



# QUIK TRAVEL STAFFING, INC

## CERTIFICATION

	<b>CURRENT ACTIVE RN LICENSES:</b>	NUMBER:	EXPIRATION DATE:
1	HOME STATE:		
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

Has your license in any jurisdiction been revoked, investigated, or restricted? (please circle) YES      NO

Have you ever been convicted of a felony? YES      NO

If yes, please provide details and current status:

Do you have malpractice insurance? YES      NO

MALPRACTICE INSURANCE POLICY#:	COMPANY:	EXP. DATE:
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### SPECIAL CERTIFICATIONS

CERTIFICATE	NUMBER	EXP. DATE

### SPECIALIZATION

CURRENT SPECIALTY IN THE LAST 2 YEARS (for nursing applicants only)	YEARS OF EXPERIENCE	PROFICIENT (circle):
		YES      NO
		YES      NO
		YES      NO
		YES      NO
		YES      NO

# QUIK TRAVEL STAFFING, INC

What is your clinical area of preference?

CERTIFICATION/ CEUs (Please include copies)

NAME:	DATE TAKEN:	EXPIRATION:
BCLS		
ACLS		
NALS/NRP		
PALS		

NAME:	DATE TAKEN:	EXPIRATION:
CCRN		
CNN		

## EDUCATIONAL BACKGROUND

SCHOOL ATTENDED	LOCATION (CITY, STATE)	DATE GRADUATED	PROGRAM/ DEGREE

What languages do you speak fluently?

Additional Education:

## EMPLOYMENT HISTORY

FACILITY:		ADDRESS:		PHONE #:	
CITY:		STATE:	POSITION:		FULLTIME    PARTIME
# OF BEDS:	SHIFT:	SUPERVISOR:		PHONE #:	
DATES EMPLOYED (MM/DD/YY):		TO	ELIGIBLE FOR REHIRE?		YES    NO
Was this a travel assignment?					
FACILITY:		ADDRESS:		PHONE #:	
CITY:		STATE:	POSITION:		FULLTIME    PARTIME
# OF BEDS:	SHIFT:	SUPERVISOR:		PHONE #:	
DATES EMPLOYED (MM/DD/YY):		TO	ELIGIBLE FOR REHIRE?		YES    NO
Was this a travel assignment?					
FACILITY:		ADDRESS:		PHONE #:	
CITY:		STATE:	POSITION:		FULLTIME    PARTIME
# OF BEDS:	SHIFT:	SUPERVISOR:		PHONE #:	
DATES EMPLOYED (MM/DD/YY):		TO	ELIGIBLE FOR REHIRE?		YES    NO
Was this a travel assignment?					
FACILITY:		ADDRESS:		PHONE #:	
CITY:		STATE:	POSITION:		FULLTIME    PARTIME
# OF BEDS:	SHIFT:	SUPERVISOR:		PHONE #:	
DATES EMPLOYED (MM/DD/YY):		TO	ELIGIBLE FOR REHIRE?		YES    NO
Was this a travel assignment?					

# QUIK TRAVEL STAFFING, INC

## EMPLOYMENT APPLICATION AGREEMENT

I certify that the facts contained in this application are true and complete to the best of my knowledge, and I understand that falsification will be a basis for disqualification or termination of contract and reported to the State Board(s).

I authorize the investigation of all statements contained herein and the references listed above to give any and all information concerning my performance, conduct, and condition of health known to them, and I agree to hold harmless from liability for any cause, except willful falsification of data, arising from the release and use of said information, those who provide said information of those to whom this information is provided.

I understand and agree that, if hired, my employment is not for a definite period and may, regardless of the date of payment of my wages or salary, be terminated at any time without prior notice.

PRINT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

Please mail or fax this application to the following.

Quik Travel Staffing, Inc.  
175 E. Olive Ave, #101  
Burbank CA 91502  
800-554-2230  
800-554-7501 Fax

# SPECIALTIES

Please indicate the number of years and months of experience you have in these specialties. Include areas of float.

Specialty	Years	Mos.	Specialty	Years	Mos.
ICU			Medical		
CCU			Surgical		
Open Heart Critical Care			Telemetry		
SICU			Cardiac Stepdown		
Emergency Room			Neuro		
Geriatrics			Ortho		
Burn			Rhabilitation		
Gynecology			Dialysis		
GU			Diabetic		
Labor/ Delivery			Psych		
Post-Partum			Operating Room		
Nursery			Recovery Room		
NICU (indicate level)			Home Health		
Pediatrics			Nursing Management		
			Other (indicate)		

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

EMPLOYEE  
 SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

REVIEWED BY: \_\_\_\_\_

DATE: \_\_\_\_\_

## RN LICENSE VERIFICATION

### APPLICANT INFORMATION:

LAST NAME: \_\_\_\_\_

FIRST NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE: \_\_\_\_\_

ZIP CODE: \_\_\_\_\_

CONTACT PHONE: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

HOME STATE - LICENSE NUMBER: \_\_\_\_\_

### AUTHORIZATION:

I hereby release from all liability the company or person completing this form, and authorize him or her to release all information regarding my professional license and status.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

### CONFIRMATION (for QTS representatives only):

I verified the above named applicant's RN license with the Board of Registered Nurses as follows:

STATUS	EXPIRATION DATE	CONFIRMATION NAME

\_\_\_\_\_  
Signature of QTS Representative

\_\_\_\_\_  
Date