



# Application for Employment

**PLEASE PRINT**

Equal access to programs, services and employment is available to all persons. Those applications requiring reasonable accommodation to the Application and/or interview process should notify a representative of the Human Resource Department.

Position(s) applied for: \_\_\_\_\_ Date of Application: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City State/Province Zip Code

Home Phone: ( ) - Cell Phone: ( ) - Social Security#: \_\_\_\_\_

Email address: \_\_\_\_\_

In case of emergency, please contact \_\_\_\_\_ Telephone#: \_\_\_\_\_

What are your specialties? Please state if MS, Tele, ER ICU, Psych, OR or other \_\_\_\_\_

Have you submitted an application here before?.....  Yes  No

If Yes, give date(s)..... From \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you legally eligible for employment in this country?.....  Yes  No

Date available for work..... \_\_\_\_/\_\_\_\_/\_\_\_\_

Type of employment desired .....  Travel  Per-Diem

Shift Desired.....  Day  Night

Have you ever been convicted of a crime in the last seven (7) years? .....  Yes  No

If yes, please explain \_\_\_\_\_

Conviction will not necessarily bar employment. Each instance & explanation will be considered in relation to the position for which you are applying.

Referral Source:  Advertisement  Employee  Relative  Government Agency Employee  
 Walk-in  Private Employment Agency  Other

Name of source (if applicable) \_\_\_\_\_

*An equal opportunity Employer*

## Employee History

Provide the following information for your past and current employees, assignments or volunteer activities, starting with the most recent (use additional sheets if necessary). Explain any gaps in employment in comments section below.

<b>Employer:</b>	Tel #: (     )	Summarize the type of work performed and job responsibilities
Type:	<input type="checkbox"/> Agency <input type="checkbox"/> Facility	
Address:		
Job Title:	Immediate Supervisor & Title:	
Dates employed:	Hourly Rate / Salary	
From:                      To:	\$	
Reason for leaving:		
May we contact for reference?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Later		
<b>Employer:</b>	Tel #: (     )	
Type:	<input type="checkbox"/> Agency <input type="checkbox"/> Facility	
Address:		
Job Title:	Immediate Supervisor & Title:	
Dates employed:	Hourly Rate / Salary	
From:                      To:	\$	
Reason for leaving:		
May we contact for reference?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Later		
<b>Employer:</b>	Tel #: (     )	
Type:	<input type="checkbox"/> Agency <input type="checkbox"/> Facility	
Address:		
Job Title:	Immediate Supervisor & Title:	
Dates employed:	Hourly Rate / Salary	
From:                      To:	\$	
Reason for leaving:		
May we contact for reference?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Later		
<b>Employer:</b>	Tel #: (     )	
Type:	<input type="checkbox"/> Agency <input type="checkbox"/> Facility	
Address:		
Job Title:	Immediate Supervisor & Title:	
Dates employed:	Hourly Rate/ Salary	
From:                      To:	\$	
Reason for leaving:		
May we contact for reference?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Later		

**COMMENTS** INCLUDING EXPLANATION OF ANY GAPS IN EMPLOYMENT \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SKILLS & QUALIFICATIONS** — Summarize any special training, skills, licenses and/or certificates that may qualify you as being able to perform job-related functions in the position for which you are applying.

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**Educational Background** — IF JOB-RELATED

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**A.** List last three (3) schools attended, starting with most recent.      **B.** Dates attended.      **C.** Year graduated, if completed.  
**D.** Type of degree or diploma earned, if any.      **E.** Major field of study.

A. SCHOOL(S) ATTENDED	B. DATES	C. YEAR GRADUATED	D. TYPE OF DEGREE	E. MAJOR

**Additional Information:**

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**Certifications:**

- CPR / BLS                       PALS                       Advanced Fetal Monitoring
- ACLS                               NRP                         MAB or Equivalent

**I have a MINIMUM OF ONE YEAR experience in the following units and I am prepared to care for patients in these specialties:**

