



Thank you for allowing Millenia Medical Staffing to assist you in your endeavors as a traveling medical professional. We are excited to welcome you to our team! Please complete the following items below so that we can begin the credentialing process.

You will find the enclosed documents that are to be completed and returned.

- Application
- Work History and/or Resume'
- Skills Checklist(s)
- Reference Forms(3)
- Authorization Release

Please provide us with the following documents:

- Copy of active nursing license(s)
- Copy of all valid CPR/Life Support certification cards
- Copy of current photo for ID Badge (*must be original*)
- Copy of drivers license or identification card
- Copy of social security card or birth certificate or passport
- Copy of Signed Physician Statement
- Copy of TB/PPD Test Results *within 1 year* or Chest X-Ray *within 2 years*
- Copy of MMR vaccine or Rubella & Rubeola & Mumps titers
- Copy of Varicella Titer and Hepatitis B Titers
- Copy of Hepatitis B Series, Titter or Declination

Thank you for your prompt return of the above documents. Upon receipt of your information, you will be contacted regarding available assignments.

Sincerely,

Travel Division



APPLICATION

INSTRUCTIONS: Please complete all sections and sign. If a section does not apply, please indicate by answering "N/A". If additional explanations are provided please write "See Attached" and include the documentation.

PERSONAL INFORMATION

Full Name: _____ Maiden (if applicable): _____
Last First Middle Initial

Temporary Address: _____

Home Address: _____

Mailing Address: (check one) _____ Home _____ Temporary _____ SS#: _____

Phone: (____) _____ (____) _____ (____) _____ (____) _____
Home Cell Work Pager

E-Mail: _____ Place of Birth: _____

Date of Birth: _____ Referral Source/Name: _____

Emergency Contact: _____ (____) _____
Name Relationship Phone

Can you, upon employment, submit verification of your legal right to work in the United States? Yes No

EMPLOYMENT INFORMATION

RN <input type="checkbox"/> YES <input type="checkbox"/> NO	LPN <input type="checkbox"/> YES <input type="checkbox"/> NO	CST <input type="checkbox"/> YES <input type="checkbox"/> NO	ST <input type="checkbox"/> YES <input type="checkbox"/> NO
Specialty: _____	1 st Choice _____	2 nd Choice _____	3 rd Choice _____
Years Experience: _____	1 st Choice _____	2 nd Choice _____	3 rd Choice _____
Geographical Preference: _____	1 st Choice _____	2 nd Choice _____	3 rd Choice _____

EDUCATION AND TRAINING

*If information is on resume', please write "resume'." If not, please complete information thoroughly.

◆ UNDERGRADUATE: _____	<i>School</i>	<i>City</i>	<i>State</i>	<i>Start</i>	<i>End</i>	<i>Degree</i>
◆ UNDERGRADUATE: _____	<i>School</i>	<i>City</i>	<i>State</i>	<i>Start</i>	<i>End</i>	<i>Degree</i>
◆ GRADUATE: _____	<i>School</i>	<i>City</i>	<i>State</i>	<i>Start</i>	<i>End</i>	<i>Degree</i>

Did you graduate from a foreign school? YES NO When did you pass the U.S Nursing Boards Exams?



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CERTIFICATIONS

Certification	Issue Date	Expiration Date	Instructor
<input type="checkbox"/> ACLS	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> BCLS	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> ATLS	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> PALS	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> CCRN	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> NRP	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> CEN	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> TNCC	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> CHEMO	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> FHM	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO

LICENSURE INFORMATION

List all active and inactive licenses. If you have an inactive license, please note why that license is inactive. Attach a separate sheet if necessary.

Name of State	Active or Inactive	Date Issued	Expiration Date	License Number
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

GENERAL HISTORY (Please provide a brief explanation below of all "YES" answers or attach a separate sheet if necessary.)

