



HEALTH CARE RECRUITERS

APPLICATION

INSTRUCTIONS:

- Attach a current resume to complete application that covers all periods of time, from undergraduate school to present. Indicate month and year.
- Provide a thorough explanation for every malpractice claim, suit, or incident you have EVER experienced. At minimum, this must include information on type of care, procedure, major allegations, and other pertinent information, such as the name and location of court, names of parties involved, and a brief description of the nature of the claim.

IDENTIFYING INFORMATION	Last Name		First Name		Middle Name		Previous Surname	
	Profession	List every state you currently are licensed State: _____ Licensed # _____ Exp. Date: _____					Social Security Number	
	Cell Phone		Pager		Home Phone		Work Phone	
	Emergency Contact				Relationship to Applicant		Phone	
	Address							
MAILING ADDRESS	Street				Email			
	City			State		Zip Code		
OTHER ADDRESS	Street				Email			
	City			State		Zip Code	Other Phone	
AVAILABILITY & PREFERENCES	How many weeks per year would you like to work with UNI?				When can you start? <input type="checkbox"/> Part time <input type="checkbox"/> Full time <input type="checkbox"/> Per diem			
	What kind of work setting(s) do you prefer?		What shifts can you work?		How many shifts per week?			
	Clinical area of expertise		What age groups can you work with, if applicable?					
	What location(s) would you prefer?		Where did you hear about UNI?					
ACTIONS/ SANCTIONS	Have any of the following been, or are any currently in the process of being, investigated, denied, revoked, suspended, reduced, limited, placed on probation, terminated, or placed under other disciplinary action? If yes, please provide a full explanation on a separate sheet.							
	(a) Professional license in any state		<input type="checkbox"/> Yes <input type="checkbox"/> No		(g) Training program		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	(b) Membership and/or employment		<input type="checkbox"/> Yes <input type="checkbox"/> No		(h) Professional society membership		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	(c) Clinical privileges/other rights		<input type="checkbox"/> Yes <input type="checkbox"/> No		(i) Professional position		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	(d) Rights on any hospital staff		<input type="checkbox"/> Yes <input type="checkbox"/> No		(j) Other type of professional sanction		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	(e) Other institutional affiliation or status		<input type="checkbox"/> Yes <input type="checkbox"/> No		(k) Participation in any private, state, or federal health insurance program (e.g. Medicare, Medicaid)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	(f) Academic appointment		<input type="checkbox"/> Yes <input type="checkbox"/> No					
	Have you ever been employed where your employment was terminated by the employer?							<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever been convicted of, or pleaded guilty or no contest to, a criminal felony or misdemeanor, or are you currently under indictment for any alleged criminal activities?							<input type="checkbox"/> Yes <input type="checkbox"/> No
	Driving under the influence is not considered a minor traffic violation. Exceptions due to state employment law: Conviction(s) that have been sealed, expunged, or eradicated and California Health and Safety Code #111357 (b) & (c), 11360 (c), convictions over 2 years old, should not be revealed.							
Are you currently engaged in any illegal drug activity?							<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever been the object of an administrative, civil, or criminal investigation regarding sexual misconduct?							<input type="checkbox"/> Yes <input type="checkbox"/> No	

I affirm that all information given on this page is true and accurate. Initial _____ Date _____

I understand and agree that once employed by UNI, I will not become employed by any UNI client where I have been assigned for a period of three-hundred-sixty-five (365) days following the last date of assignment by UNI.

By signing below, you acknowledge that UNI has made a substantial investment in the recruitment, screening, and training of its employees and UNI incurs a significant administrative and marketing expense in connection with the placement of its employees. In consideration thereof, you agree not to seek or engage in employment with any UNI client where you have been assigned. You agree not to accept employment with UNI clients on a direct or indirect basis or through any other entity of employment for a period of three-hundred-sixty-five (365) days following your last date of assignment through UNI.

If you seek employment on a direct or indirect basis (i.e. by being hired on the client's payroll) prior to the end of the three-hundred-sixty-five day waiting period you agree to immediately advise UNI and comply with the following terms:

- You agree to pay a direct placement fee to UNI of twenty-five percent (25%) of your annual salary. Your placement fee is due to UNI upon your first day of assignment with any UNI client.
- A ten percent (10%) late fee will be assessed after ten (10) days for non-payment of the placement fee. Interest will be assessed on the 11th day and shall accrue at a rate of 1.5% per month or 18% APR.
- If either party to this Agreement institutes any legal action or proceeding against the other party arising out of the Agreement, the prevailing party shall be entitled to recover its reasonable attorney's fees and costs from the non-prevailing party.

• **ARBITRATION**

Any controversy or claim arising out of or relating to this Agreement, or the performance or breach thereof, shall be settled by means of binding arbitration in accordance with the rules of the American Arbitration Association in the State of California.

I have read, agree, and understand the above.

Print Name

Signature

Date

PROFESSIONAL REFERENCES <i>Please list 4 professional references with whom you have had clinical contact within the last 2 years. (At least 2 of these should be within your specialty). They should be able to assess your professional skills and capabilities.</i>	Name	Hospital/Institution	Phone
	Name	Hospital/Institution	Phone
	Name	Hospital/Institution	Phone
	Name	Hospital/Institution	Phone

PROFESSIONAL LIABILITIES

Have malpractice claims, lawsuits, settlements, or judgements been made against you in the past? Yes (if yes, how many? _____) No

Are any pending? Yes No

Has your malpractice insurance coverage ever been denied, limited, or cancelled? Yes No

Has a professional liability insurance carrier ever excluded any specific procedures from your insurance coverage? Yes No

If you answered "Yes" to any of the above, please provide details on a separate sheet.

