

**Personal Information (Please Print)**

Date: \_\_\_\_\_

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Present Address: (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

How long at this address? \_\_\_\_\_ United States Social Security Number  Yes  No

Transportation: Type of car: \_\_\_\_\_ Make: \_\_\_\_\_ Year: \_\_\_\_\_ ST/Lic#: \_\_\_\_\_

Professional License Number: (State) \_\_\_\_\_ (Number) \_\_\_\_\_

RN  LPN  MA  MD  PA  Med Tech  Phlebotomist  Other: \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact: (Name) \_\_\_\_\_ (Phone) \_\_\_\_\_

**EDUCATION**

Name of High School Attended or Name of College or University Attended	Semester Units Completed	From Month/Year	To Month/Year	High School	
				Graduation Date	Equivalence Date
Address (number and street name)					
City	State	ZIP code			

**EDUCATION**

Name of High School Attended or Name of College or University Attended	Semester Units Completed	From Month/Year	To Month/Year	High School	
				Graduation Date	Equivalence Date
Address (number and street name)					
City	State	ZIP code			

**DIDACTIC INSTRUCTION in PHLEBOTOMY** *Attach a copy of the certificate issued to you by the phlebotomy training program.*

Name of phlebotomy training program attended	From Month/Year	To Month/Year	Total Hours Attended
Address (number and street name)			
City	State	ZIP code	

**DIDACTIC INSTRUCTION in PHLEBOTOMY** *Attach a copy of the certificate issued to you by the phlebotomy training program.*

Name of phlebotomy training program attended			From Month/Year	To Month/Year	Total Hours Attended
Address (number and street name)					
City	State	ZIP code			

**PRACTICAL INSTRUCTION in PHLEBOTOMY**

*Attach copy of certificate if different than certificate from above.*

Name of phlebotomy training program attended			Hours Per Week	From Month/ Year	To Month/Year	Estimated Number of <b>Successful</b> Punctures		
						SKIN	VENI PUNCTURES	ARTERIA L
Address (number, street)								
City	State	ZIP code						

**PRACTICAL INSTRUCTION in PHLEBOTOMY**

*Attach copy of certificate if different than certificate from above.*

Name of phlebotomy training program attended			Hours Per Week	From Month/ Year	To Month/Year	Estimated Number of <b>Successful</b> Punctures		
						SKIN	VENI PUNCTURES	ARTERIA L
Address (number, street)								
City	State	ZIP code						

*If more space is needed, please attach a separate sheet.*

**ON-THE-JOB-EXPERIENCE (OTJE) in PHLEBOTOMY**

Name of laboratory, public health department, doctor's office, or clinic			Hours Per Week	From Month/ Year	To Month/Year	Estimated Number of <b>Successful</b> Punctures		
						SKIN	VENI PUNCTURES	ARTERIA L
Phone: Address (number, street)								
City	State	ZIP code						

**ON-THE-JOB-EXPERIENCE (OTJE) in PHLEBOTOMY**

Name of laboratory, public health department, doctor's office, or clinic			Hours Per Week	From Month/ Year	To Month/Year	Estimated Number of <b>Successful</b> Punctures		
						SKIN	VENI PUNCTURES	ARTERIA L
Phone: Address (number, street)								
City	State	ZIP code						

*If more space is needed, please attach a separate sheet.*

Check of equipment that you have:  Blood Pressure Cuff  Stethoscope  Scale  Centrifuge

Ekg Machine  Other - specify: \_\_\_\_\_

What Foreign Languages do you: Speak fluently? \_\_\_\_\_ Read? \_\_\_\_\_ Write? \_\_\_\_\_

Are you willing to travel within a 20 mile air radius of your home?  Yes  No Farther:  No

When do you have school, a job, or other definite commitments which would interfere with scheduling clients?(Mark "X" in blocks)  
When is your free time?(Mark "✓" in blocks)

*This will not be your work schedule, but we must know when you are available.*

Notes:

	M	T	W	T	F	S	SUN
Morning							
Afternoon							
Evening							

If related to anyone at ExamOne/LabOne state name and department \_\_\_\_\_

Referred by \_\_\_\_\_

If related to any insurance company personnel list title and relationship? \_\_\_\_\_

If there are no available assignments in your immediate area, do you wish to be called when an opening occurs?  Yes  No

If yes, you will be called as soon as we have available assignments.

