



NEW HIRE NURSE WORKSHEET

State Form 53516 (6-08)

INDIANA STATE PERSONNEL DEPARTMENT

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.

Name		Social Security Number * XXX - XX -	
Title of class and code			
License number		Date of Issue (month, day, year)	

Place of Employment	Begin Date (month, day, year)	End Date (month, day, year)	Full Time / Part time	Total Years / Months
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Education: BSN
 MSN

Total Nursing Experience:

Comparative Employees:

Employee Identification Number	Years of Experience	<input type="checkbox"/> BSN <input type="checkbox"/> MSN	Annual Salary:
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Employee Identification Number	Years of Experience	<input type="checkbox"/> BSN <input type="checkbox"/> MSN	Annual Salary:
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Salary Offered:

Salary Accepted:

Rationale for Rate of Salary Offered:

Signature: _____ Date: _____