

TO: _____

FAX: _____

UNITED MEDICAL STAFFING NETWORK (UMSN)

EDUCATION VERIFICATION & RELEASE AUTHORIZATION

The person listed below has applied with us for employment. Your confidential response will be appreciated.

Applicant: _____

SSN: _____

Last Four Digits

I understand that in the event my application is accepted for consideration of employment, I authorize an investigation of all statements contained in the application.

I also do hereby release any and all persons, companies or agencies responding to such investigation from any damage due to releasing information, whether or not it is in their records or otherwise available to them, provided it relates to my employment or other statement made in this application.

I hereby release UMSN from any and all liability for issuing this information.

Signature: _____

Date: _____

(APPLICANT)

EDUCATION

(TO BE COMPLETED BY EDUCATIONAL INSTITUTION, NOT APPLICANT)

Name of College, University or Educational Institution: _____

Location/Address: _____

Degree(s) or Certification(s) Received: _____

Date of Completion: _____

Person completing this form:

Name _____ Title _____ Date _____

Signature _____ Telephone Number: _____

Please fax to:

UNITED MEDICAL STAFFING NETWORK

A MEDSEARCH Division

Attn: Human Resources

Illinois (847) 228-0060

Ohio (440) 243-9117

www.unitedmsn.com