



SOUTHERN CRESCENT PERSONNEL

REGISTRATION GUIDE

- A clean copy of resume
- Fill out an application and return –4 pages
- I-9 form
- 2 copies of government issued ID- see list of acceptable documents
- Proof of American Citizenship- **see list of acceptable documents. Must have a certified copy or original**
- W-4 tax form
- State tax form (if applicable)
- Direct Deposit form
- Background Release form
- Form fire completed-see directions-Please go on line and complete this as if you are enrolling, regardless if you will need benefits. (We are currently trying to get rates for insurance programs and need this as a census.) Filling out this form does not mean you are accepting any form of insurance.
- Confidentiality agreement
- 2 letters of recommendation- see personal qualifications sheet for reference, must be current within last year
- Dental Assistant Certification
- X-ray Certification (DD214 is acceptable)
- Take the HIPPA Quiz
- Take the OSHA Quiz
- Health Examination And Immunization/Screening Requirement Form
- Physical examination record (current)
- Questionnaire for Public Trust-**must be original**
- Personal Qualification sheet- **3 pages must be original**
- Hepatitis declination if needed
- Flu declination if needed
- CPR card (current)
- PPIS – **must be original**
- Skills Tests DA_____ Computer Skills_____

If you have any questions please call Susan Monroe (smonroe@scp-jobs.com) or Tamika Noel (tnoel@scp-jobs.com) at 770-968-4602. All forms can be mailed to SCP at the following address:

Southern Crescent Personnel
7179 Jonesboro Rd Suite 101
Morrow, GA 30260

Once we have all completed forms, we will be in touch to set you up for testing.



Southern Crescent PERSONNEL

hiring.

Southern Crescent Personnel, Inc.
7179 Jonesboro Road
Suite 101
Morrow, GA 30260

Date:		For Internal use: Entered by: _____ References: _____ Position: _____ ■ 1-9 incomplete
Phone:		
Mobile/Cell:		
E-mail:		

PART I - GENERAL

NAME	First _____	Middle _____	Last _____	Maiden Name _____	Nickname _____
PRESENT ADDRESS	Street _____	Apt. No. _____		Social Security No. _____	
	City _____	State _____	Zip _____		
IN CASE OF EMERGENCY NOTIFY:	Name _____	Relationship _____			
	Address _____	Phone _____			
REFERRAL SOURCE	<input type="checkbox"/> Advertisement <input type="checkbox"/> Friend/Relative Name: _____ <input type="checkbox"/> Internet <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other				
Have you the legal right to work in the U.S.? Yes <input type="checkbox"/> No <input type="checkbox"/>			(FOR PART TIME APPLICANTS ONLY)		
Were you ever bonded? _____ Were you ever refused bond? _____			How long are you available for work? _____ wks., mos., yrs.		
Within the last five years have you been fired from any job for any reason? _____			What hours will you be available? _____		
Within the last five years have you quit a job after being notified that you would be fired? _____					
Have you ever worked for any military installations? Yes <input type="checkbox"/> No <input type="checkbox"/>					
<i>* If your answer is "yes" give details. Show the name and address (including ZIP code) of employer, approximate date, and reason in each case. This information should agree with your answers in PART III - EXPERIENCE.</i>					
Have you ever been convicted of a crime? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain _____ (NOT NECESSARILY A DISQUALIFYING FACTOR. ALL CIRCUMSTANCES WILL BE CONSIDERED)					
Have you ever been convicted of a crime involving a child? Yes <input type="checkbox"/> No <input type="checkbox"/> If your answer is yes, please give a description of the disposition of the charge. _____					
Will you require special assistance to perform the job for which you have applied? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes please explain. _____					

PART II - EDUCATION

Circle Highest Grade Completed: 1 2 3 4 5 6 7 8 High School: 9 10 11 12 College: 1 2 3 4 Graduate School: 1 2 3 4

Last School Attended: _____
(Name) _____ (City /State)

List any college or graduate degrees earned, your major and the school from which degrees were received: _____

Telephone # to contact schools, colleges, etc. _____

List any special training completed _____

So that our placement managers will not waste your time in duplicating your efforts and to avoid questions on referrals, will you kindly list below companies you have contacted on your own or through some other sources.

- _____
- _____
- _____
- _____

ALL QUALIFIED APPLICANTS ARE CONSIDERED FOR EMPLOYMENT WITHOUT REGARD TO RACE, COLOR, RELIGION, CREED, SEX, NATIONAL ORIGIN, AGE, MARITAL STATUS, SEXUAL ORIENTATION, ANCESTRY OR PHYSICAL OR MENTAL DISABILITY.

PART III - EXPERIENCE

Show history for the **past ten years** in consecutive order with **PRESENT OR MOST RECENT EMPLOYER LISTED FIRST**. Account for all periods of time including military service, education and any periods of unemployment. If self-employed, give firm name and supply business references. List any verified work performed on volunteer basis.

	Dates of employment (month/year) From ____ / ____ / ____ To ____ / ____ / ____	Exact title or position	Kind of business or organization (Medical, Dental, Insurance, Etc.)
Salary	Avg. hrs. per week	Name of employer (firm, organization, etc.) and address (ZIP Code)	
Starting \$ _____ per			
Final \$ _____ per			
Name of immediate supervisor			
Area code and phone number			
Reason for leaving			
Major Responsibilities:			

	Dates of employment (month/year) From ____ / ____ / ____ To ____ / ____ / ____	Exact title or position	Kind of business or organization (Medical, Dental, Insurance, Etc.)
Salary	Avg. hrs. per week	Name of employer (firm, organization, etc.) and address (ZIP Code)	
Starting \$ _____ per			
Final \$ _____ per			
Name of immediate supervisor			
Area code and phone number			
Reason for leaving			
Major Responsibilities:			

	Dates of employment (month/year) From ____ / ____ / ____ To ____ / ____ / ____	Exact title or position	Kind of business or organization (Medical, Dental, Insurance, Etc.)
Salary	Avg. hrs. per week	Name of employer (firm, organization, etc.) and address (ZIP Code)	
Starting \$ _____ per			
Final \$ _____ per			
Name of immediate supervisor			
Area code and phone number			
Reason for leaving			
Major Responsibilities:			

