



Impact Medical Staffing LLC Employment Application

Personal Information:

First Name: _____ Middle Name: _____ Last Name: _____
 SSN: _____ Date of Birth: _____ Gender: M _____ F _____
 Nickname: _____ Address: _____ Apt. _____
 City: _____ State: _____ Zip: _____ County: _____
 Country: _____ Home Phone: _____ Work Phone: _____
 Cell Phone: _____ Other Phone: _____ Pager: _____
 Pager Code: _____ Fax: _____ Email: _____
 Secondary Email: _____ Text Message Address: _____
 Emergency Contact: _____
 Emergency Phone: _____
 Emergency Relationship: _____

Certification:

Specialty:

CCRU _____	CCU _____	Endo _____	ER _____
ICU _____	IMC _____	IV/Ther _____	L&D _____
Mom/Baby _____	Med/Surg _____	MICU _____	NICU _____
Oncology _____	OR _____	PACU _____	PCU/Telemetry _____
Peds _____	Peds-ER _____	PICU _____	Psych _____
SICU _____	Rad-Cath _____	Rad-CT _____	Rad-Dexa _____
Rad-Diag _____	Rad-Diag-OR _____	RAd-Echo _____	Rad-IR _____
Rad-Mammo _____	Rad-MRI _____	Rad-NucMed _____	Rad-OnCall _____
Rad-RadTher _____	Rad-OB/US _____	Rad-Vas/US _____	

Years Experience: _____



Professional Licenses:

State: _____ Exp. Date: _____ Number: _____

State: _____ Exp. Date: _____ Number: _____

State: _____ Exp. Date: _____ Number: _____

Have you ever had any disciplinary action against your professional license(s)
(suspended, restrictions, investigation or revoked)?

If YES, please explain: _____

Have you ever been convicted of a felony or misdemeanor crime?

If YES, please explain: _____

Have you ever failed a drug test?

If YES, please explain: _____

Certifications:

CPR/BCLS Exp. Date: _____ ACLS Exp. Date: _____

PALS Exp. Date: _____ NRP/NALS Exp. Date: _____

AART Exp. Date: _____ Other Exp. Date: _____

Other Exp. Date: _____

Test & Dates:

Hepatitis B Date Completed: _____

MMRV Date Completed: _____

Drug Screen Date Completed: _____

OSHA/JCAHO/HIPPA Date Completed: _____

Skills Check List Date Completed: _____

Proficiency Test Date Completed: _____

Equipment Check List Date Completed: _____

Age Specific Date Completed: _____

Physical Exam Date Completed: _____

New Hire Evaluation Date Completed: _____

Annual Evaluation Date Completed: _____



Background Check Date Completed: _____

Driver License Date Completed: _____

I-9 Date Completed: _____

W-4 Date Completed: _____

Reference 1 Date Completed: _____

Reference 2 Date Completed: _____

Badge Photo Date Completed: _____

Education:

High School: _____ Address: _____

City: _____ State: _____ Zip: _____ Year of Graduation: _____

College: _____ Address: _____

City: _____ State: _____ Zip: _____ Year of Graduation: _____

Graduate School: _____ Address: _____

City: _____ State: _____ Zip: _____ Year of Graduation: _____

Are you currently employed? _____ Date you can begin: _____

Full Time: Part Time: App. how many hours per week? _____

Preferred shift(s):

- | | |
|-----------------------|------------------------|
| _____ 8 hour Days | _____ 12 hour Days |
| _____ 8 hour Evenings | _____ 12 hour Evenings |
| _____ 8 hour Nights | _____ 12 hour Nights |
| _____ Weekends | _____ Holidays |

Desired work environment:

Hospital _____ Clinic _____ Private Duty _____ Rehab _____ MD Office _____

Have you ever worked "Agency" before? Yes No

If YES, are you a DNR (do not return) at any facilities? Yes No

If Yes, which facilities? _____

Briefly please explain why: _____

Language Skills: Other than English do you speak any other languages?

French _____ German _____ Spanish _____ Other _____

How were you referred to us?

_____ Impact Medical Staffing Employee: _____



_____ Chesapeake Medical Staffing Employee: _____
_____ Web Site _____
_____ Medical Publication: _____
_____ Job Fair: _____
_____ Newspaper: _____
_____ Other: _____

Employment History: (Please list in order with most current/recent first)

Employer: _____ Address: _____
City: _____ State: _____ Zip: _____ Supervisor: _____
Dates of Employment: _____ Position: _____
Reason for Leaving: _____
May we contact? Yes No Telephone: _____

Employer: _____ Address: _____
City: _____ State: _____ Zip: _____ Supervisor: _____
Dates of Employment: _____ Position: _____
Reason for Leaving: _____
May we contact? Yes No Telephone: _____

Employer: _____ Address: _____
City: _____ State: _____ Zip: _____ Supervisor: _____
Dates of Employment: _____ Position: _____
Reason for Leaving: _____
May we contact? Yes No Telephone: _____

References: (Please list 3 individuals, not related to you, who are familiar with your clinical/work related skills- at least one should be a direct supervisor)

Name: _____ Address: _____
City: _____ State: _____ Zip: _____ Telephone: _____
Years Acquainted: _____ Affiliation: _____

Name: _____ Address: _____
City: _____ State: _____ Zip: _____ Telephone: _____



Years Acquainted: _____ **Affiliation:** _____

Name: _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____ **Telephone:** _____

Years Acquainted: _____ **Affiliation:** _____

I certify that the information in this application is accurate, current and complete. I understand that misrepresentation or omission of facts herein is cause for termination, if employed.

I authorize Impact Medical Staffing to obtain any relevant information (including a criminal background check and drug screening test) needed to make an employment decision both now and at anytime during the course of my employment should I be hired. I authorize Impact Medical Staffing to disclose this application along with any information about me obtained through the hiring process or during the course of employment for federal, state, contractual or accreditation purposes.

I understand that should I become employed by Impact Medical Staffing, my work assignments, schedules and/or work locations are subject to change according to the needs of the business and the clients of Impact Medical Staffing. I also understand that if I become employed by Impact Medical Staffing that my employment is “at will”, in which it may be terminated by either party, at any time, with or without cause.

I have read and understand the application and have answered all portions of the application truthfully and correctly with no omissions.

Applicant Signature: _____ **Date:** _____

Impact Medical Staffing is an Equal Opportunity Employer; pursuant to the Civil Rights Act of 1964, Rehabilitation Act of 1973 and Age Discrimination Act of 1975 we do not discriminate because of age, race, color, sex, sexual preference, marital status, military status, religion, national origin or disability.