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>1. Medical</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Genito-Urinary</li> <li><input type="checkbox"/> Rehabilitation</li> <li><input type="checkbox"/> Cardio-Vascular</li> <li><input type="checkbox"/> Respiratory</li> <li><input type="checkbox"/> Gastro-Intestinal</li> <li><input type="checkbox"/> General Medicine</li> <li><input type="checkbox"/> HIV</li> <li><input type="checkbox"/> Infectious Disease</li> <li><input type="checkbox"/> Metabolic</li> <li><input type="checkbox"/> Neurology</li> <li><input type="checkbox"/> Renal/Dialysis</li> <li><input type="checkbox"/> Oncology</li> </ul> | <p><b>2. Maternal Health</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Postpartum</li> <li><input type="checkbox"/> Prenatal</li> <li><input type="checkbox"/> Nursery II</li> <li><input type="checkbox"/> Labor / Delivery</li> <li><input type="checkbox"/> NICU</li> <li><input type="checkbox"/> Couplet Care</li> </ul> <p><b>3. Pediatrics</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Burns</li> <li><input type="checkbox"/> Cardio-Vascular</li> <li><input type="checkbox"/> Gastro-Intestinal</li> <li><input type="checkbox"/> Respiratory</li> <li><input type="checkbox"/> Orthopedic</li> <li><input type="checkbox"/> General Medical</li> <li><input type="checkbox"/> Metabolic</li> <li><input type="checkbox"/> Neurology</li> </ul> | <p><b>4. Surgical</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Burns</li> <li><input type="checkbox"/> Cardiac</li> <li><input type="checkbox"/> Thoracic</li> <li><input type="checkbox"/> Orthopedic</li> <li><input type="checkbox"/> ENT Surgery</li> <li><input type="checkbox"/> Gastro-Intestinal</li> <li><input type="checkbox"/> Gentic-Urinary</li> <li><input type="checkbox"/> Gynecology</li> </ul> <p><b>5. Psychiatric</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chemical Dependency</li> <li><input type="checkbox"/> Suicidal Precaution</li> <li><input type="checkbox"/> General Psychiatric</li> <li><input type="checkbox"/> Adult</li> <li><input type="checkbox"/> Adolescent</li> <li><input type="checkbox"/> Closed unit</li> </ul> | <p><b>6. Levels of Care</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> General Medical / Surgical</li> <li><input type="checkbox"/> Telemetry</li> <li><input type="checkbox"/> Intensive Care / ICU</li> <li><input type="checkbox"/> PICU</li> <li><input type="checkbox"/> Recovery Room</li> <li><input type="checkbox"/> Operating Room</li> <li><input type="checkbox"/> Emergency Room</li> <li><input type="checkbox"/> Out-Patient / Clinic</li> <li><input type="checkbox"/> Hospice / Sub-Acute</li> <li><input type="checkbox"/> Cath Lab / Cardiology</li> <li><input type="checkbox"/> Pre-Op Holding</li> <li><input type="checkbox"/> GI-Lab</li> </ul> |
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I understand that if am employed, any misinterpretation or material omission made by me on this application will be sufficient cause for cancellation of this application or immediate discharge from the employer's service, whenever it is discovered.

I give the employer the right to contact and obtain information from all references, employers, educational institutions and to otherwise verify the accuracy of the information contained in this application. I hereby release from liability the employer and its representatives for seeking, gathering and using such information and all other persons, corporations or organizations for furnishing such information.

The employer does not unlawfully discriminate in employment and no question on this application is used for the purpose of limiting or excusing any applicant from consideration for employment on a basis prohibited by local, state or federal law.

I understand it is this company's policy not to refuse to hire a qualified individual with a disability because of that person's need for a reasonable accommodation as required by the ADA.

I also understand that if I am hired, I will be required to provide proof of identity and legal work authorization.

I represent and warrant that I have read and fully understand the foregoing and seek employment under these conditions.

Signature of applicant \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# Form W-4 (2009)

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

**Exemption from withholding.** If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2009 expires February 16, 2010. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** You cannot claim exemption from withholding if (a) your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/multiple job situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

**Head of household.** Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or

dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

**Two earners or multiple jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

**Nonresident alien.** If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2009. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

## Personal Allowances Worksheet (Keep for your records.)

**A** Enter "1" for yourself if no one else can claim you as a dependent. . . . . **A** \_\_\_\_\_

**B** Enter "1" if:   
 { • You are single and have only one job; or   
 • You are married, have only one job, and your spouse does not work; or   
 • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. } . . . **B** \_\_\_\_\_

**C** Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . **C** \_\_\_\_\_

**D** Enter number of dependents (other than your spouse or yourself) you will claim on your tax return . . . . . **D** \_\_\_\_\_

**E** Enter "1" if you will file as head of household on your tax return (see conditions under **Head of household** above) . . . **E** \_\_\_\_\_

