SPECIALTY
PROFESSIONAL SERVICES

PROFESSIONAL PROFILE

CHECK ONE: RN ☐ LPN ☐ ORT/STE ☐ PCA ☐ PCT ☐ CNA ☐ OTHER

Today's Date:				Home Phone #:	
Name:				Cell Phone #:	
Address/Apt#:				Work Phone #:	
City:				Cell Phone Carrier (AT&T/Verizon...):	
State:		Zip:		Email Address:	
County:				Emergency Contact / Relationship:	
Maiden /Alias Names:				Contact Phone:	
Social Security #:				Main Specialty:	
Referred by: Important for when we pay out bonuses	Internet ☐ Job Fair ☐ Referral ☐ Referred Name Other				

LICENSURE (Include photocopies of licenses) {License Type (RN/LPN)} {Date Format: M/D/YYYY}

License Type:	_____	License Number	_____	State	__	Expiration Date	_____
License Type:	_____	License Number	_____	State	__	Expiration Date	_____
License Type:	_____	License Number	_____	State	__	Expiration Date	_____

CERTIFICATIONS (Include photocopies of certifications) {Date Format: M/D/YYYY}

☐ ENPC	Exp. Date:	☐ CNRN	Exp. Date:	☐ STABLE	Exp. Date:
☐ TNCC	Exp. Date:	☐ RNC	Exp. Date:	☐ PICC	Exp. Date:
☐ Chemo	Exp. Date:	☐ FHM	Exp. Date:	☐ MAB/PART	Exp. Date:
☐ OCN	Exp. Date:	☐ CEN	Exp. Date:	☐	Exp. Date:
☐ CCRN	Exp. Date:	☐ CNOR	Exp. Date:	☐	Exp. Date:

LIFE SUPPORT

☐ CPR	Exp. Date:	☐ ACLS	Exp. Date:	☐ PALS	Exp. Date:
☐ NRP	Exp. Date:	Other	Exp. Date:		

ELECTRONIC MEDICAL RECORD

☐ eMar ☐ MediTech ☐ Paper Charting ☐ Eclipsys ☐ QuadraMed Other _____

Education	School Name & Location	Course of Study	Graduation Date	Degree/Diploma
High School				
Trade/Vocational				
College				
Graduate School				

SPECIALTY	YEARS	YEAR LAST USED	SPECIALTY	YEARS	YEAR LAST USED
ICU			OR		
SICU			CVOR		
Burn ICU			First Assist		
MICU			Charge/Supervisor		
Corrections			Case Manager		
CVICU			Psychology		
PICU			PACU – Recovery Room		
Medical/Surgical			M/S Telemetry		
Emergency Room			Telemetry / PCU		
Emergency Room Psych			Labor & Delivery		
Oncology			Mother/Baby		
Dialysis			Post Partum		
Cath Lab			Long Term Care		
Endoscopy			Home Health		
Pediatrics			Rehab		
Occupational Health			Other -		
Radiology			Other -		

Corporate Toll Free: 800.863.3666

SPECIALTY
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PROFESSIONAL PROFILE – WORK HISTORY

Applicant's Name:

Please indicate all of your work history for the past seven (7) years starting with your most recent employer. Please indicate reasons for gaps in employment. **RESUMES ARE ACCEPTED BUT DO NOT REPLACE APPLICATION**

Are you currently working? ☐ **Yes** ☐ **No**
If so, may we contact your current employer? ☐ **Yes** ☐ **No**

Hospital Name:	**Type of Unit:**
City / State:	**Nurse Patient Ratio:**
Hospital Level:	**Beds Per Unit:**
Teaching Hospital: ☐ **Yes** ☐ **No**	**Floated to other units?** ☐ **Yes** ☐ **No**
Was this a Staff Position? ☐ **Yes** ☐ **No**	**If so to which units?**
Dates of Employment: From To	

Hospital Name:	**Type of Unit:**
City / State:	**Nurse Patient Ratio:**
Hospital Level:	**Beds Per Unit:**
Teaching Hospital: ☐ **Yes** ☐ **No**	**Floated to other units?** ☐ **Yes** ☐ **No**
Was this a Staff Position? ☐ **Yes** ☐ **No**	**If so to which units?**
Dates of Employment: From To	

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City / State:	**Nurse Patient Ratio:**
Hospital Level:	**Beds Per Unit:**
Teaching Hospital: ☐ **Yes** ☐ **No**	**Floated to other units?** ☐ **Yes** ☐ **No**
Was this a Staff Position? ☐ **Yes** ☐ **No**	**If so to which units?**
Dates of Employment: From To	

Hospital Name:	**Type of Unit:**
City / State:	**Nurse Patient Ratio:**
Hospital Level:	**Beds Per Unit:**
Teaching Hospital: ☐ **Yes** ☐ **No**	**Floated to other units?** ☐ **Yes** ☐ **No**
Was this a Staff Position? ☐ **Yes** ☐ **No**	**If so to which units?**
Dates of Employment: From To	

Hospital Name:	**Type of Unit:**
City / State:	**Nurse Patient Ratio:**
Hospital Level:	**Beds Per Unit:**
Teaching Hospital: ☐ **Yes** ☐ **No**	**Floated to other units?** ☐ **Yes** ☐ **No**
Was this a Staff Position? ☐ **Yes** ☐ **No**	**If so to which units?**
Dates of Employment: From To	

Hospital Name:	**Type of Unit:**
City / State:	**Nurse Patient Ratio:**
Hospital Level:	**Beds Per Unit:**
Teaching Hospital: ☐ **Yes** ☐ **No**	**Floated to other units?** ☐ **Yes** ☐ **No**
Was this a Staff Position? ☐ **Yes** ☐ **No**	**If so to which units?**
Dates of Employment: From To	

Disclosures / Releases & Acknowledgments

1. I have at least one year of relevant work experience within the United States facility? ☐ Yes ☐ No If you don't please explain:

2. 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.

3. Have you ever been the subject of an investigation by any private or government agency concerning your participation in any Medicare or Medicaid Program? ☐ Yes ☐ No If yes, please indicate dates, conviction, final outcome and attach a separate sheet with full particulars.

4. 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.

5. Do you have any limitations that would restrict you from performing essential functions in the position you are applying for? ☐ Yes ☐ No If so, please explain:

6. Are you either a U.S. Citizen or can show proof of verification of your legal right to work in the U.S.? ☐ Yes ☐ No if No, Please Explain

7. I have a current malpractice policy. ☐ Yes☐ No If Yes, Please indicate Insurance Carrier and Policy #:_____

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 Specialty Professional Services, Corp (SPS), 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 SPS, .as my employer, to release any medical information which may be relevant to my employment to their client facilities. Nothing contained in this employment application, or in the granting of an interview, is intended to create an employment contract between SPS 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 SPS. 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: By signing below, I am advising all the information on this application is accurate. 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 SPS to release this application along with other information to prospective client facilities for an employment decision through SPS. I hereby release SPS, its employees, and any individual or entity providing information to SPS, from all liability from any damages from the disclosure of this information.

Equal Opportunity
Specialty Professional Services, Corp is an equal opportunity employer and manages employment and employee relations practices without regard to race, color, religion, national origin, age, sex medical condition or disability. SPS does not discriminate again any employee or applicant for employment because of sex, race, creed, age, sexual orientation or natural origin, marital status, medical condition or physical disability.

Click here if you agree with the above terms: ☐

Print Name: _____

Signature_____

Date: _____

Please fill out the above Release / Disclaimer & Consent form. Please use black ink. Upon completion, fax back to Specialty Professional Services, Corp.