



Alpha Omega Allied Healthcare, Inc.

Thank you for your interest in becoming an Independent Contractor with Alpha Omega Allied Healthcare, Inc. (AOAH). Attached is our credentialing application. We must have a completed application on file in order to place you on a temporary assignment, or in a permanent location. Our ultimate goal is to streamline the staffing process, which includes credentialing. Please read the instructions below for completing Alpha Omega Allied Healthcare's application.

Instructions:

- Please fill out the application completely. List the facility and/or the hospital group (not the agency, even if it was an agency placement). If you are a full-time locum, we need a complete 5 (five)-year work history. **DO NOT WRITE, "SEE CV" ON THE APPLICATION.**

- **Required Documentation**
 - Copies of all state licenses/certifications
 - Nursing School/Technical School Certificate
 - Copy of Continuing Education Units (CEUs/CMEs) – last two years (if applicable)
 - Copy of ACLS/BCLS/PALS card(s)
 - Curriculum Vitae (CV)/Resume'
 - Passport Photograph (1) or you may take a photo in our offices
 - Copy of Drivers License
 - Copy of TB test (current within last year)
 - Copy of Hep. B
 - Copy of Varicella
 - Signed ESS Form
 - Signed W-9 (no taxes taken out) OR signed W-4 (taxes taken out)
 - Signed Reference Form (this gives us permission to check your references, printout 4)

Alpha Omega Allied Healthcare, Inc. credentials every application received in our office. A completed file helps to expedite the credentialing process at the facility. Your cooperation with our credentialing process is appreciated.

If you have any questions concerning the application, please give us a call at 817-886-3041 or email me at danaybrooks@alliedhealthcare.org. Thanks again for your interest in becoming an Independent Contractor with Alpha Omega Allied Healthcare, Inc., we look forward to working with you

AOAH

Alpha Omega Allied Healthcare, Inc.

Allied Health Professional Application PERSONAL INFORMATION

Date _____ Social Security Number _____

Name _____
Last First Middle Maiden

Present Address _____
Street City State Zip

Permanent Address _____
Street City State Zip

Phone Number: () _____ Cell Phone: () _____

Pager Number: () _____ E-Mail _____

U.S. Citizen: Yes ___ No ___ Place of Birth: _____

Sex: M ___ F ___ Date of Birth (mm/dd/year) _____ Height: _____ Weight: _____

The Name and Phone Number of Someone Who Will Always Be Able to Reach You:

Name _____ Relationship: _____ Phone _____

Permanent Placement _____ Short Term Assignments _____ Date Available _____

Geographical Preference 1. _____ 2. _____ 3. _____

Are You Currently Employed? _____ If So, May We Contact Your Present Employer? _____

Have You Ever Applied To Us Before? _____ When? _____

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PROFESSIONAL INFORMATION: Please answer each of the following questions either “Yes” or “No”. DO NOT LEAVE ANY QUESTIONS UNANSWERED. Provide documentation/additional information for every “Yes” answer (i.e., elaboration and details of all malpractice claim history, elaboration and details of any sanction activity, details and circumstances of denials, etc. Use an extra sheet of paper if needed).

- | | | | |
|-----|---|-----|----|
| 1. | Has your license, registration or certification to practice in this state or any other state or region ever been denied, restricted, limited, suspended or revoked; have you ever been reprimanded by any state licensing agency; or, are any of these actions pending with respect to your license, registration or certification? | YES | NO |
| 2. | Have your hospital or surgical facility privileges ever been revoked, suspended, limited, reduced, non-renewed; have disciplinary proceedings ever been instituted against you by a hospital or surgical facility; or, are any of these actions now pending with respect to your hospital or surgical facility privileges? | YES | NO |
| 3. | Have you ever voluntarily relinquished hospital or surgical facility privileges, academic appointments, professional associations, memberships or any other professional status for any reason? | YES | NO |
| 4. | Have any complaints ever been filed against you with a Medical or other Professional Society? | YES | NO |
| 5. | Are you now or have you ever been involved in any malpractice action(s), including litigation, arbitration or mediation, regardless of the method or amount of the outcome that resulted; or, have you ever received any notice of any claim or complaint against you? | YES | NO |
| 6. | Have any insurers cancelled coverage, declined coverage, refused renewal or renewal under restrictive circumstances for your Professional Liability Coverage? | YES | NO |
| 7. | Have you ever been convicted of a felony or crime other than a traffic violation? | YES | NO |
| 8. | Has your professional liability insurance ever been cancelled, non-renewed or have you ever been denied professional liability insurance? | YES | NO |
| 9. | Have you ever been prosecuted for, convicted of, or charged with a felony or misdemeanor, excluding minor traffic violations but, including driving while intoxicated or under the influence (please include information related to any deferred adjudication, deferred prosecution or plea of <i>nolo contendere</i>)? | YES | NO |
| 10. | Have you ever practiced or worked as an allied health professional in a different geographic area other than the one in which you are now practicing (other than during training, as noted in the Education Section)? | YES | NO |
| 11. | Have you ever been the subject of an administrative, civil or criminal complaint or investigation involving sexual misconduct or child abuse? | YES | NO |
| 12. | Have you ever been required to obtain additional education or training as a result of peer review or quality assurance activities? | YES | NO |

