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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_____

yyyy/mm/dd

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
Birth Certificate		
Landed Immigrant		
Work Permit/Visa		

Eligibility to work in USA:

	Certificate #	Expiry Date
Birth Certificate		
Landed Immigrant		
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 British Columbia (please specify) _____ ☐ Within North America (please specify)_ _____

☐ Within Canada (please specify) _____ ☐ Outside North America (please specify)_ _____

www.selectmedconnections.com
4183B Dawson Street
Burnaby BC, Canada
V5C 4B3

Toll free: 1.877.525.3870
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Fax: 604.484.6357
info@selectmedconnections.com

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PROFESSION

☐ RN ☐ LPN / LVN ☐ PT ☐ Pharmacist

☐ Other ☐ Other (please specify)_____

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 ll	_____	☐ Operating Room	_____
☐ Recovery Room	_____	☐ Long Term Care	_____
☐ CVICU	_____	☐ Psychiatric Care	_____
☐ Administrative	_____	☐ Other	_____

PROFESSIONAL LICENSURE

What **year** and **month** 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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Nurse Name _____

EDUCATION

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

CERTIFICATES

	Expiration Date		Expiration Date
☐ CPR/BCLS		☐ ACLS	
☐ TNCC		☐ NALS	
☐ PALS		☐ OTHER	
☐ OTHER		☐ OTHER	

PLEASE ATTACH COPIES OF ALL CERTIFICATES WITH THIS APPLICATION.

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Nurse Name _____

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_____

Start Date:_____End Date:_____

Unit(s) worked in_____Position_____ Charge Experience: ☐ yes ☐ no

Number of unit beds_____Nurse/Patient ratio_____to_____ Was this a travel assignment? ☐ yes ☐ no

Reason for leaving_____

Are you eligible for rehire? ☐ yes ☐ no If no, please explain_____

_____

Supervisor_____Supervisor's Title_____

Supervisor Phone_____Best time to call_____

May we call this person for a reference? ☐ yes ☐ no

Employer_____

Address: Street_____City_____Province/State_____

Postal Code/Zip_____Country_____Phone_____

Start Date:_____End Date:_____

Unit(s) worked in_____Position_____ Charge Experience: ☐ yes ☐ no

Number of unit beds_____Nurse/Patient ratio_____to_____ Was this a travel assignment? ☐ yes ☐ no

Reason for leaving_____

Are you eligible for rehire? ☐ yes ☐ no If no, please explain_____

_____

Supervisor_____Supervisor's Title_____

Supervisor Phone_____Best time to call_____

May we call this person for a reference? ☐ yes ☐ no

Employer_____

Address: Street_____City_____Province/State_____

Postal Code/Zip_____Country_____Phone_____

Start Date:_____End Date:_____

Unit(s) worked in_____Position_____ Charge Experience: ☐ yes ☐ no

Number of unit beds_____Nurse/Patient ratio_____to_____ Was this a travel assignment? ☐ yes ☐ no

Reason for leaving_____

Are you eligible for rehire? ☐ yes ☐ no If no, please explain_____

_____

Supervisor_____Supervisor's Title_____

Supervisor Phone_____Best time to call_____

May we call this person for a reference? ☐ yes ☐ no

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Nurse Name _____

EMPLOYMENT HISTORY – cont'd

Employer_____

Address: Street_____ City_____ Province/State_____

Postal Code/Zip_____ Country_____ Phone_____

Start Date:_____ End Date:_____

Unit(s) worked in_____ Position_____ Charge Experience: ☐ yes ☐ no

Number of unit beds_____ Nurse/Patient ratio_____ to_____ Was this a travel assignment? ☐ yes ☐ no

Reason for leaving_____

Are you eligible for rehire? ☐ yes ☐ no If no, please explain_____

_____

Supervisor_____ Supervisor's Title_____

Supervisor Phone_____ Best time to call_____

May we call this person for a reference? ☐ yes ☐ no

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. I consent to receive emails and other form of electronic communication from SMC. My signature below indicates that I have read, understood and agree to the above terms.

Signature_____ Date_____

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