



**Employment History Verification Form**

Applicant Name: \_\_\_\_\_

Name of Facility: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Beginning date of employment: \_\_\_\_\_

End date of employment: \_\_\_\_\_

Hours worked per week: \_\_\_\_\_

Travel assignment: \_\_\_\_\_

Type of critical care unit: \_\_\_\_\_ Number of beds: \_\_\_\_\_  
(Please specify)

\_\_\_\_\_ Number of beds: \_\_\_\_\_

\_\_\_\_\_ Number of beds: \_\_\_\_\_

Signature of unit manager/charge nurse: \_\_\_\_\_

Printed name of unit manager/charge nurse: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_