Select Medical Connections Ltd
Search Professionals to the Healthcare Industry

Employment Application

PERSONAL INFORMATION

First Name________________ Middle Name________________ Last Name________________
Maiden Name 1)________________ 2)________________
Current Address: Street________________ City:________________ Province/State________________
Postal Code / Zip________________ Country________________ E-Mail Address________________
Mailing Address: Street________________ City:________________ Province/State________________
Postal Code / Zip________________ Country________________ Citizenship________________
Phone: Home________________ Cell________________ Pager________________
SIN________________ SSN (USA only)________________ DOB________________ Age________________
Emergency Contact
First Name________________ Middle Name________________ Last Name________________
Address: Street________________ City________________ Province/State________________
Postal Code / Zip________________ Country________________
Phone: Home________________ Cell:________________ Relationship________________

EMPLOYMENT STATUS

Eligibility to work in Canada:	Certificate #	Expiry Date	Eligibility to work in USA:	Certificate #	Expiry Date
Birth Certificate			Birth Certificate		
Landed Immigrant			Landed Immigrant		
Work Permit/Visa			Work Permit/Visa		

TYPE OF EMPLOYMENT DESIRED:

□ Casual Employment □ 2-4 Week Travel Assignment □ 13 Week Travel Assignment □ Permanent Placement

Preferred Shifts: (please check all that apply)

□ days □ evenings □ nights □ weekdays □ weekends
□ 8 hour □ 12 hour □ other________________

Geographical Preferences:

□ Within BC/AB (please specify) ________________ □ Within North America (please specify)________________
□ Within Canada (please specify) ________________ □ Outside North America (please specify)________________

PROFESSION

□ RN □ LPN / RPN □ PT □ Pharmacist
□ Other □ Other (please specify)________________

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toll free: 1-877-525-3870 fax: 604-484-6357 local ph: 604-484-6355
email: resume@smcjobs.com www.smcjobs.com
Head Office: 4183B Dawson Street, Burnaby, BC, Canada, V5C 4B3

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AREAS OF EXPERIENCE - NURSING

	Years Worked		Years Worked
□ Medical	_______________	□ Surgical	_______________
□ Pediatrics	_______________	□ Paeds Special Care	_______________
□ Intensive Care	_______________	□ Emergency	_______________
□ Maternal/Child	_______________	□ Labour/Delivery	_______________
□ Hemodialysis	_______________	□ Community Health	_______________
□ NICU Level II	_______________	□ Operating Room	_______________
□ Recovery Room	_______________	□ Long Term Care	_______________
□ CVICU	_______________	□ Psychiatric Care	_______________
□ Administrative	_______________	□ Other	_______________

PROFESSIONAL LICENSURE

What month and year did you pass your Canadian or US nursing boards/registration exam?_______________Where? □ Canada □ US

Original Province/State_____________ License #______________________ Expiration Date__________________

Province/State___________________ License #______________________ Expiration Date__________________

Province/State___________________ License #______________________ Expiration Date__________________

Province/State___________________ License #______________________ Expiration Date__________________

Province/State___________________ License #______________________ Expiration Date__________________

Have you ever had your professional license or certificate investigated or suspended? □ yes □ no If yes, please explain (include dates and outcome)____

Have you ever been named as a defendant in a malpractice claim? □ yes □ no If yes, please explain (include dates and outcome________

____

Have you ever been convicted of a crime? □ yes □ no If yes, please explain (include dates and outcome)__________________________

____

Do you hold a professional licensure under any other name? □ yes □ no If yes, under what name?______________________________

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EDUCATION

	Name & Address of School	Month/Year Graduated	Diploma, Degree Received
Secondary	______	______	______
College/University	______	______	______
	______	______	______
	______	______	______
Other Courses Completed	______	______	______
	______	______	______
	______	______	______
	______	______	______

CERTIFICATES

	Expiration Date		Expiration Date
□ CPR/BCLS	______	□ ACLS	______
□ TNCC	______	□ NALS	______
□ PALS	______	□ OTHER	______
□ OTHER	______	□ OTHER	______