	Dates of employment (month/year) From ____ / ____ / ____ To ____ / ____ / ____	Exact title or position	Kind of business or organization (Medical, Dental, Insurance, Etc.)
Salary	Avg. hrs. per week	Name of employer (firm, organization, etc.) and address (ZIP Code)	
Starting \$ _____ per			
Final \$ _____ per			
Name of immediate supervisor			
Area code and phone number			
Reason for leaving			
Major Responsibilities:			

	Dates of employment (month/year) From ____ / ____ / ____ To ____ / ____ / ____	Exact title or position	Kind of business or organization (Medical, Dental, Insurance, Etc.)
Salary	Avg. hrs. per week	Name of employer (firm, organization, etc.) and address (ZIP Code)	
Starting \$ _____ per			
Final \$ _____ per			
Name of immediate supervisor			
Area code and phone number			
Reason for leaving			
Major Responsibilities:			

I understand and agree that, if hired, my employment is AT WILL (i.e. for non definite period) and regardless of the date of payment of my wages, or salary, I may be terminated at any time with or without prior notice or cause. I authorize investigation of all statements contained in this application. I understand that misrepresentation or omission of facts is cause for dismissal. I further understand that this application is being signed under penalty of perjury, with applicable federal punishment for perjury stated on the application.

I have read and understand the Employment Guide Book and Drug Policy of Southern Crescent Personnel, Inc. Should I become employed with Southern Crescent Personnel, Inc. I agree to abide by all policies and procedures of Southern Crescent Personnel, Inc. I understand it is my responsibility to contact Southern Crescent Personnel, Inc. when I am available to work.

I have read and fully understand the foregoing statements.

Signature _____ Date _____

Name: _____
Position: _____
Salary: _____
Date: _____
File #: _____

Code Of Ethics

Standard of Conduct Policy

Southern Crescent's reputation for honesty, integrity, and fairness is determined by the personal reputation of our individual employees.

To protect this reputation and to warrant our client's trust, each of us must strive to avoid situations that might reflect poorly on our company.

Southern Crescent Personnel must require the highest standard of behavior for its employees when engaging in any activity concerning the company, clients, competitors, suppliers, the public or other employees.

We, the management and employees of Southern Crescent, must hold one another accountable for superior ethical conduct while undertaking any activity on company or client premises.

Each of us has a responsibility to support the company's code of ethics and to take necessary action to preserve and protect the reputation of Southern Crescent Personnel.

Dress Code Policy

As part of the Southern Crescent Personnel image, I will abide by the following regulations for all assignments and/or placements:

- Regulation fingernails - short clean nails
- Light perfume or body fragrance
- Clean, pressed clothes and polished shoes
- Limited Jewelry - no multiple earrings or visible body piercing
- Cover any visible tattoos

I have read and I understand that the Code of Ethics (Standards of Conduct and the Dress Code) are considered part of my employment requirements. If they are not followed, it could result in my hourly rate being reduced to minimum wage.

Employee Signature _____ Date _____

Matching talent to opportunity

DENTAL/MEDICAL

Current Dental/Medical License Held _____ State _____

License Number _____ Expires _____ Original Issue Date _____

Hepatitis B Declination: I understand that due to my occupational exposure to blood and other potentially infectious materials I may be at risk of acquiring Hepatitis B Virus infection. I have been given the opportunity to be vaccinated at no charge to myself; however, I decline such vaccination at this time. I understand that by declining the vaccine I continue to be at risk of acquiring HBV, a serious disease. If in the future I continue to have occupational exposure to blood or OPIM and I wish to be vaccinated with HBV vaccine, I can receive the vaccination at no charge to me.

Signature: _____

I have already been vaccinated for HBV on the following dates: _____

Signature: _____

Date of last PPD and results _____

Have you previously been exposed to blood or other potentially infectious materials? (Include date and circumstances) _____

What vaccination and follow-up was completed after the above occupational exposure? (Include dates) _____

Have you ever worked with toxic products such as chemicals, gasses, ethylene oxide, asbestos, formaldehyde, or other? Please circle those that apply.

Signature: _____

Position Desired _____

Date Available _____

Administrative / Clerical / Legal / Accounting Skills

Please indicate areas of actual working experience. Indicate by entering years exp., speed, etc...

Typing	# Years	T/S	General	# Years	T/S	Accounting	# Years	T/S	Software	# Years	T/S
Dictaphone	_____	_____	Cust. Service	_____	_____	Full Charge	_____	_____	Word	_____	_____
Word Proc.	_____	_____	Phones	_____	_____	Payroll	_____	_____	Access	_____	_____
Typing	_____	_____	Filing	_____	_____	Acct.'s Rec.	_____	_____	Power Point	_____	_____
10 Key	_____	_____	Reception	_____	_____	Acct.'s Pay.	_____	_____	Excel	_____	_____
Data Entry	_____	_____	Switchboard	_____	# Lines _____	Quick Books	_____	_____	Outlook	_____	_____
Computer	_____	_____				Quicken	_____	_____	Other	_____	_____
Basic Clerical	_____	_____				Peachtree Acct.	_____	_____			
			Bilingual			Billing	_____	_____			
			Spanish _____ Other _____			Legal	_____	_____			
			Read _____ Speak _____ Write _____								

Dental Skills Please indicate areas of actual working experience. Indicate by entering years exp., speed, etc...

Front Office	# Years	T/S	Back Office	# Years	T/S	Current Certifications	# Years	Fields	# Years
Terminology	_____	_____	Hygienist	_____	_____	Dental Assistant	_____ <input type="checkbox"/>	Endodontics	_____
Transcription	_____	_____	Assistant	_____	_____	CPR	_____ <input type="checkbox"/>	Orthodontics	_____
Insurance	_____	_____	Surgery	_____	_____	X-Ray	_____ <input type="checkbox"/>	Perio.	_____
Billing	_____	_____	Implants	_____	_____	Other _____	_____ <input type="checkbox"/>	Peds.	_____
Scheduling	_____	_____	X-Ray	_____	_____			Prosth.	_____
Collections	_____	_____	4-Handed	_____	_____	Software	# Years _____ T/S _____	Other	_____
Reception	_____	_____	Expanded Duties	_____	_____	Dentrix	_____		
Typing	_____	_____	Impressions	_____	_____	Eaglesoft	_____	Bilingual	
OSHA	_____	_____	Temporaries	_____	_____	SoftDent	_____	Spanish _____ Other _____	
			Root Canals	_____	_____	Other: _____		Read _____ Speak _____ Write _____	

Medical Skills Please indicate areas of actual working experience. Indicate by entering years exp., speed, etc...

