

TRAVELER APPLICATION



Please enter your full legal name.

 Last Name First Name Middle Name U.S. Social Security No.

Current Address: _____
 Street Address City State/Province Zip/Postal Code Country

Permanent Address (if different): _____
 Street Address City State/Province Zip/Postal Code Country

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email Address: _____ Best time/day to reach you: _____

Other names under which you have been employed: _____

Discipline: _____

Current Specialty: _____ Other/Secondary Specialty: _____

How did you hear about us? Internet Magazine Convention Referral Other: _____

Date available to work: _____ Rank your top 3 U.S. Destinations: 1st: _____ 2nd: _____ 3rd: _____

Name of Emergency Contact: _____ Relationship: _____ Phone: _____

 Street Address City State/Province Zip/Postal Code Country

LICENSURE *(Include photocopies of licenses held.)*

Licensing Authority/State Board: _____ Type: _____ License #: _____ Date of Issue: _____ Exp. Date: _____
 Licensing Authority/State Board: _____ Type: _____ License #: _____ Date of Issue: _____ Exp. Date: _____
 Licensing Authority/State Board: _____ Type: _____ License #: _____ Date of Issue: _____ Exp. Date: _____

Have you passed the NCLEX? Yes No Have you passed the IELTS? Yes No

Have you passed the CGFNS? Yes No Have you passed the TOEFL? Yes No

Have you passed the TSE? Yes No

Are you currently a Registered Midwife, ever held a license as a Registered Midwife or was Midwifery part of your basic nurse training? Yes No

Malpractice Insurance Carrier Name & Address: _____ Policy#: _____

While on assignment, OGP International offers you professional coverage of up to \$2 million, paid for by the Company, with no additional cost to you.

Has your license or certification ever been investigated or suspended? Yes No

Have you ever been convicted of a crime other than a minor traffic violation? Yes No

Driving under the influence is not considered a minor traffic violation. Exceptions due to state employment law: Conviction(s) that have been sealed, expunged, eradicated, dismissed, or overturned, and California Health & Safety Code §§11357 (b) & (c), 11360(c), 11364, 11365, 11550 marijuana-related convictions over 2 years old, should not be revealed.

Have you ever been named as a defendant in a professional liability action? Yes No

If you responded "Yes" to any of the above, please attach a separate sheet with explanation.

Do you have current authorization to work in the U.S.? Yes No

(If you do not have current authorization to work in the U.S., O'Grady Peyton International will work with you to obtain this)

EDUCATION	Name and Location of School	Graduation Date	Diplomas/Degrees Received
College	-----		
Graduate School	-----		
Other School (if applicable)	-----		

EMPLOYMENT PROFILE

Applicant's Name: _____

Please indicate all of your post-graduate employment for the past ten (10) years, beginning with your most recent employer. Please list each agency or institution in which you have worked. If you were employed by a specific patient, this information should be documented. Supervisors are defined as persons having knowledge of your performance at each location.

Are you employed now? Yes No If so, may we contact your present employer? Yes No

Since graduation from Nursing School, have you had any lapse(s) in employment of 60 days or greater? Yes No
If "Yes", please give details: _____

Agency/Institution/Employer: _____ Unit/Floor/Dept.: _____
City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____
Dates Employed: From: _____ To: _____ Reason for leaving: _____
Position Held: _____ Discipline: _____ Unit Specialty: _____
Supervisor's Name and Title: _____ Supervisor's Phone: _____
Other Supervisor Name: _____ Phone: _____
Teaching Hospital? Yes No Patient Ratio: _____ Number of Beds in Unit: _____ Number of Beds in Facility: _____

Agency/Institution/Employer: _____ Unit/Floor/Dept.: _____
City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____
Dates Employed: From: _____ To: _____ Reason for leaving: _____
Position Held: _____ Discipline: _____ Unit Specialty: _____
Supervisor's Name and Title: _____ Supervisor's Phone: _____
Other Supervisor Name: _____ Phone: _____
Teaching Hospital? Yes No Patient Ratio: _____ Number of Beds in Unit: _____ Number of Beds in Facility: _____

Agency/Institution/Employer: _____ Unit/Floor/Dept.: _____
City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____
Dates Employed: From: _____ To: _____ Reason for leaving: _____
Position Held: _____ Discipline: _____ Unit Specialty: _____
Supervisor's Name and Title: _____ Supervisor's Phone: _____
Other Supervisor Name: _____ Phone: _____
Teaching Hospital? Yes No Patient Ratio: _____ Number of Beds in Unit: _____ Number of Beds in Facility: _____

Agency/Institution/Employer: _____ Unit/Floor/Dept.: _____
City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____
Dates Employed: From: _____ To: _____ Reason for leaving: _____
Position Held: _____ Discipline: _____ Unit Specialty: _____
Supervisor's Name and Title: _____ Supervisor's Phone: _____
Other Supervisor Name: _____ Phone: _____
Teaching Hospital? Yes No Patient Ratio: _____ Number of Beds in Unit: _____ Number of Beds in Facility: _____

Please document reasons for periods you were not employed.

