PROMED AGENCY

Application for International Employment

PERSONAL INFORMATION

Name: ____________________ S.S.N. ____ -- ____ -- ____
Last First M.I.

Current Address: ____________________

____

USA Address (if known): ____________________
Street City State Zip Code

Birth Date: ___ / ___ / ___ Place of Birth: ____________________

Home Phone Number: ____________ Cell Phone Number: ____________

Other Phone Number: ____________ Pager: ____________

USA Phone Number: ____________ Email: ____________

If you can not be reached at the above phone numbers, where may we contact you? ____________

____
Name of Person

Do you have a valid work permit? ☐ Yes ☐ No If No, why not? ____________

Do you have current Visa status? ☐ Yes ☐ No Visa A-Number: ____________

Are you working as a Nurse now? ☐ Yes ☐ No In what Specialty? ____________

Have you ever been to the USA? ☐ Yes ☐ No If Yes, where and when? ____________

Do you have relatives in the USA? ☐ Yes ☐ No If so, where? ____________

When will you be ready to come? ___ / ___ / ___ Where will you locate? ____________

Do you have **RN friend(s)** who want to come to the USA? ☐ Yes ☐ No

How many International Employment Applications should we send you for your RN friend(s)? ______

FAMILY INFORMATION

Name of Spouse: ____________________ S.S.N. ____ -- ____ -- ____
Last First M.I.

Current Address: ____________________

____

Spouse's Birth Date: ___ / ___ / ___ Place of Birth: ____________________

Does spouse have a valid work permit? ☐ Yes ☐ No If No, why not? ____________

Does spouse have current Visa status? ☐ Yes ☐ No Visa A-Number: ____________

Name(s) of Children: ____________________ Birth Date: ___ / ___ / ___

____________________ Birth Date: ___ / ___ / ___

____________________ Birth Date: ___ / ___ / ___

____________________ Birth Date: ___ / ___ / ___

____________________ Birth Date: ___ / ___ / ___

____________________ Birth Date: ___ / ___ / ___

EDUCATION / TRAINING

School	Name and Address of School	Did you graduate?	Degree / Certification Received
High School		☐ Yes ☐ No Date: / /	
College		☐ Yes ☐ No Date: / /	
Nursing College		☐ Yes ☐ No Date: / /	

Specialty Training (M/S, OR, ICU): ______________________

Continuing Education or
Professional Development Courses: ______________________

Professional Organization Membership, Honors Received, Volunteer or Community Service, or other Qualifications related to the position for which you are applying: ______________________

PROFESSIONAL LICENSES AND / OR CERTIFICATIONS

Type	Organization or Country Issued	Number	Date Issued
1			/ /
2			/ /

Total years of nursing experience: ______________

Is there anything, which may limit your ability to perform any functions required of a Registered Nurse?

☐ Yes ☐ No If Yes, please describe: ______________________

QUALIFYING TEST EVALUATION

If you are a citizen of India, Philippines, Indonesia, Nigeria, Barbados, Jamaica, Guyana, Ghana, Trinidad, Zimbabwe, South Africa, Israel, China, Korea, Ethiopia, St. Lucia, Bermuda, Switzerland, Germany, Nepal, Malaysia, or any other country with the exception of UK, New Zealand, Canada, Ireland or Australia, you are required to take the TOEFL/TSE Exams, unless you have completed your nursing education in the United States and graduated from a US college.

1 Have you passed the **CGFNS Exam**? ☐ Yes ☐ No

If No, when are you scheduled to take the CGFNS Exam? ____/____/____

2 Have you passed the **NCLEX Exam**? ☐ Yes ☐ No

3 Have you passed the **TOEFL Exam**? ☐ Yes ☐ No

If No, when are you scheduled to take the TOEFL Exam? ____/____/____

4 Have you passed the **TSE Exam**? ☐ Yes ☐ No

CGFNS Exam: Commission on Graduates of Foreign Nursing Schools exam is given by CGFNS of Philadelphia, PA. To get an application call: **(215) 349-6721**.

TOEFL Exam: Test of English as a Foreign Language & **TSE** (Test of Spoken English) are offered by **ETS**. For more information for to **www.ets.org** or call **(609) 771-7100.**

Visa Screen Certificate: In order to complete your permanent residency filing, you must contact **The International Commission on Healthcare Professionals (ICHP)** at **(215) 349-6721** to obtain a Visa Screen Application. You must complete the application and pay the Visa Screen Application fee in order to receive your Visa Screen Certificate.

