# 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 your ever had a disciplinary action taken against any of your nursing licenses, or are you currently the subject tof 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's Name: ____________________________________________ 

***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): ____

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): ____

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: ______________________________________



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