**F** Enter "1" if you have at least \$1,800 of child or dependent care expenses for which you plan to claim a credit . . . **F** \_\_\_\_\_

(Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

**G** **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.   
 • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children.   
 • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children. **G** \_\_\_\_\_

**H** Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ► **H** \_\_\_\_\_

For accuracy, complete all worksheets that apply.   
 { • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.   
 • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$25,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.   
 • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

Form <b>W-4</b> Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">► Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-0074 <div style="font-size: 2em; font-weight: bold; margin: 5px 0;">2009</div>
1 Type or print your first name and middle initial. Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ► <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 _____
6 Additional amount, if any, you want withheld from each paycheck		6 \$ _____
7 I claim exemption from withholding for 2009, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> <li>• Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and</li> <li>• This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.</li> </ul> If you meet both conditions, write "Exempt" here . . . . . ►		7 _____

Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature (Form is not valid unless you sign it.) ►	Date ►
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)
10 Employer identification number (EIN)	

Department of Homeland Security  
U.S. Citizenship and Immigration Services

**Form I-9, Employment Eligibility Verification**

Please read instructions carefully before completing this form. The instructions must be available during completion of this form.

**ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work eligible individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Verification.** To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #
<b>I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.</b>		I attest, under penalty of perjury, that I am (check one of the following): <input type="checkbox"/> A citizen or national of the United States <input type="checkbox"/> A lawful permanent resident (Alien #) A _____ <input type="checkbox"/> An alien authorized to work until _____ (Alien # or Admission #) _____	
		Employee's Signature _____ Date (month/day/year) _____	

**Preparer and/or Translator Certification.** (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature _____	Print Name _____
Address (Street Name and Number, City, State, Zip Code) _____	
Date (month/day/year) _____	

**Section 2. Employer Review and Verification.** To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____

**CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) \_\_\_\_\_ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative _____	Print Name _____	Title _____
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code) _____		Date (month/day/year) _____

**Section 3. Updating and Reverification.** To be completed and signed by employer.

A. New Name (if applicable) _____	B. Date of Rehire (month/day/year) (if applicable) _____	
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.		
Document Title: _____	Document #: _____	Expiration Date (if any): _____

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.**

Signature of Employer or Authorized Representative _____	Date (month/day/year) _____
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## **AUTHORIZATION AND RELEASE**

### **To the employee:**

From time to time 24/7 Staffing Solutions' client facilities will request to audit the employee files of employees who have worked in their facility. These audits are intended only to verify that 24/7 Staffing Solutions and consequently their employees are, and have been, in compliance with Regulations and Accepted Industry Standards with regard to, but not limited to, Annual In-Services and Health Exams. In order for 24/7 Staffing Solutions to comply with these hospital audits the employee (you) must sign an Authorization allowing these facilities access to your Personnel file. Since compliance by 24/7 Staffing Solutions with these audit requests are mandatory, it is necessary for 24/7 Staffing Solutions to require that ALL EMPLOYEES sign this Authorization and Consent as a condition of employment. This Authorization is required due to the "AMERICAN DISABILITY ACT" which prohibits employers from disclosing medical information about their employees without their knowledge and consent.

## **AUTHORIZATION AND RELEASE**

I hereby authorize 24/7 Staffing Solutions, and its' employees and representatives to provide any information it deems appropriate regarding me to all hospitals and any of their employees, representatives, and agents. This information may be provided either verbally or in writing. In addition to authorizing the release of any information, I hereby fully waive any rights or claims I have against 24/7 Staffing Solutions, its' employees, or representatives from any and all liability, claims, or damages that may directly or indirectly result from the disclosure or release of any information, whether such information is favorable or unfavorable.

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Date

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Signature

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Print Name

# 24/7 STAFFING SOLUTIONS

## IN-SERVICE ACKNOWLEDGMENT

### ACKNOWLEDGMENT OF RECEIPT OF HIRING POLICY AGREEMENT

I have received, reviewed and understand my job description for 24/7 Staffing Solutions given to me at the time of orientation. I agree to abide by the job description as terms of my continued employment with 24/7 Staffing Solutions. Below please initial and date only the current year.

