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Medical Staffing Partners, Inc.

Partnership Equals Solutions

Employment Application

Medical Staffing Partners, Inc. requires one year minimum hospital experience.

First Name: | Last Name: | Middle Name:

Previous Names: (i.e. maiden names, aka's, etc.

Current Address:

City: | State: | Zip:

Home Phone:

Cell Phone:

Pager:

Email

Emergency Contact Include Number:

Registered Nurse Education

School Name & Location	Years Completed	Degree Received

Graduate Education

School Name & Location	Years Completed	Degree Received

RN Licensure(s)

State	License Number	State	License Number	State	License Number

Professional References

(Please include at least two (2))

Name	Telephone	Facility and Unit	Dates of Employment

Tel: 800-896-4164 **Fax: 800-544-2602**

1. Can you provide proof of your right to work in the U.S.A.? Yes ☐ No ☐
2. Have you ever been convicted of a crime that would prohibit your employment in a healthcare facility? Yes ☐ No ☐
   If yes, please provide applicable information.

3. Are you willing to submit to a criminal background check? Yes ☐ No ☐
4. Medical Staffing Partners is a drug free environment. Are you willing to submit to a drug test? Yes ☐ No ☐
5. Are there any limitations to performing the basic functions of the position for which you are applying? Yes ☐ No ☐
   If so, please explain (in accordance with the Americans with Disabilities Act this can not be a determining factor in a decision for hire)

In what state(s) do you possess an active driver's license?

If applicable, provide state(s) where driving privileges have been revoked or suspended.

Employment History

Employer:		Start Date:		End Date:	
Address:				Full-Time: ◯	Part Time: ◯
Supervisor's Name		Supervisor's Telephone Number:			
Position / Dept		Eligible for Rehire: Yes ◯ No ◯			
Was this a travel assignment? Yes ◯ No ◯		Agency:			

Employer:		Start Date:	07/19/2021	End Date:	
Address:				Full-Time: ◯	Part Time: ◯
Supervisor's Name		Supervisor's Telephone Number:			
Position / Dept		Eligible for Rehire: Yes ◯ No ◯			
Was this a travel assignment? Yes ◯ No ◯		Agency:			

Employer:		Start Date:		End Date:	
Address:				Full-Time: ◯	Part Time: ◯
Supervisor's Name		Supervisor's Telephone Number:			
Position / Dept		Eligible for Rehire: Yes ◯ No ◯			
Was this a travel assignment? Yes ◯ No ◯		Agency:			

Employer:		Start Date:		End Date:	
Address:				Full-Time: ◯	Part Time: ◯
Supervisor's Name		Supervisor's Telephone Number:			
Position / Dept		Eligible for Rehire: Yes ◯ No ◯			
Was this a travel assignment? Yes ◯ No ◯		Agency:			

Employer:		Start Date:		End Date:	
Address:				Full-Time: ◯	Part Time: ◯
Supervisor's Name		Supervisor's Telephone Number:			
Position / Dept		Eligible for Rehire: Yes ◯ No ◯			
Was this a travel assignment? Yes ◯ No ◯		Agency:			

Employer:		Start Date:		End Date:	
Address:				Full-Time: ◯	Part Time: ◯
Supervisor's Name		Supervisor's Telephone Number:			
Position / Dept		Eligible for Rehire: Yes ◯ No ◯			
Was this a travel assignment? Yes ◯ No ◯		Agency:			

Age Specific Growth and Development

Levels of Ability:

1. Able to compare and contrast an individual's developmental phase by depicting a wide range of normal elements in physical and motor growth.
2. Able to discuss tasks which are crucial to emotional and social development for each developmental phase.
3. Able to communicate with regard to age-appropriateness.
4. Able to discuss implications and safety issues in caring for the hospitalized patient.
5. Able to offer interventions when teaching or caring for a patient.
6. Able to involve the family and/or significant other in the patient's plan of care.

Please indicate your experience for caring for patients in the following age levels as described above:

☐ Infant ☐ Child ☐ Adolescent ☐ Adult Geriatric ☐ Adult

I certify that all the information provided in this Application for Employment is true and I have completed it to the best of my knowledge. I hereby authorize Medical Staffing Partners, Inc. to investigate all statements contained in this Employment Application and I release any party from any claims based upon their providing information to Medical Staffing Partners, Inc.

I agree and understand that any employment relationship with Medical Staffing Partners, Inc. is of an 'at will' nature, which means that I may resign at any time and Medical Staffing Partners, Inc. may discharge me at any time with or without cause and with or without prior notice. It is further understood that this 'at will' employment relationship may not be changed by any verbal statement or written document or by conduct unless such change is specifically acknowledged in writing by an authorized representative of Medical Staffing Partners, Inc.

I understand that all information on this application is confidential and will be used for the purpose of employment.

In the event of my employment, I understand that false or misleading information given in my application or interview(s) may result in discharge.

Signature of Applicant _____ Date: _____

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