

WINGS OF MERCY
FLIGHT NURSE APPLICATION



LPN, RN, BSN, EMT, OTHER _____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME TELE. _____ WORK TELE. _____

FAX _____

CAN BE CALLED AT WORK Yes No

NURSING
SPECIALTY _____

EMERGENCY CONTACT

NAME _____ TELE. _____

PLEASE ATTACH PHOTOCOPY OF CURRENT MINNESOTA NURSING (or other)
LICENSES.

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AS OF
THIS DATE.

SIGNATURE _____ DATE _____