



INTERNATIONAL EMPLOYMENT APPLICATION

Please complete all 5 pages of this document and ensure that you sign and date the last page.

SECTION A

Surname	First Name	Middle Name	Title <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss
Please note any other names used previously			
Correspondence Address			
Street Address			
Suburb		State & Postcode	
Telephone # - Home	Telephone # - Work	Telephone # - Mobile	Telephone # - Other
Email Address			

Permanent Residence (if different from above)			
Street Address			
Town/City		County/Postcode	
Date of Birth (Day/Month/Year)		How did you hear about Nurses in Partnership, Inc.?	
Have you spoken to a Nurses in Partnership, Inc. recruiter? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, who was the recruiter you spoke with?	
Do you hold a current passport?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nationality	Date of issue (D/M/Y)	Place of issue	Date of expiration (D/M/Y)
Have you ever been excluded entry into any country?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please state where, date (D/M/Y), and why			

SECTION B

Do you hold a current U.S. nursing license? <input type="checkbox"/> Yes <input type="checkbox"/> No (If No, please proceed to Section C)		If Yes, in which state(s)?	
Have you worked in the US previously?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Date started work in US (D/M/Y)	Duration of work in the US	Type of visa when in the US	
Have you ever had a US visa? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, has it ever been cancelled? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any relatives in the US?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, please state your relationship to them and indicate what they are doing in the US (i.e. work/leisure/study)			
Do you have a US Social Security Number? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, what is the number?	



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SECTION C - EDUCATION

Secondary School

Street Address

Suburb

State & Postcode

Date Completed (D/M/Y)

Highest Qualification Achieved

Nursing School

Street Address

Suburb

State & Postcode

Date Completed (D/M/Y)

Highest Qualification Achieved

Other School

Street Address

Suburb

State & Postcode

Date Completed (D/M/Y)

Highest Qualification Achieved

PROFESSIONAL CERTIFICATIONS

Please list all of your certifications (i.e. RSCN, RMN, RM, ENB Courses, etc.)

Type	Expiration Date (D/M/Y)	Type	Expiration Date (D/M/Y)
Type	Expiration Date (D/M/Y)	Type	Expiration Date (D/M/Y)

PROFESSIONAL EDUCATION

Course Name	Date (D/M/Y)	Hours/Credits
Course Name	Date (D/M/Y)	Hours/Credits
Course Name	Date (D/M/Y)	Hours/Credits



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SECTION D – PREVIOUS EMPLOYMENT

Your Name _____

Are you currently employed? Yes No

May we contact your present employer? Yes No

May we contact your previous employer(s)? Yes No

List your most recent employer first.

PLEASE COMPLETE ALL INFORMATION FOR EACH HOSPITAL

Hospital Name: _____	Telephone #: _____
Street Address: _____	
Suburb: _____	State & Postcode: _____
Immediate Supervisor Name: _____	Title: _____
Dates Employed (D/M/Y) From _____	To: _____
Position Held: _____	Unit: _____
Number of Beds in Unit _____ in Hospital _____	Nurse/Patient Ratio _____
Reason for Leaving: _____	
Brief Description of Duties: _____	

Hospital Name: _____	Telephone #: _____
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Suburb: _____	State & Postcode: _____
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Dates Employed (D/M/Y) From _____	To: _____
Position Held: _____	Unit: _____
Number of Beds in Unit _____ in Hospital _____	Nurse/Patient Ratio _____
Reason for Leaving: _____	
Brief Description of Duties: _____	



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SECTION D – PREVIOUS EMPLOYMENT (continued)

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Hospital Name: _____	Telephone #: _____
Street Address: _____	
Suburb: _____	State & Postcode: _____
Immediate Supervisor Name: _____	Title: _____
Dates Employed (D/M/Y) From _____	To: _____
Position Held: _____	Unit: _____
Number of Beds in Unit _____ in Hospital _____	Nurse/Patient Ratio _____
Reason for Leaving: _____	
Brief Description of Duties: _____	

Hospital Name: _____	Telephone #: _____
Street Address: _____	
Suburb: _____	State & Postcode: _____
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Dates Employed (D/M/Y) From _____	To: _____
Position Held: _____	Unit: _____
Number of Beds in Unit _____ in Hospital _____	Nurse/Patient Ratio _____
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Brief Description of Duties: _____	



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SECTION D – PREVIOUS EMPLOYMENT (continued)

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Hospital Name: _____	Telephone #: _____
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Dates Employed (D/M/Y) From _____	To: _____
Position Held: _____	Unit: _____
Number of Beds in Unit _____ in Hospital _____	Nurse/Patient Ratio _____
Reason for Leaving: _____	
Brief Description of Duties: _____	

By signing this application, I certify: That this application is complete and accurate to the best of my knowledge and that I have not made any attempt to conceal information, and that falsification could be cause for dismissal. Further, Nurses in Partnership, Inc. or its agents may request employment information from my previous employers and persons or corporations who provide information related to my previous employment and will be released from any liability or damage.

Signature _____ Date (DD/MM/YY) _____

Name (PLEASE PRINT) _____