	YES	NO
1. Have you ever had a state license to practice nursing refused, suspended or revoked?	_____	_____
2. Have you ever voluntarily surrendered or non-renewed a state license to practice nursing?	_____	_____
3. Has membership in any professional association or society ever been revoked or refused?	_____	_____
4. Has a hospital ever suspended, restricted or refused your staff privileges at any time while under peer investigation?	_____	_____
5. Have you suffered from or been treated for a chronic illness or a physical defect for more than 30 days or are you suffering from or being treated for a chronic illness or a physical defect now?	_____	_____
6. Have you ever been or are you currently being treated for mental illness including inpatient, outpatient or counseling? (If YES, provide details of rehabilitation program, including dates of treatment)	_____	_____
7. Have you ever had counseling for mental therapy for more than 30 days or are you receiving counseling now?	_____	_____
8. Have you ever taken psychiatric medications for more than 30 days or are you taking them now?	_____	_____
9. Have you ever been treated for alcoholism or narcotic addiction including inpatient, outpatient or counseling? (If YES, provide details of rehabilitation program, including dates of treatment)	_____	_____
10. Are you currently being treated for alcoholism or narcotic addiction including inpatient, outpatient or counseling? (If YES, provide details of rehabilitation program, including dates of treatment)	_____	_____
11. Have you ever been convicted of a felony?	_____	_____

If you answered yes on any of the above please attach separate sheet with thorough explanation

I hereby authorize the above information is true and accurate to the best of my knowledge

Signature

Date



WORK HISTORY

Millenia Medical Staffing requires all work history, so please list all facilities where you have worked during your career. If all information is on your Resume', you may write "Resume'." If not, please complete information.

Facility Name		Teaching or Non Teaching		City	State
Start	End	Class	Specialty Unit	# Beds in Unit	# Beds in Facility
Nurse: Patient Ratio		Average Daily Census		Reason for Leaving	
Shift	Supervisor		Phone	Travel Assignment?	

Facility Name		Teaching or Non Teaching		City	State
Start	End	Class	Specialty Unit	# Beds in Unit	# Beds in Facility
Nurse: Patient Ratio		Average Daily Census		Reason for Leaving	
Shift	Supervisor		Phone	Travel Assignment?	

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Facility Name		Teaching or Non Teaching		City	State
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Nurse: Patient Ratio		Average Daily Census		Reason for Leaving	
Shift	Supervisor		Phone	Travel Assignment?	

I hereby authorize the above information is true and accurate to the best of my knowledge

Signature

Date

NEONATAL SKILLS CHECKLIST



KEY

Please place an X in the column best describing your expertise level.

- 1** No Experience.
- 2** Limited Experience; Performs Intermittently.
- 3** Moderate Experience; Needs Resource for Backup.
- 4** Experienced; Performs Independently.

	1	2	3	4
AA SKILLS				
admission assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
gestational assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
physical assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

AA INTRAVENOUS THERAPY				
administration of TPN/hyperalimentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
assessment of infant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
documentation of data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV infusion pumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mixing solutions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
monitoring IV fluids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
scalp vein administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
set-up and use of equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
start/regulate/discontinue IV's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
syringe pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
treatment by exchange transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

AA VITAL SIGNS				
BP/dynamap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
intra-arterial/HP monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
monitor breath sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
monitor heart sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TPR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
utilization of monitors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

AA MEDICATION ADMINISTRATION				
documenting drug reactions/responses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IM administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
oral administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

AA FEEDING TECHNIQUES				
baby at breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
breast milk collection and storage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OGT continuous feed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	1	2	3	4
AA FEEDING TECHNIQUES - continued				
OGT insertion and feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OGT intermittent feed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
oral/nipple	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

AA PHOTOTHERAPY				
iatrogenic complications of ICN care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
neonatal CPR/use of bag and mask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
provide ostomy care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
recording of data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
utilization of bilimeter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
utilization of transcutaneous monitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

AA SUCTION TECHNIQUES				
endo-tracheal tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
oral/nasal suctioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tracheostomy suctioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

AA CERTIFICATIONS	EXPIRATION DATE
NRP	
ECMO	
other _____	

type of equipment used:

additional skills:

Signature: _____

Name: _____

Date: _____



PROFESSIONAL REFERENCE

In order for Millenia Medical Staffing to obtain a professional reference, please complete the following. Thank you.

