

Coastal Staff Relief Inc.

Health Professional Employment Application - Please attach resume.

Position Applying For:

RN LVN/LPN PT OT PTA OTA ST MSW CNA Other

I. Personal Profile: (Please Print)

Name: _____ Maiden Name: _____
 First MI Last

Social Security #: _____ Date of Birth _____

Date Available: _____

Hospital Preference: _____, _____, _____

Geographic Preference: _____

Referred by: _____

Current Address: (Please Print)

E-Mail Address: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Cell Number: _____ Pager Number: _____

Best Time To Reach You: _____

In Case of Emergency, Contact: (Please Print)

Relationship: _____

Address: _____ City: _____ State: _____

Phone: _____ Pager Number: _____

Criminal History:

Have you ever been convicted of a felony or Misdemeanor? Yes No (If yes, submit dates and details on a separate sheet of paper).

Have you ever been convicted of a drug-related misdemeanor? Yes No

(If Yes, submit dates and details on a separate sheet of paper). If you are not a U.S. Citizen, do you have a legal right to remain in the U.S.? Yes No Attach verification.

II. PHYSICAL RECORD: (Please Print)

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

If yes, please explain: _____

III. EDUCATION: (Please Print)

Name/Location of School	Month/Year	Type of
Graduated		
High School _____		
Vocational / Technical _____		
College / University _____		
Graduate School _____		
Other _____		

IV. LICENSURE: (Please Print)

Licensed: Yes No Registered: Yes No Licensed/Registry Eligible: Yes No
State of Original Licensures / Registry: _____
Active: Yes No License number: _____
(Enclose photocopies of both sides marked "COPY" where permitted by law).
State: _____ # _____ Active: Yes No
State: _____ # _____ Active: Yes No

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 _____

NURSING EXPERIENCE
(Number of years worked by specialty)

Med/Surg _____	Peds _____	Geriatrics _____
ICU _____	PICU _____	Oncology _____
Telemetry _____	NICU _____	Rehab _____
ER _____	Lab/Del _____	Clinic _____

CERTIFICATION

BLS _____	PALS _____	IV _____
ACLS _____	NRP _____	OTHER _____

V. EMPLOYMENT PROFILE: (MINIMUM OF 7 YEARS HISTORY IS REQUIRED)

LIST ALL EMPLOYMENT FROM THE MOST RECENT EMPLOYMENT THROUGH THE TIME OF GRADUATION FROM YOUR HEALTH CARE PROGRAM. All information must be completed. Your employers will be contacted for verification. (Please list additional employers on a separate sheet of paper should you run out of space), or Resume.

1. Facility: _____ **Number of Beds:** _____

City: _____ State: _____

Teaching Facility: Yes No Trauma Facility: Yes No

Charge / Management Experience: Yes No

Specialty Unit Experience:

1. _____ Years: _____ Number of Beds: _____

2. _____ Years: _____ Number of Beds: _____

3. _____ Years: _____ Number of Beds: _____

Unit Manager: _____ Shift: _____

Phone: _____ Extension: _____

Dates of Employment: _____

Reason for Leaving: _____

2. Facility: _____ **Number of Beds:** _____

City: _____ State: _____

Teaching Facility: Yes No Trauma Facility: Yes No

Charge / Management Experience: Yes No

Specialty Unit Experience:

4. _____ Years: _____ Number of Beds: _____

5. _____ Years: _____ Number of Beds: _____

6. _____ Years: _____ Number of Beds: _____

Unit Manager: _____ Shift: _____

Phone: _____ Extension: _____

Dates of Employment: _____

Reason for Leaving: _____

3. Facility: _____ **Number of Beds:** _____

City: _____ State: _____

Teaching Facility: Yes No Trauma Facility: Yes No

Charge / Management Experience: Yes No

Specialty Unit Experience:

7. _____ Years: _____ Number of Beds: _____

8. _____ Years: _____ Number of Beds: _____

9. _____ Years: _____ Number of Beds: _____

Unit Manager: _____ Shift: _____

Phone: _____ Extension: _____

Dates of Employment: _____

Reason for Leaving: _____

Drug Testing Consent Form

I have applied for employment with Coastal Staff Relief in a position that requires me to do direct patient care. As a condition for my application being considered, I understand and agree to undergo substance screening. I understand that if my test results are positive, I shall not be considered further by Coastal Staff Relief for a nursing position.

I hereby authorize any physician, laboratory, hospital or medical professional retained by Coastal Staff Relief for screening purposes to conduct such screening and to provide the results to Coastal Staff Relief, and I release Coastal Staff Relief and any person affiliated with Coastal Staff Relief and any such institution or person conducting the screening, from liability therefore.

Applicant's signature: _____

Date: _____

Inquiry Release

In connection with my application with Coastal Staff Relief, Inc. I understand that investigative background inquiries may be made on myself including but not limited to Previous Employer Verifications, Education Verifications, Criminal Convictions or History, Motor Vehicle Reports, Social Security Trace Reports, and other reports. These reports may include reasons for termination of past employment from previous employers. Further, I understand that Coastal Staff Relief, Inc. and/or its authorized agent may be requesting information from various Federal, State and other agencies which maintain records concerning my past activities relating to my driving, credit, criminal, civil and other experiences and may include information involving me in the files of insurance companies.

I hereby authorize, without any reservation, any party or agency contracted by Coastal Staff Relief, Inc., USA-FACT, Inc. and their employees or assigns from any and all claims, actions, suits, agreements or liabilities arising from the release of said information to Coastal Staff Relief, Inc. or any authorized agent thereof.

Note: Before signing this document, read it thoroughly and complete all requested information. If not applicable, indicate by drawing a line through the section.

I have read and understand the above notice.

Signature: _____ Date: _____

Print Name: _____

Print Entire Name Legibly

Mailing Address: _____

City, State and Zip Code: _____

Telephone Number Including Area Code: _____

Coastal Staff Relief, Inc.

Employment Verification and Reference Check

(Applicant Section)

Date: _____

Former Employer: _____

Street Address: _____

Phone: _____

Applicants Name: _____

Social Security Number: _____

(Employer Section)

To Whom It May Concern:

The above named individual has applied for employment and has named you as a former employer. In order to make an informed hiring decision, we need to know the applicant's work history. The applicant has signed a release permitting you to provide us with the information listed below. All the information you give will be held in the strictest of confidence.

Position held: _____

Dates of Employment: _____

Punctuality: _____

Adaptability: _____

Follows Policies / Rules: _____

Team Player: _____

Safety Minded: _____

Information furnished by: _____

Thank you for your cooperation and prompt response,

Sincerely,

Coastal Staff Relief, Inc. _