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PROFESSIONAL INFORMATION (cont'd):

13. Have you ever been sanctioned or disciplined by a Professional Review Organization or by a Utilization and Quality Control Peer Review Organization? YES NO

Please elaborate/give details on all "Yes" answers given in the Professional Information section above: _____

PROFESSIONAL LICENSE/CERTIFICATION INFORMATION: Please provide a current copy of **ALL** professional licenses/certifications that you currently maintain (as well as copies of all current out-of-state professional certifications).

1. State of License _____ # _____ Expiration Date _____
2. State of License _____ # _____ Expiration Date _____
3. State of License _____ # _____ Expiration Date _____
4. State of License _____ # _____ Expiration Date _____
5. State of License _____ # _____ Expiration Date _____
6. State of License _____ # _____ Expiration Date _____

Please list any other state licensures with the name of the state, license number and expiration dates on a separate Sheet of paper.

List Any License Pending _____

BCLS Certification Expiration Date: _____ ACLS Certification Expiration Date: _____

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PROFESSIONAL LIABILITY INFORMATION: Please list your current and previous professional liability/malpractice carrier information, to include all carriers over the past ten (10) years. Provide a current copy of your Professional Liability Policy Facesheet.

Current Malpractice Carrier: _____

Address: _____

Phone Number: () _____

Policy Number: _____ Issue Date: _____ Exp. Date : _____

Per Occurrence Amount: _____ Aggregate Amount: _____

Previous Malpractice Carrier: _____

Address: _____

Phone Number: () _____

Policy Number: _____ Issue Date: _____ Exp. Date: _____

Per Occurrence Amount: _____ Aggregate Amount: _____

EDUCATION

Name and Location of School	Dates Attended	Diplomas, Degrees Received
High School _____		
Address _____		
Phone () _____		

Name and Location of School	Dates Attended	Diplomas, Degrees Received
Nursing School _____		
Address _____		
Phone () _____		

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EDUCATION (cont'd)

Name and Location of School	Dates Attended	Diplomas, Degrees Received
LVN School/Program _____		
Address _____		
Phone () _____		

Name and Location of School	Dates Attended	Diplomas, Degrees Received
Surgical Technology School/Program _____		
Address _____		
Phone () _____		

Name and Location of School	Dates Attended	Diplomas, Degrees Received
College or Graduate School _____		
Address _____		
Phone () _____		

Name and Location of School	Dates Attended	Diplomas, Degrees Received
College or Graduate School _____		
Address _____		
Phone () _____		

Name and Location of School	Dates Attended	Diplomas, Degrees Received
College or Graduate School _____		
Address _____		
Phone () _____		

What month and year did you pass nursing boards? _____ State of original licensure _____

What month and year did you complete your surgical technologist program? _____

Are you a Certified Surgical Technologist? YES or NO If Yes, month and year you passed the exam _____

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WORK HISTORY List all work beginning with most recent. If working through an agency, please indicate the specific hospital in which you were working, as well as, the name of the agency.

1. Name of Hospital or Agency _____
Address: _____
Supervisor Name and Title: _____ Phone () _____
Employed From: _____ To: _____ Position Held: _____
Reason for Leaving: _____
2. Name of Hospital or Agency: _____
Address: _____
Supervisor Name and Title: _____ Phone () _____
Employed From: _____ To: _____ Position Held: _____
Reason for Leaving: _____
3. Name of Hospital or Agency: _____
Address: _____
Supervisor Name and Title: _____ Phone () _____
Employed From: _____ To: _____ Position Held: _____
Reason for Leaving: _____
4. Name of Hospital or Agency: _____
Address: _____
Supervisor Name and Title: _____ Phone () _____
Employed From: _____ To: _____ Position Held: _____
Reason for Leaving: _____
5. Name of Hospital or Agency: _____
Address: _____
Supervisor Name and Title: _____ Phone () _____
Employed From: _____ To: _____ Position Held: _____
Reason for Leaving: _____
6. Name of Hospital or Agency: _____
Address: _____
Supervisor Name and Title: _____ Phone () _____
Employed From: _____ To: _____ Position Held: _____
Reason for Leaving: _____

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HEALTH STATEMENT:

- | | | |
|--|-----|----|
| 1. Do you presently have any mental or physical condition, illness or injury (including use of or dependency on any chemical substance or alcohol), which may limit or hinder your performance in the position for which you are applying? | YES | NO |
| 2. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you? | YES | NO |
| 3. Are you currently engaged in illegal use of controlled dangerous substances? | YES | NO |
| 4. Have you received treatment or been advised to receive treatment for alcohol or other substance dependency? | YES | NO |
| 5. Are you currently taking any medications that may affect either your clinical judgment or motor skills? | YES | NO |
| 6. Do you have any allergies to food or drugs: | YES | NO |
| 7. Have you ever been hospitalized for treatment of drugs, alcohol, or psychological condition? | YES | NO |

Please elaborate/give detail on all "Yes" answers given in the Health Statement Section above:

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PROFESSIONAL REFERENCES:

Name	Address	Occupation	Years Acquainted	Phone Number
1.				
2.				
3.				
4.				

In Case of Emergency Notify:

Name Relationship

Address: _____

City State Zip

Phone Number: () _____

These facts set forth in this application for seeking a position are true and complete. I understand that if utilized, false statements on this application shall be considered sufficient cause for non-utilization. Alpha Omega Allied Healthcare, Inc. is hereby authorized to make any investigations of my personal and professional history through any agency or bureau necessary. You are also authorized to investigate my ability, work records or character through inquiries to the individual and employers mentioned in this application. I hereby release you and the person to whom inquiry is made from any and all claims and liability growing out of such inquiries.

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REGISTERED NURSE (RN)

SKILLS CHECKLIST

RN NAME: _____ DATE: _____

SKILLS	TRAINED	PROFICIENT
General Surgery		
GYN		
Orthopedics		
Neuro		
Pediatrics		
OB		
Hearts		
Bariatrics		
Plastic Surgery		
Neuro		
ENT		
Vascular		
Operating Room		
ACLS		
BCLS		
Other		

Name particular skill in which you specialize _____

Do you feel comfortable with solo positions: _____

Comments: _____

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ICU/STEP DOWN RN SKILLS CHECKLIST

RN NAME: _____ DATE: _____

SKILLS	TRAINED	PROFICIENT
Telemetry		
ICU Monitors		
Arterial Lines		
Arterial Blood Draws		
Central Line Mgmt		
Swan Ganz monitoring/mgmt		
Endotracheal Tubes		
Suctioning		
Tracheostomy Mgmt		
Ventilator Mgmt		
Drsg Changes		
IV start/Mgmt		
ACLS		
BCLS		
PALS		
Other		

Name particular skill in which you specialize _____

Do you feel comfortable with solo positions: _____

Comments: _____

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LICENSED VOCATIONAL NURSE (LVN)

SKILLS CHECKLIST

LVN NAME: _____ DATE: _____

SKILLS	TRAINED	PROFICIENT
General Surgery		
GYN		
Orthopedics		
Neuro		
Pediatrics		
OB		
Hearts		
Bariatrics		
Plastic Surgery		
Neuro		
ENT		
ACLS		
BCLS		
PALS		
Other		

Name particular skill in which you specialize _____

Do you feel comfortable with solo positions: _____

Comments: _____

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CERTIFIED SURGICAL TECHNOLOGIST (CST)

OPERATING ROOM TECHNOLOGIST

SKILLS CHECKLIST

CST NAME: _____ DATE: _____

SKILLS	TRAINED	PROFICIENT
General Surgery		
GYN		
Orthopedics		
Neuro		
Pediatrics		
OB		
Hearts		
Bariatrics		
Plastic Surgery		
Neuro		
ENT		
Vascular		
ACLS		
BCLS		
PALS		
Other		

Name particular skill in which you specialize _____

Do you feel comfortable with solo positions: _____

Comments: _____

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DISCLOSURE FOR INDEPENDENT CONTRACTORS

I hereby acknowledge that I am an independent contractor and that as such I am totally responsible for, including but not limited to, federal, state and city taxes, social security, unemployment, disability insurance and workman's compensation.

I further acknowledge that I am not an employee or agent of Alpha Omega Allied Healthcare, Inc. (hereinafter referred to as AOAH). I indemnify and hold harmless AOAH, its agents and employees from all claims for damages or injuries or other actions or occurrences incurred by the hospitals or groups in which I am placed. I indemnify and hold harmless AOAH, their employees, patrons, patients, visitors or any other person for any claims which they may have due to my being placed with a hospital or group.

Independent Contractor

Date

PLEASE READ THE INSTRUCTION PAGE BEFORE FILLING OUT THIS APPLICATION. THE COMPLETED APPLICATION MUST BE RETURNED TO ALPHA OMEGA ALLIED HEALTHCARE, INC., WITH THE REQUESTED DOCUMENTATION BY _____

If more room is needed, please attach a separate sheet of paper.