I attest that I am the applicant and the information provided in this application is complete and accurate, to the best of my knowledge. Providing incomplete or inaccurate information may result in disqualification from the program, and may be a violation of state law(s) that could result in civil penalties. I hereby authorize the Company to request and receive from all prior employers within one year of the date of this application, any and all pertinent information concerning my prior employment and its termination, including the reasons for such terminations, and to release information in support of my application (application, references, background search results, etc.) to the Company's client institutions and to appropriate governmental or licensing entities. The Company may also share applicant information with its affiliates. I understand that the Company, certain states and/or Client institutions may require criminal background checks, and I consent to such checks. Prior to conducting any background checks that qualify as consumer or investigative consumer reports, I will be provided, and will return, separate disclosure and acknowledgement forms as required by the Company.

Signature: _____ Date: _____

EMPLOYMENT PROFILE

Applicant's Name: _____

Agency/Institution/Employer: _____ Unit/Floor/Dept.: _____
City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____
Dates Employed: From: _____ To: _____ Reason for leaving: _____
Position Held: _____ Discipline: _____ Unit Specialty: _____
Supervisor's Name and Title: _____ Supervisor's Phone: _____
Other Supervisor Name: _____ Phone: _____
Teaching Hospital? Yes No Patient Ratio: _____ Number of Beds in Unit: _____ Number of Beds in Facility: _____

Agency/Institution/Employer: _____ Unit/Floor/Dept.: _____
City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____
Dates Employed: From: _____ To: _____ Reason for leaving: _____
Position Held: _____ Discipline: _____ Unit Specialty: _____
Supervisor's Name and Title: _____ Supervisor's Phone: _____
Other Supervisor Name: _____ Phone: _____
Teaching Hospital? Yes No Patient Ratio: _____ Number of Beds in Unit: _____ Number of Beds in Facility: _____

Agency/Institution/Employer: _____ Unit/Floor/Dept.: _____
City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____
Dates Employed: From: _____ To: _____ Reason for leaving: _____
Position Held: _____ Discipline: _____ Unit Specialty: _____
Supervisor's Name and Title: _____ Supervisor's Phone: _____
Other Supervisor Name: _____ Phone: _____
Teaching Hospital? Yes No Patient Ratio: _____ Number of Beds in Unit: _____ Number of Beds in Facility: _____

Agency/Institution/Employer: _____ Unit/Floor/Dept.: _____
City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____
Dates Employed: From: _____ To: _____ Reason for leaving: _____
Position Held: _____ Discipline: _____ Unit Specialty: _____
Supervisor's Name and Title: _____ Supervisor's Phone: _____
Other Supervisor Name: _____ Phone: _____
Teaching Hospital? Yes No Patient Ratio: _____ Number of Beds in Unit: _____ Number of Beds in Facility: _____

Agency/Institution/Employer: _____ Unit/Floor/Dept.: _____
City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____
Dates Employed: From: _____ To: _____ Reason for leaving: _____
Position Held: _____ Discipline: _____ Unit Specialty: _____
Supervisor's Name and Title: _____ Supervisor's Phone: _____
Other Supervisor Name: _____ Phone: _____
Teaching Hospital? Yes No Patient Ratio: _____ Number of Beds in Unit: _____ Number of Beds in Facility: _____

EMPLOYMENT PROFILE

Applicant's Name: _____

Agency/Institution/Employer: _____ Unit/Floor/Dept.: _____
City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____
Dates Employed: From: _____ To: _____ Reason for leaving: _____
Position Held: _____ Discipline: _____ Unit Specialty: _____
Supervisor's Name and Title: _____ Supervisor's Phone: _____
Other Supervisor Name: _____ Phone: _____
Teaching Hospital? Yes No Patient Ratio: _____ Number of Beds in Unit: _____ Number of Beds in Facility: _____

Agency/Institution/Employer: _____ Unit/Floor/Dept.: _____
City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____
Dates Employed: From: _____ To: _____ Reason for leaving: _____
Position Held: _____ Discipline: _____ Unit Specialty: _____
Supervisor's Name and Title: _____ Supervisor's Phone: _____
Other Supervisor Name: _____ Phone: _____
Teaching Hospital? Yes No Patient Ratio: _____ Number of Beds in Unit: _____ Number of Beds in Facility: _____

Agency/Institution/Employer: _____ Unit/Floor/Dept.: _____
City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____
Dates Employed: From: _____ To: _____ Reason for leaving: _____
Position Held: _____ Discipline: _____ Unit Specialty: _____
Supervisor's Name and Title: _____ Supervisor's Phone: _____
Other Supervisor Name: _____ Phone: _____
Teaching Hospital? Yes No Patient Ratio: _____ Number of Beds in Unit: _____ Number of Beds in Facility: _____

Agency/Institution/Employer: _____ Unit/Floor/Dept.: _____
City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____
Dates Employed: From: _____ To: _____ Reason for leaving: _____
Position Held: _____ Discipline: _____ Unit Specialty: _____
Supervisor's Name and Title: _____ Supervisor's Phone: _____
Other Supervisor Name: _____ Phone: _____
Teaching Hospital? Yes No Patient Ratio: _____ Number of Beds in Unit: _____ Number of Beds in Facility: _____

Agency/Institution/Employer: _____ Unit/Floor/Dept.: _____
City: _____ State/Province: _____ Zip/Postal Code: _____ Country: _____
Dates Employed: From: _____ To: _____ Reason for leaving: _____
Position Held: _____ Discipline: _____ Unit Specialty: _____
Supervisor's Name and Title: _____ Supervisor's Phone: _____
Other Supervisor Name: _____ Phone: _____
Teaching Hospital? Yes No Patient Ratio: _____ Number of Beds in Unit: _____ Number of Beds in Facility: _____