



APPLICATION

P.O. Box 4070 Phone: 304-623-5777
 Clarksburg, WV 26302 1-866-644-4484
 Email: Info@usnursingnetwork.com Fax: 304-623-6044

Name: _____ Application Date: _____
Last First M

Permanent address: _____
Street Address City State Zip Code

Home phone: _____ Work phone: _____ Cell phone: _____

Professional discipline: _____ Specialty: _____

Social Security Number: _____ Date available: _____

How did you learn about USNN: _____ E-Mail address: _____

Education	School Name & Address	Month / Year Graduated	Diploma or Degree Received
Trade School or Training Site			
College			
Other School (if applicable)			

Licensure *(Include photocopies of all licenses held.)*

State: _____ Lic #: _____ Original Issue Date: _____ Expiration Date: _____	State: _____ Lic #: _____ Original Issue Date: _____ Expiration Date: _____	State: _____ Lic #: _____ Original Issue Date: _____ Expiration Date: _____
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Professional Registration(s) / Certification(s) *(Include photocopies of all certifications held.)*

Certification: _____ Exp. Date: _____ Certification: _____ Exp. Date: _____

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Employment Profile

Applicant's Name _____

Page _____

Please indicate all of your employment history, beginning with most recent:

Are you currently employed? Yes No If so, may we contact your current employer? Yes No

Please document reasons for periods you were not employed.

Facility / Employer _____	Dept. _____
Street address _____	City _____ State _____ Zip _____
Dates employed: From _____ To _____	Reason for leaving _____
Position held _____	Shift _____ Unit / Floor _____ # Beds _____
Supervisor's name and title _____	Phone _____

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Other names under which you have been employed _____

Can you submit verification of your legal right to work in the U.S.? YES NO

If you will be employed on a visa, please specify type of work visa: _____

Have you ever pled guilty to or been convicted of a criminal Offense other than a misdemeanor?* YES NO

Have you ever been investigated by federal or state authorities for an alleged violation of a health care law?* YES NO

Have you ever been excluded from participation in a federal health care program (e.g. Medicare/Medicaid)?* YES NO

Has any license or certification that you have had ever been subject to disciplinary action, suspension, or revocation?* YES NO

**If you answered yes to any of the above, please explain on a separate sheet.*

I certify that all information provided in this application is accurate, true, and correct. I acknowledge that any misstatement or omission of fact on this application may result in my disqualification for employment with U.S. Nursing Network (USNN). I authorize USNN to release this application and reference information to USNN client institutions. This signed application will serve as my written consent for release of this information.

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