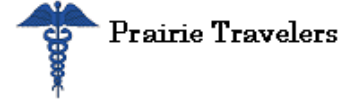


APPLICATION FOR EMPLOYMENT



PERSONAL INFORMATION

Last Name: First Name: MI: Social Security Number:

Address: City: State: Zip Code:

Home Phone: Cell Phone: E-Mail Address:

Best Time to Reach You: Other names under which you have been employed:

Job desired: Number of hours: Hospital or Long Term Care: Shift preference:

Are you legally authorized to work in the United States? Yes: No:

Have you ever filed an application with Prairie Travelers? Yes: No:

Have you worked for other temporary staffing agencies? *Yes: No:

*If yes, please complete the information below:

Company Name: Assignment Type: Employment Dates:

Emergency Contact Name: Relationship: Telephone Number:

Address: City: State: Zip Code:

How did you learn about Prairie Travelers?

Pulse: Website/Internet: Job Service: Other:

Referred: Referred By:

Are you employed at this time? Yes: No:

May we contact your current employer? Yes: No:

Do you have a reliable means of transportation? Yes: No:

Do you have a current drivers license? Yes: No:

Will you take a pre-employment drug screen if requested? Yes: No:

How many consecutive evenings can you be away from home?

What number of miles are you willing to commute for an assignment?

200 Miles (Required Minimum): 200-300 Miles: No limitations:

License Type: License Number: State: **CERTIFICATIONS:** ACLS: CHEMO: PALS:

License Type: License Number: State: CPR/BLS: NRP: Other:

Primary Specialty: Experience (years):

Secondary Specialty: Experience (years):

NURSES ONLY: Please indicate if you are capable and willing to work the following areas:

ER: OB: ICU: LTC: Psych: Med/Surg:

EMPLOYMENT HISTORY

CURRENT OR MOST RECENT EMPLOYER:

Facility/Employer: Date of Hire: End Date:

City: State: Zip Code: Hourly Rate:

Job Title: Immediate Supervisor: Telephone Number:

Summarize nature of work performed:

Reason for leaving:

SECOND MOST RECENT EMPLOYER:

Facility/Employer:	Date of Hire:	End Date:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
City:	State:	Zip Code:	Hourly Rate:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Job Title:	Immediate Supervisor:	Telephone Number:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Summarize nature of work performed:

Reason for leaving:

THIRD MOST RECENT EMPLOYER:

Facility/Employer:	Date of Hire:	End Date:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
City:	State:	Zip Code:	Hourly Rate:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Job Title:	Immediate Supervisor:	Telephone Number:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Summarize nature of work performed:

Reason for leaving:

EDUCATIONAL BACKGROUND

Professional Education/College:

Graduation Date:	Degree:	Major/Course of Study:	Years Attended:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
City:	State:	Zip Code:	Country:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

PROFESSIONAL REFERENCES

Must be individuals in a supervisory role (current or prior healthcare employer preferred):

Reference 1

Name:

Phone Number:

Address:

City:

State:

Zip Code:

Reference 2

Name:

Phone Number:

Address:

City:

State:

Zip Code:

I attest that I am the applicant and the information provided in this application is complete and accurate, to the best of my knowledge. Providing incomplete or inaccurate information may result in disqualification from the program and may be a violation of state law(s) that could result in civil penalties.

Name (Printed):

Name (Signature):

Date: