

TRAVELER APPLICATION



First Name _____

Last Name _____

(RN / CST / LPN) _____

Please help us give this person fair consideration by answering the questions below. Any information you provide will be kept confidential. Thank you for your assistance.

Professional Reference

Previous Employer: _____	Unit Type: _____
Address: _____	Size of Unit: <input type="radio"/> 0-5 <input type="radio"/> 615 <input type="radio"/> 16-25 <input type="radio"/> 25+
City: _____	Position Held: _____
State: _____	Shift: _____
Supervisor Name: _____	Start Date: _____
Supervisor Phone: _____	End Date: _____
Eligible for Rehire: <input type="radio"/> Yes <input type="radio"/> No	Reason for Leaving: _____

Performance Evaluation

	Exceeds Standards	Meets Standards	Does Not Meet Standards
Demonstrates knowledge of therapeutic patient care?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prioritizes nursing interventions?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Recognizes critical changes and reacts appropriately?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Completes job duties in a timely manner?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Promotes continuity of care?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Works as a team member?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Punctuality and Attendance?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Evaluator Signature: _____
 Evaluator Name: _____

Date: _____
 Title: _____

(Please Print)

I authorize my previous employer to provide my employment-related information as requested by RNNetwork.

Employee Signature: _____ Date: _____

TRAVELER APPLICATION



First Name _____

Last Name _____

(RN / CST / LPN) _____

Please help us give this person fair consideration by answering the questions below. Any information you provide will be kept confidential. Thank you for your assistance.

Professional Reference

Previous Employer: _____	Unit Type: _____
Address: _____	Size of Unit: <input type="radio"/> 0-5 <input type="radio"/> 615 <input type="radio"/> 16-25 <input type="radio"/> 25+
City: _____	Position Held: _____
State: _____	Shift: _____
Supervisor Name: _____	Start Date: _____
Supervisor Phone: _____	End Date: _____
Eligible for Rehire: <input type="radio"/> Yes <input type="radio"/> No	Reason for Leaving: _____

Performance Evaluation

	Exceeds Standards	Meets Standards	Does Not Meet Standards
Demonstrates knowledge of therapeutic patient care?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prioritizes nursing interventions?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Recognizes critical changes and reacts appropriately?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Completes job duties in a timely manner?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Promotes continuity of care?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Works as a team member?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Punctuality and Attendance?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Evaluator Signature: _____

Date: _____

Evaluator Name: _____

Title: _____

(Please Print)

I authorize my previous employer to provide my employment-related information as requested by RNNetwork.

Employee Signature: _____

Date: _____