

Online Application  
(Fields marked with \* are all required)

**Personal Information**

First Name*	<input type="text"/>	Middle Initial	<input type="text"/>	Last Name*	<input type="text"/>
Mobile Phone*	<input type="text"/> - <input type="text"/> - <input type="text"/>	Home Phone	<input type="text"/> - <input type="text"/> - <input type="text"/>		
Email	<input type="text"/>				
Current Address*	<input type="text"/>				
City*	<input type="text"/>	State*	- <input type="text"/>	ZIP*	<input type="text"/>
<input type="checkbox"/>	<b>Same as current address</b>				
Permanent Address	<input type="text"/>				
City	<input type="text"/>	State	- <input type="text"/>	ZIP	<input type="text"/>
Shift Preference	- <input type="text"/>	How did you heard about us?	<input type="text"/>		
Emergency Contact Name*	<input type="text"/>	Relationship	<input type="text"/>	Phone*	<input type="text"/> - <input type="text"/> - <input type="text"/>

**Education** (Please enter applying degree.)  
(Must fill in Name of School, City, State, Year, and Degree)

Name of School	City	State	Year	Degree
<input type="text"/>	<input type="text"/>	- <input type="text"/>	<input type="text"/>	<input type="text"/> (required*)
<input type="text"/>	<input type="text"/>	- <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	- <input type="text"/>	<input type="text"/>	<input type="text"/>

**Nursing Certifications** (Please list all certifications - i.e., BLS/CPR, ACLS, NRP, PALS, Fetal Monitoring, etc.)

*(Must fill in Type and Expiration date. Cannot enter duplicate certifications)*

Type Expiration Date(mm/dd/yyyy)

ACLS  (required\*)

ACLS

**Licensure (Active)**

*(Must fill in State License, License#, and Expiration date.)*

State License License# Expiration Date(mm/dd/yyyy)

-   (required\*)

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Has your nursing license ever been investigated, suspended or revoked?\*

YES  NO

Please provide explanation\* (If you answered yes to the above question, please send an email with additional support document(s) to recruitment@allstatenursing.com)

Have you ever been convicted of a crime other than a minor traffic violation?\*

YES  NO

Please provide explanation\* (If you answered yes to the above question, please send an email with additional support document(s) to recruitment@allstatenursing.com )

At any time in your career have you been denied malpractice insurance?\*

YES  NO

Please provide explanation\* (If you answered yes to the above question, please send an email with additional support document(s) to recruitment@allstatenursing.com )

Can you submit verification of your legal right to work in the United States?\*

YES  NO

Please provide explanation\* (If you answered no to the above question, please send an email with additional support document(s) to recruitment@allstatenursing.com)

### Specialties and Unit Experience

Please identify the recent Primary unit experience(s) you have had (in years) in each of these units. In addition, identify the unit(s) that you could float by placing a check in the Float column next to unit name. *Greater flexibility with Float experiences translates into more opportunities for staffing assignments.*





*(Must fill in Specialty and Primary Exp. Floating Ability is optional. Cannot enter duplicate Specialty)*

Specialty	Primary Exp. (# of Years)	Floating ability	
Select a specialty: ▼	- ▼	<input type="checkbox"/>	(required*)
Select a specialty: ▼	- ▼	<input type="checkbox"/>	
Select a specialty: ▼	- ▼	<input type="checkbox"/>	
Select a specialty: ▼	- ▼	<input type="checkbox"/>	
Select a specialty: ▼	- ▼	<input type="checkbox"/>	





## Clinical References

Please provide us with two Clinical References that we can contact. Please make sure these Clinical References are (A) People who have managed you (i.e. Charge Nurse, Unit Manager, Director, etc...), (B) from within the past year and (C) from the Clinical Unit in which you would most like a Travel Assignment.

### Reference #1

Reference's Name*	<input type="text"/>	Title*	<input type="text"/>	Clinical Unit*	<input type="text"/>
Facility Name*	<input type="text"/>				
Primary Phone*	<input type="text"/> - <input type="text"/> - <input type="text"/>	Secondary Phone	<input type="text"/> - <input type="text"/> - <input type="text"/>		
From*	<input type="text"/>   (mm/yyyy)	To*	<input type="text"/> Present   (mm/yyyy)		
Facility Address	<input type="text"/>				
City*	<input type="text"/>	State*	<input type="text"/> - <input type="text"/>	ZIP	<input type="text"/>

### Reference #2

Reference's Name*	<input type="text"/>	Title*	<input type="text"/>	Clinical Unit*	<input type="text"/>
Facility Name*	<input type="text"/>				
Primary Phone*	<input type="text"/> - <input type="text"/> - <input type="text"/>	Secondary Phone	<input type="text"/> - <input type="text"/> - <input type="text"/>		
From*	<input type="text"/>   (mm/yyyy)	To*	<input type="text"/> Present   (mm/yyyy)		
Facility Address	<input type="text"/>				
City*	<input type="text"/>	State*	<input type="text"/> - <input type="text"/>	ZIP	<input type="text"/>

**Previous Employment History** (Please try and cover the last 7 years of experience. Start with the most recent employer.)