Front Office	# Years	T/S	Back Office	# Years	T/S	Current Certifications	# Years	Fields	# Years
Terminology	_____	_____	I.V.	_____	_____	CPR	_____ <input type="checkbox"/>	OB/GYN	_____
Transcription	_____	_____	Injections	_____	_____	X-Ray	_____ <input type="checkbox"/>	Inter. Med.	_____
Insurance	_____	_____	Venipuncture	_____	_____	NRP	_____ <input type="checkbox"/>	Fam. Pract.	_____
Billing	_____	_____	EKG	_____	_____	ACLS	_____ <input type="checkbox"/>	Peds.	_____
ICD-9	_____	_____	X-Ray	_____	_____	PALS	_____ <input type="checkbox"/>	Gastro	_____
CPT-4	_____	_____	Vitals	_____	_____	Med. Assistant	_____ <input type="checkbox"/>	Urology	_____
Scheduling	_____	_____	Treadmill	_____	_____	Phlebotomist	_____ <input type="checkbox"/>	Vasc.	_____
Collections	_____	_____	Clinical Back	_____	_____	Other _____	_____ <input type="checkbox"/>	Cardio.	_____
Reception	_____	_____	Laboratory	_____	_____			Orthopedics	_____
Typing	_____	_____	MA, CMA, RMA	_____	_____	Software	# Years _____ T/S _____	Optical	_____
Med. Records	_____	_____	CNA	_____	_____	Medical Manager	_____	Oncology	_____
			PCT	_____	_____	NextGen	_____		
			LPN	_____	_____	Medisoft	_____	Bilingual	
			RN	_____	_____	EMR	_____	Spanish _____ Other _____	
			Other	_____	_____	Other: _____		Read _____ Speak _____ Write _____	

Counselor Ratings

Longevity _____	Appearance _____	Personality _____	Communication _____	Professionalism _____
Notice Required _____	Dependability _____	Attitude _____	Experience Level _____	Attire _____
I-9 _____	W4 _____	G4 _____	Resume _____	Employee Guidebook _____
Dress Code Concerns _____				

Test Scores:

HIPAA _____

Medication Evaluation _____

JCAHO/OSHA _____

Workplace Violence _____

Basic Skills _____

Piedmont _____

OSHA _____

Basic _____

Interviewer **Comments**

Department of Homeland Security
U.S. Citizenship and Immigration Services

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification (To be completed and signed by employee at the time employment begins.)

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- A citizen of the United States
- A noncitizen national of the United States (see instructions)
- A lawful permanent resident (Alien #) _____
- An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - month/day/year)

Employee's Signature	Date (month/day/year)
----------------------	-----------------------

Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

Section 2. Employer Review and Verification (To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address (Street Name and Number, City, State, Zip Code)		Date (month/day/year)

Section 3. Updating and Reverification (To be completed and signed by employer.)

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)	
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.		
Document Title: _____	Document #: _____	Expiration Date (if any): _____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date (month/day/year)
--	-----------------------

ATTACHMENT AA**List of Acceptable Documents to establish U.S. Citizenship**

Excerpt from SECNAV M-5510.30 of June 2006, Appendix F. For a full copy of the Manual, go to <http://doni.daps.dla.mil/SECNAV%20Manuals1/5510.30.pdf>.

4. All documents submitted as evidence of U. S. citizenship must be original documents or certified copies. Uncertified copies are not acceptable. The following documents are acceptable proof of citizenship:

- a. The original U. S. birth certificate with a raised seal issued at the time of birth from one of the 50 states, or outlying territories or possessions.
 - b. A hospital birth certification (clinic and commercial birth center certification is not permitted) with an authenticating raised seal or signature provided all vital information is given.
 - c. A delayed birth certificate provided it shows the birth record was filed within one year after birth, it bears the registrar's seal and signature, and cites secondary evidence such as a baptismal certificate, certificate of circumcision, affidavits of persons having personal knowledge of the facts of the birth or other official records such as early census, school or insurance.
 - d. U.S. Passport (current or expired) or U.S. passport issued to individual's parent in which the individual is included.
 - e. FS-240 Report of Birth Abroad of a Citizen of the United States of America/Consular Report of Birth.
 - f. FS-545 Certification of Birth issued by a U.S. Consulate or DS-1350 the Department of State Certification.
 - g. INS N-550/570 U.S. Immigration and Naturalization Service Naturalization Certificate.
 - h. INS N-560/561 U.S. Immigration and Naturalization Service Certificate of Citizenship. If the individual does not have a Certificate of Citizenship, the original Certificate of Naturalization of the parent(s) may be accepted if the naturalization occurred while the individual was under 18 years of age (or under 16 years of age before 5 October 1978) and residing permanently in the U.S.
 - i. Certificate of birth issued by the Canal Zone government indicating U.S citizenship is only acceptable if verified by direct government inquiry to: Vital Records Section, Passport Services, 1111 19th Street NW, Suite 510, Washington, D.C. 20522-1705.
 - j. DD 372, Verification of Birth is acceptable for military members (officer and enlisted) provided the birth data is listed and verified by the Department of Vital Statistics.
 - k. DD 1966, Application for Enlistment into the Armed Forces of the United States are acceptable provided the documents sighted are listed and attested to by a recruiting official.
5. If none of the above forms of evidence are obtainable, a notice from the registrar issued by the state with the individual's name, date of birth, which years were searched for a birth record and that there is no birth certificate on file for the applicant should be presented. *The registrar's notice must be accompanied by the best combination of the following secondary evidence:
- a. Baptismal certificate

- b. Census record
- c. Certificate of circumcision
- d. Early school record
- e. Family Bible record
- f. Doctor's record of post-natal care
- g. Newspaper files and insurance papers

** NOTE: These documents must be early public records showing the date and place of birth, created within the first five years of life. The individual may also submit an Affidavit of Birth, Form DSP-10A, from an older blood relative, i.e., a parent, aunt, uncle, sibling, who has personal knowledge of the birth. It must be notarized or have the seal and signature of the acceptance agent.*

**PERSONAL AND PROFESSIONAL INFORMATION SHEET
NON-PRIVILEGED PROVIDER**

Complete all items and sections. List all dates as day-month-year. Use "NA" if not applicable. "Yes" answers require full explanation in the comments section or on an attached sheet of paper. Indicate the section number and subsection for those items being commented upon in attachments.