Date: \_\_\_/\_\_\_/ 2009 Initials\_\_\_\_\_ Date: \_\_\_/\_\_\_/ 2010 Initials\_\_\_\_\_ Date: \_\_\_/\_\_\_/ 2011 Initials\_\_\_\_\_

### ACKNOWLEDGMENT OF RECEIPT OF PERSONNEL MANUAL

This is to acknowledge that I have received a copy of the Personnel Manual and understand that it contains important information on 24/7 Staffing Solutions general personnel policies and my duties and obligation as an employee. I will familiarize myself with the manual and understand that I am governed by its contents. I further understand that the company may change, rescind or add any policies, benefits, or practices described in the handbook from time to time in its sole and absolute discretion with or without prior notice.

Date: \_\_\_/\_\_\_/ 2009 Initials\_\_\_\_\_ Date: \_\_\_/\_\_\_/ 2010 Initials\_\_\_\_\_ Date: \_\_\_/\_\_\_/ 2011 Initials\_\_\_\_\_

### ACKNOWLEDGMENT OF RECEIPT OF FACTS ABOUT WORKERS COMPENSATION BENEFITS BROCHURE

I have received, reviewed and understand Facts about Workers Compensation Benefits Brochure given to at the time of my application. I have been informed that I have the right to choose a personal physician to treat me in the event of an injury occurring while providing services for 24/7 Staffing Solutions. I agree to abide by the Workers Compensation policies and procedures outlined in the personnel manual.

Date: \_\_\_/\_\_\_/ 2009 Initials\_\_\_\_\_ Date: \_\_\_/\_\_\_/ 2010 Initials\_\_\_\_\_ Date: \_\_\_/\_\_\_/ 2011 Initials\_\_\_\_\_

### ACKNOWLEDGMENT OF RECEIPT OF JOINT COMMISSION AND OSHA CORE MANDATORIES PART I AND PART II

I have received, reviewed and understand the JOINT COMMISSION and OSHA Core Mandatories Part I & Part II. 24/7 Staffing Solutions strives to keep all staff updated on current health care practices and encourages all staff to become familiar with these competencies and to implement them in their daily practice.

Date: \_\_\_/\_\_\_/ 2009 Initials\_\_\_\_\_ Date: \_\_\_/\_\_\_/ 2010 Initials\_\_\_\_\_ Date: \_\_\_/\_\_\_/ 2011 Initials\_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## PATIENT CONFIDENTIALITY AGREEMENT

The patient has the right to expect healthcare providers to share only that information that is relevant to their care delivery and within the classification and job responsibilities of the healthcare provider.

The patient's right to privacy shall be respected.

Patient information shall be shared only with those who are directly involved in their care.

### ACCOUNTABILITY TO SAFEGUARD:

- Home Telephone Numbers & Addresses
- Spouses & other Relatives Names & Addresses
- Physical Medical Records including:
  - Data Communications
  - Paper Documentation
  - Photo(s)
  - Video(s)
  - Diagnostics & Therapeutic Report(s)
  - Laboratory and Pathology Samples
- Social Security Numbers
- Income Tax Withholding Records
- Information related to Evaluation of Performance(s)
- Patient Business Records
- Alpha-Numeric Radio Pager Messages
- Misuse of verbal information provided by or about a patient
- Mainframe & Department-Based Computerized Patient-Data
- Other such information, which if disclosed, would constitute an unwarranted invasion or breach of privacy

### VIOLATION OF CONFIDENTIALITY

- Unauthorized access, use, misuse, discussion or disclosure of confidential and proprietary information during and after my employment with 24/7 Staffing Solutions, Inc.
- Breach of confidentiality may be subject to civil or criminal action for invasion of privacy including termination.
- Unauthorized access, use, misuse, discussion or disclosure of electronic records for patients and employees.

### RESPONSIBILITY

I am responsible, obligated and will protect confidential, patient, proprietary and employee information and will not misuse or abuse this confidentiality policy.

The access to and authorized use of all personal, medical, data and information considered confidential and proprietary in any form shall be available during the course of employment only and shall be subject to and will be treated as confidential and proprietary. My obligation of confidentiality becomes effective immediately after being employed by 24/7 Staffing Solutions, Inc and will continue after my separation.

My conduct will be in strict conformance to applicable state and federal laws, statues, regulatory guidelines and codes.

Question regarding confidentiality of information are to be addressed with management.

