



Advanced Medical

P L A C E M E N T

"Expect Excellence"

EMPLOYMENT APPLICATION

EMPLOYMENT APPLICATION

PERSONAL INFORMATION

Last Name		Middle Name	First Name		Maiden Name
Address			City	State	Zip
Permanent Mailing Address			City	State	Zip
Daytime Telephone	Evening Telephone	Cell Phone	Email Address		
Social Security Number	Driver's License Number				

EDUCATION

POST GRADUATE

Program	
Address	
Year Attended	Degree Obtained

COLLEGE NURSING

Program	
Address	
Year Attended	Degree Obtained
Graduation (Month/Year)	

MILITARY (COMPLETE THIS SECTION IF YOU SERVED IN THE U.S. ARMED FORCES)

Branch of Service	From (Month/Year)	To (Month/Year)
Rank at Discharge		
Describe Your Duties and Any Special Training		
Were you Honorably Discharged?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Discharge



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CERTIFICATION

State of Original Licensure	All States of Licensure (Please Enclose Copies with License Number)
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Professional Organizations to Which You Belong
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Professional Liability Insurance Carrier (If Applicable)	Amount of Coverage	Expiration date
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WORK HISTORY / EMPLOYMENT

Employer's Name	Supervisor's Name	Telephone
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Address	City	State	Zip Code
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Exact Title of Your Position	Dates Employed (Month/Year)	Ending Salary
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Department	Reason for Leaving
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Description of Duties

May We Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Employer's Name	Supervisor's Name	Telephone
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Address	City	State	Zip Code
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Exact Title of Your Position	Dates Employed (Month/Year)	Ending Salary
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Department	Reason for Leaving
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Description of Duties

May We Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Employer's Name	Supervisor's Name	Telephone
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Address	City	State	Zip Code
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Exact Title of Your Position	Dates Employed (Month/Year)	Ending Salary
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Department	Reason for Leaving
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Description of Duties

May We Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No
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EMPLOYMENT APPLICATION

HEALTH

Date of your Last Examination by a Physician

Do You Have Any Physical / Health Limitations That Might Effect Your Ability to Practice as a Nurse?

Yes No

If Yes, Please Explain

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name	Relationship	Day Time Telephone	Evening Telephone
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Address	City	State	Zip Code
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Name	Relationship	Day Time Telephone	Evening Telephone
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Address	City	State	Zip Code
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Have You Ever Been Dismissed From Employment of Drug Use / Addiction or Ever Been Treated for Drug Use / Addiction?

Yes No

If Yes, Please Explain

How did You Hear About Advanced Medical Placement

Direct Mail Internet Yellow Pages Newspaper Ad _____
 Website Search Engine _____ Other _____

PLEASE MAKE SURE TO ATTACH COPIES OF YOUR RESUME, RN LICENSURE, ANY SPECIALTY CERTIFICATION AND/OR ADVANCED TRAINING, PROFESSIONAL INSURANCE POLICY, RESUME, AND PROPERLY SIGNED REFERENCE CHECK AUTHORIZATION FORM.

I HEREBY CERTIFY THAT THE INFORMATION PRESENTED HEREIN IS MOST AUTHENTIC, TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I FURTHER UNDERSTAND THAT ANY MISGUIDED OR FALSE STATEMENT WILL BECOME BASIS FOR DISQUALIFICATION FOR MY EMPLOYMENT OR TERMINATION OF SERVICES WITHOUT ANY FURTHER NOTICE. I ALSO FULLY AUTHORIZE AMP TO REVIEW AND VERIFY ALL INFORMATION SET FORTH IN THIS APPLICATION, INCLUDING BUT NOT LIMITED TO REFERENCES, STATE LICENSURES AND INSURANCE POLICY VERIFICATIONS.

Applicant's Signature

Date

