|  |  |
| --- | --- |
|  | Paceline Anesthesia PLLCCONFIDENTIAL APPLICATION Please complete and return to:  [info@paceline.com](mailto:info@paceline.com) or fax to 253-862-6139 |

# **Employment Application**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Applicant Information | | | | | | | | |
| Last Name: |  | First Name |  | | | | Date: |  |
| Street Address: |  | | Apartment/Unit # | | |  | | |
| City: |  | | | State: | |  | ZIP: |  |
| Phone: |  | | Email Address: | | |  | | |
| Date Available: |  | Social Security No. |  | | | | Desired Salary: | $ |
| Position Applied For | Full-time | | Part-time | | | Per Diem | | |
| Are you a citizen of the United States? | YES | NO | If no, are you authorized to work in the U.S.? | | | | YES | NO |
| Have you ever been convicted of a felony? | YES | NO | If yes, explain | |  | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Educational Experience: | | | | | | |
| Anesthesia School: | |  | | | City, State: |  |
| From: |  | To: |  | Degree: |  | |
| Nursing School: | |  | | | City, State: |  |
| From: |  | To: |  | Degree: |  | |
| Undergraduate College: | |  | | | City, State: |  |
| From: |  | To: |  | Degree: |  | |
| Undergraduate College: | |  | | | City, State: |  |
| From: |  | To: |  | Degree: |  | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Current Licenses (RN and ARNP) | | | | | | | |
| License Type: |  | State: |  | License # |  | Expiration Date: |  |
| License Type: |  | State: |  | License # |  | Expiration Date: |  |
| License Type: |  | State: |  | License # |  | Expiration Date: |  |
| License Type: |  | State: |  | License # |  | Expiration Date: |  |
| License Type: |  | State: |  | License # |  | Expiration Date: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Current Certifications: | | | | |
| NBCRNA | YES | NO | Expiration Date: |  |
| ACLS | YES | NO | Expiration Date: |  |
| BCLS | YES | NO | Expiration Date: |  |
| PALS | YES | NO | Expiration Date: |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Malpractice Insurance: | | | | | | |
| Do you have you own Malpractice insurance? | | | YES | NO | | |
| Coverage Limits | $1,000,000/$3,000,000 | | Other | | | |
| Hospital Based: | YES | NO | Stand-Alone: | | YES | NO |
| Previous Claims | YES | NO | If yes, please explain (include dates) : | |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| Electronic Medical Records: | | | |
| Do you have experience with electronic medical records? | | YES | NO |
| If yes, which EMR: |  | | |
|  |  | | |
|  |  | | |
|  |  | | |
|  |  | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Professional Experience: | | | | | |
| *List most recent employer first* | | | | | |
| Facility Name: |  | | | Phone: |  |
| Address: |  | | | | |
| Position Held: |  | | | Ending Salary: | $ |
| Specialty: |  | | | | |
| From: |  | To: |  | Reason for Leaving: |  |
| Additional Information: |  | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Facility Name: |  | | | | Phone: | |  |
| Address: |  | | | | | | |
| Position Held: |  | | | | Ending Salary: | | $ |
| Specialty: |  | | | | | | |
| From: |  | To: |  | Reason for Leaving: | |  | |
| Additional Information: |  | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Facility Name: |  | | | | Phone: | |  |
| Address: |  | | | | | | |
| Position Held: |  | | | | Ending Salary: | | $ |
| Specialty: |  | | | | | | |
| From: |  | To: |  | Reason for Leaving: | |  | |
| Additional Information: |  | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Professional References: | | | | | | |
| *Please list three professional references* | | | | | | |
| Name of Reference: | |  | | Title of Reference: | |  |
| Company/Facility: | |  | | Phone: |  | |
| Address: |  | | | | | |
| Your relationship with reference: | | |  | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name of Reference: | |  | | Title of Reference: | |  |
| Company/Facility: | |  | | Phone: |  | |
| Address: |  | | | | | |
| Your relationship with reference: | | |  | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name of Reference: | |  | | Title of Reference: | |  |
| Company/Facility: | |  | | Phone: |  | |
| Address: |  | | | | | |
| Your relationship with reference: | | |  | | | |

|  |
| --- |
| Self-Description: |
| Please tell us more about you both professionally and personally: |

|  |  |  |  |
| --- | --- | --- | --- |
| Release, Authorization, and Acknowledgment: | | | |
| * I certify that the above information I have provided on this application and attachments is true, complete and accurate, that is can be used by Paceline Anesthesia PLLC for evaluating my potential as an anesthesia provider, and that Paceline Anesthesia PLLC can rely on the truthfulness of my application. * If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release. * I acknowledge in making medical application for membership to the medical staff, I authorize Paceline Anesthesia PLLC and its representatives, to obtain any information that may be relevant to an evaluation of my professional qualifications, including references, information about disciplinary actions or other credentials or confidential information. * I hereby release Paceline Anesthesia PLLC, its officers, employees, and representatives, and third parties which provide or receive information regarding my credentials. Further, I agree to indemnify, defend and hold Paceline Anesthesia PLLC, its officers, employees, and representatives and third parties harmless from any and all claims, causes of action, damages, judgments and expenses, including reasonable attorney’s fees, arising from or related to the collection, verification and dissemination of my credentialing information. * I understand that I have the burden of providing accurate information to Paceline Anesthesia PLLC to demonstrate my qualifications. I understand that any misrepresentation on this application may constitute grounds for denial or referral to practice assignments. * I understand that I am responsible for notifying Paceline Anesthesia PLLC of any changes affecting my professional status. I certify that the information contained in this application is accurate and complete. * I authorize my previous employers, schools, or persons listed as references to give any information regarding employment or educational record. I agree that this company and my previous employers will not be held liable in any respect if a job offer is not extended, or is withdrawn, or employment is terminated because of false statements, omissions, or answers made by myself on this application. In the event of any employment with this company, I will comply with all rules and regulations as set by the company in any communication distributed to the employees. | | | |
| Signature: |  | Date: |  |