Are you employed now?  Yes  No If so may we Inquire of your present employer?  Yes  No

If Yes, Name of Employer, Address, Telephone Number: \_\_\_\_\_

First date you can accept assignments: \_\_\_\_\_

Are you now performing Insurance Exams or have you previously performed these services?  Yes  No; If Yes, list Company

Name, Dates and Fee Arrangements \_\_\_\_\_

Have you ever applied to this company before?  Yes  No

Where? \_\_\_\_\_ When? \_\_\_\_\_

**Former Employers**

Date Month & Year	Name & Address of Employer	Salary/Fees	Position	Reason for leaving
To				
From	Phone #:			
To				
From	Phone #:			
To				
From	Phone #:			
To				
From	Phone #:			

References: The names of three persons not related to you, whom you have known at least one year.



## CONFIDENTIALITY AND NON-DISCLOSURE ACKNOWLEDGMENT

Through my business relationship with IMS/ 388 ("ExamOne Office"), I acknowledge that I may from time to time provide services on behalf of ExamOne World Wide, Inc., ("ExamOne"), for various insurance company clients of ExamOne ("Clients") and individuals who have applied for insurance with Clients ("Applicants").

I hereby acknowledge that the identity and any other personal, business or medical information of Applicants, and proprietary business information of the ExamOne Office, ExamOne and Clients (collectively referred to as "Protected Information") is confidential in nature, and agree that I will not use or disclose Protected Information for any purpose other than to provide services to the ExamOne office or to ExamOne. I will not release, disclose, or provide copies of Protected Information without the written permission of the ExamOne Office or ExamOne.

I agree to maintain and hold in complete confidence any and all information received on behalf of the ExamOne Office, ExamOne, Clients or Applicants. I agree to comply with all privacy and confidentiality laws and regulations as are applicable to the Protected Information I maintain or obtain in the performance of the services I provide, including the Health Insurance Portability and Accountability Act of 1996, and the Gramm-Leach-Bliley Act. I also agree to abide by the Fair Credit Reporting Act and all other applicable federal or state laws and regulations. I agree to implement reasonable safeguards to prevent theft or any use or disclosure other than as permitted by this Acknowledgment, including misuse or unauthorized disclosure to third parties.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date





A Quest Diagnostics Company

### EXAMINER COMPETENCY CHECKLIST

Branch Location: \_\_\_\_\_ Branch # \_\_\_\_\_  
*(Please Print Clearly)*

Examiner Name: \_\_\_\_\_ Contract Date: \_\_\_\_\_

Credentials (RN, LPN, EMT, etc.): \_\_\_\_\_ BFW \_\_\_\_\_ BAT \_\_\_\_\_

<u>REQUIREMENTS</u>	<u>VERIFIED BY</u>	<u>DATE VERIFIED</u>
Completed Contractor Information Form		
Phlebotomy Certification/Training Documents		
Professional License/Certificate verified(if applicable)		
Original Social Security Card Reviewed		
Social Security Number entered into ExamView		
Identification Badge issued		
Incident reporting procedure reviewed		

<i>Originals of the following documents in examiner file:</i>		
Signed Disclosure and Confidentiality Forms		
Signed Loaned Equipment Agreement		
Signed Technician Manual Acknowledgment		

<i>Copies of the Following Documents:</i>		
Background check - verify subject is found		
Photo ID (may be Motor Vehicle Operators License)		
Vehicle Insurance Card (if using motor vehicle), of N/A		

Examiner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Branch Manager: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

