



Holsman Healthcare, LLC
 Healthcare Staffing and Consulting Services
 Tel: 973-393-5545 / 973-759-1494 / 877-268-9100 Fax: 973-759-0557

Application

General Information

| | | | | |
|--------------------------|--------------------|--|--------------------------------|------------|
| First Name | Middle Name | Maiden Name | Last Name | |
| | | | | |
| Address | | City | State | Zip |
| | | | | |
| Email Address | | How did you hear of Holsman Healthcare? | | |
| | | | | |
| Home Phone | Cell Phone | Other Contact Number | Best Time to Contact | |
| | | | | |
| Emergency Contact | | Relationship | Emergency Contact Phone | |
| | | | | |

Employment Profile

Please check yes or no for each of the following questions.

| | | |
|---|------------------------------|-----------------------------|
| Can you provide proof of eligibility to work in the United States? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Have you ever been convicted of a crime that would prevent employment at a health care facility? If yes, please provide a detailed explanation on a separate sheet of paper. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Have you ever had a license or certification investigated, revoked, or suspended? If yes, please provide a detailed explanation on a separate sheet of paper. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you have at least one year of current experience on a hospital floor? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Are you willing to submit to a criminal background check? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Are you willing to submit to a drug screen? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you have any limitations that would restrict you from performing essential functions in the position for which you are applying? If yes, please provide a detailed explanation on a separate sheet of paper. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Are your driving privileges suspended or revoked in any state? If yes, please provide a detailed explanation on a separate sheet of paper. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Can you provide proof of auto insurance for rental car usage? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Education

| School / University | Location | Month / Year Graduated | Degree / Diploma Awarded |
|----------------------------|-----------------|-------------------------------|---------------------------------|
| | | | |
| | | | |
| | | | |
| | | | |

Expertise / Experience

| Specialty | Years of Experience | Equipment / Procedures |
|------------------|----------------------------|-------------------------------|
| | | |
| | | |
| | | |
| | | |



Holsman Healthcare, LLC
 Healthcare Staffing and Consulting Services
 Tel: 973-393-5545 / 973-759-1494 / 877-268-9100 Fax: 973-759-0557

| |
|-------------|
| Name |
| |

Work History *List below all permanent positions (full-time & part-time), local agency, and travel assignments.*

| | | | | |
|-------------------|-----------------|---------------------------|---|--|
| Facility | Location | Dates Employed | Salary | |
| | | | | |
| Supervisor | Phone | Reason for Leaving | <input type="checkbox"/> Full-time <input type="checkbox"/> Part-Time <input type="checkbox"/> Local Agency <input type="checkbox"/> Travel (company: _____) | |
| | | | | |

| | | | | |
|-------------------|-----------------|---------------------------|---|--|
| Facility | Location | Dates Employed | Salary | |
| | | | | |
| Supervisor | Phone | Reason for Leaving | <input type="checkbox"/> Full-time <input type="checkbox"/> Part-Time <input type="checkbox"/> Local Agency <input type="checkbox"/> Travel (company: _____) | |
| | | | | |

| | | | | |
|-------------------|-----------------|---------------------------|---|--|
| Facility | Location | Dates Employed | Salary | |
| | | | | |
| Supervisor | Phone | Reason for Leaving | <input type="checkbox"/> Full-time <input type="checkbox"/> Part-Time <input type="checkbox"/> Local Agency <input type="checkbox"/> Travel (company: _____) | |
| | | | | |

| | | | | |
|-------------------|-----------------|---------------------------|---|--|
| Facility | Location | Dates Employed | Salary | |
| | | | | |
| Supervisor | Phone | Reason for Leaving | <input type="checkbox"/> Full-time <input type="checkbox"/> Part-Time <input type="checkbox"/> Local Agency <input type="checkbox"/> Travel (company: _____) | |
| | | | | |

| | | | | |
|-------------------|-----------------|---------------------------|---|--|
| Facility | Location | Dates Employed | Salary | |
| | | | | |
| Supervisor | Phone | Reason for Leaving | <input type="checkbox"/> Full-time <input type="checkbox"/> Part-Time <input type="checkbox"/> Local Agency <input type="checkbox"/> Travel (company: _____) | |
| | | | | |

| | | | | |
|-------------------|-----------------|---------------------------|---|--|
| Facility | Location | Dates Employed | Salary | |
| | | | | |
| Supervisor | Phone | Reason for Leaving | <input type="checkbox"/> Full-time <input type="checkbox"/> Part-Time <input type="checkbox"/> Local Agency <input type="checkbox"/> Travel (company: _____) | |
| | | | | |

Professional References

| | | | |
|-------------|--------------|-----------------|-----------------------|
| Name | Title | Facility | Contact Number |
| | | | |
| | | | |
| | | | |
| | | | |



Holsman Healthcare, LLC
 Healthcare Staffing and Consulting Services
 Tel: 973-393-5545 / 973-759-1494 / 877-268-9100 Fax: 973-759-0557

| |
|-------------|
| Name |
| |

Licensure

| State | License Number | Issue Date | Expiration Date |
|-------|----------------|------------|-----------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Certifications

| Certification | Expiration Date | Certification | Expiration Date |
|-----------------|-----------------|-----------------|-----------------|
| GCS | | OCS | |
| PCS | | CCS | |
| SCS | | ECS | |
| NCS | | Other (_____) | |
| CHT | | Other (_____) | |
| Other (_____) | | Other (_____) | |
| ACLS | | BLS | |
| Other (_____) | | Other (_____) | |

Application Certification

I certify that all statements made in this application are true to the best of my knowledge. I understand that any falsification or misleading information given in my application may result in the termination of my employment with Holsman Healthcare, LLC. Furthermore, I understand that my professional conduct and clinical performance is directly related to my ability to be placed on assignments for Holsman Healthcare and that I will adhere to all expectations set forth in the employee handbook. I authorize Holsman Healthcare, LLC to verify the information I have provided, to contact references, and to conduct a criminal background check concerning my ability, character, and past employment record.

I understand that nothing contained in this application is intended to create an employment contract, either verbal or written, with Holsman Healthcare, LLC or its' clients. Furthermore, I understand that in the event of my employment, it is "at will" and that Holsman Healthcare or I may terminate my employment at any time with or without notice and with or without cause.

Signature

Date