WHITE COAT HEALTHCARE STAFFING SERVICES, LLC

NURSE STAFFING REQUEST

FACILITY INFORMATION, NURSING POSITIONS & SCHEDULE

Please complete this form to describe your nursing coverage needs. Fields marked with an asterisk (*) are requested so our staffing team can follow up.

1. FACILITY AND CONTACT INFORMATION

Facility / Organization Name *

Contact Person *

Title / Department

Email Address *

Direct Phone Number *

Facility Street Address

City

State

ZIP Code

2. NURSING STAFFING REQUEST

Type of Staffing Requested

Select one

Number of Staff Needed

Select one

Nursing Position(s) Requested

- ☐ Registered Nurse (RN)
- ☐ Licensed Practical Nurse (LPN)
- ☐ Nurse Practitioner (NP)
- ☐ Nurse Manager / Supervisor
- ☐ Other (specify on page 2)

3. UNIT / DEPARTMENT AND CLINICAL SPECIALTY

- ☐ Long-Term Care / Nursing Home
- ☐ Assisted Living
- ☐ Medical-Surgical
- ☐ ICU / Critical Care
- ☐ Emergency Department
- ☐ Behavioral / Mental Health
- ☐ Operating Room
- ☐ PACU / Recovery
- ☐ Ambulatory Surgery Center
- ☐ Other unit / department

Specialty, Unit or Patient Population Details

Use page 2 to provide shift details, required experience, credentials and additional instructions.

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SHIFT DETAILS, CREDENTIALS & REQUESTOR AUTHORIZATION

4. SCHEDULE AND ASSIGNMENT DETAILS

Requested Start Date

Requested End Date (if known)

Shift Length

Select one

Shift / Tour

Select one

Shift Start and End Time

Days Needed

Select one

Hours per Week / Coverage Pattern

Weekend or holiday coverage required?

Select one

On-call coverage required?

Select one

5. EXPERIENCE AND CLINICAL REQUIREMENTS

Minimum Experience Required

Select one

Specialty Experience

Required License / Certifications

Required Clinical Skills, Equipment or EMR Experience

6. FACILITY CREDENTIALING AND ONBOARDING REQUIREMENTS

- ☐ BLS
- ☐ ACLS
- ☐ PALS
- ☐ NIHSS
- ☐ Background check
- ☐ Drug screening
- ☐ TB screening
- ☐ Immunization records

Other Credentialing / Orientation Instructions

7. ADDITIONAL COMMENTS AND AUTHORIZATION

Additional Coverage Details / Special Instructions

By completing this request, I confirm that the information provided is accurate to the best of my knowledge and authorize White Coat Healthcare Staffing Services, LLC to contact me regarding this request. This request does not guarantee staff placement or confirm availability.

☐ I authorize White Coat Healthcare Staffing Services, LLC to contact me.

Authorized Requestor Name

Date

Signature / Typed Name