I have read and agree to comply with the requirements listed in this Patient Confidentiality Agreement.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
24/7 Staffing Solutions Representative Signature

\_\_\_\_\_  
Date

# 24/7 Staffing Solutions

## Core Mandatory Attestation

**Candidate Name** \_\_\_\_\_

**Candidate Signature** \_\_\_\_\_

**Completion Date** \_\_\_\_\_

The above candidate has successfully completed and passed the Core Mandatory topics and testing listed below:

- Unit specific or position specialty Test (score) \_\_\_\_\_ %
- HIPAA
- Environmental Safety
- Emergency Preparedness
- Pain Management
- Infection Control/Bloodborne Pathogens
- Body Mechanics
- Age Specific
- Restraints
- Patients Rights
- Advanced Directives
- Hazardous Chemicals
- Workplace Violence
- Abuse
- Preventing Medication Errors
- Sexual Harassment
- Cultural Diversity
- Abbreviations- Do Not Use
- Drugs in the Workplace
- Domestic Violence
- National Patient Safety
- End of Life Care
- Fire Safety

**Copies of the complete file are available upon request**

**Authorized 24/7 Staffing Solutions Representative:**

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

**Signature:** \_\_\_\_\_ **(877) 247-8847**

# 24/7 Staffing Solutions

## FINGERNAIL HYGIENE POLICY

Nails must be neat, rounded rather than pointed.  
They must be short enough to prevent scratching the patients when providing care.  
No artificial nails or overlay wraps (silk) are allowed.

Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Date \_\_\_\_\_

## EMPLOYMENT REFERENCE

I, \_\_\_\_\_, have applied to **24/7 Staffing Solutions** for employment. They place great importance on thorough screening of all applicants; they would appreciate a prompt and thoughtful response. The information will be kept in strictest confidence by them. Thank you in advance.

I, \_\_\_\_\_, hereby authorize my employers, school, law enforcement agencies and/or persons who may aid 24/7 Staffing Solutions in determining my suitability for employment, to provide reference information to 24/7 Staffing Solutions. I hereby release all such employees, individuals and/or organizations contacted from all liabilities for issuing this information to 24/7 Staffing Solutions.

\_\_\_\_\_  
My signature Date

I am a:       RN                       LVN                       CNA

**Employer/Manager/Supervisor full name + title** \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Name of Hospital/Nursing Home/Facility/Unit \_\_\_\_\_

Employment Dates      From: \_\_\_\_\_                      To: \_\_\_\_\_

Reason For Leaving: \_\_\_\_\_

**Area Below To Be Filled Out By Person Giving Reference**

Is Nurse eligible for rehire:     Yes       No      If No, please explain below:

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

PERFORMANCE EVALUATION	Meets Standard	Does Not Meet Standard
Demonstrates competency in caring for patients		
Implements a coordinated plan of patient care		
Adheres to facility policies and procedures		
Communicates appropriate with patients/families		
Completes accurate documentation of patient care		
Flexibility and adaptability		
Willingness and ability to float (if applicable)		
Ability to communicate		
Attendance and punctuality		

\_\_\_\_\_  
Name and title of person giving reference Date

**Please fax this form to (562) 494-8795 or (562) 685-0911**

## EMPLOYMENT REFERENCE

I, \_\_\_\_\_, have applied to **24/7 Staffing Solutions** for employment. They place great importance on thorough screening of all applicants; they would appreciate a prompt and thoughtful response. The information will be kept in strictest confidence by them. Thank you in advance.

I, \_\_\_\_\_, hereby authorize my employers, school, law enforcement agencies and/or persons who may aid 24/7 Staffing Solutions in determining my suitability for employment, to provide reference information to 24/7 Staffing Solutions. I hereby release all such employees, individuals and/or organizations contacted from all liabilities for issuing this information to 24/7 Staffing Solutions.

\_\_\_\_\_  
My signature Date

I am a:       RN                       LVN                       CNA

**Employer/Manager/Supervisor full name + title** \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Name of Hospital/Nursing Home/Facility/Unit \_\_\_\_\_

Employment Dates      From: \_\_\_\_\_                      To: \_\_\_\_\_

Reason For Leaving: \_\_\_\_\_

**Area Below To Be Filled Out By Person Giving Reference**

Is Nurse eligible for rehire:     Yes       No      If No, please explain below:

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

PERFORMANCE EVALUATION	Meets Standard	Does Not Meet Standard
Demonstrates competency in caring for patients		
Implements a coordinated plan of patient care		
Adheres to facility policies and procedures		
Communicates appropriate with patients/families		
Completes accurate documentation of patient care		
Flexibility and adaptability		
Willingness and ability to float (if applicable)		
Ability to communicate		
Attendance and punctuality		

\_\_\_\_\_  
Name and title of person giving reference Date

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*When Quality and Integrity go hand in hand.*

**PHYSICIAN'S STATEMENT**

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

Physician (Print): \_\_\_\_\_ Telephone: \_\_\_\_\_

Please circle answers with a YES or NO. This health questionnaire is for the purpose of assisting your employer in placing you in a job safe to yourself and others according to your physical ability.

