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: _____