



APPLICATION / RECORD CARD

NAME	LAST	FIRST	MIDDLE	HOME PHONE	DATE
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ADDRESS	STREET	APT#	CITY	STATE	ZIP	CELL PHONE
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EMAIL ADDRESS	NOTIFY IN CASE OF EMERGENCY	NAME	PHONE
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ARE YOU PRESENTLY 18 YEARS OF AGE OR OLDER?	<input type="checkbox"/> YES <input type="checkbox"/> NO	BIRTHDAY (month/day)	SOCIAL SECURITY NUMBER	U.S. CITIZEN OR LEGAL RIGHT TO WORK IN U.S.?	<input type="checkbox"/> YES <input type="checkbox"/> NO	SPECIAL EMERGENCY INSTRUCTIONS
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WOULD YOU BE WILLING TO TAKE A DRUG TEST IF IT WERE A CONDITION OF EMPLOYMENT?	<input type="checkbox"/> YES <input type="checkbox"/> NO	HOW DID YOU HEAR OF ASSURED HEALTHCARE?	REFERRED BY:
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HAVE YOU EVER BEEN CONVICTED OF A CRIMINAL OFFENSE, OTHER THAN A MINOR TRAFFIC VIOLATION?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, GIVE DETAILS	DATE	CITY, STATE	WHICH TYPE OF OF TRANSPORTATION DO YOU USE?	<input type="checkbox"/> CAR AVAILABLE <input type="checkbox"/> PUBLIC TRANSPORTATION	DRIVER'S LICENSE NUMBER	STATE	DATE EXPIRES	CLASS
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	CITY, STATE	MAJOR COURSE OF STUDY	DATES ATTENDED	DEGREES REC'D
<input type="checkbox"/> HIGH SCHOOL	_____	_____	_____	_____
<input type="checkbox"/> COLLEGE	_____	_____	_____	_____
<input type="checkbox"/> OTHER	_____	_____	_____	_____

LICENSES:	EXPIRATION DATE	COPY ON FILE (CIRCLE)	CERTIFICATIONS	EXPIRATION DATE	COPY ON FILE (CIRCLE)
_____	_____	YES NO	_____	_____	YES NO
_____	_____	YES NO	_____	_____	YES NO
_____	_____	YES NO	_____	_____	YES NO
_____	_____	YES NO	_____	_____	YES NO

PLEASE LIST EXPIRATION DATE FOR THE FOLLOWING:

TEST:	SHOTS:	CURRENT CARDS / PHYSICAL:	TRAINING:
TB _____	HEP B _____	CPR CARD _____	BBP TRAINING _____
TB CHEST X-RAY _____	OTHER _____	PHYSICAL _____	SCHEDULE TRAINING DATE _____
OTHER _____		ACLS _____	OTHER _____

WORK HISTORY - LIST CURRENT OR MOST RECENT FIRST

MAY WE CONTACT? <input type="checkbox"/> YES <input type="checkbox"/> NO	EMPLOYER	ADDRESS				PHONE
	JOB TITLE AND DUTIES					
	START DATE	PAY RATE	END DATE	PAY RATE	REASON FOR LEAVING	SUPERVISOR'S NAME
MAY WE CONTACT? <input type="checkbox"/> YES <input type="checkbox"/> NO	EMPLOYER	ADDRESS				PHONE
	JOB TITLE AND DUTIES					
	START DATE	PAY RATE	END DATE	PAY RATE	REASON FOR LEAVING	SUPERVISOR'S NAME
MAY WE CONTACT? <input type="checkbox"/> YES <input type="checkbox"/> NO	EMPLOYER	ADDRESS				PHONE
	JOB TITLE AND DUTIES					
	START DATE	PAY RATE	END DATE	PAY RATE	REASON FOR LEAVING	SUPERVISOR'S NAME

(CIRCLE AREA OF EXPERIENCE)

RN LVN/LPN CNA MEDICAL ASSISTANT THERAPIST _____ PARAMEDIC EMT X-RAY TECHNICIAN PHLEBOTOMIST

BILINGUAL YES NO

HAVE YOU DONE ANY OF THE FOLLOWING?	CHECK MARK	YRS OF EXPERIENCE	HAVE YOU DONE ANY OF THE FOLLOWING?	CHECK MARK	YRS OF EXPERIENCE
IV	_____	_____	MEDICAL RECORDS	_____	_____
IM	_____	_____	MEDICAL BILLING	_____	_____
SUB Q	_____	_____	MANUAL	_____	_____
ID	_____	_____	COMPUTER (List Software)	_____	_____
INJECTIONS	_____	_____	_____	_____	_____
BLOOD PRESSURES	_____	_____	_____	_____	_____
URINALYSIS	_____	_____	INSURANCE	_____	_____
DIPSTICKS	_____	_____	HMO'S	_____	_____
EKG'S	_____	_____	PPO'S	_____	_____
VITAL SIGNS	_____	_____	MEDICAL	_____	_____
ASSIST MINOR SURGERIES	_____	_____	MEDICARE	_____	_____
ASSIST MAJOR SURGERIES	_____	_____	CPT CODES	_____	_____
BLOOD DRAWS	_____	_____	ICD9 CODES	_____	_____
BABIES	_____	_____	AUDIOMETRY	_____	_____
CHILDREN	_____	_____	PULMONARY FUNCTION	_____	_____
ELDERLY	_____	_____	VISUAL EXAM	_____	_____
ADDICTS	_____	_____	CASE MANAGEMENT	_____	_____
AT DRAW STATIONS	_____	_____	OSHA LOG	_____	_____
WORKED ALONE AT DRAW STATION	_____	_____	WORKERS COMPENSATION	_____	_____
BUTTERFLIES	_____	_____	FLMA	_____	_____
ACCU CHECKS	_____	_____	PHYSICAL ASSESSMENTS	_____	_____
PHONES	_____	_____	CATHETER INSERTION	_____	_____
BOOKKEEPING	_____	_____	CATHETER REMOVAL	_____	_____
MEDICAL TRANSCRIPTION	_____	_____	IV INSERTION	_____	_____
SCHEDULING	_____	_____	IV REMOVAL	_____	_____
MEDICAL COLORING FILING	_____	_____			