Have you ever filed a claim or received benefits for an occupational injury, disease, or accident?	Yes	No
Been refused insurance for health reasons?	Yes	No
Have you ever had any back/spinal problems?	Yes	No
Have you ever had any form of hepatitis?	Yes	No
Have you ever had heart problems including irregular heartbeats?	Yes	No
Have you ever had liver disease or kidney disease?	Yes	No
Have you have diabetes or been treated for diabetes?	Yes	No
Have you ever had mental disorder?	Yes	No
Do you have an existing temporary medical condition?	Yes	No
Have you ever had cancer, tuberculosis, or blood disorder?	Yes	No

**HAVE YOU DEVELOPED ANY OF THE FOLLOWING IN THE LAST YEAR:**

Are you a smoker?	Yes	No
Have you had a persistent cough?	Yes	No
Have you had persistent skin rashes, abscesses, or sores?	Yes	No
Do you have excessive fatigue despite adequate rest?	Yes	No
Have you had diarrhea lasting more than 48 hours?	Yes	No
Have you had an unexplained change in your weight?	Yes	No
If so, how much weights have you lost? _____		
Are you having any unexplained elevation of temperature?	Yes	No

**EXPLANATION OF ALL QUESTIONS ANSWERED YES ABOVE:**


**PLEASE PROVIDE 24/7 SS WITH YOUR PHYSICAL AND TUBERCULOSIS STATUS ANNUALLY.**

PPD	SITE	RESULTS:	CHEST X-RAY DATE:	RESULTS:
Date Given:				
Date Read:		_____mm		

If you have a positive PPD, a baseline **Chest X-Ray** is required and then required every 4 years thereafter.

If you have a **Chest X-Ray** please attach the **Radiology Report** to this Form.

Rubella/Immunization: <input type="checkbox"/> Yes <input type="checkbox"/> No	(If Yes)Date Immunized:_____
Date Titer Drawn:	<input type="checkbox"/> Immune
Date of Result:	<input type="checkbox"/> Non-Immune

Rubeola/Immunization: <input type="checkbox"/> Yes <input type="checkbox"/> No	(If Yes)Date Immunized:_____
Date Titer Drawn:	<input type="checkbox"/> Immune
Date of result:	<input type="checkbox"/> Non-Immune

Mumps/Immunization:  Yes  No (If Yes)Date Immunized:\_\_\_\_\_

Date Titer Drawn: \_\_\_\_\_  Immune

Date of result: \_\_\_\_\_  Non-Immune

Varicella/Immunization: <input type="checkbox"/> Yes <input type="checkbox"/> No	(If Yes)Date Immunized:_____
Date Titer Drawn:	<input type="checkbox"/> Immune
Date of result:	<input type="checkbox"/> Non-Immune

Hepatitis B/Immunization	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vaccine Dates Given: Dose 1		
Dose 2		
Dose 3		
<b>OR</b> Signed Waiver: (Waiver only valid for Hep B)		

**RESULTS:** **Please stamp area above with Doctor's Office Stamp.**

*The aforementioned individual is found to be physically and mentally capable, free from communicable diseases, able to perform assigned duties without limitation, and has no apparent health condition that would cause a hazard to patients or others.*

\_\_\_\_\_  
**Physician's name**

\_\_\_\_\_  
**Physician's ID number**

\_\_\_\_\_  
**Physician's signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Physician's address**

# 24/7 STAFFING SOLUTIONS

## TUBERCULOSIS QUESTIONNAIRE

This TB Questionnaire is a 24/7 Staffing Solutions ANNUAL EMPLOYMENT REQUIREMENT and a method to monitor infection control and reportable diseases. The incidence of Tuberculosis (TB) and drug resistant strains is an increasing occurrence in the United States. You are informed that a client facility/specific state can mandate a 2-step Mantoux Tuberculin Skin Test as a specific requirement.

