APPLICATION & AUTHORIZATION

Personal Information

Full name
AKA/Maiden Name
Home address
How long at this address _____years _____months
Home phone
Mobile or cellular phone
Home fax
Email address
Birthday (MM/DD/YYYY)
Do you have a vehicle? ☐ Yes ☐ No
Driver's license number and State
Driver's license expiration date
Social Security Number/Tax ID #
Company Name or DBA (if company)

Citizenship Information

I attest, under penalty of perjury, that I am (check one of the following)

A citizen of the United States	☐ Yes ☐ No
A lawful permanent resident (alien #)	☐ Yes ☐ No
An alien authorized to work (alien # or Admission #)	☐ Yes ☐ No
Have you ever worked for Blue Cross Blue Shield (BOBS) of Florida?	☐ Yes ☐ No
Are you presently dependent on or abusive of illegal or chemical substances?	☐ Yes ☐ No
Do you have a history of chemical dependency and/or substance abuse?	☐ Yes ☐ No
Have you been outside of the United States for a period of at least a year or more during the past ten years?	☐ Yes ☐ No

Experience

Are you currently performing insurance examination services?	☐ Yes ☐ No
If not, have you previously performed insurance examination services?	☐ Yes ☐ No

Education

High School Attended	
Address	
Years Attended	
Degree Received	
College/Voc School Attended	
Address	
Years Attended	
Degree Received	
Other School/Training	
Address	
Years Attended	
Degree Received	

Are you proficient in the following skills?	Yes	No	Please provide details: Formal Training ✓ ✕	On the Job Training ✓ ✕	Practical Experience ✓ ✕	Years of Experience
Venipuncture using vacutainer needles						
Venipuncture using butterfly needles						
Vital sign collection						
Medical history collection						
12-lead EKG administration						
Finger stick testing						
Pulmonary function test measurement						
Mobility assessment						
Long Term Care Assessment						
Securing application and checks						
BAT Training						
Wellness Training						

Indicate the equipment you currently possess:

	Blood Pressure Cuff
	EKG machine

	Stethoscope
	Scale

	Centrifuge

WORK HISTORY VERIFICATION:

Contact Person:	Company Name:
Phone #:	Email Address:
Position:	Dates Worked:
Phlebotomy Experience?	☐ Yes ☐ No ☐ Vacutainer Needle ☐ Butterfly
Degree Received	
Contact Person:	**Company Name:**
Phone #:	Email Address:
Position:	Dates Worked:
Phlebotomy Experience?	☐ Yes ☐ No ☐ Vacutainer Needle ☐ Butterfly
Degree Received	
Contact Person:	**Company Name:**
Phone #:	Email Address:
Position:	Dates Worked:
Phlebotomy Experience?	☐ Yes ☐ No ☐ Vacutainer Needle ☐ Butterfly
Degree Received	

If you will be hired as an independent contractor, your relationship with MedPhysicals Plus Group (MedPhysicals Plus, LLC, MedPhysicals Plus Midwest, LLC, MedPhysicals Plus South, LLC) would be that of an independent business operator providing services to MedPhysicals Plus Group 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.

The answers in this application are true and complete. Any incorrect or missing information is cause for rejection or dismissal from work at any time. By signing I authorize the investigation of information included in this application, and any persons or entities provided to disclose any information they deem appropriate. I authorize disclosure of motor vehicle and criminal background checks, credit and investigative consumer reports. If made, this information may include information as to my character, general reputation, personal characteristics and mode of living. I have the right to make a written request concerning the nature and scope of any such investigative inquiry.

Signature _____ Printed Name and Date _____

PLEASE ATTACH A COPY OF YOUR DRIVER'S LICENSE AND PROOF OF VEHICHLE INSURANCE AT SUBMISSION OF THIS APPLICATION. FAX TO (907)561-7002 OR TOLL FREE (855)561-7002

ExamOne®

A Quest Diagnostics Company

CONTRACTOR COMPETENCY CHECKLIST

Branch Location: Alaska

Branch # 2988

Examiner Name:

Contract Date:

Credentials (Phlebotomist, RN, LPN, EMT, etc.):

Examiner ID:

Examiner email address:

No independently contracted examiner may provide services on ExamOne's behalf until requirements below have been completed.

All documents to be included in examiner file

REQUIREMENTS	MANAGER INITIALS	DATE
Contractor Information Form	DH	
LLC/Corporation/Partnership Certifications	DH	
Phlebotomy Certification/Training Documents	DH	
Professional License/Certificate verified (if applicable – including physician information form and physician waiver)	DH	
Government Issued Photo ID (Must be driver's license if operating a motor vehicle)	DH	
Vehicle Insurance Card (N/A if not operating a motor vehicle)	DH	
Original Social Security Card Reviewed *(do not file)*	DH	
Signed Background Check Consent	DH	
Background check (verify subject has passed)	DH	
Signed contract (cannot sign unless background check is received and passed)	N/A	
W-9	N/A	
Direct Deposit form	N/A	
Social Security Number entered into ExamView/Portal		
Screen shot of ExamView/Portal Examiner Maintenance page		
Signed Loaned Equipment Agreement	N/A	
Signed Technician Manual Acknowledgment		
Incident reporting procedure reviewed		
Identification Badge issued		
ADDITIONAL REQUIREMENTS IF APPLICABLE		
EKG procedures reviewed if applicable or mark N/A		
BFW Certificates if applicable or mark N/A		
BAT Certificate if applicable or mark N/A		

* Examiner Signature: _____ *Date: _____

Branch Manager: Doug Hallauch Phone: 901-409-5517 Date: _____

ExamOne®

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	☐	☐	☐	
Vital sign collection	☐	☐	☐	
Medical history collection	☐	☐	☐	
12-lead EKG administration	☐	☐	☐	
Finger stick testing	☐	☐	☐	
Pulmonary function test measurement	☐	☐	☐	
Mobility assessment	☐	☐	☐	
Long Term Care assessments	☐	☐	☐	
Securing applications and checks	☐	☐	☐	
BAT Training	☐	☐	☐	
Wellness Training	☐	☐	☐	

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 Med Physicals Plus may be requesting information from public and private sources about any of the information noted earlier in this paragraph in connection with Med Physicals Plus consideration of me for employment, promotion or position re-assignment or contract now, or at any time during my tenure with Med Physicals Plus, 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.

ADHERENCE TO LABORATORY STANDARD OPERATING PROCEDURES

As independent medical professionals, Exam*One* expects examiners to perform all services with the appropriate level of due care and professional skill while maintaining adherence to industry accepted standard procedures.

The services you are contracted to provide may include collection of specimens which are to be tested at a federally licensed medical testing laboratory. Federal regulations mandate that all such laboratories publish standard procedures related to the collection and handling of specimens and that anyone performing such collection or handling of specimens follows the established procedures. You agree to perform such collections in compliance with all applicable standards and procedures for each individual specimen collection as defined by the laboratory that will be testing the specimen. The standard procedures and practices for ExamOne, a Quest Diagnostics Company are specifically included by this reference.

Acknowledgement

I have received a copy of the Exam*One* Examiners' Standards & Protocols Manual and I have read and completely understand all Protocols and Standards.

_____ _____

Examiner Date

_____

Print name