**Acknowledgement**

**This states that the technician/physician has received a copy of the ExamOne Technician Training Manual. The technician/physician also states that he/she has read and has completely understood all ExamOne procedures.**

\_\_\_\_\_  
Technician's Name

\_\_\_\_\_  
Technician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
ExamOne Office Affiliated with

\_\_\_\_\_  
Branch Manager's Signature

**Note: This must be kept in every Technician's file as long as they are doing services for ExamOne**

# CONSUMER AUTHORIZATION

I. I understand that an investigative report may be generated on me that may include information as to my character, general reputation, personal characteristics, or mode of living; work habits, performance or experience, along with reasons for termination of past employment/professional license or credentials; financial/credit history; or criminal/civil/driving record history. I understand that General Information Services, Inc., on behalf of \_\_\_\_\_ may be requesting information from public and private sources about any of the information noted earlier in this paragraph in connection with \_\_\_\_\_'s consideration of me for employment, promotion or position re-assignment or contract now, or at any time during my tenure with \_\_\_\_\_, and give my full consent for this information to be obtained.

II. IF APPLICABLE, medical and worker's compensation information will only be requested in compliance with the Federal Americans with Disabilities Act (ADA) and/or any other applicable state laws. According to the Fair Credit Reporting Act (FCRA, Public Law 91-508, Title VI), I am entitled to know if the considerations for which I am applying are denied because of information obtained from a consumer reporting agency. If so, I will be notified and be given the name of the agency providing that report.

III. I acknowledge that a telephonic facsimile (FAX) or photographic copy of this release shall be as valid as the original. This release is valid for most federal, state and county agencies.

IV. I understand that if I am a resident of Minnesota/Oklahoma (only) I may obtain a copy of the report ordered, and now indicate my desire to do so by checking this box .

V. I hereby authorize, without reservation, any financial institution, law enforcement agency, information service bureau, school, employer or insurance company contacted by General Information Services, Inc. to furnish the information described in Section I.

VI. Communications with General Information Services, Inc. should be directed to PO Box 353, Chapin SC 29036 or (877) 590-4012.

## CANDIDATE COMPLETE THE FOLLOWING:

Signature \_\_\_\_\_

Today's Date \_\_\_\_\_

Please print full name \_\_\_\_\_

The following information is required by law enforcement agencies and other entities for positive identification purposes when checking public records. It is confidential and will not be used for any other purposes.

Month, Day and Year of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Driver's License Number and State \_\_\_\_\_

Name as it appears on License \_\_\_\_\_

Have you ever been convicted of a crime?  No  Yes If yes, please provide city and state of conviction and details of conviction.

## FAIR CREDIT REPORTING ACT NOTICE:

In accordance with the Fair Credit Reporting Act (FCRA, Public Law 91-508, Title VI), this information may only be used to verify a statement(s) made by an individual in connection with legitimate business needs. The depth of information available varies from state to state. Status of updates are available on request. Although every effort has been made to assure accuracy, General Information Services, Inc. cannot act as guarantor of information accuracy or completeness. Final verification of an individual's identity and proper use of report contents are the user's responsibility. General Information Services, Inc.'s policy requires purchasers of these reports to have signed a Service Agreement. This assures General Information Services, Inc. that users are familiar with and will abide by their obligations, as stated in the FCRA, to the individuals named in these reports. If information contained in this report is responsible for the suspension or termination of an employee or the application process, have the Candidate/employee contact General Information Services, Inc.

## NOTICE TO CALIFORNIA CANDIDATES

You have a right to obtain a copy of any consumer report or investigative consumer report obtained by ExamOne, a Quest Diagnostics Subsidiary by checking the box provided below. The report will be provided to you within three (3) business days after we receive the requested reports related to the matter investigated.

I request to receive a free copy of this report by checking this box.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by GIS during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services, by appearing at GIS in person or by mail. You may also receive a summary of the file by telephone. The agency is required to have personnel available to explain your file to you and the agency must explain to you any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper identification.