Employment Verification Form

I,_____(Print Name) Voluntarily and knowingly authorize ALPHA CARE INC. to contact the following employers listed in the "Company" box below to give records or information they may have concerning my present or prior employment (including character, earnings, history and reason for termination) and any other information requested by ALPHA CARE INC to determine my eligibility for employment.

Candidate - please complete the highlighted areas only below.

Signed:_____ Date: _____

Company: (Print current or prior employer name here)	**Company:** (Print prior employer name here)	**Company:** (Print prior employer name here)
Phone:	**Phone:**	**Phone:**
Position Held:	**Position Held:**	**Position Held:**
Dates of Employment:	**Dates of Employment:**	**Dates of Employment:**
Attendance: Good Fair Poor	**Attendance:** Good Fair Poor	**Attendance:** Good Fair Poor
Eligible for Re-hire: Yes No	**Eligible for Re-hire:** Yes No	**Eligible for Re-hire:** Yes No
Contact /Title:	**Contact /Title:**	**Contact /Title:**
Info Verified by:	**Info Verified by:**	**Info Verified by:**

Work Experience Checklist

Nursing Specialty			Dates of Experience (mm/YYYY) i.e. 01/2020 – 12/2021
Computer Charting	Yes	No	
Adult ICU	Yes	No	
Neuro ICU	Yes	No	
CVICU	Yes	No	
Dialysis	Yes	No	
ER	Yes	No	
Tele Med	Yes	No	
Tele Cardiac	Yes	No	
Med/Surg	Yes	No	
Rehab	Yes	No	
Psych	Yes	No	
Burn Unit	Yes	No	
OR	Yes	No	
Oncology	Yes	No	
PICU	Yes	No	
NICU	Yes	No	
Pediatrics	Yes	No	
Psych Peds	Yes	No	
OB	Yes	No	
Nursery	Yes	No	
L&D	Yes	No	
Level II Nursery	Yes	No	
Ventilators	Yes	No	
Balloon Pumps	Yes	No	
PACU	Yes	No	
Hospice	Yes	No	
Epidurals	Yes	No	
LTC	Yes	No	
Private Duty	Yes	No	
Home Health	Yes	No	
H/H Infusion	Yes	No	
Intermittent Skill Visit	Yes ☐	No ☐	☐ ☐

Recognition of EKG Arrhythmias Yes No	Use of Emergency Equipment Yes No
Blood Glucose Monitor Type: AccuCheck	OSHA TB Fit Mask Type: 3M N95

Employee Signature:_____Date: _____

Reference Inquiry Form

To: _____

I have applied for employment at ALPHA CARE INC, and I, _____ (Print Name) authorize you to release all information requested below by ALPHA CARE INC, including information concerning my character, habits, abilities, and reason(s) for leaving your company. The following information may help in identifying my records:

Name:		Social Security Number:	
Position:		Dates of Employment:	
Applicant's Signature:			

	Excellent	**Good**	**Standard**	**Fair**	**Poor**
Job Performance	(	(	(	(	(
Attendance	(	(	(	(	(
Quality of Work	(	(	(	(	(
Ability to Work with Others	(	(	(	(	(
Comments:					
Signature of person completing this Form:				Date:	

Reference Inquiry Form

To: _____

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	Excellent	**Good**	**Standard**	**Fair**	**Poor**
Job Performance	(	(	(	(	(
Attendance	(	(	(	(	(
Quality of Work	(	(	(	(	(
Ability to Work with Others	(	(	(	(	(
Comments:					
Signature of person completing this Form:				Date:	

Medical Release

_____

Applicant Name Position

Based on qualifications presented on your application form and/or in your job interview, you are hereby, offered a job with our organization conditional upon

submitting to our standard medical review and the verification of your answers to the following questions. Your job offer cannot and will not be rescinded unless a medical review reveals that you cannot perform the essential functions of the job (with accommodations if requested), or you present a hazard to yourself or others. False or misleading statements are also grounds for rescinding this offer. This form must be accurate and complete for us to process. This information is considered personal and medical in nature and will be treated as such by handling it confidentially in strict compliance with the American with Disabilities Act.

PHYSICIAN'S STATEMENT

I have examined the individual named above, and to the best of my knowledge, he/she is in good physical and mental health, free of any communicable diseases, and is able to perform in his/her profession at full capacity.

Comments:

Signature of Physician:_____Date: _____

Printed Name of Physician: _____