Name of Command: _____

1. General

Last Name, First, MI: _____
 Alias (Last, First, MI): _____
 Grade: _____ Desig: _____ SSN: _____
 Date of Birth: _____ Branch of Service: _____
 Citizenship (Country): _____ Reporting Date: _____
 PRD: _____
 Specialty(ies): _____
 Office Telephone Number: (____) _____ - _____
 Office Fax Number: (____) _____ - _____
 Office E-mail Address: _____
 Office Address: _____
 Local Address: _____
 Home Telephone Number: (____) _____ - _____

2. Professional Education and Training (most recent first)

a. Basic Qualifying Credential (e.g., BS, MS, PhD)

Institution	Address	Credential	From	To

b. Special Education. (Include professional course of 2 week's duration or greater, Navy Leadership Training or other relevant programs that pertain to practice.)

Institution	Address	Specialty	Type	From	To

3. Specialty Certifications

Certification	Number	Agency	Issue Date	Expires

4. List all Licenses or Certificates by State or Federal Agency. Include all those that have been either voluntarily or involuntarily withdrawn (include DEA certification).

a. License Information

License Number	State	Type	Expires

5. Relative Work Experience. (List chronologically, most recent first.)

6. Membership in Professional Organizations

Organization	Full Address	Office	From	To

7. Continuing Education Credits for the Past 2 Years

a. Academic

Institution	Course Title/Subject	Credit Hours	Date

b. Contingency Training (indicate certified [C] or trained [T])

Training	C/T	Expiration	Training	C/T	Expiration
BLS			ACLS		
ATLS			CTTC		
C-4			NALS		
PALS					

8. Personal Awards and Letters of Recognition (List chronologically, most recent first.)

Award/Recognition	Month/Year Awarded

9. Publications (List chronologically, most recent first.)

Title/Publication	Publication Date

10. Health Status and History (Answer "yes" or "no." Explain all "yes" answers in comments section).

- ___ a. Do you currently have any physical or mental impairments that could limit your clinical practice?
- ___ b. Are you currently taking any medications?
- ___ c. Do you have a potentially-communicable disease?
- ___ d. Have you been hospitalized for any reason during the last 5 years?
- ___ e. Have you ever been hospitalized for or diagnosed with a major psychiatric disorder?
- ___ f. Are you currently under or have you ever received treatment for an alcohol or drug-related condition?
- ___ g. Have you ever been involved in the illegal use of controlled substances?

Comments: _____

11. Malpractice, Licensure, Reduction in Clinical Scope and Legal History. (Answer "yes" or "no." Explain all "yes" answers in comments section.)

- ___ a. Have you ever been the subject of a malpractice claim? (Indicate final disposition or current status of claim in comments.)
- ___ b. Have you ever been a defendant in a felony or misdemeanor case? (Indicate final disposition of case in comments.)

____ c. Has there been previously successful or currently pending challenges, investigations, revocation, restriction, disciplinary action taken, suspension, reprimand, probation, denial, or withdrawal to any licensure, certification, or registration (State, district, or DEA) to practice in any jurisdiction, or the voluntary/involuntary relinquishment of such licensure, certification, or registration?

Comments: _____

12. Moonlighting Information. (Specify other facilities where you currently work.)

Institution	Full Address	Department	Priv Spec

13. Other Information. (Include any additional information that you wish to bring to the attention of the privileging authority.)

(Signature)

(Date)

Form W-4 (2011)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2011 expires February 16, 2012. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using

Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	<u> </u>
B	Enter "1" if: <ul style="list-style-type: none"> • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. 	B	<u> </u>
C	Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	<u> </u>
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	<u> </u>
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	<u> </u>
F	Enter "1" if you have at least \$1,900 of child or dependent care expenses for which you plan to claim a credit	F	<u> </u>
(Note. Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)			
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> • If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children. • If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children 	G	<u> </u>
H	Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.) ▶ H For accuracy, complete all worksheets that apply. <ul style="list-style-type: none"> • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$40,000 (\$10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld. • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below. 	H	<u> </u>

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form W-4 Department of the Treasury Internal Revenue Service	Employee's Withholding Allowance Certificate ▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.	OMB No. 1545-2159 <div style="font-size: 2em; font-weight: bold;">2011</div>
1 Type or print your first name and middle initial. Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <small>Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.</small>
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 <u> </u>
6 Additional amount, if any, you want withheld from each paycheck		6 \$ <u> </u>
7 I claim exemption from withholding for 2011, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶		7 <u> </u>
<small>Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.</small>		
Employee's signature <small>(This form is not valid unless you sign it.) ▶</small>		Date ▶
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional)
		10 Employer identification number (EIN)



DIRECT DEPOSIT AUTHORIZATION FORM

Please attach a voided check in the box below.

Note: Must be an actual check, not a deposit slip:

Your Name as it appears on account: _____

Type of Account: (checking) or (savings) _____

Name of Bank: _____

Percent to be deposited from each payroll check: _____%

Date to be effective: _____

Note: You should be active with Direct Deposit two weeks after your effective date indicated above or after the business office has received your authorization. Once your account is active, funds appear in your account on Fridays. You will be issued a Financial Statement weekly in the place of an actual payroll check. Please notify the Business Office immediately in the event that you should change any information on the active account being used to directly deposit funds. You may discontinue your direct deposit at any time.



Southern Crescent Personnel

CONFIDENTIALITY AGREEMENT

It is the policy of Southern Crescent Personnel, Inc. or its assigned Client(s); that any patient, financial, employee, payroll and related information are strictly confidential and/or proprietary information.

I understand that, in the course of my work, I may learn information which is confidential and under federal and state law or which is considered confidential and/or proprietary by Southern Crescent Personnel, including but not limited to patient medical information, or other information considered personal by patients and their families, financial information, and employee and payroll information. I agree to keep confidential all such information, whether verbal, written or computerized, which I learn in the course of my work for Southern Crescent Personnel. I will not discuss patient or family information with anyone not immediately concerned with or involved with a particular patient's care or treatment. I will not discuss organizational information with anyone who does not have a business need to know. In addition, I will not discuss patient or organizational information in public areas (such as elevators, cafeterias, etc.).

I agree that I will not access or attempt to access any information paper or electronically unless the information is relevant to my job and I am clearly authorized to access it.

