



# Employment Application

## Your Personal Information

Name \_\_\_\_\_  
First Last Middle Initial

Nickname \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Available \_\_\_\_\_

Current Mailing Address  / / \_\_\_\_\_  
Good Until Street Apt. #

City State / Province Zip Country

Current Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ Email \_\_\_\_\_

Permanent Address \_\_\_\_\_  
Street Apt. #

City State / Province Zip Country

Permanent Phone ( ) \_\_\_\_\_ Are you currently eligible for employment in the U.S.?  Yes  No

In Case of Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Address \_\_\_\_\_  
Street Apt. #

City State / Province Zip Country

Were you referred by anyone? If so, whom? \_\_\_\_\_

Geographic Preference 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

## Professional Credentials

**Rehabilitation Professionals:** Current License(s) \_\_\_\_\_

RPT  PTA  OTR  OTA  SLP

Professional Certification/Registration #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

What month and year did you pass certification/CCCs/registration exams? Month \_\_\_\_\_ Year \_\_\_\_\_ Certification #: \_\_\_\_\_

**Radiologic Technologists, Imaging and Radiation Professionals:** Current License(s) \_\_\_\_\_

Specialty (1) \_\_\_\_\_ Years Experience \_\_\_\_\_

(2) \_\_\_\_\_ Years Experience \_\_\_\_\_

Registered by:  ARRT  NMTCB  ARDMS  Other \_\_\_\_\_ Registration #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

**Respiratory Care Practitioner:** Current License(s) \_\_\_\_\_

Registered  Certified  Other /Specialty \_\_\_\_\_

What month and year did you pass certification/registration exams? Month \_\_\_\_\_ Year \_\_\_\_\_ Certification #: \_\_\_\_\_

**Medical Laboratory Professionals:**

MT  MLT  Other \_\_\_\_\_ Certifications:  ASCP  HEW  AMT  Other \_\_\_\_\_

**Pharmacist:**

Hospital Experience  Retail Experience  Mail Order Experience  Compounding Years Experience \_\_\_\_\_

## Education

**SCHOOL/EDUCATIONAL PROGRAM:** \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

**COLLEGE/UNIVERSITY:** \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Degree Earned \_\_\_\_\_

**COLLEGE/UNIVERSITY:** \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Degree Earned \_\_\_\_\_

### Legal Questions

1. At any time before or after becoming a healthcare professional, have you ever been charged with a crime or been convicted or pled guilty or no contest (nolo contendere) to any criminal charge (whether disciplined or cleared)?

Yes  No *If yes, please indicate dates, conviction, final outcome and attach a separate sheet with full particulars.*  
 Date \_\_\_\_\_ Conviction \_\_\_\_\_  
 Outcome \_\_\_\_\_

2. Are you aware of any circumstances, which may result in a malpractice claim or suit being made or brought against you?

Yes  No *If yes, please indicate dates, circumstances and attach a separate sheet with full particulars.*  
 Date \_\_\_\_\_ Circumstances \_\_\_\_\_  
 Outcome \_\_\_\_\_

3. Has any medical malpractice claim or suit ever been brought or threatened against you or your employer for your acts?

Yes  No *If yes, please provide detail of the suit and its current status and attach a separate sheet with full particulars.*  
 Date \_\_\_\_\_ Circumstances \_\_\_\_\_  
 Outcome \_\_\_\_\_

4. Have you ever been the subject of a reprimand or disciplinary action or refused employment or admission to a professional society or had professional privileges suspended by any court or administrative agency, regulatory board, or State Board of Nursing, or ever been the subject of any ethics investigation at local, state or national level (whether disciplined or cleared)?

Yes  No *If yes, please indicate dates, circumstances, final outcome and attach a separate sheet with full particulars.*  
 Date \_\_\_\_\_ Circumstances \_\_\_\_\_  
 Outcome \_\_\_\_\_

