



**Applicant Information (Please Print)**

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First M.I.

Previous Name(s) \_\_\_\_\_  
Last First M.I.

Address: \_\_\_\_\_  
Street Address Apartment/Unit #  
 \_\_\_\_\_  
City State ZIP Code

Home Phone: ( ) \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ Driver's license: State No.

Social Security No.: \_\_\_\_\_ Emergency Contact Name: \_\_\_\_\_ Emergency Contact No.: \_\_\_\_\_

Referred by: \_\_\_\_\_

**RN Licensure Information (Please indicate license number and expiration date)**

State:	License No.:	Expiration Date:	State:	License No.:	Expiration Date:

Please list your original state of licensure: \_\_\_\_\_

**Specialties and Professional Credentials**

Specialties (Indicate if Primary):	Years of Experience:	Approximate Date Last Worked:	Please include copies of credential			
			Credential:	Expiration Date:	Credential:	Expiration Date:
_____	_____	_____	ACLS	_____	CNOR	_____
_____	_____	_____	BLS/CPR	_____	ENCP	_____
_____	_____	_____	PALS	_____	Chemo	_____
_____	_____	_____	NALS/NRP	_____	CRRN	_____
_____	_____	_____	CEN	_____	OCN	_____
_____	_____	_____	TNCC	_____	Critical Care Course	_____

**Education**

Nursing School: \_\_\_\_\_ Address: \_\_\_\_\_



From: \_\_\_\_\_ To: \_\_\_\_\_ Did you graduate? YES  NO  Degree: \_\_\_\_\_

**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 suspended? YES  NO  If yes, explain: \_\_\_\_\_  
Have you ever worked for this Company? YES  NO  If so, when? \_\_\_\_\_

**Employment History**

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 No. 866.463.0387