I understand that the logon ID, computer password, and other credentials (hereinafter "credentials") assigned to me by Southern Crescent Personnel and/or assigned Client(s) are to be used solely by me in connection with my authorized access to information. I understand that use of my credentials by anyone other than myself is strictly prohibited. I will not share my credentials with anyone and I will take all necessary steps to protect the confidentiality of my credentials.

I understand electronic mail is Southern Crescent Personnel and/or assigned Client(s) property and subject to organizational review and should be used only for business purposes. I also understand and certify that the use of my electronic or digital signature to authenticate documents is the equivalent of my handwritten signature on the documents.

I understand it is my responsibility to read and to abide by any and all policies and procedures regarding the use and distribution of information by Southern Crescent Personnel and/or assigned Client(s) currently in effect or which may be implemented or revised from time to time. I understand that information access will be monitored and any violation of Southern Crescent Personnel and/or assigned Client(s) policies and procedures will be reported to the appropriate individual(s) and may result in disciplinary action against me including termination of employment or other affiliation(s) with Southern Crescent Personnel and/or assigned Client(s), as well as prosecution to the fullest extent of the law.

I HAVE READ THE ABOVE CONFIDENTIALITY AGREEMENT AND I AGREE TO COMPLY FULLY WITH ITS TERMS.

Please print your name clearly

Signature

Date

Name: _____ Title: _____ Date: _____

Congress recognized the need for national patient record privacy standards in 1996 when they enacted HIPAA (Health Insurance Portability & Accountability Act). The law required new safeguards to protect the security and confidentiality of that information. In December 2000 HHS issued a final rule that made significant changes in how medical records and their content were handled by covered entities.

Important: Keep yourself updated on current and future HIPAA Policies & Procedures. Do Not Violate HIPAA!

1. What is HIPAA?
 - A. The Health Insurance Portability & Accountability Act
 - B. The Health Insurance Professional Administration Act
 - C. The Honorable Integrity Professional & Administrative Act
 - D. None of the Above
2. HIPAA calls for:
 - A. Standardization of electronic patient, health, administration and financial data
 - B. Unique Health identifiers for individuals, employers and healthcare providers
 - C. Security standards protecting the confidentiality and integrity of individually identifiable health information, past, present and future.
 - D. All of the Above
3. An individual working for a doctors office cannot be held responsible for violating HIPAA
 - A. TRUE
 - B. FALSE
4. Are there any penalties for HIPAA violation?
 - A. YES
 - B. NO
5. Which of the following is true about the HIPAA Privacy Rule?
 - A. Gives individuals more control over their information
 - B. Sets boundaries on the use and disclosure of health information
 - C. Establishes safeguards to protect health information
 - D. All of the Above
6. Among the voicemail messages to be avoided:
 - A. Laboratory and test results
 - B. Information that links a patient's name to a particular medical condition
 - C. The type of clinic or specialist the patient is seeing
 - D. All of the Above
7. It is lawful to send a fax that contains individually identifiable patient information (PHI) Protected Health Information if the pre-printed confidentiality statement is included and delivery is confirmed.
 - A. TRUE
 - B. FALSE
8. Information covered by the HIPAA Privacy Rule:
 - A. Is restricted to computer databases
 - B. Covers only electronically exchanged data
 - C. Includes electronic, paper and oral communications
 - D. Is limited to electronic and paper communications
9. Individually identifiable health information includes the
 - A. Medical Record
 - B. Patient Account Number
 - C. Social Security Number
 - D. All of the Above
10. Under HIPAA, for the first time there will be specific Federal penalties if a patient's right to privacy is violated.
 - A. TRUE
 - B. FALSE



TRAINING QUIZ

OSHA BLOODBORNE PATHOGENS/NEEDLE STICK SAFETY AND PREVENTION ACT

Name: _____ Title: _____ Date: _____

- T F 1. An employee has the "Right to Know" about hazards in the dental and/or medical office.
- T F 2. The CDC estimates 600,000 percutaneous injuries to workers.
- T F 3. The revision to OSHA's Bloodborne Pathogens Standard effective in April 2001 added new requirements for employers.
- T F 4. "Universal Precautions" refers to the handling of all blood and body fluids as if known to be contaminated.
- T F 5. Water splashed into eyes during cleaning of instruments is considered an occupational exposure.
- T F 6. The process of infection requires a source means of transmission and susceptible host.
- T F 7. **PPE** stands for Personal Protective Equipment.
- T F 8. Engineering controls and work practices are not mentioned in the OSHA standards.
- T F 9. **Engineering Controls** include all controls measures that isolate or remove a hazard from the workplace; such as sharps disposal.
- T F 10. Safer medical devices must be used to reduce or eliminate worker exposure.
- T F 11. Employees should wash hands after all patient contact.
- T F 12. The proper emergency response to an eye splash exposure would be to flush copiously with water.
- T F 13. It is not necessary to wash hands after every glove removal.
- T F 14. The storage of food is allowed in areas with potentially infectious materials as long as it is properly labeled.
- T F 15. Specimens of blood, body fluids or **OPIM** must be placed in a container labeled with the **BIOHAZARD SYMBOL** or color coded red.
- T F 16. If the outside of a regulated waste container becomes contaminated it is not necessary to "rebag" if the contaminated area is cleaned with a disinfectant.
- T F 17. A **PPE** garment penetrated by blood or other potentially infectious materials must be removed immediately.
- T F 18. Contaminated work surfaces must be wiped off only if you can see a blood spill.
- T F 19. Contaminated laundry shall be bagged or containerized where it was used and shall not be sorted or rinsed in the area of use.
- T F 20. The "**BIOHAZARD SYMBOL**" is a notification to the health care employee that the item or contents may present a possible occupational exposure and that precautions should be observed.
- T F 21. Employee health and vaccination records are confidential.
- T F 22. An employee may decline Post-Exposure testing after an exposure incident.
- T F 23. All "needle stick" accidents must be reported to the employer.
- T F 24. OSHA requires that all healthcare employees that have exposure to blood or OPIM are eligible for the Hepatitis B vaccination at no cost to the employee.
- T F 25. Hepatitis B virus can lead to severe illness, liver damage or death.
- T F 26. Under the **Needle Stick Safety and Prevention Act** non-managerial employees have an opportunity to choose the type of sharps used by the office or facility.

