

APPLICATION  
**ALLIED 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, Foundation Rehab Staffing, Inc., 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		Pager
	Are you able to work legally in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No (You may be asked to provide proof of eligibility to work in the US.) 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 Foundation?			When can you start?		<input type="checkbox"/> Part time <input type="checkbox"/> Full time <input type="checkbox"/> Per diem		
	What kind of work setting(s) do you prefer?			What shifts can you work?		How many shifts per week can you work?		
	Clinical area of expertise:				What age groups can you work with, if applicable?			
	What location(s) would you prefer?				Where did you hear about Foundation?			
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		(g) Training program		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	(b) Membership and/or employment		<input type="checkbox"/> Yes <input type="checkbox"/> No		(h) Professional society membership		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	(c) Clinical privileges/other rights		<input type="checkbox"/> Yes <input type="checkbox"/> No		(i) Professional position		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	(d) Rights on any hospital staff		<input type="checkbox"/> Yes <input type="checkbox"/> No		(j) Other type of professional sanction		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	(e) Other institutional affiliation or status		<input type="checkbox"/> Yes <input type="checkbox"/> No		(k) Participation in any private, state, or federal health insurance program (e.g., Medicare, Medicaid)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	(f) Academic appointment		<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 \_\_\_\_\_

<b>EDUCATION/ TRAINING</b>	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)		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"/> ACLS expires:		<input type="checkbox"/> NRP expires:		<input type="checkbox"/> PALS expires:		
<input type="checkbox"/> Other: expires:		List other courses/certificates						
<b>HEALTH STATUS</b> <i>Please attach current copies of TB Skin Test, Hepatitis B, MMR, Rubella Titers, Tetanus, Varicella, and Physical exams</i>	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		
<b>WORK EXPERIENCE</b> <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				
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	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

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<b>MILITARY SERVICE</b>	Branch _____	Dates of Service (mm/yy - mm/yy) _____	Discharge Status: <input type="checkbox"/> Honorable <input type="checkbox"/> Dishonorable <input type="checkbox"/> Other (please specify) _____
<b>PROFESSIONAL REFERENCES</b> <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		Fax
	2		Phone
	3		Fax
	4		Phone
			Fax
			Phone
			Fax
<b>PROFESSIONAL LIABILITY</b>	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>		
<b>RELEASE &amp; AUTHORIZATION</b>	<p>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 Foundation Rehab Staffing, Inc. ("Foundation") for evaluating my potential as a health care provider.</p> <p>I hereby authorize Foundation, 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.</p> <p>I authorize Foundation to disclose to current, prior, or potential employers making a reasonable inquiry, information relating to my qualifications, ability, and character</p> <p>Only to the extent requested and required by the practices, facilities, groups and hospitals staffed by Foundation where I will be providing clinical services, I agree to provide and authorize the release of the same by Foundation to Foundation 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.</p> <p>I hereby release Foundation, 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.</p> <p>I agree to hold Foundation 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 Foundation harmless from claims, causes of action and damages which may arise as a result of information provided about me from sources other than myself.</p> <p>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.</p> <p>If any material changes occur affecting my professional status, it is my obligation to notify Foundation 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 Foundation.</p> <p>I understand that any information received from references by Foundation 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.</p> <p>A copy or facsimile of this document shall have the same effect as the original.</p> <p>This document shall be interpreted according to the laws of the State of Oklahoma.</p> <p>Name _____</p> <p>Signature _____ Date _____</p>		

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