



**Paramedical Examiner Credential**

Date of contract or Employment Date \_\_\_\_\_

Branch name & number \_\_\_\_\_

Name \_\_\_\_\_ Sex  Male  Female  
(First) (Middle) (Last)

Address \_\_\_\_\_  
Street Address  
City State Zip Code Phone ( ) \_\_\_\_\_

Social Security number \_\_\_\_\_ Tax ID # \_\_\_\_\_

**List all Licensors and License Numbers (A copy of current license must be attached).**

License # \_\_\_\_\_ Expires \_\_\_\_\_ State \_\_\_\_\_

License # \_\_\_\_\_ Expires \_\_\_\_\_ State \_\_\_\_\_

**Title and Level**

RN  LPN/LVN  EMT  PA  MT  Other \_\_\_\_\_

**Education**

School attended \_\_\_\_\_ Address \_\_\_\_\_  
(City) (State)

Year attended \_\_\_\_\_ Degree received \_\_\_\_\_

School attended \_\_\_\_\_ Address \_\_\_\_\_  
(City) (State)

Year attended \_\_\_\_\_ Degree received \_\_\_\_\_

School attended \_\_\_\_\_ Address \_\_\_\_\_  
(City) (State)

Year attended \_\_\_\_\_ Degree received \_\_\_\_\_

**Professional Experience**

Company name \_\_\_\_\_ Address \_\_\_\_\_

Job title \_\_\_\_\_ Employment date from \_\_\_\_\_ to \_\_\_\_\_

List job responsibilities \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Company name \_\_\_\_\_ Address \_\_\_\_\_

Job title \_\_\_\_\_ Employment date from \_\_\_\_\_ to \_\_\_\_\_

List job responsibilities \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Company name \_\_\_\_\_ Address \_\_\_\_\_  
Job title \_\_\_\_\_ Employment date from \_\_\_\_\_ to \_\_\_\_\_  
List job responsibilities \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Company name \_\_\_\_\_ Address \_\_\_\_\_  
Job title \_\_\_\_\_ Employment date from \_\_\_\_\_ to \_\_\_\_\_  
List job responsibilities \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Professional Affiliations/Memberships You Belong To**

\_\_\_\_\_  
\_\_\_\_\_

Are you CPR certified?  Yes  No

List any certifications you have received \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Special Skills (Mark all applicable boxes)**

ECG	<input type="checkbox"/>	Health Teaching	<input type="checkbox"/>	TVC	<input type="checkbox"/>
Utilization Review	<input type="checkbox"/>	Health Assessments	<input type="checkbox"/>	Special Projects	<input type="checkbox"/>
Phlebotomy (basic)	<input type="checkbox"/>	Computer Skills	<input type="checkbox"/>		
Phlebotomy (advanced)	<input type="checkbox"/>	Pharmaceutical	<input type="checkbox"/>		

Other \_\_\_\_\_  
\_\_\_\_\_

**Availability** (Please list hours) Days \_\_\_\_\_ Evenings \_\_\_\_\_ Weekends \_\_\_\_\_

Are you interested in participating in any special projects conducted by PORTAMEDIC Services?  Yes  No

In performing paramedical examinations, I accept the responsibility of accurately obtaining and completely recording the applicant's history and physical findings.

Examiner signature \_\_\_\_\_ Date \_\_\_\_\_



CA, MN & OK Criminal Background Check
Authorization & Release Form
Independent Contractor Examiner

BRANCH NAME: \_\_\_\_\_ BRANCH CODE: \_\_\_\_\_ [ ] Check for PORTAMEDIC DIRECT
CONTRACTOR AFFILIATE (If Applicable): \_\_\_\_\_ FAX # / E-Mail \_\_\_\_\_

Pursuant to the Violent Crime Control And Law Enforcement Act of 1984, 18 U.S.C §1033(e), and individual may not engage in the business of insurance if the individual has been convicted of a felony involving dishonesty or breach of trust, unless the individual has the written consent of an insurance regulatory official authorized to regulate the insurer.

I hereby authorize Hooper Holmes, Inc. and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for the purpose of engaging my services. Should Hooper Holmes, Inc. choose to utilize my services, I further authorize them to conduct such investigations at any time during the period I am actively providing services.

I understand that the scope of the consumer report/investigative consumer report may include, but is not limited to, the following areas:
Verification of social security number; current and previous residences; employment history; education including transcripts; criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; birth records; motor vehicle records to include traffic citations and registration; and any other public records.

I further authorize any individual, company, firm, corporation, or public agency (including the Social Security Administration and law enforcement agencies) to divulge any and all information, verbal or written, pertaining to me to Hooper Holmes, Inc. or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources.

