

Employment Application

MEDICAL TRAVELERS, INC.

"Your Doorway to Freedom"

Candidate Profile

Name _____
Last Middle First

Have you had a travel nursing job before? Yes No

Will your spouse travel with you? Yes No N/A

Shift Desired _____

Will your children travel with you? Yes No N/A

Can you travel immediately? Yes No

Will your pets travel with you? Yes No N/A

How quickly do you want to travel? _____

What is Important to you?

	Very Important	Somewhat Important	A Minor Factor	Not Important at All
High hourly wage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to learn & build skills at leading hospitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to travel to especially beautiful or attractive locations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to name my destination where I would like to travel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Benefits for myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Benefits for my spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travel Expenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Free Housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing Stipend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private Housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Completion Bonus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Licensure assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Where would you like to work? _____

Where would you like to live permanently? _____

What are your overall career goals? _____

What is your ideal assignment length? 8 weeks 13 weeks 26 weeks 1 year

Are you interested in a permanent position? Immediately In 6 months In 1 year
 Would prefer freedom to travel and choose assignment by assignment.

Please use the space below to give us any other comments on specific things you are looking for in your next nursing job. Medical Travelers, Inc. wants to know anything and everything we can do to make you as happy and satisfied with your assignments as possible.

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Today's Date ____ / ____ / ____

Name _____
Last Middle First

Social Security Number _____ Email Address _____

Birthdate ____ / ____ / ____ Citizenship US Other _____

Current Address

Street Address _____

City _____ State _____ Zip _____ Phone (____) ____ - ____

I will be at this address until ____ / ____ / ____ Cellphone (____) ____ - ____

Best time to reach me: _____ Please contact me via: Telephone Email

Permanent Address

Street Address _____

City _____ State _____ Zip _____ Phone (____) ____ - ____

Emergency Contacts

Name _____ Name _____

Current Street Address _____ Current Street Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Phone (____) ____ - ____ Phone (____) ____ - ____

Preferences

Date I am available to start ____ / ____ / ____

Location Preference A. _____ B. _____ C. _____
Facility, City, State, or Region

Are you traveling with family members? Yes No Traveling with friends? Yes No Pets? _____
Please Specify

Education

College _____
School Name Location Dates of attendance Diploma or Degree

Graduate _____
School Name Location Dates of attendance Diploma or Degree

Professional _____
School Name Location Dates of attendance Diploma or Degree

Please attach Resume if available.

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Career

Specialties			
Years Experience			

Licensure

Please attach/include photocopies of all licenses held.

Original State/Date of Licensure and number: State _____ Number _____ Date _____

State _____ Number _____ Date _____ State _____ Number _____ Date _____

State _____ Number _____ Date _____ State _____ Number _____ Date _____

State _____ Number _____ Date _____ State _____ Number _____ Date _____

Have you ever held a nursing license under a different name? If yes, list name and location: No Yes Name _____ Location _____

Credentials

Type: _____ Exp. Date _____

Type: _____ Exp. Date _____

Type: _____ Exp. Date _____

Type: _____ Exp. Date _____

Type: _____ Exp. Date _____

Type: _____ Exp. Date _____

Type: _____ Exp. Date _____

Type: _____ Exp. Date _____

Type: _____ Exp. Date _____

Type: _____ Exp. Date _____

Certifications

Type: _____ Exp. Date _____

Type: _____ Exp. Date _____

Type: _____ Exp. Date _____

Type: _____ Exp. Date _____

Type: _____ Exp. Date _____

Type: _____ Exp. Date _____

Type: _____ Exp. Date _____

Type: _____ Exp. Date _____

Type: _____ Exp. Date _____

Type: _____ Exp. Date _____

Type: _____ Exp. Date _____

Type: _____ Exp. Date _____

If you answer yes to any of the below questions, please attach a separate sheet with circumstances, dates, and final outcome:

Have you ever been convicted of a crime? No Yes – Attach Details

Has your license or certification ever been investigated? No Yes – Attach Details

Has your license or certification ever been suspended? No Yes – Attach Details

Have you ever been named as a defendant in a malpractice claim? No Yes – Attach Details

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Employment History

Please list your employment for the past 10 years. Begin with your most recent employment. Please document any periods of unemployment.