HEALTH EXAMINATION AND IMMUNIZATION/SCREENING REQUIREMENT FORM

**AFTER contract award, but prior to performing services, the contract health care worker shall have this form completed by a licensed medical practitioner.
All health care workers providing services under this contract must meet all the requirements specified under the "Required Documentation" column of this form.***

COPIES OF IgG TITER LABORATORY RESULTS MUST BE ATTACHED TO THIS FORM

IMMUNIZATION/ SCREENING	REQUIRED DOCUMENTATION	DATES and RESULTS (to be completed by examining licensed practitioner)	
VARICELLA (CHICKENPOX)	Physician documented history of varicella (chickenpox/herpes zoster) disease, OR	Hx:	
	2-dose vaccine series, OR	Dates of Shots: 1. 2.	
	Positive IgG titer	Titer/Date:	
MEASLES/ MUMPS/ RUBELLA (MMR)	MMR live virus 2-dose vaccine, OR	Dates of Shots: 1. 2.	
	Positive IgG titer for each of Measles, Mumps, and Rubella	Titer/Date:	
HEPATITIS B	HBV 3-dose vaccine series AND positive IgG titer, OR	Dates of Shots:	Dates of Repeat Shots:
	HBV 3-dose vaccine series with negative titer AND repeat 3-dose HBV series with repeat titer AND in the case of persistent negative titer, counseling by licensed practitioner regarding implications of non-response.	1. 2. 3. Titer/Date:	1. 2. 3. Titer/Date: Counseling provided:
TETANUS/ DIPHTHERIA	Tetanus/Diphtheria (TD) booster, OR	Date of TD booster:	
	Tetanus/Diphtheria/Pertussis (Tdap) within the preceding 10 years.	Date of Tdap:	
TUBERCULOSIS	Two-step Tuberculin Skin Test (TST), OR	2-Step TST dates:	BAMT date:
	One Blood Assay for Mycobacterium Tuberculosis (BAMT), OR	1 st test: 1 st result: 2 nd test: 2 nd result:	Result:
	An annual evaluation if known TST reactor, including chest x-ray within 1 year if new hire	CXR Date: Pos: Neg:	Date/result of last annual eval:
LATEX	Latex sensitivity screening questionnaire administered	Date of evaluation: Results: Sensitive Not sensitive	
	If latex sensitivity suspected, follow with appropriate allergy testing	Date of test: Results:	

_____ [Name of Contract Health Care Worker] has presented for a physical examination. He/She is applying for the position of _____ [Please enter job title].

He/She was examined on _____ [date] and found to be in good health, meeting the immunization/ screening required above, and is free of any medical condition or infectious disease that may prevent his/her ability to perform services for the position described above. YES NO [Please circle either YES or NO.]

Provider's Signature: _____ Provider's Name: _____

Facility/Address: _____

Phone Number: _____ Date: _____

*The facility will identify any **incumbent** HCWs who are not required to complete this documentation.

Questionnaire for Public Trust Positions

Follow instructions fully or we cannot process your form. Be sure to sign and date the certification statement on Page 7 and the release on Page 8. *If you have any questions*, call the office that gave you the form.

Purpose of this Form

The U.S. Government conducts background investigations and reinvestigations to establish that applicants or incumbents either employed by the Government or working for the Government under contract, are suitable for the job and/or eligible for a public trust or sensitive position. Information from this form is used primarily as the basis for this investigation. Complete this form only after a conditional offer of employment has been made.

Giving us the information we ask for is voluntary. However, we may not be able to complete your investigation, or complete it in a timely manner, if you don't give us each item of information we request. This may affect your placement or employment prospects.

Authority to Request this Information

The U.S. Government is authorized to ask for this information under Executive Orders 10450 and 10577, sections 3301 and 3302 of title 5, U.S. Code; and parts 5, 731, 732, and 736 of Title 5, Code of Federal Regulations.

Your Social Security number is needed to keep records accurate, because other people may have the same name and birth date. Executive Order 9397 also asks Federal agencies to use this number to help identify individuals in agency records.

The Investigative Process

Background investigations are conducted using your responses on this form and on your Declaration for Federal Employment (OF 306) to develop information to show whether you are reliable, trustworthy, of good conduct and character, and loyal to the United States. The information that you provide on this form is confirmed during the investigation. Your current employer must be contacted as part of the investigation, even if you have previously indicated on applications or other forms that you do not want this.

In addition to the questions on this form, inquiry also is made about a person's adherence to security requirements, honesty and integrity, vulnerability to exploitation or coercion, falsification, misrepresentation, and any other behavior, activities, or associations that tend to show the person is not reliable, trustworthy, or loyal.

Your Personal Interview

Some investigations will include an interview with you as a normal part of the investigative process. This provides you the opportunity to update, clarify, and explain information on your form more completely, which often helps to complete your investigation faster. It is important that the interview be conducted as soon as possible after you are contacted. Postponements will delay the processing of your investigation, and declining to be interviewed may result in your investigation being delayed or canceled.

You will be asked to bring identification with your picture on it, such as a valid State driver's license, to the interview. There are other documents you may be asked to bring to verify your identity as well.

These include documentation of any legal name change, Social Security card, and/or birth certificate.

You may also be asked to bring documents about information you provided on the form or other matters requiring specific attention. These matters include alien registration, delinquent loans or taxes, bankruptcy, judgments, liens, or other financial obligations, agreements involving child custody or support, alimony or property settlements, arrests, convictions, probation, and/or parole.

Instructions for Completing this Form

1. Follow the instructions given to you by the person who gave you the form and any other clarifying instructions furnished by that person to assist you in completion of the form. Find out how many copies of the form you are to turn in. You must sign and date, in black ink, the original and each copy you submit.
2. Type or legibly print your answers in black ink (if your form is not legible, it will not be accepted). You may also be asked to submit your form in an approved electronic format.
3. All questions on this form must be answered. If no response is necessary or applicable, indicate this on the form (for example, enter "None" or "N/A"). If you find that you cannot report an exact date, approximate or estimate the date to the best of your ability and indicate this by marking "APPROX." or "EST."
4. Any changes that you make to this form after you sign it must be initialed and dated by you. Under certain limited circumstances, agencies may modify the form consistent with your intent.
5. You must use the State codes (abbreviations) listed on the back of this page when you fill out this form. Do not abbreviate the names of cities or foreign countries.
6. The 5-digit postal ZIP codes are needed to speed the processing of your investigation. The office that provided the form will assist you in completing the ZIP codes.
7. All telephone numbers must include area codes.
8. All dates provided on this form must be in Month/Day/Year or Month/Year format. Use numbers (1-12) to indicate months. For example, June 10, 1978, should be shown as 6/10/78.
9. Whenever "City (Country)" is shown in an address block, also provide in that block the name of the country when the address is outside the United States.
10. If you need additional space to list your residences or employments/self-employments/unemployments or education, you should use a continuation sheet, SF 86A. If additional space is needed to answer other items, use a blank piece of paper. Each blank piece of paper you use must contain **your name and Social Security Number at the top of the page.**

Final Determination on Your Eligibility

Final determination on your eligibility for a public trust or sensitive position and your being granted a security clearance is the responsibility of the Office of Personnel Management or the Federal agency that requested your investigation. You may be provided the opportunity personally to explain, refute, or clarify any information before a final decision is made.