Do you have your own professional liability insurance coverage? Yes No *If yes, please list name of carrier and amounts of coverage:*

RELEASE & AUTHORIZATION

I hereby affirm that the information I have provided on this application and attachments are true and correct and that it can be relied upon by UNI for evaluating my potential as a health care provider:

I hereby authorize UNI, its affiliates and successors, to obtain any information that may be relevant to an evaluation of my professional qualifications, including information pertaining to disciplinary actions, criminal background and history, or other confidential or privileged information, and other credentials.

I authorized UNI to disclose current, prior, or potential employers making a reasonable inquiry, information relating to my qualification, ability and character. Only to the extent requested and required by the practices, facilities, groups and hospitals staffed by UNI where I will be providing clinical services, I agree to provide and authorize the release of the same by UNI to UNI clients, the following: a) vaccination records, b) reasonable documentation evidencing that I am in good health and free of communicable diseases, c) the result of and/or a copy of any criminal background check, if any, and d) the result of and/or a copy of my drug screen, if any.

I hereby release UNI its officers, employees, and agents, and third parties which provide or receive information regarding my credentials, including, but not limited to, all credentialing information sources, individuals or companies who provide references, companies or agencies that perform criminal background checks, and companies that perform drug screens from any claims, causes of action, damages and expenses, including reasonable attorney's fees arising from or relating to the collection, verification, and dissemination of any credentialing and other information.

I agree to hold UNI harmless from and against any and all claims, causes of action, damages, judgements and expenses, including reasonable attorney's fees, arising from or related to the accuracy of the information provided by me. I understand that this does not contemplate a duty to hold UNI harmless from claims, causes of action and damages which may arise as a result of information provided about me from sources other than myself.

This is a continuing authorization and shall be effective from the date of signature below until such time as I have specifically revoked the same in writing.

If any material changes occur affecting my professional status, it is my obligation to notify UNI or the appropriate affiliate or successor as soon as possible. I understand that the decision to employ me or refer me to practice opportunities is solely at the discretion of UNI.

I understand that any information received from references by UNI is confidential and may not be released to me without the consent of the references. I understand, agree and acknowledge that references are not part of my personnel file.

A copy or facsimile of this document shall have the same effect as the original.

Name: _____

I affirm that all information given on this page is true and accurate. Initial _____ Date _____

HOW DID YOU HEAR ABOUT OUR REGISTRY?

Professional Journal _____ Which one Newspaper _____ Which one Job Fair _____ Where Friend _____ Name

Yellow Pages Mail Employee _____ Name Other _____ Be Specific

THIS COMPANY IS AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

As an Equal Opportunity/Affirmative Action Employer, UNI, does not discriminate in employment on the basis of Age, Gender, Race, Color, Religion, National Origin, Disability, Veteran Status or any other classifications protected by Local State, and Federal Laws. Please omit any references to organizations or activities that would indicate Race, Religion, Age, Gender, Sexual Orientation, National Origin or Ancestry, Disability, or Political Persuasion.

EDUCATION/ TRAINING	School Name or Institution		Degree/Certificate		Honors
	City	State	Telephone	Dates attended (mm/yy-mm/yy)	Date of Graduation (mm/yy)
	School Name or Institution		Degree/Certificate		Honors
	City	State	Telephone	Dates attended (mm/yy-mm/yy)	Date of Graduation (mm/yy)
	<input type="checkbox"/> MAB CERT. expires:	<input type="checkbox"/> FETAL MOR CRT. expires:	<input type="checkbox"/> OCRN CHEMO. expires:	<input type="checkbox"/> BLS expires:	<input type="checkbox"/> ACLS expires:

PALS expires: Other: expires:

List other courses/certificates

WORK EXPERIENCE	Name of Hospital/Company		Name & Title of Immediate Supervisor		
	Address:				
	Position held/Job Description	Dates (mm/yy-mm/yy)	Starting Salary	Ending Salary	
	Was this a <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Registry Travel <input type="checkbox"/> Salary Position				
	If the above employer is an employment agency, please list the facilities you have worked, Department name and supervisor contact:				
	Name of Hospital/Company		Name & Title of Immediate Supervisor		
	Address:				
	Position Held/Job Description	Dates (mm/yy-mm/yy)	Starting Salary	Ending Salary	
	Was this a <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Registry Travel <input type="checkbox"/> Salary Position				
	If the above employer is an employment agency, please list the facilities you have worked, Department name and supervisor contact:				
	Name of Hospital/Company		Name & Title of Immediate Supervisor		
	Address:				
	Position Held/Job Description	Dates (mm/yy-mm/yy)	Starting Salary	Ending Salary	
	Was this a <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Registry Travel <input type="checkbox"/> Salary Position				
	If the above employer is an employment agency, please list the facilities you have worked, Department name and supervisor contact:				
Name of Hospital/Company		Name & Title of Immediate Supervisor			
Address:					
Position Held/Job Description	Dates (mm/yy-mm/yy)	Starting Salary	Ending Salary		
Was this a <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Registry Travel <input type="checkbox"/> Salary Position					
If the above employer is an employment agency, please list the facilities you have worked, Department name and supervisor contact:					

MILITARY SERVICE	Branch	Dates of Service (mm/yy-mm/yy)	<input type="checkbox"/> Discharge Status: Honorable <input type="checkbox"/> Dishonorable
	<input type="checkbox"/> Other (please specify)		

I affirm that all information given on this page is true and accurate. Initial _____ Date _____