



Please Read before continuing:
You must be currently licensed with the State of Florida as an RN, LPN, or CNA!
You must also have at least (1) year of experience within the past (3) years
in a Hospital or Nursing Home setting.

*Print Full Name: _____ Date: _____

*Street/Apt #: _____

*City: _____ County: _____ *State: _____ *Zip: _____

*Primary Phone # : (____) _____ Secondary Phone # : (____) _____

Email: _____ *Social Security #: _____ - _____ - _____

*FL Nursing License or Certificate #, and Expiration Date: _____

*Position Applying for: _____ Have you ever worked for AMS? _____

Referred By: _____

Are you currently orientated at any Hospitals through another agency? _____

If yes which Hospitals? _____

Healthcare Experience-----

*1. Name of Last / Current Employer: _____

*Address: _____ (street, city, state, zip)

*Phone #: (____) _____ End Pay: _____ *Your Title: _____

Units Worked: CCU/ICU PCU/TELE/Step Down ER/ED M/S Long Term Care Other

*Supervisor Name: _____ *Start Date: _____ End Date: _____

Reason for Leaving: _____

*2. Name of Previous Employer: _____

*Address: _____ (street, city, state, zip)

*Phone #: (____) _____ End Pay: _____ *Your Title: _____

Units Worked: CCU/ICU PCU/TELE/Step Down ER/ED M/S Long Term Care Other

*Supervisor Name: _____ *Start Date: _____ End Date: _____

Reason for Leaving: _____

What Counties are you willing to staff? _____

Assignment Preference-----

Full Time Part Time Per Diem Contract Days Evenings Overnight 8hours 12 hours

Education-----

*Institution: _____ Location: _____

*Degree: _____ *Date Obtained: _____

Physical Condition-----

Do you have a physical condition or handicap that will limit your ability to perform the job applied for? _____

If yes, Please Explain: _____

State of Florida Employment Questionnaire-----

*1. Do you have a Criminal Record: _____ if Yes, Please Explain: _____

*2. Is your Nursing License currently in good and active standing with the State of Florida? _____
if No, Please Explain: _____

*3. How long have you resided in the State of Florida? Years _____ Months _____

If less than 5 years, have you recently completed a Background Screening that included fingerprinting? _____

I hereby certify, under penalty of immediate dismissal, that this application for employment has been completed fully and correctly. I understand that inquires will be made to my former employers or their agents including information regarding my employment dates, and position. My permission is hereby granted to make such inquires. Advantage Medical Staffing Inc. is required by the State Department of Professional Regulations to conduct background checks on all of its healthcare workers. Advantage Medical Staffing Inc. is a drug-free work place. Therefore I agree to submit to a drug screen, as well as a verification of my professional nursing license or certificate.

I understand that my status with Advantage Medical Staffing Inc. will be terminated if the background check or drug screen are returned with disqualifying offenses.

I understand that this information will be maintained as confidential and is nondiscriminatory per company policy in relation to race, creed, religion, sexual orientation, age or handicap.

*Signature: _____ *Date: _____