Employment Documentation

Today's Date	Position Applying For

Contact Information		
Name	City	
Address	State	Zip
Home Phone	Best Time to Contact	
Mobile Phone	Mobile Carrier	
Email	Preferred Method of Contact	

Tax Information	
Date of Birth	Social Security #
Maiden Name or Alias	Sex
Marital Status	Race or National Origin
AMP is an Equal Opportunity Employer. AMP is only asking for your race or national origin because we are required to by federal law. This information is completely confidential and will NOT be used in any way to discriminate or prevent you from being hired.	

Background Information		
Have you ever been fired from any job?	Y or N	Explain
Have you ever been convicted of a felony?	Y or N	Explain
Have you ever been convicted of a crime as an adult?	Y or N	Explain
Are you currently under any charges?	Y or N	Explain
Have you filed a claim for a work-related injury within the last 12 months?	Y or N	Explain
Are you a user of or under treatment for either illegal drugs or alcohol?	Y or N	Explain
Do you have any medical conditions or restrictions that would inhibit working?	Y or N	Explain
Are you currently or have you ever served in a branch of the US Military?	Y or N	Explain
Have you ever been discharged under any conditions other than honorable?	Y or N	Explain

How did you hear about us?	
Name of Friend or Co-Worker?	
Name of Website?	Other?

American Medical Personnel * 1428 Edison Street NW * Hartville, OH 44632 * 330-433-1080

Professional Experience	
Please list your most recent employer first	
Employer	Telephone
Address	City, State, Zip
Job Title	Dates Employed
Duties	Reason for Leaving
Supervisor's Name	Pay Rate
Employer	Telephone
Address	City, State, Zip
Job Title	Dates Employed
Duties	Reason for Leaving
Supervisor's Name	Pay Rate
Employer	Telephone
Address	City, State, Zip
Job Title	Dates Employed
Duties	Reason for Leaving
Supervisor's Name	Pay Rate
Employer	Telephone
Address	City, State, Zip
Job Title	Dates Employed
Duties	Reason for Leaving
Supervisor's Name	Pay Rate

AUTHORIZATION

I, the below signed applicant, state that I am applying for employment with AMP. I certify that all answers contained in this application are true and correct to the best of my knowledge. I authorize AMP to investigate any statement within and to obtain a criminal background check on me as necessary to determine my qualifications. I understand that any false, misleading or the omission of information in my application may result in immediate termination of employment.

Signature _____ Date _____

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Education		
Name of Degree	Name of Institution	
Major or Specialty	Dates Attended	Graduation Date
Name of Certificate		
Type	Date Received	Expiration Date
Name of License	License #	State
Type	Date Received	Expiration Date
List Any Training That You Feel is Important		

References	
Name & Title of Supervisor	Company Name
Dates Employed	Telephone Number
Name & Title of Supervisor	Company Name
Dates Employed	Telephone Number
Name & Title of Supervisor	Company Name
Dates Employed	Telephone Number

AUTHORIZATION

I, the below signed applicant, state that I am applying for employment with AMP. I authorize my references and their subsidiaries and affiliated companies to provide information, relating to my past employment, and to supply any and all information concering my background; and I release them from liability and hold them harmless for providing such information. I am williing that a photocopy of this authorization will be accepted with the same authority as the original.

Signature _____ Date _____

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HEALTHCARE INFORMATION	
Name	Position Applying For
Employment Preferences	
List all Job Titles	Current Pay Rate
	Desired Pay Rate
Employment: Per Diem Part Time Full Time *Driving Distance*: 15min 30min 1hr + *Availability*: Days Afternoons Midnights Weekends 12hr Shifts Short-Notice Work	

Field Experience	
Please indicate the number of years experience in each field	
Hospitals	Geriatrics
Long Term Care Facility	Pediatrics
Home Health Care	MMRD
Physicians' Office or Clinic	Assisted Living
Corporate / Industrial Nursing	Skilled Units
Flu Clinics	ICU / CCU
Travel Nursing	OR / ER
Case Management	IV Certified

Licensure			
State of License	License #	Eff. Date	Exp. Date
State of License	License #	Eff. Date	Exp. Date
Has your license ever been revoked or suspended?			
Is your license currently under investigation?			

Healthcare Compliance	
Do you have a current TB (step 1) within the last year?	Exp. Date
Do you have a current physical, within the last 5yrs?	Date completed
Have you had a Hepatitis vaccination?	Date completed
Are you BLS or CPR certified?	Exp. Date
Are you ACLS certified?	Exp. Date
Have you lived in the State of Ohio, for the last 5yrs?	If no, what other state?

County Docket Search
Last 5 counties in Ohio you have lived?