

# Application for Employment



Critical Care Professionals, Inc.  
Nursing, Respiratory and Allied Healthcare Professionals

Applications are evaluated on the information supplied. Therefore, it is important to complete the application legibly and in its entirety. Incomplete applications will be not be considered.

Position/Specialty Desired: \_\_\_\_\_ Date Available: \_\_\_\_\_

## I. PERSONAL INFORMATION (please print)

Name: Last First Middle Maiden Social Security Number: \_\_\_\_\_

Present Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_ Years/Months lived there? \_\_\_\_\_

Permanent Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_ Years/Months lived there? \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_ Are you a U.S. citizen?  Yes  No

Have you ever pled guilty or "no contest" to a crime, had adjudication withheld, or been convicted of a felony?  Yes  No  
(NOTE: Answering "yes" to this question does not constitute an automatic bar to employment.)

If yes, please give date and details of each:

## II. PROFESSIONAL INFORMATION

If you are applying for a position as a healthcare professional including Registered Nurse, please complete Sections II and III. If not, please proceed to Section 4, "Record of Previous Employment."

1st Specialty: \_\_\_\_\_ Years Exp: \_\_\_\_\_ 3rd Specialty: \_\_\_\_\_ Years Exp: \_\_\_\_\_

2nd Specialty: \_\_\_\_\_ Years Exp: \_\_\_\_\_ 4th Specialty: \_\_\_\_\_ Years Exp: \_\_\_\_\_

Region/State/City Preferences: \_\_\_\_\_

Have you worked travel assignments before?  Yes  No For which agency(s): \_\_\_\_\_

If yes, please attach a list of the dates of all travel assignments and the facilities in which you worked.

List all states in which you are currently licensed or have been licensed:

State/Country	License #	Exp. Date	State/Country	License #	Exp. Date
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List any inactive licenses you may have: \_\_\_\_\_

Has your professional license ever been suspended, revoked, or investigated?  Yes  No

If yes, attach a separate sheet with explanation and any documentation related to license suspension, reinstatement, etc.

## III. PROFESSIONAL CERTIFICATIONS

CPR (BLS)	Exp. Date: _____	NALS	Exp. Date: _____
BCLS	Exp. Date: _____	CEN	Exp. Date: _____
ACLS	Exp. Date: _____	CNOR	Exp. Date: _____
PALS	Exp. Date: _____	CHEMO	Exp. Date: _____
NRP	Exp. Date: _____	OCN	Exp. Date: _____
TNCC	Exp. Date: _____	CRRN	Exp. Date: _____
CCRN	Exp. Date: _____	Critical Care Nurse	<input type="checkbox"/> Yes <input type="checkbox"/> No Exp. Date: _____
Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Exp. Date: _____	

Related courses/certification (i.e. chemotherapy, EKG, Balloon Pump, etc. Please attach certification):

## IV. RECORD OF PREVIOUS EMPLOYMENT

Please list the names of your present or previous employers in chronological order with present or last employer listed first. Be sure to account for all periods of time including military service and any period of unemployment. If self-employed, give Company name and supply business references.

PRESENT OR LAST EMPLOYER:		Position:	
Address:		Employed From (month/year): To (month/year):	
City, State, Zip:		Starting pay:	Final Pay:
		\$	\$
Last Supervisor name/title:	Phone:	May we contact them? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reason for leaving:		Duties/Responsibilities:	
PREVIOUS EMPLOYER 2:		Position:	
Address:		Employed From (month/year): To (month/year):	
City, State, Zip:		Starting pay:	Final Pay:
		\$	\$
Last Supervisor name/title:	Phone:	May we contact them? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reason for leaving:		Duties/Responsibilities:	
PREVIOUS EMPLOYER 3:		Position:	
Address:		Employed From (month/year): To (month/year):	
City, State, Zip:		Starting pay:	Final Pay:
		\$	\$
Last Supervisor name/title:	Phone:	May we contact them? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reason for leaving:		Duties/Responsibilities:	
PREVIOUS EMPLOYER 4:		Position:	
Address:		Employed From (month/year): To (month/year):	
City, State, Zip:		Starting pay:	Final Pay:
		\$	\$
Last Supervisor name/title:	Phone:	May we contact them? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reason for leaving:		Duties/Responsibilities:	
PREVIOUS EMPLOYER 5:		Position:	
Address:		Employed From (month/year): To (month/year):	
City, State, Zip:		Starting pay:	Final Pay:
		\$	\$
Last Supervisor name/title:	Phone:	May we contact them? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reason for leaving:		Duties/Responsibilities:	

If there are any employers listed above whom you do not wish for us to contact, please explain circumstances:

Have you ever been terminated or asked to resign from any job?  Yes  No If yes, please explain circumstances:

Please explain fully any gaps in employment history:

### V. EDUCATIONAL HISTORY

List ALL of the schools attended since high school in chronological order, starting with the most recent.