<b>HEALTH HISTORY</b>			
1.	Are you currently pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Have you received any vaccines in the last six weeks? (i.e. mumps, measles, rubella)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Have you had a recent viral, fungal, or bacterial infection within the last month?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Have you been treated with steroids, corticosteroids or immunosuppressive agents?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Have you had pneumonia or bronchitis in the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Are you experiencing a productive, prolonged cough?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Are you experiencing chest pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Are you experiencing hemoptysis (coughing up blood)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Are you experiencing a fever that persists?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	Are you experiencing chills that recur?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11.	Are you experiencing night sweats?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12.	Are you experiencing fatigue - easily and ongoing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13.	Are you experiencing an unexplained loss of appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14.	Are you experiencing an unexplained weight loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15.	Have you ever had any lung disease(s)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16.	Have you ever been exposed to TB?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17.	Has anyone in your household been diagnosed with TB?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
18.	Have you ever been diagnosed with TB?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
19.	Have you ever received the BCG immunization against tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
20.	<b>Had a PPD tuberculin skin test within the last 12 months?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
21.	If you had a tuberculin skin test (PPD), was the result positive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
22.	If tuberculin skin test (PPD) results were positive, did you receive treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
23.	Did you complete a 2-step Mantoux tuberculin skin test within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
24.	Have you had a chest x-ray within the past <input type="checkbox"/> one (1) year	<input type="checkbox"/> Yes	<input type="checkbox"/> No
25.	Have you had a chest x-ray within the past <input type="checkbox"/> four (4) years	<input type="checkbox"/> Yes	<input type="checkbox"/> No
26.	Have you traveled to Mexico, Far East or any other country where TB rates are high?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
27.	Have you lived in another country, other than the United States?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If YES to any of the above questions, please provide date, location and explanation.

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EMPLOYEE INFORMATION

24/7 Staffing Solutions Representative

Print Name: \_\_\_\_\_

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

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

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

Unless contraindicated, a purified protein derivative (PPD) of the tubercle bacillus is injected intradermally. Immuno-suppressed individuals or other health conditions may cause a TB skin test to be negative when a TB infection is present. Interpretation of a result and varied induration of x mm is based on risk groups or factors.

## 24/7 Staffing Solutions

### Hepatitis B Vaccine Declination Form

I understand that due to my occupational exposure to blood or other potentially infectious materials (OPIM), I may be at risk of acquiring hepatitis B virus (HBV) infection.

You have given me the opportunity to be vaccinated with the hepatitis B vaccine, at no charge to myself.

However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

I have already received the hepatitis B vaccination series.

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Employee's Name (Print)

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Employee's Signature

---

Date

# 24/7 Staffing Solutions

## Drug Screening Consent

I, \_\_\_\_\_, give my consent to be screened for drugs prior to being hired for employment with 24/7 Staffing Solutions. I understand the need to screen for use of drugs or illegal substances to ensure that only the highest quality of nurses are hired by 24/7 Staffing Solutions.

I likewise consent to be screened for drugs any time and at any hospital that I shall be assigned to by 24/7 Staffing Solutions.

I am fully aware that if my Drug Screen Result is positive, I will be ineligible to work with 24/7 Staffing Solutions.

I hold 24/7 Staffing Solutions free from any liability should results of my drug screening influence future employment.

Name: \_\_\_\_\_ Witness: \_\_\_\_\_

Signature: \_\_\_\_\_ Signature: \_\_\_\_\_

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



## Screening for Influenza Vaccination 2008 – 2009

<b>Name:</b>	<b>24/7 Staffing Solutions</b>
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**Influenza facts:**

- Influenza is a serious respiratory disease that kills, on average, 36,000 Americans every year.
- Influenza virus may be shed for up to 48 hours before symptoms begin, allowing transmission to others.
- Up to 30% of people with influenza have no symptoms, allowing transmission to others.
- Flu virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months. In California, influenza usually arrives around New Year through February or March.
- Influenza vaccine cannot transmit influenza.
- A signed declination is required from any employee or healthcare personnel who declines Influenza Vaccine (Senate Bill 739).

### Attestation for Receipt of Influenza Vaccination

I have received the influenza vaccine for the 2008 - 2009 season.

Setting where vaccine was administered:

Hospital     Clinic     MD office     Other

**Attestation:** Signature \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_

### Declination

I have declined to receive the influenza vaccination for the 2008 - 2009 season. I acknowledge that influenza vaccination is recommended by the CDC for all healthcare workers to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community.

