Holsman Healthcare, LLC
Healthcare Staffing and Consulting Services
Tel: 973-393-5545 / 973-759-1494 / 877-268-9100 Fax: 973-759-0557

Application & Employment Checklist

In order for your recruiter to submit your profile to a client facility, the following items must be complete and on file prior to the submittal:

- **Signed Application (3 total pages)**
- **Two recent letters of reference or 2 completed reference release forms**
- **Skills checklist appropriate for unit of submittal**
- **Copies of current nursing licenses**
  - **You must provide a copy of your home state (state of permanent residence) license.**
  - **You must provide a copy of your license for the state in which you have been accepted for work. In an instance of walk-through or new licensure, you must provide a copy of work state licensure prior to your assignment start date.**
- **Copies of current certifications**
  - **All candidates must provide a copy of a current valid BLS certification.**
  - **You must provide copies of all other certifications (i.e., ACLS, PALS, NRP, TNCC, ENPC) as required by the facility and/or unit.**
  - **Letters of participation or certificates of completion will only be accepted for certification documentation for one month after completion. Upon receipt of a wallet card, you must provide a copy for your personnel file.**
- **Disclosure & Release form**
- **Health Information Privacy & Consent Confidentiality Statement**

Once accepted for a position, you must complete and return the following items for your personnel file **prior** to any request for travel and/or housing arrangements. Your recruiter will fax, e-mail, or overnight mail all required forms to you upon acceptance.

- **Signed assignment agreement**
- **Current physician's statement within the past year that includes physician's signature and contact phone number.**
- **Current tuberculosis screening**
  - **If using PPD to meet this requirement, you must provide documentation of placement and reading current within the past year with signatures.**
  - **If using a chest x-ray to meet this requirement, you must provide documentation of chest x-ray which includes statement that the test was done as tuberculosis screening. Additionally, you must complete the TB Screening Questionnaire form.**
- **Proof of immunity for Measles, Mumps, and Rubella**
  - **If using MMR or MR vaccination to meet this requirement, you must provide documentation of the vaccination that includes complete dates (month, date, and**

year) of immunization. For anyone born after 1957, the record MUST include documentation of two injections to meet this requirement.

- **If using titers to meet this requirement, you must provide copies of the lab results showing a numerical reading to prove immunity.**
- **Immunity by history is not acceptable in proving immunity to Rubella, Rubeola or Mumps.**

- **Proof of immunity for Varicella (chicken pox)**
  - **If using Varivax vaccination to meet this requirement, you must provide documentation of the vaccination that includes complete date(s) (month, date, and year) of immunization.**
  - **If using a titer to meet this requirement, you must provide a copy of the lab results showing a numerical reading to prove immunity.**
  - **Immunity by history is not acceptable in proving immunity to Varicella.**
- **Proof of immunity for Hepatitis B or declination of vaccination series**
  - **If using the vaccination series to meet this requirement, you must provide documentation of the three-step series that includes complete dates (month, date, and year) of the three immunizations.**
  - **If using a titer to meet this requirement, you must provide a copy of the lab results showing a numerical reading to prove immunity.**
  - **If declining the immunization, you must complete, sign, and date the HBV vaccination declination form.**
- **W-4 form**
- **Notarized I-9 and copies of appropriate documentation**
- **Personnel Data form**
- **Direct Deposit Authorization form with cancelled check (if applicable)**
- **Permanent Tax Residence Notification form**
- **Job Description**
- **Handbook Acknowledgement**

Fax completed documentation to 973-759-0557*. If you have any questions about the required documentation, please contact our Quality Assurance department at 973-393-5545.*

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Application

General Information

First Name	Middle Name	Last Name		
Address		**City**	**State**	**Zip**
Email Address		**How did you hear of** Holsman Healthcare**?**		
Home Phone	**Cell Phone**	**Other Contact Number**	**Best Time to Contact**	

Employment Profile *Please check yes or no for each of the following questions.*

Can you provide proof of eligibility to work in the United States?	☐ YES	☐ NO
Have you ever been convicted of a crime that would prevent employment at a health care facility? If yes, please provide a detailed explanation on a separate sheet of paper.	☐ YES	☐ NO
Have you ever had a license or certification investigated, revoked, or suspended? If yes, please provide a detailed explanation on a separate sheet of paper.	☐ YES	☐ NO
Do you have at least one year of current experience on a hosptial floor?	☐ YES	☐ NO
Are you willing to submit to a criminal background check?	☐ YES	☐ NO
Are you willing to submit to a drug screen?	☐ YES	☐ NO
Do you have any limitations that would restrict you from performing essential functions in the position for which you are applying? If yes, please provide a detailed explanation on a separate sheet of paper.	☐ YES	☐ NO
Are your driving privileges suspended or revoked in any state? If yes, please provide a detailed explanation on a separate sheet of paper.	☐ YES	☐ NO
Can you provide proof of auto insurance for rental car usage?	☐ YES	☐ NO

