



Hospital		Complete Address	
Position/Specialty		Full or Part Time	Start Date
			End Date
Supervisor's Name		Supervisor's Phone Number	Hourly Pay
<input type="checkbox"/> Staff	<input type="checkbox"/> Agency/PRN	<input type="checkbox"/> Travel	
Number of Beds in Hospital/Unit:		Teaching Hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Agency Name (if travel or PRN)	City/State	Phone Number	
Reason for Leaving?		Eligible for Rehire?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please use an employment history form for additional information so that we may better match you to your perfect position!

**PERSONAL INFORMATION**

Are you aware of any reasons you would not be able to perform the duties of the position for which you are making an application? Yes \_\_\_ No \_\_\_ If yes, please explain \_\_\_\_\_

Have you ever been convicted of a crime, which has not been annulled, expunged or sealed by a court? Yes/No If yes, explain \_\_\_\_\_

Have you ever been involved as a defendant or witness in a malpractice suite? Yes/No If yes, explain \_\_\_\_\_

Date available: \_\_\_\_\_ Hours available: \_\_\_\_\_ Geographical preference: \_\_\_\_\_

In case of emergency, please contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Statement: Read carefully before signing.**

I authorize the verification of all references listed above to give any and all information concerning my previous employment and pertinent information they may have, personal or otherwise, and release the company from all liability for any damage that may result from utilization of such information. I hereby declare that the information given by me in this application is true, correct and complete. If accepted for employment I will comply with the rules set forth in the INS Handbook. I understand that any misrepresentation, falsification, or omission will be sufficient cause for cancellation of the application, or discharge if I have been assigned. I understand that my employment is at will and that I may be terminated or laid off by Independent Nursing Services if the corporation determines that my conduct does not meet acceptable standards or if economic conditions necessitate a reduction of force. I understand that I must pass a pre-employment physical prior to starting work. As a condition for employment, I understand that at such time or times during my employment that the hospital and/or Independent Nursing Services, may require that I must consent to and undergo blood and/or urine and/or hair follicle drug testing. Additionally, I understand that I must consent to undergo blood and/or urine and/or hair follicle drug screen as a prerequisite to my employment. Applicant Initials \_\_\_\_\_

**Restrictions on employment:** If applicant is employed by Independent Nursing Services, one condition of such employment is that applicant shall not be eligible for employment with any Medical Facility that is staffed by Independent Nursing Services until applicant shall have worked a total of 520 hours for Independent Nursing Services. Applicant Initials \_\_\_\_\_

**Application Disclosure/Release:** Independent Nursing Service requires all Healthcare Professionals to submit to a Background check for Licensure, Criminal Background and employment verification as part of our application and hiring policy. In order to run a background check your signature is required on the application disclosure form. Please be advised that by signing this form you consent to the procurement of a consumer report for the above in connection with your application for employment. Applicant Initials \_\_\_\_\_

Date: \_\_\_\_\_ Legal Signature: \_\_\_\_\_