

# APPLICANT PROFILE

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_ Maiden \_\_\_\_\_

Current Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Permanent Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cellular Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Email Address \_\_\_\_\_

Specialty \_\_\_\_\_ Availability Date \_\_\_\_\_

How did you hear about Advantage Allied?  Web search  Referral  Magazine  Conference  
 Other: \_\_\_\_\_

Can you provide proof of eligibility to work in the United States?  Yes  No

Emergency Contact / Relationship \_\_\_\_\_ Contact Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

## PROFESSIONAL LICENSURE *(Provide copies of all licenses held)*

License Type: \_\_\_\_\_ License #: \_\_\_\_\_ State: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

License Type: \_\_\_\_\_ License #: \_\_\_\_\_ State: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

## PROFESSIONAL CERTIFICATION *(Provide copies of all certifications held)*

- |   |                  |                                       |                  |
|---|------------------|---------------------------------------|------------------|
| <input type="checkbox"/> ARDMS (RVT)          | Exp. Date: _____ | <input type="checkbox"/> HT (ASCP)    | Exp. Date: _____ |
| <input type="checkbox"/> ARDMS (Sonography)   | Exp. Date: _____ | <input type="checkbox"/> HTL (ASCP)   | Exp. Date: _____ |
| <input type="checkbox"/> ARRT (CIT)           | Exp. Date: _____ | <input type="checkbox"/> MLT (ASCP)   | Exp. Date: _____ |
| <input type="checkbox"/> ARRT (CT)            | Exp. Date: _____ | <input type="checkbox"/> MT (ASCP)    | Exp. Date: _____ |
| <input type="checkbox"/> ARRT (MAMMO)         | Exp. Date: _____ | <input type="checkbox"/> NBRC (PFT)   | Exp. Date: _____ |
| <input type="checkbox"/> ARRT (MRI)           | Exp. Date: _____ | <input type="checkbox"/> NMTCB (NMT)  | Exp. Date: _____ |
| <input type="checkbox"/> ARRT (NMT)           | Exp. Date: _____ | <input type="checkbox"/> OTR          | Exp. Date: _____ |
| <input type="checkbox"/> ARRT (Rad Tech)      | Exp. Date: _____ | <input type="checkbox"/> RCIS (CIT)   | Exp. Date: _____ |
| <input type="checkbox"/> ARRT (Rad Therapist) | Exp. Date: _____ | <input type="checkbox"/> RCIS (VIT)   | Exp. Date: _____ |
| <input type="checkbox"/> ARRT (Sonograph)     | Exp. Date: _____ | <input type="checkbox"/> RCS          | Exp. Date: _____ |
| <input type="checkbox"/> ARRT (VIT)           | Exp. Date: _____ | <input type="checkbox"/> RDCS         | Exp. Date: _____ |
| <input type="checkbox"/> CMD                  | Exp. Date: _____ | <input type="checkbox"/> RPSGT        | Exp. Date: _____ |
| <input type="checkbox"/> COTA                 | Exp. Date: _____ | <input type="checkbox"/> RRT          | Exp. Date: _____ |
| <input type="checkbox"/> CRT                  | Exp. Date: _____ | <input type="checkbox"/> Other: _____ | Exp. Date: _____ |
| <input type="checkbox"/> EEG                  | Exp. Date: _____ | <input type="checkbox"/> Other: _____ | Exp. Date: _____ |

**FAX COMPLETED APPLICATION TO:  
 866-740-9957 or 866-390-2780**

## EDUCATION

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College Name and Location	Month/Year Graduated	Diploma/Degree Received
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Graduate School Name and Location	Month/Year Graduated	Diploma/Degree Received
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Other School Name and Location	Month/Year Graduated	Diploma/Degree Received
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## EMPLOYMENT PROFILE

Have you ever been convicted of a crime that would prevent employment at a healthcare facility?

Yes  No *If yes, please explain on a separate sheet of paper*

Have you ever had a license or certification investigated, revoked or suspended?

Yes  No *If yes, please explain on a separate sheet of paper*

Have you ever been named as a defendant in a professional liability action?

Yes  No *If yes, please explain on a separate sheet of paper*

Do you have any limitations that would restrict you from performing essential functions in the position you are applying for?

Yes  No *If yes, please explain on a separate sheet of paper*

Do you have at least two years of experience at a hospital/facility?

Yes  No

Are your driving privileges suspended or revoked in any state?

Yes  No *If yes, please explain on a separate sheet of paper*

Can you provide proof of insurance for the purpose of using a rental car?

Yes  No

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## EMPLOYMENT HISTORY

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Facility/Employer Name

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City	State	Zip
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From: \_\_\_\_\_ To: \_\_\_\_\_

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Dates employed	Reason for leaving
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Unit/Department	Position Held
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Equipment Used

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Supervisor's Name/Title	Phone #
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Travel Assignment?  Yes  No

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**EMPLOYMENT HISTORY (CONTINUED)**

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Facility/Employer Name

---

City State Zip  
From: To:

---

Dates employed Reason for leaving

---

Unit/Department Position Held

---

Equipment Used

---

Supervisor's Name/Title Phone #

---

Travel Assignment?  Yes  No

---

---

Facility/Employer Name

---

City State Zip  
From: To:

---

Dates employed Reason for leaving

---

Unit/Department Position Held

---

Equipment Used

---

Supervisor's Name/Title Phone #

---

Travel Assignment?  Yes  No

---

---

Facility/Employer Name

---

City State Zip  
From: To:

---

Dates employed Reason for leaving

---

Unit/Department Position Held

---

Equipment Used

---

Supervisor's Name/Title Phone #

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Travel Assignment?  Yes  No

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## EMPLOYMENT HISTORY (CONTINUED)

---

Facility/Employer Name

---

City State Zip

From: To:

---

Dates employed Reason for leaving

---

Unit/Department Position Held

---

Equipment Used

---

Supervisor's Name/Title Phone #

Travel Assignment?  Yes  No

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## SPECIAL SKILLS, QUALIFICATIONS, EXPERIENCE

Do you have other related experiences, skills, or qualifications that are not documented in this application? Please explain:

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I certify that the statements in this application are true to the best of my knowledge. I understand that any falsification or misleading information given in the application may result in the termination of my employment with Advantage Allied. Furthermore, I understand that my professional conduct and clinical performance is directly related to my ability to be placed on assignments and that I adhere to all expectations set forth in the Advantage RN/Advantage Allied handbook. I authorize Advantage RN/Advantage Allied to verify the information I have provided and to contact references concerning my ability, character and past employment.

I understand that my employment is "at will" and that Advantage RN/Advantage Allied or I may terminate my employment at any time, with or without notice, as well as with or without cause. I agree that nothing contained in this application is intended to create an employment contract, either verbal or written, between Advantage RN/Advantage Allied and its clients.

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Signature of Application

Date

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