

RN/LVN Curriculum Vitae



INSTRUCTIONS: This form is a professional document. It must be complete, true, and accurate. Falsification of professional documents by omission or false statements is an offense reportable to the State Board (s).

Referred by: _____ Tel: _____

NAME: _____

Maiden name and/or other practiced under: _____ " RN " LVN

CURRENT ADDRESS: _____

City/State/Zip: _____

Permanent Address: _____

City/State/Zip: _____

Current Phone: _____ Message Phone: _____

Permanent Phone: _____ Fax: _____

E-Mail Address: _____

SS# _____ Date/ Birth: _____ U.S. Citizen?
" Yes " No

Emergency Contact (EC): List information on nearest relative not living with you, for emergency notification.

Name: _____

Address: _____

City/State/Zip: _____

EC Phone 1: _____ EC Phone 2: _____

PLEASE LIST TWO PERSONAL REFERENCES, not related to you, who have known you at least 2 years or one travel assignment.

Name: _____ City: _____ State: _____ Phone: () _____

Name: _____ City: _____ State: _____ Phone: () _____

DATE AVAILABLE FOR TRAVEL RN/LVN POSITION: _____ SHIFT PREFERENCES, IN ORDER: 1) _____ 2) _____ 3) _____

Clinical Area	Yrs Exp.	Clinical Area	Yrs Exp.	Clinical Area	Yrs Exp.	Clinical Area	Yrs Exp.

You must have a minimum of 1 year's current RN experience in the clinical area you are submitted to. Clinical Areas Preferred: _____
TRANSPORTATION: Car? _____ Other: _____ HAVE YOU EVER WORKED AS A TRAVEL RN? _____ Did you successfully complete your travel assignments? " Yes " No If not, please give details on a separate Privacy Page, together with name/phone of official who can verify the information.

MO/YR PASSED STATE BOARDS:	STATE:	RN/LVN EDUCATION (Include graduate hours)	
School name	City/State	Mo/Yr Graduated	Degree

RN LICENSURE: List original first, then all others:						CERTIFICATIONS/CEs (Enclose copies):					
State	Number	Expires	State	Number	Expires	Name	Date Taken	Expires	Name	Date Taken	Expires
						BCLS			CCRN		
						ACLS					
						NALS/NRP					
						PALS					

Have you ever had a disciplinary action taken against any of your nursing licenses, or are you currently the subject of a report or investigation?
" Yes " No If so, give details on a separate Privacy Page.
Are you eligible for rehire at all previous and current RN positions? " Yes " No If not, please explain on Privacy Page.

PERSONAL PROFESSIONAL REFERENCES For each of your RN/LVN POSITIONS FOR THE LAST 3 YEARS, list a SUPERVISORY RN with direct personal knowledge of your professional skills. Please contact them and make sure these RNs are willing to provide personal references for you.					
Name	Tel	Fax	Hospital/Facility	Dates worked	Unit

MALPRACTICE insurance Policy # : _____ Company: _____ Policy Exp. Date (Enclose copy of policy): _____

CONDITION OF HEALTH/PRACTICE CERTIFICATION: ___ Excellent ___ Good ___ Fair Height _____ Weight _____ Date last physical _____

I, the undersigned RN/LVN, do hereby certify by my signature on this document that I am able without limitation to practice and perform all of the duties of an RN/LVN, that I am licensable without limitation, and that no complaints or investigations are pending against my license(s). If previously impaired, I have successfully completed an approved program, and my State Board has released me to perform as an RN/LVN without limitation. I understand and agree that prior to starting an assignment with Capstone, I must provide a list of all medications I currently take, and if requested, provide a Physician's Statement, lab work, and do Drug/Alcohol Screens.

Signature _____ Date: _____

RN/LVN EMPLOYMENT HISTORY. List most recent employment first. You must account for all time from the present to the month/year you passed the State Boards and received your RN/LVN license. Use additional sheets as necessary. Do not omit any RN/LVN position. If there was a problem, explain on a separate sheet. Enter Agency if you worked PRN or Travel positions. Explain all breaks in employment and provide verification information.

Dates Employed (Mo/Day/Yr.): _____ to _____ AGENCY: _____ TEL _____
FACILITY _____ City: _____ State: _____ Fulltime? _____
Position: _____ Unit Name: _____ # of Beds: _____ Your Shift: _____ N/P Ratio: _____ Charge Experience?: _____
Immediate Supervisor: _____ Phone: _____ Eligible for Rehire? (Y/N): _____

Dates Employed (Mo/Day/Yr.): _____ to _____ AGENCY: _____ TEL _____
FACILITY _____ City: _____ State: _____ Fulltime? _____
Position: _____ Unit Name: _____ # of Beds: _____ Your Shift: _____ N/P Ratio: _____ Charge Experience?: _____
Immediate Supervisor: _____ Phone: _____ Eligible for Rehire? (Y/N): _____

Dates Employed (Mo/Day/Yr.): _____ to _____ AGENCY: _____ TEL _____
FACILITY _____ City: _____ State: _____ Fulltime? _____
Position: _____ Unit Name: _____ # of Beds: _____ Your Shift: _____ N/P Ratio: _____ Charge Experience?: _____
Immediate Supervisor: _____ Phone: _____ Eligible for Rehire? (Y/N): _____

Dates Employed (Mo/Day/Yr.): _____ to _____ AGENCY: _____ TEL _____
FACILITY _____ City: _____ State: _____ Fulltime? _____
Position: _____ Unit Name: _____ # of Beds: _____ Your Shift: _____ N/P Ratio: _____ Charge Experience?: _____
Immediate Supervisor: _____ Phone: _____ Eligible for Rehire? (Y/N): _____

Dates Employed (Mo/Day/Yr.): _____ to _____ AGENCY: _____ TEL _____
FACILITY _____ City: _____ State: _____ Fulltime? _____
Position: _____ Unit Name: _____ # of Beds: _____ Your Shift: _____ N/P Ratio: _____ Charge Experience?: _____
Immediate Supervisor: _____ Phone: _____ Eligible for Rehire? (Y/N): _____

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FACILITY _____ City: _____ State: _____ Fulltime? _____
Position: _____ Unit Name: _____ # of Beds: _____ Your Shift: _____ N/P Ratio: _____ Charge Experience?: _____
Immediate Supervisor: _____ Phone: _____ Eligible for Rehire? (Y/N): _____

EXPLAIN BREAKS:

The statements herein are true and complete to the best of my knowledge. I understand that falsification will be basis for disqualification or termination of contract and report to the State Board(s). I, the undersigned RN/LVN, do hereby request, direct, and give permission to any and all physicians, RNs, contractors, employers, and their employees, agents, designated or authorized representatives to release any and all information concerning my performance, conduct, and nursing practice known to them, and I authorize the retention of information relating to my previous, current, and future RN/LVN positions in Capstone's employee database and the use of this information in quality assurance activities. I agree to hold harmless from liability for any cause, except willful falsification of data, arising from the release and use of said information those who provide said information and those to whom this information is provided. I understand that refusal by any party to provide said information may result in denial of a professional position.

SIGNATURE: _____

DATE: _____