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Alpha Omega Allied Healthcare, Inc._____

Applicant's Attestation

I, _____, Certify that the information
(Please Print Full Name)

I have provided and the statements I have made on this application are correct, true, and complete to the best of my knowledge. I will abide by the applicable bylaws, rules and regulations, and policies and procedures of all the healthcare entities I am assigned to work.

Signature

Date



Alpha Omega Allied Healthcare, Inc.

REFERENCE LETTER

TO: _____ TITLE: _____ TELEPHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

The following named individual has applied to Alpha Omega Allied Healthcare, Inc., as an Independent Contractor and has submitted your name for reference purposes. The serious nature of our responsibility to our client institutions and their patients is such that any consideration of the individual is dependent upon receipt of satisfactory references. We would therefore, appreciate your cooperation in replying to the questions listed below. All responses will be kept confidential. Thank you in advance for your cooperation.

APPLICANT'S NAME: _____
EMPLOYMENT DATES: From: _____ to: _____

PERSONAL EVALUATION	ABOVE AVERAGE	SATISFACTORY	BELOW AVERAGE
Attendance			
Punctuality			
Appearance			
Rapport with physicians, co-workers, and patients			
Knowledge and ability to apply sound and safe			
Attitude			
Physical assessment and management of patients with increased risk			
Technical skills			
Functions in emergency situations			
Administrative and teaching ability			
Seeks consultation when necessary			
Overall professional competence			

Did individual resign or was he/she terminated? _____ Reason for leaving: _____

Is individual eligible for re-hire with your facility? _____ Any questionable problems? (drugs, alcohol, psychiatric, etc.) (please specify): _____

ADDITIONAL COMMENTS: _____

Signature Title Date

I hereby authorize you to fulfill this request for information and authorize Alpha Omega Allied Healthcare, Inc., to make any investigation of my personal or professional history through any agency or bureau necessary. You are authorized to investigate my ability, employment records and/or character through inquiries to the individuals mentioned in this reference letter and I hereby release AOA and the person to whom this inquiry is made from any and all claims and liability growing out of such inquiries.

Signature of Applicant _____ Date _____



A Hire Rate of Success

Investigation Consent Form and Receipt of Summary of FCRA Rights

FAX: 888-454-7679 or 205-380-7548

I understand and acknowledge that an investigative consumer report may be obtained for employment purposes. I authorize the company I have made application with, or its designated agent, to conduct pre-employment or other employment related inquiries after I am hired (to the extent allowed by law) and authorize any past or present employer, or other business, governmental agency or individual contacted to supply the requested information and documents concerning me and to provide full and complete disclosure. I understand that all pre-employment screening activities are conducted in compliance with ADA, EEOC and the Fair Credit Reporting Act (FCRA) requirements. I release from liability the company I have made application with, and its representatives for gathering and using such information. I fully release the person or entity providing the information of any right or claim of confidentiality concerning disclosure of the information requested below or any and all claims, actions, or causes of action which may arise as a consequence of the release of such information as may be requested concerning: (1) Complete background reference and work history checks; (2) Criminal and civil litigation history information or any other public records (such as driving records, liens, judgments, and sex offender status); (3) Credit reports, academic achievement, professional licensure, bankruptcy filings; (4) Previous incidents of alleged sexual or racial harassment; (5) Previous incidents of violent behavior and/or suspected dishonest acts; (6) Results of previous drug testing within the past two years if positive for illegal substances; (7) Eligibility for rehire and circumstances of previous separations from employment; (8) Social Security Number verification; and (9) information concerning any or all worker's compensation claims if a conditional offer of employment has been made. I request that any law enforcement agency, institution, information service bureau, school, employer, reference, or insurance company contacted pursuant to this investigation consent form cooperate fully and completely in responding to the inquiries. By my signature below, I acknowledge that I have received a Summary of my Rights under the Fair Credit Reporting Act (FCRA).

Signature

Date

APPLICANT INFORMATION:

Form with fields for Last Name, First Name, Middle Initial, Maiden Name, Home Address, City, State, Zip Code, Former Address, City, State, Zip Code, Social Security Number, Date of Birth, Drivers License Number, State License Issued.

EMPLOYER INFORMATION:

Form with fields for Contact Name (Dana Brooks), Client Name (Alpha Omega Allied Healthcare, Inc), Client ID (400613), Phone Number (817-886-3041), Fax Number (866-842-4031).

SERVICES ORDERED:

Form with checkboxes for Criminal History, National Crim Search, Motor Vehicle Report, Education Verification, Employment Verification, Trace/SSN Check, Reference Verification, State Sex Offender Search, National Sex Offender Search, Professional License Check, OIG Check (Med. Fraud), Peer Credit Report, Drug Screening, OFAC Report, Search AKA's.

RETURN RESULTS BY:

Form with checkboxes for Fax Only, Mail, Web Site, Call Before Fax, Email.