**Reasons for declination:**

- I am allergic to components of the vaccine (specify) \_\_\_\_\_
- I don't believe in vaccines.
- I won't take the vaccine because of side effects.
- I'm in good health and have never had flu before.
- I got severe influenza-like symptoms from the influenza vaccine in the past.
- I am fearful of injections.
- I am not convinced that influenza vaccination prevents flu.
- Other (specify) \_\_\_\_\_

**Attestation:** Signature \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_

**DISCLOSURE AND AUTHORIZATION**

[IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING AUTHORIZATION]

**DISCLOSURE REGARDING BACKGROUND INVESTIGATION**

[24-7 Staffing Solutions] ("the Company") may obtain information about you from a consumer reporting agency for employment purposes. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews with sources such as your neighbors, friends, or associates. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by **Pre-Employ.com, Inc., Compliance Department, P.O. Box 491570, Redding, California 96049-1570, or by fax to (888) 999-3839**, or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing [24-7 Staffing Solutions] to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your employment to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

**ACKNOWLEDGMENT AND AUTHORIZATION**

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout my employment, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by **Pre-Employ.com, Inc., Compliance Department, P.O. Box 491570, Redding, California 96049-1570, or by fax to (888) 999-3839**, another outside organization acting on behalf of [24-7 Staffing Solutions], and/or [24-7 Staffing Solutions] itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

**New York Applicants or Employees only:** By signing below, you also acknowledge receipt of Article 23-A of the New York Correction Law.  
[www.labor.state.ny.us/agencyinfo/PDFs/CorrectionLaw%20Article%2023-A%204.pdf](http://www.labor.state.ny.us/agencyinfo/PDFs/CorrectionLaw%20Article%2023-A%204.pdf)

**NEW YORK Applicants or Employees Only:** You have the right to inspect and receive a copy of any investigative consumer report requested by [ 24-7 Staffing Solutions ] by contacting the consumer reporting agency identified above directly.

**Minnesota and Oklahoma Applicants or Employees only:** Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company.

**California Applicants or Employees only:** By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law.

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
Social Security\* # \_\_\_\_\_ Date of Birth\* \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*\*This information will be used for background screening purposes only and will not be used as hiring criteria.  
Disclosure and Authorization 5/7/09*

The following information is for identification purposes only. Please print clearly in Black Ink!

<b>Name: Last</b>	<b>First</b>	<b>Middle</b>
List all other names used in the last 7 years:		
<b>Date of Birth:</b>		<b>Social Security Number:</b>
Drivers License Number:		State issued:
Current Address:		
City:	State:	Zip:
<b>Address History</b> - Please list the city, state, and zip you have lived or worked in for the past 7 years with approximate dates:		
Dates:	City:	State: Zip:
Dates:	City:	State: Zip:
Dates:	City:	State: Zip:
Daytime phone number: (     )		Email Address:
<b>***** APPLICANT – DO NOT WRITE BELOW THIS LINE *****</b>		
<b>Company ID:</b>	<b>Company Name:</b> 24-7 Staffing Solutions	<b>PO#</b>
<p>Please indicate the services you would like to request for this applicant.                  Fax this sheet to 888-999-3839 or enter the information at <a href="https://www.pre-employ.com">https://www.pre-employ.com</a></p>		
<b>Basic Services Requested:</b>		
Package A : SSN, Criminal (all names, all counties)		
Package B : SSN, Criminal (current name, current county)		
<b>Additional Services Requested: Please check box</b>		
<input type="checkbox"/> Social Security Trace <input type="checkbox"/> Criminal History Check <input type="checkbox"/> Drivers License Check <input type="checkbox"/> Employment Verification <input type="checkbox"/> Degree/Education Verification <input type="checkbox"/> Reference Check <input type="checkbox"/> OIG/GSA Check <input type="checkbox"/> National Wants and Warrants <input type="checkbox"/> Credit Report	<input type="checkbox"/> Anti Terrorist Watch List <input type="checkbox"/> US Criminal File Search <input type="checkbox"/> Civil History <input type="checkbox"/> Federal Criminal History <input type="checkbox"/> Federal Civil History <input type="checkbox"/> Sex Offender <input type="checkbox"/> Workers Compensation <input type="checkbox"/> Drug Test	