School Name	Years Completed <i>(circle one)</i>	Diploma/Degree	Describe Course of Study or Major	Describe Specialized Training Experience, Skills, and Extracurricular Activities
High school:	9 10 11 12			
College/University:	1 2 3 4			
Graduate/Professional:	1 2 3 4			
Other:				

### VI. EMERGENCY INFORMATION

In case of accident or other emergency, whom should we contact?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street City State Zip

Work Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Street City State Zip

### VII. PERSONAL REFERENCES

Please list two persons who know you well who are not previous employers or relatives:

Name of Reference 1:	Relationship:	Years known:
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Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone:	Occupation:
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Name of Reference 2:	Relationship:	Years known:
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Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone:	Occupation:
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### VIII. DRIVING INFORMATION

Do you have a current driver's license?  Yes  No

Country: \_\_\_\_\_ State: \_\_\_\_\_ License #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Has your driver's license ever been suspended or revoked?  Yes  No If yes, please explain circumstances:

## IX. CONDITION OF HEALTH/CERTIFICATION

Excellent    Good    Fair   Height: \_\_\_\_\_   Weight: \_\_\_\_\_   Date of last physical: \_\_\_\_\_

Are you now or have you ever applied for/received worker's compensation?  Yes  No   Suffered from: Back injury?  Yes  No  
Hernia?  Yes  No   Alcoholism?  Yes  No   Drug Addiction?  Yes  No   Emotional/Psychological illness?  Yes  No

If yes to any question, please explain separately: \_\_\_\_\_

Please list any medications you take and explain: \_\_\_\_\_

Have you had any chronic illness or disability, including psychological?  Yes  No   If yes to this question, please provide Critical Care Professionals, Inc. with a physician's statement releasing to return to work without limitations (able to perform all duties as LPN/RN).

## X. APPLICANT ACKNOWLEDGEMENT AND AUTHORIZATION

I understand that if I am hired by Critical Care Professionals, Inc. (hereafter referred to as "the Company"), my employment will be for no definite period, regardless of the period of payment of my wages. I further understand that I have the right to terminate my employment at any time with or without notice, and the Company has the same right. No one other than the President or Director of Human Resources of the Company has authority to modify this relationship or make any agreement to the contrary. Any such modification or agreement must be in writing.

I understand that the Company reserves the right to require me to submit to a drug test at any time and also reserves the right to require me to submit to an alcohol test and/or medical examination to the extent permitted by law. I authorize the Company to investigate my driving record, my criminal record and my credit history, and I understand that an investigative consumer report may be prepared whereby information is obtained through personal interviews with neighbors, friends and others with whom I am acquainted. This inquiry would include information as to my character, general reputation, personal characteristics and mode of living. I understand that I have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

I further understand that the Company may contact my previous employers, and I authorize those employers to disclose to the Company all records and other information pertinent to my employment with them. I also authorize the Company to provide truthful information concerning my employment with it to my future prospective employers, and I agree to hold it harmless for providing such information.

I understand and voluntarily agree that, if hired, I will complete all educational courses and take all tests necessary to keep all of my licenses, including driver's license, and certifications current and valid, as required by the Company or local, state or federal law or regulation. I further agree to advise the Company if at any time my licenses or certifications become invalid or expire. I understand that failure to take such tests when required or requested or to keep my licenses, including driver's license, current and valid or to advise the Company that my licenses have expired or become invalid may result in my immediate dismissal.

I certify that all of the information that I provide on this application and in any interview will be true and accurate. I understand that if I am employed and any such information is later found to be false or misleading in any respect, I may be dismissed.

I, the undersigned, do hereby certify by my signature on this document that I am free from infectious/contagious disease(s), that I am free from drug(s) and/or alcohol, and that I am able, without limitation, to practice and perform all of the duties of an RN.

I CERTIFY THAT ALL OF THE INFORMATION THAT I HAVE PROVIDED ON THIS APPLICATION IS TRUE AND ACCURATE.

### DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Questions regarding employment opportunities with Critical Care Professionals, Inc. or items on this application form can be directed to:  
Critical Care Professionals, Inc., Human Resources Director, (410) 321-5850; or E-mail: [info@criticalcarepros.com](mailto:info@criticalcarepros.com)

**CRITICAL CARE PROFESSIONALS, INC. IS AN EQUAL OPPORTUNITY EMPLOYER.**