Penalties for Inaccurate or False Statements

The U.S. Criminal Code (title 18, section 1001) provides that knowingly falsifying or concealing a material fact is a felony which may result in fines of up to \$10,000, and/or 5 years imprisonment, or both. In addition, Federal agencies generally fire, do not grant a security clearance, or disqualify individuals who have materially and deliberately falsified these forms, and this remains a part of the permanent record for future placements. Because the position for which you are being considered is one of public trust or is sensitive, your trustworthiness is a very important consideration in deciding your suitability for placement or retention in the position.

Your prospects of placement are better if you answer all questions truthfully and completely. You will have adequate opportunity to explain any information you give us on the form and to make your comments part of the record.

Disclosure of Information

The information you give us is for the purpose of investigating you for a position; we will protect it from unauthorized disclosure. The collection, maintenance, and disclosure of background investigative information is governed by the Privacy Act. The agency which requested the investigation and the agency which conducted the investigation have published notices in the Federal Register describing the system of records in which your records will be maintained. You may obtain copies of the relevant notices from the person who gave you this form. The information on this form, and information we collect during an investigation may be disclosed without your consent as permitted by the Privacy Act (5 USC 552a(b)) and as follows:

PRIVACY ACT ROUTINE USES

1. To the Department of Justice when: (a) the agency or any component thereof; or (b) any employee of the agency in his or her official capacity; or (c) any employee of the agency in his or her individual capacity where the Department of Justice has agreed to represent the employee; or (d) the United States Government, is a party to litigation or has interest in such litigation, and by careful review, the agency determines that the records are both relevant and necessary to the litigation and the use of such records by the Department of Justice is therefore deemed by the agency to be for a purpose that is compatible with the purpose for which the agency collected the records.
2. To a court or adjudicative body in a proceeding when: (a) the agency or any component thereof; or (b) any employee of the agency in his or her official capacity; or (c) any employee of the agency in his or her individual capacity where the Department of Justice has agreed to represent the employee; or (d) the United States Government is a party to litigation or has interest in such litigation, and by careful review, the agency determines that the records are both relevant and necessary to the litigation and the use of such records is therefore deemed by the agency to be for a purpose that is compatible with the purpose for which the agency collected the records.
3. Except as noted in Question 21, when a record on its face, or in conjunction with other records, indicates a violation or potential violation of law, whether civil, criminal, or regulatory in nature, and whether arising by general statute, particular program statute, regulation, rule, or order issued pursuant thereto, the relevant records may be disclosed to the appropriate Federal, foreign, State, local, tribal, or other public authority responsible for enforcing, investigating or prosecuting such violation or charged with enforcing or implementing the statute, rule, regulation, or order.
4. To any source or potential source from which information is requested in the course of an investigation concerning the hiring or retention of an employee or other personnel action, or the issuing or retention of a security clearance, contract, grant, license, or other benefit, to the extent necessary to identify the individual, inform the source of the nature and purpose of the investigation, and to identify the type of information requested.
5. To a Federal, State, local, foreign, tribal, or other public authority the fact that this system of records contains information relevant to the retention of an employee, or the retention of a security clearance, contract, license, grant, or other benefit. The other agency or licensing organization may then make a request supported by written consent of the individual for the entire record if it so chooses. No disclosure will be made unless the information has been determined to be sufficiently reliable to support a referral to another office within the agency or to another Federal agency for criminal, civil, administrative, personnel, or regulatory action.
6. To contractors, grantees, experts, consultants, or volunteers when necessary to perform a function or service related to this record for which they have been engaged. Such recipients shall be required to comply with the Privacy Act of 1974, as amended.
7. To the news media or the general public, factual information the disclosure of which would be in the public interest and which would not constitute an unwarranted invasion of personal privacy.
8. To a Federal, State, or local agency, or other appropriate entities or individuals, or through established liaison channels to selected foreign governments, in order to enable an intelligence agency to carry out its responsibilities under the National Security Act of 1947 as amended, the CIA Act of 1949 as amended, Executive Order 12333 or any successor order, applicable national security directives, or classified implementing procedures approved by the Attorney General and promulgated pursuant to such statutes, orders or directives.
9. To a Member of Congress or to a Congressional staff member in response to an inquiry of the Congressional office made at the written request of the constituent about whom the record is maintained.
10. To the National Archives and Records Administration for records management inspections conducted under 44 USC 2904 and 2906.
11. To the Office of Management and Budget when necessary to the review of private relief legislation.

STATE CODES (ABBREVIATIONS)

Alabama	AL	Hawaii	HI	Massachusetts	MA	New Mexico	NM	South Dakota	SD
Alaska	AK	Idaho	ID	Michigan	MI	New York	NY	Tennessee	TN
Arizona	AZ	Illinois	IL	Minnesota	MN	North Carolina	NC	Texas	TX
Arkansas	AR	Indiana	IN	Mississippi	MS	North Dakota	ND	Utah	UT
California	CA	Iowa	IA	Missouri	MO	Ohio	OH	Vermont	VT
Colorado	CO	Kansas	KS	Montana	MT	Oklahoma	OK	Virginia	VA
Connecticut	CT	Kentucky	KY	Nebraska	NE	Oregon	OR	Washington	WA
Delaware	DE	Louisiana	LA	Nevada	NV	Pennsylvania	PA	West Virginia	WV
Florida	FL	Maine	ME	New Hampshire	NH	Rhode Island	RI	Wisconsin	WI
Georgia	GA	Maryland	MD	New Jersey	NJ	South Carolina	SC	Wyoming	WY
American Samoa	AS	District of Columbia	DC	Guam	GU	Northern Marianas	CM	Puerto Rico	PR
Trust Territory	TT	Virgin Islands	VI						

PUBLIC BURDEN INFORMATION

Public burden reporting for this collection of information is estimated to average 60 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to Reports and Forms Management Officer, U.S. Office of Personnel Management, 1900 E Street, N.W., Room CHP-500, Washington, D.C. 20415. Do not send your completed form to this address.

