



APPLICATION
PHARMACY HEALTH
PROFESSIONAL

INSTRUCTIONS:

- Attach a current resume to completed application that covers all periods of time, from undergraduate school to present. Indicate month and year.
- Provide a thorough explanation for every malpractice claim, suit, or incident you have EVER experienced. At minimum, this must include information on: type of care, procedure, major allegations, and other pertinent information, such as the name and location of court, names of parties involved, and a brief description of the nature of the claim.

THIS COMPANY IS AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

As an Equal Opportunity/Affirmative Action Employer, AHR Pharmacy Solutions, does not discriminate in employment on the basis of Age, Gender, Race, Color, Religion, National Origin, Disability, Veteran/Military Status, Pregnancy Status or any other classification protected by State and Federal laws.

IDENTIFYING INFORMATION	Last Name		First name		Middle name		Previous Surname		
	Profession		License/Certificate Number		Social Security Number		NPI (if applicable)		
	Home Phone		Work Phone		Cell Phone		Email		
	Are you able to work legally in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(You may be asked to provide proof of eligibility to work in the US.)</i> If yes, please indicate the following: <input type="checkbox"/> US Citizen <input type="checkbox"/> Visa or work authorization								
	In case of emergency, notify: Name			Relationship to Applicant			Phone		
	Address								
MAILING ADDRESS	Street					Email			
	City			State		ZIP Code			
OTHER ADDRESS	Street								
	City			State		ZIP Code		Other Phone	
AVAILABILITY & PREFERENCES	How many weeks per year would you like to work with AHR?			When can you start?		<input type="checkbox"/> Part time <input type="checkbox"/> Full time <input type="checkbox"/> Per diem <input type="checkbox"/> Travel			
	What kind of work setting(s) do you prefer?		<input type="checkbox"/> Retail <input type="checkbox"/> Long-term care <input type="checkbox"/> Hospital-Inpatient settings <input type="checkbox"/> Hospital-Outpatient settings						
	<input type="checkbox"/> Mail-order <input type="checkbox"/> Ambulatory <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Government Facility <input type="checkbox"/> Other _____								
	What shifts can you work? <input type="checkbox"/> Sunday <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday								
	Clinical area of expertise:								
	What location(s) would you prefer?				Where did you hear about AHR?				
ACTIONS/ SANCTIONS <i>If your answer is "yes" to any of these questions, please provide full details on a separate sheet.</i>	Have any of the following been, or are any currently in the process of being, investigated, denied, revoked, suspended, reduced, limited, placed on probation, terminated, or placed under other disciplinary action? If yes, please provide a full explanation on a separate sheet.								
	(a) Professional license in any state		<input type="checkbox"/> Yes <input type="checkbox"/> No		(f) Professional position		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	(b) Membership and/or employment		<input type="checkbox"/> Yes <input type="checkbox"/> No		(g) Other type of professional sanction		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	(c) Clinical privileges/other rights		<input type="checkbox"/> Yes <input type="checkbox"/> No		(h) Participation in any private, state, or federal health insurance program (e.g., Medicare, Medicaid)		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	(d) Other institutional affiliation or status		<input type="checkbox"/> Yes <input type="checkbox"/> No						
	(e) Training program		<input type="checkbox"/> Yes <input type="checkbox"/> No						
	Have you ever been employed where your employment was terminated by the employer?							<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Have you ever been convicted of, or pled guilty or no contest to, a criminal felony or misdemeanor, or are you currently charged with any alleged criminal activities?							<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you currently engaged in any illegal drug activity?							<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever been the object of an administrative, civil, or criminal complaint or investigation regarding sexual misconduct?							<input type="checkbox"/> Yes <input type="checkbox"/> No		

I affirm that all information given on this page is true and accurate. Initials _____ Date _____

EDUCATION/ TRAINING	School Name or Institution		Degree/Certificate		Honors	
	City		State	Telephone	Dates attended (mm/yy - mm/yy)	Date of graduation (mm/yy)
	School Name or Institution		Degree/Certificate		Honors	
	City		State	Telephone	Dates attended (mm/yy - mm/yy)	Date of graduation (mm/yy)
	<input type="checkbox"/> BLS expires: _____	<input type="checkbox"/> Other: _____ expires: _____				
List other courses/certificates						

HEALTH STATUS	Are there any reasons that would prevent you from being able to perform competently the functions of your specialty?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are there any reasons that would prevent you from being able to travel and promptly assume responsibilities in unfamiliar facilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No