Education

School / University	Location	Month / Year Graduated	Degree / Diploma Awarded

Expertise / Experience

Specialty	Years of Experience	Equipment / Procedures

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Name

Work History *List below all permanent positions (full-time & part-time), local agency, and travel assignments.*

Facility	Location	Dates Employed	Salary	
Supervisor	**Phone**	**Reason for Leaving**	☐ Full-time ☐ Part-Time ☐ Local Agency ☐ Travel (company: _________________)	

Facility	Location	Dates Employed	Salary	
Supervisor	**Phone**	**Reason for Leaving**	☐ Full-time ☐ Part-Time ☐ Local Agency ☐ Travel (company: _________________)	

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Facility	Location	Dates Employed	Salary	
Supervisor	**Phone**	**Reason for Leaving**	☐ Full-time ☐ Part-Time ☐ Local Agency ☐ Travel (company: _________________)	

Professional References

Name	Title	Facility	Contact Number

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Name

Licensure

State	License Number	Issue Date	Expiration Date

Certifications

Certification	Expiration Date	Certification	Expiration Date
GCS		OCS	
PCS		CCS	
SCS		ECS	
NCS		Other (_____)	
CHT		Other (_____)	
Other (_____)		Other (_____)	
ACLS		BLS	
Other (_____)		Other (_____)	

Application Certification

I certify that all statements made in this application are true to the best of my knowledge. I understand that any falsification or misleading information given in my application may result in the termination of my employment with Holsman Healthcare, LLC. Furthermore, I understand that my professional conduct and clinical persfromance is directly related to my ability to be placed on assignments for Holsman Healthcare and that I will adhere to all expectations set forth in the employee handbook. I authorize Holsman Healthcare to verify the information I have provided, to contact references, and to conduct a criminal background check concerning my ability, character, and past employment record.

I understand that nothing contained in this application is intended to create an employment contract, either verbal or written, with Holsman or their clients. Furthermore, I understand that in the event of my employment, it is "at will" and that Holsman Healthcare or I may terminate my employment at any time with or without notice and with or without cause.

_____ _____

Signature **Date**

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Reference Check

Applicant Name:	
Facility:	
Position & Unit:	
Dates of Employment:	
Supervisor Name & Title:	
Supervisor Phone Number:	
Date / Time of Reference Check:	
Person Conducting Reference Check:	

The applicant above has listed you as a current reference for previous employment. Please take a moment to evaluate the performance level you feel this candidate has shown in your experiences while employed under your supervision.

Holsman Healthcare requests the following information for the purpose of securing future employment for the applicant as a travel employee with our agency. If you wish this reference to remain confidential, please return the form with your signature only and check the box below for "Decline Comment". We appreciate your assistance in helping to verify the performance and skill level of our applicant. Thank you.

☐ **Declined Comment (Verify Dates of Employment Only)**

	Poor	Below Average	Satisfactory	Above Average	Excellent
Attitude					
Cooperation					
Professional Appearance					
Dependability					
Attendance & Punctuality					
Adaptability to Work Situations					
Quality of Work					
Quantity of Work					
Critical Thinking Skills					
Clinical Skills					
Prioritizing Skills					
Safety Awareness					
Comments:					
Signature of person conducting reference check				**Date of Reference check:**	

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Cooperation					
Professional Appearance					
Dependability					
Attendance & Punctuality					
Adaptability to Work Situations					
Quality of Work					
Quantity of Work					
Critical Thinking Skills					
Clinical Skills					
Prioritizing Skills					
Safety Awareness					
Comments:					
Signature of person conducting reference check				**Date of Reference check:**	

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Disclosure and Release

In connection with my application for employment (including contract for services) with Holsman Healthcare, I understand that a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment purposes will be conducted. I understand that the scope of the consumer report/investigative consumer report may include, but is not limited to, the following areas:

> Verification of social security number; current and previous residences; employment history including all personnel files; education including transcripts; character references; criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; birth records; motor vehicle records to include traffic citations and registration; and any other public records or to conduct interviews with third parties relative to my character, general reputation, personal characteristics or mode of living.