I hereby release Hooper Holmes, Inc., the Social Security Administration, and its agents, officials, representatives, or assigned agencies, including officers, employees, or related personnel both individually and collectively, from any and all liability for damages of whatever kind, which may, at any time, result to me, my heirs, family, or associates because of compliance with this authorization and request to release. You may contact me as indicated below. I understand that I have the right to revoke this authorization at any time, provided I do so in writing.

If you would like to receive a copy of your background information obtained by Hooper Holmes, Inc., please indicate by checking the following box. Please send me a copy of my background report: [ ]

Print Name \_\_\_\_\_
(First) (Middle) (Last) (Maiden)

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male Female
(I.D. Purposes Only) (circle one)

Former Name(s) and Dates Used \_\_\_\_\_

Current Address Since \_\_\_\_\_
(Mo/Yr) (Street) (City) (State/Zip)

Previous Address \_\_\_\_\_
(Mo/Yr) (Street) (City) (State/Zip) (Name Used at This Address)

Previous Address \_\_\_\_\_
(Mo/Yr) (Street) (City) (State/Zip) (Name Used at This Address)

Previous Address \_\_\_\_\_
(Mo/Yr) (Street) (City) (State/Zip) (Name Used at This Address)

Drivers License Number: \_\_\_\_\_ State of Issue: \_\_\_\_\_

Have you ever been convicted of a felony? (Circle one) YES NO

If yes, please describe in detail the felony committed: \_\_\_\_\_

Date of conviction: \_\_\_\_\_ City, State & County of conviction: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Hooper Holmes, Inc. Compliancy Unit • 170 Mt. Airy Road, Basking Ridge, NJ 07920



Independent Contractor License Check List



This form must be completed in its entirety and submitted with all paperwork to initiate the criminal check for an independent contractor or a Portamedic Direct examiner. Failure to submit this form will delay your use of the contractor's services.

Independent Contractor Name: \_\_\_\_\_

- 1) This independent contractor is being considered as a Contract Phlebotomist/Examiner
2) This independent contractor will perform work in California and/or Nevada and/or Louisiana.
3) Although this independent contractor's work may not require a License, he/she has claimed to possess a valid License to practice as a \_\_\_\_\_ (ex.: RN, LPN, MD).

ONLY IF YOU ANSWERED NO TO 1 AND 3 ABOVE, SKIP TO BOTTOM AND SIGN, PRINT, DATE

- 4) Because the independent contractor claims to be a Licensed Professional and/or will perform exams as a Phlebotomist/Examiner in CA, NV, or LA it is required that the individual have a State License.
5) I have utilized the State's online or telephone resources and I attest that I have verified that the License was issued to the bearer and that the License is in good standing.

NOTE: Failure to view, copy, submit and verify the validity of the License through the State will subject me to Disciplinary action including the possibility of immediate dismissal for gross misconduct which jeopardizes the operations of the Company.

(SIGNATURE OF BRANCH MANAGER)

(DATE)

(PRINTED NAME OF BRANCH MANAGER)



Criminal Background Check
Authorization & Release Form
Independent Contractor Examiner

BRANCH NAME: \_\_\_\_\_ BRANCH CODE: \_\_\_\_\_ [ ] Check for PORTAMEDIC DIRECT
CONTRACTOR AFFILIATE (If Applicable): \_\_\_\_\_ FAX # / E-Mail \_\_\_\_\_

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I further authorize any individual, company, firm, corporation, or public agency (including the Social Security Administration and law enforcement agencies) to divulge any and all information, verbal or written, pertaining to me to Hooper Holmes, Inc. or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources.

I hereby release Hooper Holmes, Inc., the Social Security Administration, and its agents, officials, representatives, or assigned agencies, including officers, employees, or related personnel both individually and collectively, from any and all liability for damages of whatever kind, which may, at any time, result to me, my heirs, family, or associates because of compliance with this authorization and request to release. You may contact me as indicated below. I understand that I have the right to revoke this authorization at any time, provided I do so in writing.

Print Name \_\_\_\_\_ (First) (Middle) (Last) (Maiden)

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: Male Female (I.D. Purposes Only) (circle one)

Former Name(s) and Dates Used \_\_\_\_\_

Current Address Since \_\_\_\_\_ (Mo/Yr) (Street) (City) (State/Zip)

Previous Address \_\_\_\_\_ (Mo/Yr) (Street) (City) (State/Zip) (Name Used at This Address)

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Date of conviction: \_\_\_\_\_ City, State & County of conviction: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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