

UNITED MEDICAL STAFFING NETWORK

A MEDSEARCH Division

Presentation of Qualifications

(confidential)

www.unitedmsn.com

Please complete all blanks – this will enable us to represent you with complete knowledge of your needs and requirements

Date: ____/____/____

Interviewed By: _____

Position Applied For: _____

Last Name <i>(Full name as it appears on your S.S. card)</i>		First Name	Middle Initial
Street Address		City	State Zip
Home Phone	Pager # /Emergency # /Cell #	Soc. Security # Last Four Digits	
<input type="checkbox"/> Ans. Machine	<input type="checkbox"/> Voice mail	E-mail Address: _____	

Availability: Full time Part time Temporary Permanent Summer

Locations Preferred: _____

Education:	School Name	Course of study	Graduated	#Yrs Attended	GPA
High School	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	_____
Vocational/ College/Other	_____	_____	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	_____

Professional Healthcare License

License Number _____ Expiration Date _____, I, _____, do hereby attest that I have a current and valid _____ license for the state of _____.

Signature: _____ Date: ____/____/____ Witness: _____

Hepatitis B Vaccine Status ____/____/____ I have received the complete series
(Please read information provided on Hepatitis) I decline at this time

Most Recent Physical ____/____/____ Most Recent Mantoux: ____/____/____

How did you hear about UNITED MEDICAL STAFFING NETWORK? Mailing Referral _____
(who referred you)

Newspaper _____ Telephone Book/Yellow Pages Internet

Other _____ Radio Station listened to: _____

An Equal Employment Opportunity Employer

EMPLOYMENT HISTORY
(List Most Recent Employer First)

<hr/> Employer	<hr/> Job Title	<hr/> Supervisor Name/Title		
<hr/> Address	<hr/> City	<hr/> State	<hr/> Zip	<hr/> Phone
<hr/> / /	<hr/> / /	<hr/> \$	Check Reference? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<hr/> Starting Date	<hr/> Ending Date	<hr/> Ending Salary		
<hr/> Reason For Leaving				
<hr/> Specialty _____ Duties Performed _____				

<hr/> Employer	<hr/> Job Title	<hr/> Supervisor Name/Title		
<hr/> Address	<hr/> City	<hr/> State	<hr/> Zip	<hr/> Phone
<hr/> / /	<hr/> / /	<hr/> \$	Check Reference? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<hr/> Starting Date	<hr/> Ending Date	<hr/> Ending Salary		
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<hr/> / /	<hr/> / /	<hr/> \$	Check Reference? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<hr/> Starting Date	<hr/> Ending Date	<hr/> Ending Salary		
<hr/> Reason For Leaving				
<hr/> Specialty _____ Duties Performed _____				

Personal References:		
<hr/> Name	<hr/> Address	<hr/> Phone
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Valid Driver's License? YES NO Driver's License # _____ State Issued _____

Have you ever been convicted of a felony? YES NO

U.S. Citizen? YES NO

If no, are you legally permitted to work in the U.S.? YES NO

U.S. Military Veteran? YES NO Branch _____

SKILLS: Please check all items and equipment that you can use.

TYPING MACHINE/ WPM:

Electric _____ WPM

Word Processor _____ WPM

Word Processor Systems:

WordPerfect

Microsoft Word

ELCOMP

COMPUTERS:

Operator

Programmer

Data Entry _____ keystrokes

Systems:

Windows 95

Windows NT

Macintosh

TRANSCRIPTION:

Type of Machine
Specialty (Radiology, Peds, etc.)

Shorthand _____ WPM

CLERICAL:

Filing

Copiers

Calculator

Adding Machine

Other: _____

BOOKKEEPING:

Accounts Payable

Accounts Receivable

Billing

Collections

Financial Statements

General Ledger

Payroll

Pegboard Accounting

Taxes

Other: _____

MEDICAL FRONT DESK:

Medical Terminology

Specialty (I.M., Peds, OB/GYN, etc)

Switchboard _____ # lines

Receptionist

Call in Prescriptions

Order Supplies

Schedule Surgery

Schedule Appointments

Manual Computer

INSURANCE FORMS:

Properly complete forms

Precertify

Medicare

Medicaid

Private Carrier

Workers' Comp

Insurance Billing

Claims Processing

Coding (ICD9/CPT4)

Manual Computer

Electronic

Other: _____

MEDICAL ASSISTING:

Allergy Tests

Vital Signs

EKG

Injections

Type _____

Draw Blood

Youngest: _____ Oldest: _____

Finger sticks

Heel sticks

Experience with butterflies

CBC, WBC, RBC (Differential)

Sedimentation Rate

Hgb, Hct

Prothrombin Times

Throat Cultures

Urinalysis

DENTAL:

HYGIENIST:

_____ How long

_____ Specialty

EFDA:

_____ How long

_____ Specialty

DENTAL ASSISTANT:

_____ How long

X-ray certified

Panorex machine

4 handed

Sterilization

Make temporaries

DENTAL RECEPTION:

Soft dent

Easy dent

Billing

Recall

Payment Plans

SPECIALTIES:

Mam. Tech

Ultrasound Tech

X-ray Tech

Nuclear Med Tech

EEG Tech

ECHO Tech

EKG Tech

OPH Tech

Respiratory Therapy

Med Tech

P.T.

L.P.T.A.

O.T.

C.O.T.A.

Audiology

Speech

Other: _____

**AUTHORIZATION CONTRACT BETWEEN
UNITED MEDICAL STAFFING NETWORK (UMSN)**
A MEDSEARCH Division
AND APPLICANT

This will serve to confirm the filing of my application seeking employment through the services and assistance of your employment agency. I certify that all of the information supplied by me in this application is accurate and true. This information will be relied upon by UMSN as a condition of employment and I agree that if any of it is found to be false, such false information will constitute sufficient reason for my dismissal.

As a UMSN applicant, I am required to deal directly through UMSN on any position offered to me by potential employers which UMSN has introduced to me. This agreement stands in effect for six months from my last contract with said potential employer.

I understand that, subject to my compliance with UMSN policies regarding any offer of employment, I will never be charged a fee by UMSN. All fees are paid by the employer.

I acknowledge you have advised me that in connection with this application, reference verifications may be requested. I hereby authorize your obtaining such a reference verification from past employers and/or coworkers. I further understand that I have the rights to make a written request to UMSN to learn the reference information supplied by past employers and/or coworkers. I hereby release any such employer or person from any and all liability of whatever nature as the result of furnishing such information.

I understand and agree that I must contact/inquire for work with UMSN for available work upon the conclusion of each work assignment as a condition of my employment. If suitable work assignments are available with UMSN, upon conclusion of a work assignment and I fail to inquire about another work assignment, I may not be eligible for unemployment benefits. (ORC 4141.29)(A)(5)).

I acknowledge that I have read and understand this statement. My signature serves as authorization to request such information from previous employers and/or coworkers; and also confirms I understand my responsibility as a UMSN applicant.

Applicant's Signature

Date

**---DO NOT WRITE IN THIS SPACE---
---FOR OFFICE USE ONLY---**

Availability

Reason for leaving most recent position

Salary requirements

Ideal position

Applications submitted

Additional Information

Notes