



# BRIDGE STAFFING

## Employee Application

Date Available: \_\_\_\_\_

**Applicant Information:**

Last Name	First Name	Middle Name	
Current Address	City	State	Zip
Permanent Address	City	State	Zip
( ) - Telephone: Home	( ) - Cellular	Email Address	
Social Security Number			

**Emergency Contact:**

Name	Relationship	Phone ( ) -
Permanent Address	City	State Zip

**Credentials:**

RN  
  LPN  
  ORT  
  Rad. Tech.  
  Resp. Ther.  
  PT  
  OT  
  SLP  
  Other :

Professional Designation

Primary Specialty	Other Specialty	Other Specialty	Other Specialty
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**Original State of Licensure**

License #	State	Expiration Date	Date Issued	Active/Inactive?
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**Additional Licensure**

License #	State	Expiration Date	Active/Inactive?
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License #	State	Expiration Date	Active/Inactive?
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License #	State	Expiration Date	Active/Inactive?
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**Certifications**

Certification	Cert. #	Cert. Date	Exp. Date
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Certification	Cert. #	Cert. Date	Exp. Date
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Certification	Cert. #	Cert. Date	Exp. Date
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Certification	Cert. #	Cert. Date	Exp. Date
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**Background Questions:**

Has your professional license or certification ever been under investigation, subject to disciplinary action, suspension or revocation?

Yes  No

Have you ever plead guilty to or been convicted of a crime other than a misdemeanor?

Yes  No

Have you ever plead guilty to or been convicted of a DUI?

Yes  No

Have you ever been investigated by state or federal authorities for an alleged violation of a health care law?

Yes  No

Have you ever been a defendant in a professional liability action?

Yes  No

**Education:**

	Name, City and State	Month/Year of Graduation	Diplomas/Degrees Received ADN/BSN/Certificate
High School			
College			
Graduate School			
Other Education			

**Employment History:** Provide employment history beginning with your most recent employer. If more entries are needed, please provide on additional sheets.

Facility/Employer		# of Beds (Hospital)	
Address		City	State Zip
Position Held	Unit/Area	# of Beds (Unit)	
# of Cases / Patients	Shift	Charge Experience? <input type="checkbox"/> Yes <input type="checkbox"/> No	Travel Assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No
		( ) -	( ) -
Name and Title of Supervisor		Phone Number	Fax Number
From:	To:	Employment Dates (mm/yyyy)	
		Reason for Leaving	



**Employment History (Cont.):**

Facility/Employer		# of Beds (Hospital)	
Address		City	State Zip
Position Held	Unit/Area	# of Beds (Unit)	
# of Cases / Patients	Shift	Charge Experience? <input type="checkbox"/> Yes <input type="checkbox"/> No	Travel Assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No
		( ) -	( ) -
Name and Title of Supervisor		Phone Number	Fax Number
From:	To:	Employment Dates (mm/yyyy)	
		Reason for Leaving	

Facility/Employer		# of Beds (Hospital)	
Address		City	State Zip
Position Held	Unit/Area	# of Beds (Unit)	
# of Cases / Patients	Shift	Charge Experience? <input type="checkbox"/> Yes <input type="checkbox"/> No	Travel Assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No
		( ) -	( ) -
Name and Title of Supervisor		Phone Number	Fax Number
From:	To:	Employment Dates (mm/yyyy)	
		Reason for Leaving	

Facility/Employer		# of Beds (Hospital)	
Address		City	State Zip
Position Held	Unit/Area	# of Beds (Unit)	
# of Cases / Patients	Shift	Charge Experience? <input type="checkbox"/> Yes <input type="checkbox"/> No	Travel Assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No
		( ) -	( ) -
Name and Title of Supervisor		Phone Number	Fax Number
From:	To:	Employment Dates (mm/yyyy)	
		Reason for Leaving	



**Employment History (Cont.):**

Facility/Employer		# of Beds (Hospital)			
Address		City	State		Zip
Position Held	Unit/Area		# of Beds (Unit)		
# of Cases / Patients	Shift	Charge Experience?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Agency:	
		Travel Assignment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	( ) -	( ) -
Name and Title of Supervisor		Phone Number		Fax Number	
From:		To:		Employment Dates (mm/yyyy)	
			Reason for Leaving		

**Professional References:**

References must be a Charge Nurse, Supervisor or Manager in a medical setting

Facility/Employer		Contact Name		Title	
Address		City	State	Zip	Phone

Facility/Employer		Contact Name		Title	
Address		City	State	Zip	Phone

Facility/Employer		Contact Name		Title	
Address		City	State	Zip	Phone

Upon submitting and signing this employment application, I certify all of the foregoing information to be true, accurate and complete. I understand and acknowledge that any misrepresentation or omission of fact on this application may result in disqualification from employment with Bridge Staffing, Inc. I authorize Bridge Staffing and its agents to conduct any investigation concerning my background, civil and criminal records, educational records and any other such records or information related to my potential employment with Bridge Staffing. If employed by Bridge Staffing, I agree to abide by all rules and regulations adopted by Bridge Staffing and understand that those rules and regulations are subject to change from time to time. I understand that, if employed by Bridge Staffing, I may be required to undergo a physical examination, including drug screening, in order to determine my ability to perform the duties required in my position. I hereby authorize my former employers to release to Bridge Staffing and its agents any and all information concerning my past employment.

Signature

Date