To be completed by Traveler

Applicant's Name: _____ Classification: _____ Clinical Specialty: _____
 Employment dates: From _____ To: _____ Facility Name: _____
 City/State: _____ Contact: _____ Phone #: _____

To be completed by Facility or Agency

Please indicate whether the above information is correct: _____ Yes _____ No Average Patient Case Load: _____
 # beds in the unit: _____ Charge experience? _____ Yes _____ No Teaching hospital? _____ Yes _____ No
 Reason for leaving: _____ Would you rehire? _____ Yes _____ No

Performance Evaluation:	Exceptional	Above Standard	Standard	Below Standard
1. Demonstrates competency in caring for patients.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provides a safe & therapeutic patient environment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Implements a coordinated plan or patient care.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Adheres to facility policies & procedures.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Communicates appropriately with patients & families.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Completes accurate documentation of patient care.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional Attributes:				
7. Flexibility & adaptability.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Willingness & ability to float (if applicable).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Interest & enthusiasm.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Ability to communicate with staff.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Attendance & punctuality.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Overall professionalism.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Evaluator / Title: _____ Date: _____ Phone: _____

This information was obtained from: Written reference Evaluation Verbal reference Recommendation letter



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3. Implements a coordinated plan or patient care.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Adheres to facility policies & procedures.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Communicates appropriately with patients & families.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Completes accurate documentation of patient care.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional Attributes:				
7. Flexibility & adaptability.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Willingness & ability to float (if applicable).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Interest & enthusiasm.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Ability to communicate with staff.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Attendance & punctuality.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Overall professionalism.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

Evaluator / Title: _____ Date: _____ Phone: _____

This information was obtained from: Written reference Evaluation Verbal reference Recommendation letter



DISCLOSURE STATEMENT AND AUTHORIZATION RELEASE

I hereby consent and give authority to the representatives of Millenia Medical Services, Inc (DBA Millenia Medical Staffing) and all of its clients or customers, including hospitals, or clinics to obtain and review all records or other information that may be pertinent to the evaluation of my professional qualifications and competence to carry out services for Millenia Medical's clients. Additionally, I consent to representatives of Millenia Medical and all of its clients or customers, including hospitals, or clinics to conduct a personal and professional background reference check including verification of licensing and certifications, verification of education and transcripts and and all other records or information concerning my past activities relating to my driving, criminal, civil and other experiences.

If you are denied employment because of the consumer investigation, it is your right under the Fair Credit Reporting Act (Law 91-508) SS 606 to have the name of the agency or agencies from whom information concerning you was obtained. You are also entitled to receive free copies of the information supplied by those agencies within sixty days upon written request. You have the right to directly dispute with the consumer reporting agency the accuracy and completeness of any information furnished by that agency.

I hereby release Millenia Medical and all of its representatives from any liability from any and all of their activities conducted in connection with this authorization. Additionally, I hereby release from liability any and all individuals and organizations who provide information to Millenia Medical or its representatives, in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for provision of services to Millenia Medical clients, and I hereby consent to the release of any and all such information.

Have you ever been convicted of a felony _____ or a misdemeanor _____? If yes, provide an explanation:

I UNDERSTAND THAT ANY FALSIFYING OR OMISSIONS CONTAINED IN MY APPLICATION, CONSTITUTES CAUSE FOR TERMINATION OF CONTRACT WITH MILLENIA MEDICAL OR DECLINING ANY PENDING JOB OFFERS. ALL INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE TO MY BEST KNOWLEDGE AND BELIEF.

Applicant's Printed Name

Date

Applicant's Signature

Social Security Number

MMS Representative Signature

Date