



A Quest Diagnostics Company

Contractor Information

(Please Print)

Office #: _____ Date: _____

Examiner Last Name: _____ First: _____ MI: _____

Examiner AKA/Maiden Last Name: _____ First: _____ MI: _____

Company Name or DBA (if operating as a company): _____

Address: _____ City: _____ St/Prov: _____ Zip/Postal Code: _____

Telephone: (Primary) _____ (Secondary) _____ (Fax) _____

Email: _____

Gender (optional: data collection only): Male Female

Ethnicity (optional: data collection only)

- American Indian/Alaskan Native Asian Black/African American
- Hispanic White Other I decline to provide my self identification details.

How long at this address: _____ yrs. _____ mo. US Social Security Number/EIN? Yes No

Do you have motor vehicle transportation? Yes No

Licensed to operate a motor vehicle? Yes No

Briefly describe your work history in the phlebotomy/insurance exam field:

Indicate any professional certifications or licensure you possess:

- MD/DO Board Certified? Yes No Specialty:
- RN LPN LVN PA MA
- Med Tech EMT-P EMT-I Phlebotomist
- Other:

Professional License Number: _____ State: _____ Expiration: _____

Provide the level of training or experience you have in the following skills which are pertinent to providing services to ExamOne:

Skill	Formal Training	On-Job Training (OJT)	Practical Experience	# Years Experience
Venipuncture / Phlebotomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vital sign collection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Medical history collection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12-lead EKG administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Finger stick testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pulmonary function test measurement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mobility assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Long Term Care assessments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Securing applications and checks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
BAT Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wellness Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Indicate the equipment you currently possess:

- Blood Pressure Cuff Stethoscope Scale Centrifuge
 EKG Machine Other (please specify): _____

Foreign languages:

Speak fluently:

Read:

Write:

What radius are you willing to travel from your base of operations to complete services: _____ miles

Although contractors are responsible to establish their own work schedules, examination schedules are often dictated by the schedule needs of the client. ExamOne may be able to refer a greater number of services if a contractor can provide specific windows of availability. If you wish to do so, please indicate by checking below which day parts you are generally available to complete services.

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Morning	-	-	-	-	-	-	-
Afternoon	-	-	-	-	-	-	-
Evening	-	-	-	-	-	-	-

Notes regarding schedule availability:

First date available to begin providing services for ExamOne?

Are you currently performing insurance examination services: Yes No

If not, have you previously performed insurance examination services? Yes No

If related to anyone at ExamOne please indicate name and location:

If related to any insurance company personnel please indicate name and company:

If there are no assignments currently available, do you wish to be contacted when assignments are available in the future?
Yes No

As an independent contractor, your relationship with ExamOne would be that of an independent business operator providing services to ExamOne as a vendor. Please check all that currently apply to your situation:

- I operate under a business name. Name of business:
- I have a separate Tax ID number for my business. Tax ID:
- I provide my services to multiple companies
- I have business cards or other marketing materials advertising my services
- I am actively engaged in the marketing of my services within the insurance industry

Please provide any additional information or comments:

----- FOR OFFICE USE ONLY -----

Date Reviewed:

Reviewed by:

Notes:

CONSUMER AUTHORIZATION

I. I understand that an investigative report may be generated on me that may include information as to my character, general reputation, personal characteristics, or mode of living; work habits, performance or experience, education history, along with reasons for termination of past employment/education/professional license or credentials; financial/credit history; or criminal/civil/driving record history. I understand that General Information Services, Inc., on behalf of _____ may be requesting information from public and private sources about any of the information noted earlier in this paragraph in connection with _____ consideration of me for employment, promotion or position re-assignment or contract now, or at any time during my tenure with _____, and give my full consent for this information to be obtained.

II. IF APPLICABLE, medical and worker's compensation information will only be requested in compliance with the Federal Americans with Disabilities Act (ADA) and/or any other applicable state laws. According to the **Fair Credit Reporting Act** (FCRA, Public Law 91-508, Title VI), I am entitled to know if the considerations for which I am applying are denied because of information obtained from a consumer reporting agency. If so, I will be notified and be given the name of the agency providing that report.

III. I acknowledge that a telephonic facsimile (FAX) or photographic copy of this release shall be as valid as the original. This release is valid for most federal, state and county agencies.

IV. I understand that if I am a resident of **Minnesota/Oklahoma (only)** I may obtain a copy of the report ordered, and now indicate my desire to do so by checking this box .

V. I hereby authorize, without reservation, any financial institution, law enforcement agency, information service bureau, school, employer or insurance company contacted by General Information Services, Inc. to furnish the information described in Section I.

VI. Communications with General Information Services, Inc. should be directed to PO Box 353, Chapin SC 29036 or (866) 265-4917.

CANDIDATE COMPLETES THE FOLLOWING:

Signature Today's Date

Please print full name AKA/Maiden Name, Please print

The following information is required by law enforcement agencies and other entities for positive identification purposes when checking public records. It is confidential and will not be used for any other purposes.

Month, Day and Year of Birth Social Security Number

Home Address City State Zip

Prior Address History, if at Home Address less than 7 years

Driver's License Number and State Name as it appears on License

Have you ever been convicted of a crime? No Yes If yes, please provide city and state of conviction and details of conviction.

FAIR CREDIT REPORTING ACT NOTICE:

In accordance with the Fair Credit Reporting Act (FCRA, Public Law 91-508, Title VI), this information may only be used to verify a statement(s) made by an individual in connection with legitimate business needs. The depth of information available varies from state to state. Status of updates are available on request. Although every effort has been made to assure accuracy, General Information Services, Inc. cannot act as guarantor of information accuracy or completeness. Final verification of an individual's identity and proper use of report contents are the user's responsibility. General Information Services, Inc.'s policy requires purchasers of these reports to have signed a Service Agreement. This assures General Information Services, Inc. that users are familiar with and will abide by their obligations, as stated in the **FCRA**, to the individuals named in these reports. If information contained in this report is responsible for the suspension or termination of an employee or the application process, have the Candidate/employee contact General Information Services, Inc.

NOTICE TO CALIFORNIA CANDIDATES

You have a right to obtain a copy of any consumer report or investigative consumer report obtained by _____ by checking the box provided below. The report will be provided to you within three (3) business days after we receive the requested reports related to the matter investigated.

I request to receive a free copy of this report by checking this box.

Under section 1786.22 of the California Civil Code, you may view the file maintained on you by GIS during normal business hours. You may also obtain a copy of this file upon submitting proper identification and paying the costs of duplication services, by appearing at GIS in person or by mail. You may also receive a summary of the file by telephone. The agency is required to have personnel available to explain your file to you and the agency must explain to you any coded information appearing in your file. If you appear in person, a person of your choice may accompany you, provided that this person furnishes proper identification.