SPECIFIC NURSING EXPERIENCE / SKILLS CHECKLIST

Indicate your experience in the following areas:	Yes	No	Amount of Experience
Anesthetist (CRNA)			______ Years ______ Months
Cardiac Catheter Lab			______ Years ______ Months
Case / Care Manager			______ Years ______ Months
Charge Nurse			______ Years ______ Months
Clinical / Physicians Office			______ Years ______ Months
Critical Care (CCU)			______ Years ______ Months
Dialysis			______ Years ______ Months
Emergency Room (ER)			______ Years ______ Months
Home Health Care			______ Years ______ Months
Hospice			______ Years ______ Months
Intensive Care (ICU)			______ Years ______ Months
Labor & Delivery (Obstetrics)			______ Years ______ Months
Long Term Care (Nursing Home)			______ Years ______ Months
Management - Mgr./Coord./Team/Chg.			______ Years ______ Months
Medical / Surgical			______ Years ______ Months
Neonatal Care			______ Years ______ Months
Obstetrics			______ Years ______ Months
Oncology			______ Years ______ Months
Operating Room (OR)			______ Years ______ Months
Orthopedics			______ Years ______ Months
Pediatric (Maternal Child Health)			______ Years ______ Months
Psychology (Mental Health)			______ Years ______ Months
Rehabilitation / Detox			______ Years ______ Months
Telemetry			______ Years ______ Months
Utilization Review / QA			______ Years ______ Months

Any other positions: ____

EMPLOYMENT HISTORY

List current (or most recent) employer first and all others in reverse chronological order.

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Company's Name: ______________________ Phone: ____________

Address: ____
Street City State Zip Code

Your Immediate Supervisor's Name & Title: ______________________

Dates Employed: Your Position Title: ______________________
From: ____/____/____ Starting Salary: $ ________
To: ____/____/____ Ending Salary: $ ________

Job Description & Responsibilities: ______________________

May we contact for reference? ☐ Yes ☐ No

Company's Name: ______________________ Phone: ____________

Address: ____
Street City State Zip Code

Your Immediate Supervisor's Name & Title: ______________________

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From: ____/____/____ Starting Salary: $ ________
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Job Description & Responsibilities: ______________________

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Job Description & Responsibilities: ______________________

May we contact for reference? ☐ Yes ☐ No

1			
2			
3			

CRIMINAL CONVICTION(S)

Conviction of a criminal offense will NOT necessarily preclude your employment.

Have you ever been convicted of a crime? ☐ Yes ☐ No
If so, for what, when and where? ______________________

Use this space to give us further information which may assist us in hiring you. ______________________

AVAILABILITY INFORMATION

Please circle the shifts you are available for each day.

DAY	SHIFT		
MON	DAY	EVE	NOC
TUE	DAY	EVE	NOC
WED	DAY	EVE	NOC
THU	DAY	EVE	NOC
FRI	DAY	EVE	NOC
SAT	DAY	EVE	NOC
SUN	DAY	EVE	NOC

Are you available to work:

Holidays ☐ Yes ☐ No

On Call ☐ Yes ☐ No

Swing Shift ☐ Yes ☐ No

Doubles ☐ Yes ☐ No

What State or States would you consider employment in order of preference?

1 ______________________

2 ______________________

3 ______________________

Do you prefer to work in:

Acute Care Facility ☐ Yes ☐ No

Long-term Care Facility ☐ Yes ☐ No

Psychiatric Facility ☐ Yes ☐ No

Health Care Clinic ☐ Yes ☐ No

I understand that emergency conditions may require me to temporarily work shifts other than the one(s) for which I am applying and agree to such scheduling change as directed by my manager of this corporation.

Applicant Name ______________ Name Initials ________ Date ______________

This corporation does NOT discriminate in hiring or any other decision on the basis of race, color, sex, citizenship, national origin, ancestry, Vietnam era veteran status, or on the basis of age or physical or mental disability unrelated to ability to perform the work required. No question on this application is intended to secure information to be used for such discrimination.

I voluntarily give this corporation the right to make a thorough investigation of my past employment and activities, agree to cooperate in such investigation and release from all liability or responsibility all persons, companies or corporations supplying such information. I consent to take the physical examination, and such future physical examinations as may be required by this corporation at such times and places as the corporation shall designate. I understand that an offer of employment may be contingent on passing the physical examination which relates to the essential duties I would be required to perform.

I understand that my employment is at will, and that either party is free to terminate the employment relationship at any time without cause. I also understand that my employment may be terminated for any misstatement or omission of fact appearing on this application form.

Applicant Name ______________ Name Initials ________ Date ______________

NOTE: You need to have an Email account setup to be able to submit this form otherwise, click on Print Form below and mail it to 20042 19th Avenue NE, Shoreline, WA 98155-1211 or 4695 Chabot Drive, Suite 200 Pleasanton, CA 94588.