Theory/Skills	[]	[]	[]	[]
Consistent Performance	[]	[]	[]	[]
Performance in Emergencies	[]	[]	[]	[]
Teaches/Directs Relative to Clinical Expertise	[]	[]	[]	[]
Infection Control/Safety Awareness	[]	[]	[]	[]
Universal Precautions	[]	[]	[]	[]

Comments: _____

Evaluator's Signature: _____ Date: _____

Position: _____ Dept./Unit _____

Phone reference: Verified By: _____ Date: _____



3805 WEST CHESTER PIKE, SUITE 200, NEWTOWN SQUARE, PA 19073

TOLL FREE: (800) 732-9992 • FAX: (610) 353-7850

www.medstaffinc.com

8/26/2008

PHYSICAL STATEMENT AND HEALTH STATUS

MEDICAL RELEASE AUTHORIZATION

I _____ (Client name) do hereby authorize _____ (Physician name) to release any information acquired during my medical examination to MedStaff, Inc. I also authorize MedStaff, Inc. to release any information on this statement, relevant to employment, to any of its client facilities.

Client Signature

TUBERCULOSIS AND IMMUNIZATION STATUS

A positive PPD must be followed by Physician contact and a chest x-ray. Some facilities require a two-step PPD, the spacing below allows for documentation of both steps.

Date given: _____	By: _____
Site: R L forearm	
Lot # _____	Exp. Date: _____
Date read: _____	By: _____
Results: Induration: _____ mm	<input type="checkbox"/> Non-significant <input type="checkbox"/> Significant reaction

Date given: _____	By: _____
Site: R L forearm	
Lot # _____	Exp. Date: _____
Date read: _____	By: _____
Results: Induration: _____ mm	<input type="checkbox"/> Non-significant <input type="checkbox"/> Significant reaction

Test	Date	Positive	Negative
BCG	_____	_____	_____
Chest x-ray	_____	_____	_____
Urine drug screen (obtained through MedStaff)	_____	_____	_____

PPD skin test is required annually by MedStaff, Inc. Documented negative chest x-ray is accepted if PPD is positive. (attach radiology report)

PLEASE FILL IN ALL OF THE APPLICABLE BLANKS. Attach laboratory results to this form.

Measles	Disease	(date)	_____	Immune	(date)	_____	Titre	(date)	_____	Pos.	_____	Neg.	_____	Numerical Value	_____
Mumps	Disease	(date)	_____	Immune	(date)	_____	Titre	(date)	_____	Pos.	_____	Neg.	_____	Numerical Value	_____
Rubella	Disease	(date)	_____	Immune	(date)	_____	Titre	(date)	_____	Pos.	_____	Neg.	_____	Numerical Value	_____
Varicella	Disease	(date)	_____	Immune	(date)	_____	Titre	(date)	_____	Pos.	_____	Neg.	_____	Numerical Value	_____
Other		(date)	_____	Immune	(date)	_____	Titre	(date)	_____	Pos.	_____	Neg.	_____	Numerical Value	_____
Other		(date)	_____	Immune	(date)	_____	Titre	(date)	_____	Pos.	_____	Neg.	_____	Numerical Value	_____

Hepatitis B	Date	1.	_____	Date	2.	_____	Date	3.	_____	Titre:	Pos.	_____	Neg.	_____	Numerical Value	_____
-------------	------	----	-------	------	----	-------	------	----	-------	--------	------	-------	------	-------	-----------------	-------

Hepatitis B acknowledgment form must be signed and submitted to MedStaff. Charges for Hepatitis B vaccine will be paid as specified by MedStaff policy.

There may be additional requirements for employment with MedStaff, a particular healthcare facility and/or standard in the healthcare industry.

HEALTH STATEMENT

I have examined this patient and determined that this person is in good physical and mental health, free of communicable diseases, and able to function and perform all job duties without any physical limitations in his/her profession at full capacity.

Physician Signature

License Number

Date

Physician Address (Please Print)

Physician Phone Number

PLEASE ATTACH ALL LAB AND RADIOLOGY RESULTS



3805 WEST CHESTER PIKE, SUITE 200, NEWTOWN SQUARE, PA 19073
TOLL FREE: (800) 732-9992 • FAX: (610) 353-7850

www.medstaffinc.com

8/26/2008