## Employment Details

Facility Name	<input type="text"/>	Dept/Unit	<input type="text"/>	<input type="text"/>
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Address

State

Dates Employed: From     
(mm/yyyy)

Reason for Leaving

Shift worked

Position Type

Name of Travel/Registry company (if applicable)

Supervisor's Name

Other Supervisor?

City

ZIP

To    
(mm/yyyy)

Title

Charge Experience?  YES  NO

Phone -- Ext.

Phone -- Ext.

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**Employment Details**

Facility Name

Address

State

Dates Employed: From     
(mm/yyyy)

Reason for Leaving

Shift worked

Position Type

Name of Travel/Registry company (if applicable)

Supervisor's Name

Other Supervisor?

Dept/Unit

City

ZIP

To    
(mm/yyyy)

Title

Charge Experience?  YES  NO

Phone -- Ext.



Phone -- Ext.

### Employment Details

Facility Name

Address

State

Dates Employed: From     
(mm/yyyy)

Reason for Leaving

Shift worked

Position Type

Name of Travel/Registry company (if applicable)

Supervisor's Name

Other Supervisor?

Dept/Unit

City

ZIP

To     
(mm/yyyy)

Title

Charge Experience?  YES  NO

Phone  -  -  Ext.



Phone  -  -  Ext.

### Employment Details

Facility Name

Address

State

Dates Employed: From     
(mm/yyyy)

Reason for Leaving

Shift worked


Position Type

Name of Travel/Registry company (if applicable)

Dept/Unit

City

ZIP

To     
(mm/yyyy)

Title

Charge Experience?  YES  NO

Supervisor's Name

Other Supervisor?

Phone -- Ext.



Phone -- Ext.

**Employment Details**

Facility Name

Address

State -

Dates Employed: From     
(mm/yyyy)

Reason for Leaving

Shift worked

Position Type

Name of Travel/Registry company (if applicable)



Supervisor's Name

Other Supervisor?

Dept/Unit

City

ZIP

To  Present    
(mm/yyyy)

Title

Charge Experience?  YES  NO

Phone -- Ext.

Phone -- Ext.

**Employment Details**

Facility Name

Address

State -

Dates Employed: From     
(mm/yyyy)



Reason for Leaving

Shift worked

Dept/Unit

City

ZIP

To  Present    
(mm/yyyy)

Title

Position Type

Charge Experience?  YES  NO

Name of Travel/Registry company (if applicable)

Supervisor's Name

Phone  -  -  Ext.

Other Supervisor?

Phone  -  -  Ext.

**Please provide reasons for periods you were not employed below**

Please read the following statement carefully. We will only consider you for employment after you accept the terms.

I authorize investigation of all statements contained in this application for employment. I understand that misrepresentation or omission of facts called for herein will be sufficient cause for cancellation of consideration for employment dismissal from the company's service if I have been employed.

I authorize Allstate Nursing Services, Inc. to verify my licenses, education, and other information included on my application and to supply that information to clients.

I understand that I must submit a current physician's statement (current within the last year and not to expire during the assignment) which includes a Rubeola, Rubella, Varicella, T.B Tine or Chest X-Ray and any other specific reports requested by the client hospital.

I understand that I am responsible for submitting an I-9 form along with appropriate documentation proving that I am authorized to be employed in the United States.

I consent to the submission of request for background check and drug testing as required by specified members of the California Hospital Association.

I agree to uphold the agency's Drug Free Workplace policy, which has been created in accordance with the 1988, Drug Free Workplace Act created by Congress. I agree to random drug screening in the event of a work place injury or "reasonable suspicion" that I may be working under the influence of alcohol or a controlled substance while on duty or on the premises of a client facility. Allstate Nursing Services, Inc Health Personnel will submit this request.

I understand that I am not officially employed by agency until I have worked at least one shift for agency, and agency is in receipt of an approved reference.

I am also giving permission to Allstate Nursing Services, Inc to allow Hospitals and Health Care Facilities that I may work for, access to employment and health information, your information may be transmitted via facsimile, verbally communicated, electronic email or written.

**I agree with the above terms:**

Agree  Disagree

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