Are you currently employed? Yes No

May we contact your current employer? Yes No If no, may we contact your previous employer? Yes No

Facility _____ From ___/___/____ To ___/___/____

Location _____
Street Address City State Zip Code

Supervisor _____ Phone (____)____-____
Name Title

Specialty _____ Shift _____ Position _____

Total # Hospital Beds _____ No. of Unit Beds _____ Avg. Patient Ratio _____ Teaching Hospital? Yes No

Charge Exp.? _____ How often? _____ Travel Assignment Yes No

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Employment opportunities presented by Medical Travelers, Inc. are conditional – based upon satisfactory background screening and professional references, successful completion of a physical exam within the last year and any other client facility mandated requirements (10 panel drug screen test for example). I hereby authorize Medical Travelers, Inc. to perform multiple employment screening checks prior to each assignment including but not limited to: background checks, employment verification, reference checks, education verification, drug screening, etc. I authorize the release of any obtained information relative to my employment to Medical Travelers, Inc. and to the client facility where I will be employed. I authorize Medical Travelers, Inc. to verify the information I have provided and to contact past employers and references concerning my ability, character and employment record, etc. I release all persons from liability for furnishing said information. Further, I certify that all of the above information is correct and that any misrepresentation or falsification of fact made as a part of this application may be considered sufficient cause for immediate dismissal from Medical Travelers, Inc. I have filled out this application to the best of my knowledge and agree that all of the information I have provided is correct.

Medical Travelers, Inc. provides equal employment opportunities to all employees and applicants for employment without regards to race, color, creed, religion, sex, national origin, age, citizenship, disability, veteran status or any other protected status. This policy governs all areas of employment at Medical Travelers, Inc. including recruitment, hiring, training, assignments, promotions, compensation, benefits, discipline and terminations. I understand that employment by Medical Travelers, Inc. is "at will", meaning that either I or Medical Travelers, Inc. can terminate the employment relationship at any time for any unsatisfactory performance or other lawful reasons with or without notice.

I understand that nothing contained in this employment application is intended to lead or create an employment contract between Medical Travelers, Inc. and myself which would in any way restrict the right of the company to terminate my employment at will. I acknowledge that any false, incomplete or misleading information I provide on the application form, in a resume or in a pre-employment interview will be grounds to deny my application or, if discovered later, for immediate dismissal from employment.

Signature _____ Date ____/____/____

(If you need additional spaces to list your employment for the previous 10 years, please continue with the form on page 9.)

Employment Application

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Applicant Reference Consent Form

Applicant Name _____
Last Middle First

Applicant: Please complete this form with three references corresponding with your employment history form.

Facility _____

Location _____
Street Address City State Zip Code

Supervisor / Head Nurse _____
Name Title

Phone (____) _____ - _____ ext. _____ Best Time to Contact _____

Facility _____

Location _____
Street Address City State Zip Code

Supervisor / Head Nurse _____
Name Title

Phone (____) _____ - _____ ext. _____ Best Time to Contact _____

By signing this form, I hereby grant the facilities listed below my consent to release any information to Medical Travelers, Inc. pertaining to my employment. I also hereby authorize Medical Travelers, Inc. to disclose my references to its employers and client facilities, institutions, affiliates, or agents.

Signature _____ Social Security Number _____ - _____ - _____ Date ____ / ____ / ____

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Request for Reference Information

Employer: The individual named below has applied for employment with Medical Travelers, Inc. To ensure a thorough screening process, we ask that you provide the information requested below.

Applicant Information

Applicant Name: _____ Position Held: _____

Facility Name: _____ Teaching Hospital: Yes No

Is this applicant eligible for rehire? Yes No

Facility Information

Unit/Floor: _____ Specialty: _____ Number of Beds in Unit _____

Charge Experience? Yes No Total Beds in Facility: _____ Avg. Patient Caseload: _____

Unit Description: _____

Evaluation

	Superior	Above Satisfactory	Satisfactory	Below Satisfactory
Prioritizes tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Demonstrates consistency in work quality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintains orderly work and patient care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Applies and carries through physician's orders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Completes all required documentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follows patient infection control and safety rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manages all routine situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can handle emergency situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contributes to the department's continuity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shows a high level of technical proficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accepts direction easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets along with the hospital staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicates well with superiors and peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Places a high value on attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Demonstrates interest and enthusiasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keeps up with advances in the field	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Reference Provided By: _____ Title: _____ Date ____/____/____

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Use this form to continue documenting your employment over the previous 10 years. Again begin with the most recent continuing from the previous Employment History form *(where you have listed your most recent 5 positions)*

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Street Address City State Zip Code

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I attest that the information I have provided in this application is true to the best of my knowledge, and I realize that the falsification of any of this information would be grounds for immediate termination. Further, I hereby authorize Medical Travelers, Inc. to verify this information, and to contact my previous employers and references regarding my employment history. I also hereby release all persons from any liability for providing information or commenting on my responses, and I hereby allow the information and responses in this application to be released to Medical Travelers Inc, its employers, and to any hospitals, clinics, medical centers, or other healthcare facilities where I may be employed.

Signature _____ Date ___/___/____

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Annual Requirements

We will require the following information to be on file for you before you begin your first travel assignment, and updated annually thereafter.

Health Requirement

- Drug Screen completed and on file
- TB Skin Test documentation
- Hepatis B Vaccination documentation
- MMR/Varicella Immunization Status documentation

Education - Annual Requirements

- OSHA/Blood Borne Pathogens
- Age Specific Competency
- Domestic Violence
- HIV/AIDS Update
- HIPAA Regulations