



Applicant Information (Please Print)

Full Name: Last First M.I. Date:
Previous Name(s): Last First M.I.
Address: Street Address Apartment/Unit #
City State ZIP Code

Please disclose all previous resident addresses within the past seven (7) years. Use separate sheet if necessary.

Home Phone: () E-mail Address:
Cell Phone: () Driver's license: State No.
Social Security No.: Emergency Contact Name: Emergency Contact No:
Referred by:

Licensure and Certification Information (Please indicate license number/certification and expiration date)

Table with 6 columns: State, License No/Cert., Expiration Date, State, License No/Cert., Expiration Date

Resuscitation Credentials

Table with 6 columns for resuscitation credentials

Education

School Name: Address:
From: To: Did you graduate? YES NO Degree:
School Name: Address:
From: To: Did you graduate? YES NO



Legal

Are you a citizen of the United States? YES NO If no, are you authorized to work in the U.S.? YES NO
Have you ever been convicted of a felony? YES NO If yes, explain:
Have you ever been party to a medical malpractice case? YES NO If yes, explain:
Has your license(s) or certification(s) ever been under investigation, revoked or YES NO

Employment History (attach additional sheet if necessary)

Hospital: Phone: ()
Address: Supervisor:
Job Title: Specialty/Unit: Agency (if any):
From: To: Reason for Leaving:
Hospital: Phone: ()
Address: Supervisor:
Job Title: Specialty/Unit: Agency (if any):
From: To: Reason for Leaving:
Hospital: Phone: ()
Address: Supervisor:
Job Title: Specialty/Unit: Agency (if any):
From: To: Reason for Leaving:

Computer Skills

Please list any hospital information systems that you have experience with (i.e., automated pharmacy or nurse documentation):

Disclaimer and Signature

I, _____, certify that my answers are true and complete. If this application leads to employment, I understand that false or misleading information in my application or interview may result in my immediate termination. I affirm that the presentation of attachments, resumes and copies of licenses and certifications applying to myself are true and correct without any omissions. I understand that as a condition of employment, I may be required to take a pre-placement medical examination, and pass a drug and alcohol screening in the following circumstances, but not limited to: pre-employment, post accident, for cause and random selection. I authorize FREEDOM HEALTHCARE STAFFING, (FHCS) or their designees, the permission to verify the information provided by me as a condition of employment, and conduct a detailed criminal/civil background investigation of myself, including any areas deemed appropriate by a client facility. FHCS will not disclose the results of any medical examination or laboratory screening without my specific written approval.

I understand and agree that my position is not for a guaranteed designated time period, and may be terminated by the client facility at any time without notice for circumstances not under the control of FHCS. I further understand that my continued employment is contingent upon my being able to successfully qualify for and perform the essential position and functions for which I am being hired, including if required by the client facility, any specific competency examination.

Signature: _____ Date: _____

Please return this form by fax or mail to:

Freedom Healthcare Staffing
3025 S. Parker Road, Suite 800
Aurora, CO 80014 Fax: 866-463-0387