WHMIS CERTIFICATION DATE______________________

RESPIRATOR FIT TEST – Model ____________________

Date ________________________

PLEASE ATTACH COPIES OF ALL CERTIFICATES & LICENSES

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EMPLOYMENT

Are you currently employed? □ yes □ no If yes, may we contact your employer? □ yes □ no

EMPLOYMENT HISTORY (start with most recent)

Employer____________________
Address: Street____________________City____________________Province/State____________________
Postal Code/Zip____________________Country____________________Phone____________________
Supervisor____________________Supervisor Title____________________
Supervisor Phone____________________Best time to call____________________
Start Date:____________________End Date:____________________
Unit(s) worked in____________________Position____________________Charge Experience □ yes □ no
Number of unit beds____________________Nurse/Patient ratio____________________
Reason for leaving____________________
Are you eligible for rehire? □ yes □ no If no, please explain____________________
____________________Was this a travel assignment? □ yes □ no

Employer____________________
Address: Street____________________City____________________Province/State____________________
Postal Code/Zip____________________Country____________________Phone____________________
Supervisor____________________Supervisor Title____________________
Supervisor Phone____________________Best time to call____________________
Start Date:____________________End Date:____________________
Unit(s) worked in____________________Position____________________Charge Experience □ yes □ no
Number of unit beds____________________Nurse/Patient ratio____________________
Reason for leaving____________________
Are you eligible for rehire? □ yes □ no If no, please explain____________________
____________________Was this a travel assignment? □ yes □ no

Employer____________________
Address: Street____________________City____________________Province/State____________________
Postal Code/Zip____________________Country____________________Phone____________________
Supervisor____________________Supervisor Title____________________
Supervisor Phone____________________Best time to call____________________
Start Date:____________________End Date:____________________
Unit(s) worked in____________________Position____________________Charge Experience □ yes □ no
Number of unit beds____________________Nurse/Patient ratio____________________
Reason for leaving____________________
Are you eligible for rehire? □ yes □ no If no, please explain____________________
____________________Was this a travel assignment ? □ yes □ no

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Employer____

Address: Street____________________ City________________ Province/State____________

Postal Code/Zip____________________ Country________________ Phone____________

Supervisor________________________ Supervisor Title____________________

Supervisor Phone____________________ Best time to call____________________

Start Date:____________________ End Date:________________

Unit(s) worked in____________________ Position________________ Charge Experience □ yes □ no

Number of unit beds____________________ Nurse/Patient ratio________________

Reason for leaving____

Are you eligible for rehire? □ yes □ no If no, please explain____________________________

____________________________ Was this a travel assignment? □ yes □ no

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Additional Information

How did you hear about us? □ Our Website □ Nursing Magazine □ Newspaper □ Convention □ Referral

□ Other If Referral or Other please indicate:____________________

Have you ever applied with us before? □ yes □ no If yes, when?____________________

Are you working with a consultant? □ yes □ no If so, what is their name?____________________

I certify the statements in this application and supporting documents are true, correct and complete to the best of my knowledge. I understand that this is an application for employment and in no way a contract. I understand that any omission, misrepresentation or falsification of facts on this application will be cause for dismissal. I understand that any employment offers are conditional upon undergoing a medical examination, a background and criminal record check, and if required by the client, a drug screen if assigned to a patient care position. I authorize Select Medical Connections Ltd. (SMC) to investigate any and all statements contained herein and request the persons, firms and/or employers named above to answer any and all questions relating to this application. I further give SMC authorization to verify the information I have provided and to conduct reference checks through contact with past employers. I release all parties providing information concerning my prior employment, education or character from all liability.

I authorize the release of this application, reference information, background checks and medical information contained in my employment file with SMC to client facilities where I may be assigned. For all other purposes, SMC shall keep my employment file confidential and shall advise any client facility to which records have been provided to keep such records confidential. I waive any privilege I may have to this information with respect to its release to SMC. I consent to the release of any drug screen test to my governing body and/or licensing authority in order to determine fitness for employment or continued employment. I understand that my employment is at will and may be terminated at any time without prior notice. My signature below indicates that I have read, understood and agree to the above terms.

Signature____________________________ Date____________________