### Current Employment

Are you currently employed?  Yes  No  
 Facility \_\_\_\_\_  
 City \_\_\_\_\_ State/Province \_\_\_\_\_  
 Dates employed \_\_\_\_\_ - \_\_\_\_\_  
 Reason for leaving? \_\_\_\_\_  
 Position Held \_\_\_\_\_ Hourly wage \_\_\_\_\_  
 Unit Specialty (if applicable) \_\_\_\_\_  
 Part Time (Hours per week? \_\_\_\_\_)  Full Time  
 Patient Caseload \_\_\_\_\_  
 Computerized Charting  Yes  No Type \_\_\_\_\_  
 Charge Experience:  Yes (How often? \_\_\_\_\_)  No  
 Supervisor \_\_\_\_\_  
 Phone ( ) \_\_\_\_\_ ext. \_\_\_\_\_  
 Is this a travel assignment?  Yes  No  
 If so, what travel company? \_\_\_\_\_  
 May we contact your current employer?  Yes  No

### Previous Employment

Facility \_\_\_\_\_  
 City \_\_\_\_\_ State/Province \_\_\_\_\_  
 Dates employed \_\_\_\_\_ - \_\_\_\_\_  
 Reason for leaving? \_\_\_\_\_  
 Position Held \_\_\_\_\_ Hourly wage \_\_\_\_\_  
 Unit Specialty (if applicable) \_\_\_\_\_  
 Part Time (Hours per week? \_\_\_\_\_)  Full Time  
 Patient Caseload \_\_\_\_\_  
 Computerized Charting  Yes  No Type \_\_\_\_\_  
 Charge Experience:  Yes (How often? \_\_\_\_\_)  No  
 Supervisor \_\_\_\_\_  
 Phone ( ) \_\_\_\_\_ ext. \_\_\_\_\_  
 Is this a travel assignment?  Yes  No  
 If so, what travel company? \_\_\_\_\_  
 May we contact employer?  Yes  No

*The statements made in this application are true to the best of my knowledge. I understand that any falsification will be the basis for disqualification of employment or termination of services. I authorize Cross Country TravCorps to verify the information I have provided and to contact past employers and references concerning my ability, character and employment records. I release all such persons from liability for furnishing said information. I authorize CC Staffing, Inc, an affiliate of Cross Country TravCorps and my employer, to release a copy of this employment application and all information which may be relevant to an assignment with their client facilities, including any required healthcare information. By applying to Cross Country TravCorps, I authorize release of this information to all other affiliates of the Company and I acknowledge and agree that they may contact me using facsimile or any other means. I understand that Cross Country TravCorps will be providing my profile to facilities and that any opportunity I may have to arrange and schedule an interview with such facility is a result of Cross Country TravCorps' effort for my benefit. Accordingly, I agree that any interview such facility schedules or arranges with me may not be redirected to another agency. Nothing contained in this employment application, or in the granting of an interview, is intended to create an employment contract between CC Staffing, Inc. and the applicant for either employment or for providing of any benefit. All offers of employment are made conditional upon the applicant's providing employment authorization and identity in accordance with the Immigration Reform and Control Act of 1986.*

X \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

Please complete all information for each hospital. If any of the employers listed below are day agencies, please provide the name of the agency as well as the name of the hospital where you provided per diem care (i.e., list each hospital you worked at separately and include the agency name as well). List the most recent employer first.

Previous Employment	
Facility _____ City _____ State/Province _____ Dates employed _____ - _____ Reason for leaving? _____ Position Held _____ Hourly wage _____ Unit Specialty (if applicable) _____ <input type="radio"/> Part Time (Hours per week? _____) <input type="radio"/> Full Time Patient Caseload _____ Computerized Charting <input type="radio"/> Yes <input type="radio"/> No Type _____ Charge Experience: <input type="radio"/> Yes (How often? _____) <input type="radio"/> No Supervisor _____ Phone ( ) _____ ext. _____ Is this a travel assignment? <input type="radio"/> Yes <input type="radio"/> No If so, what travel company? _____ May we contact employer? <input type="radio"/> Yes <input type="radio"/> No	Facility _____ City _____ State/Province _____ Dates employed _____ - _____ Reason for leaving? _____ Position Held _____ Hourly wage _____ Unit Specialty (if applicable) _____ <input type="radio"/> Part Time (Hours per week? _____) <input type="radio"/> Full Time Patient Caseload _____ Computerized Charting <input type="radio"/> Yes <input type="radio"/> No Type _____ Charge Experience: <input type="radio"/> Yes (How often? _____) <input type="radio"/> No Supervisor _____ Phone ( ) _____ ext. _____ Is this a travel assignment? <input type="radio"/> Yes <input type="radio"/> No If so, what travel company? _____ May we contact employer? <input type="radio"/> Yes <input type="radio"/> No
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