

PARAMEDICAL EXAMINER APPLICATION

Complete both sides of the form. Print or Handwrite. DO NOT TYPE. Attach additional pages if necessary.

Name: _____ <small>Last First Middle</small>	SSN: _____		
Street: _____	City: _____	St: _____	Zip: _____
Home Phone:(_____) _____	Daytime Phone:(_____) _____		
Email Address: _____			

LIST BELOW YOUR PRESENT AND PAST EMPLOYMENT: (Please list the most recent first.)

Employers Name: _____ From: _____ To: _____

Address: _____ Person to contact: _____

Job title & description of duties: _____

Employers Name: _____ From: _____ To: _____

Address: _____ Person to contact: _____

Job title & description of duties: _____

Employers Name: _____ From: _____ To: _____

Address: _____ Person to contact: _____

Job title & description of duties: _____

LIST BELOW ALL EDUCATION AND PROFESSIONAL TRAINING: (Start with high school.)

Name of School: _____ From: _____ To: _____

Address (city & state): _____

Course of study, special honors: _____ Degree, if any, and year of graduation _____

Name of School: _____ From: _____ To: _____

Address (city & state): _____

Course of study, special honors: _____ Degree, if any, and year of graduation _____

Name of School: _____ From: _____ To: _____

Address (city & state): _____

Course of study, special honors: _____ Degree, if any, and year of graduation _____

PLEASE CHECK ANY OF THE FOLLOWING WHICH APPLY TO YOU:

- | | | |
|---|---|--|
| <input type="checkbox"/> Registered Nurse | <input type="checkbox"/> Licensed Practical Nurse | <input type="checkbox"/> Emergency Technician |
| <input type="checkbox"/> Laboratory Technician | <input type="checkbox"/> Medical Secretary | <input type="checkbox"/> Physician's Assistant |
| <input type="checkbox"/> Other title (specify): _____ | | |

CONTACT, WHO HAVE OBSERVED YOUR WORK IN THE MEDICAL PROFESSION. THESE SHOULD BE SUPERVISORS OR TEACHERS, NOT CO-WORKERS

Name: _____ Phone: (_____) _____

Street: _____ City: _____ State: _____ Zip: _____

Name: _____ Phone: (_____) _____

Street: _____ City: _____ State: _____ Zip: _____

Do either you or your spouse work for an insurance company? Yes _____ No _____

Have you had any felony convictions within the last 10 years? Yes _____ No _____

(If you have had any felony convictions, please give the dates, places, and reasons for the convictions on a separate sheet and attach it to your application.)

Are you at least eighteen years of age? Yes _____ No _____

Do you have an automobile you can use? Yes _____ No _____

Have you had any moving violations in the past 3 years (if yes please list)? Yes _____ No _____

Can you draw blood? Yes _____ No _____

Approximate # of sticks you have successfully completed _____

Can you Measure a person's Blood Pressure? Yes _____ No _____

Can you record Electrocardiograms? Yes _____ No _____

If "yes", do you have an ECG machine or access to one? Yes _____ No _____

Can you read and speak the English Language well? Yes _____ No _____

Please list any languages other than English which you can read and speak well: _____

All applicants, except for registered nurses, physician's assistants, phlebotomist, emergency medical technicians and those with regular work experience drawing blood samples (specified on the other side of this application) should have a registered nurse or physician complete the following:

This is to certify that _____ as demonstrated his/her ability to perform Venipunctures.

(name of applicant)

_____ R.N. / M.D. /

D.O.

All applicants must complete the following:

I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED IN THIS APPLICATION. I UNDERSTAND THAT IF I BECOME AFFILIATED WITH INSURANCE EXAMINATIONS I WILL PERFORM AS AN INDEPENDENT CONTRACTOR, AND AS SUCH, WILL BE RESPONSIBLE FOR ALL TAXES APPLICABLE TO MY EARNINGS.

SIGNATURE: _____ DATE: _____

Please fax or email applications to:

ExamOne
Eric@ExamOneWichita.com
Fax: 316-768-4500

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.