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

109 River Landing Drive • Suite 400 • Daniel Island, SC 29492
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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 ☐ *YES* ☐ *NO* LPN ☐ *YES* ☐ *NO* CST ☐ *YES* ☐ *NO* ST ☐ *YES* ☐ *NO*

Specialty:	1st Choice	2nd Choice	3rd Choice
Years Experience:	1st Choice	2nd Choice	3rd Choice
Geographical Preference:	1st Choice	2nd Choice	3rd Choice

EDUCATION AND TRAINING

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

	School	City	State	Start	End	Degree
♦ UNDERGRADUATE:						
♦ UNDERGRADUATE:						
♦ GRADUATE:						

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

CERTIFICATIONS

Certification	Issue Date	Expiration Date	Instructor
☐ ACLS			☐ YES ☐ NO
☐ BCLS			☐ YES ☐ NO
☐ ATLS			☐ YES ☐ NO
☐ PALS			☐ YES ☐ NO
☐ CCRN			☐ YES ☐ NO
☐ NRP			☐ YES ☐ NO
☐ CEN			☐ YES ☐ NO
☐ TNCC			☐ YES ☐ NO
☐ CHEMO			☐ YES ☐ NO
☐ FHM			☐ YES ☐ 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?		

Facility Name	Teaching or Non Teaching	City	State		
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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? ______

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? ______

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

Signature ______ **Date** ______

TELEMETRY/PCU 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.

GENERAL	1	2	3	4
admission assessment	❑	❑	❑	❑
charge nurse responsibilities	❑	❑	❑	❑
diabetic teaching	❑	❑	❑	❑
discharge teaching	❑	❑	❑	❑
isolation precautions	❑	❑	❑	❑
isolation procedures	❑	❑	❑	❑
lab value assessment	❑	❑	❑	❑
pain management	❑	❑	❑	❑
patient education	❑	❑	❑	❑
primary nurse	❑	❑	❑	❑
specimen collection	❑	❑	❑	❑
team leading	❑	❑	❑	❑
use of restraints	❑	❑	❑	❑
wound and skin care	❑	❑	❑	❑

IV THERAPY	1	2	3	4
administer cont. infusions	❑	❑	❑	❑
administer IV antibiotics	❑	❑	❑	❑
administer IV chemotherapy	❑	❑	❑	❑
administer IV push	❑	❑	❑	❑
blood/blood product administration/precautions	❑	❑	❑	❑
Broviac catheters	❑	❑	❑	❑
change IV dressings	❑	❑	❑	❑
hyperalimentation	❑	❑	❑	❑
infusion pumps	❑	❑	❑	❑
monitor central lines	❑	❑	❑	❑
start peripheral IV lines	❑	❑	❑	❑

TELEMETRY/PCU	1	2	3	4
arrythmia interpretation	❑	❑	❑	❑
arterial line	❑	❑	❑	❑
assist intubation/extubation	❑	❑	❑	❑
assist with pacemaker insertion	❑	❑	❑	❑
cardiac transplant patient care	❑	❑	❑	❑
chest tube care	❑	❑	❑	❑
heart sounds interpretation	❑	❑	❑	❑
monitor pulse oximetry	❑	❑	❑	❑
pacemaker care	❑	❑	❑	❑
performs cardioversion	❑	❑	❑	❑
performs defribillation	❑	❑	❑	❑
post open heart	❑	❑	❑	❑
precardiac cath				
prep	❑	❑	❑	❑
teaching	❑	❑	❑	❑
pulmonary transplant patient care	❑	❑	❑	❑
resuscitation team leader	❑	❑	❑	❑

TELEMETRY/PCU - continued	1	2	3	4
resuscitation team member	❑	❑	❑	❑
Swan Ganz	❑	❑	❑	❑
tracheostomy care	❑	❑	❑	❑
12 lead EKG interpretation	❑	❑	❑	❑
use of doppler	❑	❑	❑	❑
ventilator management	❑	❑	❑	❑

USE AND UNDERSTANDING OF MEDICATIONS	1	2	3	4
Dose calculation and administration of:				
Dopamine	❑	❑	❑	❑
Epinepherine	❑	❑	❑	❑
Heparin protocol	❑	❑	❑	❑
Lidocane	❑	❑	❑	❑
Nitroglycerine	❑	❑	❑	❑
Pronestyl	❑	❑	❑	❑

list any other medications administered on a regular basis: ____________

NEUROLOGY	1	2	3	4
assess LOC	❑	❑	❑	❑
assist with lumbar puncture	❑	❑	❑	❑
CVA	❑	❑	❑	❑
care of overdose	❑	❑	❑	❑
care of spinal cord injury	❑	❑	❑	❑
cervical traction	❑	❑	❑	❑
closed head injury	❑	❑	❑	❑
cranial nerve assessment	❑	❑	❑	❑
halo traction	❑	❑	❑	❑
hypo/hyperthermia regulation	❑	❑	❑	❑
pre/post neuro surgery	❑	❑	❑	❑
Rotorest/kinetic bed	❑	❑	❑	❑
seizure precautions	❑	❑	❑	❑
use Glascow coma scale	❑	❑	❑	❑

ONCOLOGY	1	2	3	4
Aids/Arc	❑	❑	❑	❑
bone marrow transplant	❑	❑	❑	❑
chemo admin-cont. infusion	❑	❑	❑	❑
chemo admin-IV push	❑	❑	❑	❑
chemo side effect management	❑	❑	❑	❑

CERTIFICATIONS	EXPIRATION DATE
ACLS	____________
BCLS	____________
CCRN	____________
Enclose copies	

Signature: ______________________________

Name: ______________________________ Date: ______________

Please Print

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....................	☐	☐	☐	☐
2. Provides a safe & therapeutic patient environment.................	☐	☐	☐	☐
3. Implements a coordinated plan or patient care.......................	☐	☐	☐	☐
4. Adheres to facility policies & procedures..............................	☐	☐	☐	☐
5. Communicates appropriately with patients & families..............	☐	☐	☐	☐
6. Completes accurate documentation of patient care.................	☐	☐	☐	☐
Professional Attributes:				
7. Flexibility & adaptability..	☐	☐	☐	☐
8. Willingness & ability to float (if applicable).............................	☐	☐	☐	☐
9. Interest & enthusiasm..	☐	☐	☐	☐
10. Ability to communicate with staff...	☐	☐	☐	☐
11. Attendance & punctuality..	☐	☐	☐	☐
12. Overall professionalism..	☐	☐	☐	☐

Comments:

____

____

Evaluator / Title: ______________________________ Date:______________ Phone:__________________

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

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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....................	☐	☐	☐	☐
2. Provides a safe & therapeutic patient environment.................	☐	☐	☐	☐
3. Implements a coordinated plan or patient care......................	☐	☐	☐	☐
4. Adheres to facility policies & procedures..............................	☐	☐	☐	☐
5. Communicates appropriately with patients & families..............	☐	☐	☐	☐
6. Completes accurate documentation of patient care.................	☐	☐	☐	☐
Professional Attributes:				
7. Flexibility & adaptability..	☐	☐	☐	☐
8. Willingness & ability to float (if applicable)............................	☐	☐	☐	☐
9. Interest & enthusiasm..	☐	☐	☐	☐
10. Ability to communicate with staff..	☐	☐	☐	☐
11. Attendance & punctuality..	☐	☐	☐	☐
12. Overall professionalism...	☐	☐	☐	☐

Comments:

____

____

Evaluator / Title: ____________________________________ Date:_______________Phone:____________________

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

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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

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