Employment History Verification Form

Applicant Name: _____

Name of Facility: _____

Address:_____City:_____State: _____

Beginning date of employment:_____

End date of employment:_____

Indicate One: Full-Time _____ Part-Time _____ PRN _____

If Part-Time or PRN, # of hours worked per week on average: _____

Travel assignment: Yes _____ No _____

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: _____