WORK EXPERIENCE <i>List in reverse chronological order, beginning with the most current, ALL employment affiliations since completion of education. (Attach a separate sheet, if additional space is needed.)</i> <i>Please explain any gaps in your work history on a separate sheet.</i>	Name of Hospital/Company			Name & Title of Immediate Supervisor		
	Address					
	Position held/Job Description		Dates (mm/yy - mm/yy)		Starting Salary	Ending Salary
	Name of Hospital/Company			Name & Title of Immediate Supervisor		
	Address					
	Position held/Job Description		Dates (mm/yy - mm/yy)		Starting Salary	Ending Salary
	Name of Hospital/Company			Name & Title of Immediate Supervisor		
	Address					
	Position held/Job Description		Dates (mm/yy - mm/yy)		Starting Salary	Ending Salary
	Name of Hospital/Company			Name & Title of Immediate Supervisor		
	Address					
	Position held/Job Description		Dates (mm/yy - mm/yy)		Starting Salary	Ending Salary
	Name of Hospital/Company			Name & Title of Immediate Supervisor		
	Address					
	Position held/Job Description		Dates (mm/yy - mm/yy)		Starting Salary	Ending Salary

MILITARY SERVICE	Branch	Dates of Service (mm/yy - mm/yy)	Discharge Status: <input type="checkbox"/> Honorable <input type="checkbox"/> Dishonorable <input type="checkbox"/> Other (please specify)
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PROFESSIONAL REFERENCES <i>Please list 4 professional references with whom you have had clinical contact within the last 2 years. (At least 2 of these should be within your specialty) They should be able to assess your professional skills and capabilities.</i>	Name	Hospital/Institution	Phone
	1		Email
	2		Phone
			Email
	3		Phone
			Email
	4		Phone
			Email
PROFESSIONAL LIABILITY	Have malpractice claims, lawsuits, settlements, or judgments been made against you in the past? <input type="checkbox"/> Yes (If yes, how many? _____) <input type="checkbox"/> No Are any pending? <input type="checkbox"/> Yes <input type="checkbox"/> No Has your malpractice insurance coverage ever been denied, limited, or canceled? <input type="checkbox"/> Yes <input type="checkbox"/> No Has a professional liability insurance carrier ever excluded any specific procedures from your insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered "Yes" to any of the above, please provide details on a separate sheet.		
	Do you have your own professional liability insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please list name of carrier and amounts of coverage:</i>		
RELEASE & AUTHORIZATION	I hereby affirm that the information I have provided on this application and attachments is true and correct and that it can be relied upon by CHG Medical Staffing, Inc. d/b/a AHR Pharmacy Solutions ("AHR") for evaluating my potential as a health care provider. I hereby authorize AHR, its affiliates and successors, to obtain any information that may be relevant to an evaluation of my professional qualifications, including information pertaining to disciplinary actions, criminal background and history, or other confidential or privileged information, and other credentials. I authorize AHR to disclose to current, prior, or potential employers making a reasonable inquiry, information relating to my qualifications, ability, and character Only to the extent requested and required by the practices, facilities, groups and hospitals staffed by AHR where I will be providing clinical services, I agree to provide and authorize the release of the same by AHR to AHR clients, the following: a) vaccination records; b) reasonable documentation evidencing that I am in good health and free of communicable diseases; c) the result of and/or a copy of my criminal background check, if any; and d) the result of and/or a copy of my drug screen, if any. I hereby release AHR, its officers, employees, and agents, and third parties which provide or receive information regarding my credentials, including, but not limited to, all credentialing information sources, individuals or companies who provide references, companies or agencies that perform criminal background checks, and companies that perform drug screens from any claims, causes of action, damages and expenses, including reasonable attorney's fees arising from or relating to the collection, verification, and dissemination of my credentialing and other information. I agree to hold AHR harmless from and against any and all claims, causes of action, damages, judgments and expenses, including reasonable attorney's fees, arising from or related to the accuracy of the information provided by me. I understand that this does not contemplate a duty to hold AHR harmless from claims, causes of action and damages which may arise as a result of information provided about me from sources other than myself. This is a continuing authorization and shall be effective from the date of signature below until such time as I have specifically revoked the same in writing. If any material changes occur affecting my professional status, it is my obligation to notify AHR or the appropriate affiliate or successor as soon as possible. I understand that the decision to employ me or refer me to practice opportunities is solely at the discretion of AHR. I understand that any information received from references by AHR is confidential and may not be released to me without the consent of the reference. I understand, agree and acknowledge that references are not part of my personnel file. A copy or facsimile of this document shall have the same effect as the original. This document shall be interpreted according to the laws of the State of California. Name _____ Signature _____ Date _____		

I affirm that all information given on this page is true and accurate. Initials _____ Date _____