I further authorize any individual, company, firm, corporation, or public agency (including the Social Security Administration and law enforcement agencies) to divulge any and all information, verbal or written, pertaining to me to Holsman Healthcare or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources.

I hereby release Holsman Healthcare, the Social Security Administration, and its agents, officials, representatives, or assigned agencies, including officers, employees, or related personnel both individually and collectively, from any and all liability for damages of whatever kind, which may, at any time, result to me, my heirs, family, or associates because of compliance with this authorization and request to release. You may contact me as indicated below.

I hereby authorize procurement of consumer report(s)/investigative consumer report(s). I understand this authorization automatically expires 90 days from the date executed below. If hired (or contracted), this authorization shall remain on file and shall serve as ongoing authorization for Holsman to procure consumer report(s)/investigative consumer report(s) at any time during my employment (or contract) period. I understand I have the right to revoke the authorization at any time, provided I do so in writing.

Print Name: _____

Former Names & Dates Used: _____

Address: _____

City, State, Zip: _____

Date of Birth (mm/dd/yyyy): (____/____/_____)

Social Security No.: _____

Drivers License No.:_____ State: _____

Signature: _____ Date: _____

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Health Information Privacy & Consent
Confidentiality Statement

With the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), personally identifiable healthcare records came under a new and heightened level of confidentiality. In the regular course of business, Holsman interacts and communicates directly with candidates who may share their personally identifiable information. In turn, we collect, store and process the information electronically and/or manually. With the belief that it is a person's right to have their personal information kept private,Holsman conducts business with respect for and in compliance with all applicable health information privacy laws, including but not limited to HIPAA. We respect our legal obligation to implement privacy procedures and technical security measures to keep your personal information private and secure. As we are obligated to give you notice of our privacy practices, the statement of policies and protocols which follows describes how our staff may use and disclose your medical information and how you may get access to this information and relative accounting. After reviewing the information carefully, please complete, sign, and date this form, then return it via fax or mail to the addresses listed at the end of this statement.

For the purpose of this document and for employment through Holsman, your "health information" includes the following items that we request on behalf of our facility clients:

- Annual physician's statement
- Documentation used to prove immunity to measles, mumps, and rubella [laboratory titers or records of MMR injection(s)]
- Documentation used to prove immunity to varicella [laboratory titer, record of Varivax immunization, or immune by history statement]
- Documentation used to prove immunity to HBV [laboratory titer or record of HBV immunization series] or a declination statement thereof
- Annual tuberculosis screening [PPD test results or chest x-ray reading]
- Pre-employment drug screening [conducted by Holsman]

Generally, we cannot use your health information or disclose it outside of our office without your written permission. The written permission comes from your completed consent form. We ask you to sign the consent form allowing us to use and disclose your health information for purposes of submittal to client facilities, of assignment to job openings at client facilities, and continued employment through Holsman at client facilities. For example, your health information may be sent via fax or email to a client representative either for submittal consideration or to confirm placement. Facility representatives [HR managers, nursing officers, or unit managers] will review your health information to evaluate whether or not you meet their standard immunization requirements set forth for temporary staff. A Holsman representative will advise you of any necessary medical documentation for placement. Any variation from the facility standard may delay or cancel an assignment. We may refuse to place you if you do not sign the consent form. At times, client facilities may request further documentation than the above defined "health information" of a candidate's health and immunization records to comply with state or local regulations. At those instances, a Holsman representative will advise you of the requirements and request your consent for that additional information.

The law gives you many rights regarding your health information. You may request photocopies of your health information, an amendment to any incorrect or incomplete information, additional copies of this notice, or a list of the disclosures we have made of your health information. Holsman reserves the right to change this statement at any time in compliance with and as allowed by law. If we make any changes, the new policies and protocols will apply to your health information that we already have as well as to such information that we may generate or request in the future. We will send out notices of any changes via mail and post them in our office and on our website (www.holsmanhealthcare.com). If you should have any questions concerning Holsman Healthcare's privacy practices or wish to access or correct private information collected from you, please contact our HIPAA Privacy Officer via mail, phone, fax, or email:

MAIL: 710 Mill St. Unit H3 Belleville, NJ 07109
PHONE: 877-268-9100
FAX: 973-759-0557
EMAIL: richard@holsmanhealthcare.com

By my signature below, I confirm that I have read, understand, and consent to the policies and protocols regarding disclosure and transmission of information as outlined in this statement regarding my health information.

_____ _____
Signature Date

Printed Name:_____