**QUESTIONNAIRE FOR
 PUBLIC TRUST POSITIONS**

OPM USE ONLY	Codes	Case Number
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Agency Use Only (Complete items A through P using instructions provided by USOPM)

A Type of Investigation	B Extra Coverage	C Sensitivity/Risk Level	D Compu/ADP	E Nature of Action Code	F Date of Action	Month	Day	Year
G Geographic Location	H Position Code	I Position Title						
J SON	K Location of Official Personnel Folder	None		Other Address				ZIP Code
		At SON						
L SOI	M Location of Security Folder	None		Other Address				ZIP Code
		At SOI						
		NPI						
N OPAC-ALC Number	O Accounting Data and/or Agency Case Number							
P Requesting Official	Name and Title			Signature		Telephone Number		Date

Persons completing this form should begin with the questions below.

1 FULL NAME * If you have only initials in your name, use them and state (IO). * If you have no middle name, enter "NMN". - If you are a "Jr.," "Sr.," "II," etc., enter this in the box after your middle name.	2 DATE OF BIRTH					
Last Name	First Name	Middle Name	Jr., II, etc.	Month	Day	Year

3 PLACE OF BIRTH - Use the two letter code for the State. City	County	State	Country (if not in the United States)	4 SOCIAL SECURITY NUMBER
--	--------	-------	---------------------------------------	---------------------------------

5 OTHER NAMES USED

#1 Name	Month/Year	To	Month/Year	#3 Name	Month/Year	To	Month/Year
#2 Name	Month/Year	To	Month/Year	#4 Name	Month/Year	To	Month/Year

6 OTHER IDENTIFYING INFORMATION

Height (feet and inches)	Weight (pounds)	Hair Color	Eye Color	Sex (Mark one box)
				<input type="checkbox"/> Female <input type="checkbox"/> Male

7 TELEPHONE NUMBERS

Work (include Area Code and extension)	Home (include Area Code)
Day ()	Day ()
Night ()	Night ()

8 CITIZENSHIP

a Mark the box at the right that reflects your current citizenship status, and follow its instructions.	b Your Mother's Maiden Name
<input type="checkbox"/> I am a U.S. citizen or national by birth in the U.S. or U.S. territory/possession. Answer items b and d.	
<input type="checkbox"/> I am a U.S. citizen, but I was NOT born in the U.S. Answer items b, c and d.	
<input type="checkbox"/> I am not a U.S. citizen. Answer items b and e.	

9 UNITED STATES CITIZENSHIP If you are a U.S. Citizen, but were not born in the U.S., provide information about one or more of the following proofs of your citizenship.

Naturalization Certificate (Where were you naturalized?)

Court	City	State	Certificate Number	Month/Day/Year Issued
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Citizenship Certificate (Where was the certificate issued?)

City	State	Certificate Number	Month/Day/Year Issued
------	-------	--------------------	-----------------------

State Department Form 240 - Report of Birth Abroad of a Citizen of the United States

Give the date the form was prepared and give an explanation if needed.	Month/Day/Year	Explanation
--	----------------	-------------

U.S. Passport

This may be either a current or previous U.S. Passport	Passport Number	Month/Day/Year Issued
--	-----------------	-----------------------

d DUAL CITIZENSHIP If you are (or were) a dual citizen of the United States and another country, provide the name of that country in the space to the right.

Country

e ALIEN If you are an alien, provide the following information:

Place You Entered the United States:	City	State	Date You Entered U.S.	Alien Registration Number	Country(ies) of Citizenship
			Month Day Year		

9 WHERE YOU HAVE LIVED

List the places where you have lived, beginning with the most recent (#1) and working back 7 years. All periods must be accounted for in your list. Be sure to indicate the actual physical location of your residence: do not use a post office box as an address, do not list a permanent address when you were actually living at a school address, etc. Be sure to specify your location as closely as possible: for example, do not list only your base or ship, list your barracks number or home port. You may omit temporary military duty locations under 90 days (list your permanent address instead), and you should use your APO/FPO address if you lived overseas.

For any address in the last 5 years, list a person who knew you at that address, and who preferably still lives in that area (do not list people for residences completely outside this 5-year period, and do not list your spouse, former spouses, or other relatives). Also for addresses in the last 5 years, if the address is "General Delivery," a Rural or Star Route, or may be difficult to locate, provide directions for locating the residence on an attached continuation sheet.

Month/Year #1	Month/Year To	Month/Year Present	Street Address	Apt. #	City (Country)	State	ZIP Code
Name of Person Who Knows You			Street Address	Apt. #	City (Country)	State	ZIP Code
Telephone Number ()							
Month/Year #2	Month/Year To	Month/Year	Street Address	Apt. #	City (Country)	State	ZIP Code
Name of Person Who Knew You			Street Address	Apt. #	City (Country)	State	ZIP Code
Telephone Number ()							
Month/Year #3	Month/Year To	Month/Year	Street Address	Apt. #	City (Country)	State	ZIP Code
Name of Person Who Knew You			Street Address	Apt. #	City (Country)	State	ZIP Code
Telephone Number ()							
Month/Year #4	Month/Year To	Month/Year	Street Address	Apt. #	City (Country)	State	ZIP Code
Name of Person Who Knew You			Street Address	Apt. #	City (Country)	State	ZIP Code
Telephone Number ()							
Month/Year #5	Month/Year To	Month/Year	Street Address	Apt. #	City (Country)	State	ZIP Code
Name of Person Who Knew You			Street Address	Apt. #	City (Country)	State	ZIP Code
Telephone Number ()							

10 WHERE YOU WENT TO SCHOOL

List the schools you have attended, beyond Junior High School, beginning with the most recent (#1) and working back 7 years. List all College or University degrees and the dates they were received. If all of your education occurred more than 7 years ago, list your most recent education beyond high school, no matter when that education occurred.

Use one of the following codes in the "Code" block:

1 - High School

2 - College/University/Military College

3 - Vocational/Technical/Trade School

For schools you attended in the past 3 years, list a person who knew you at school (an instructor, student, etc.). Do not list people for education completely outside this 3-year period.

For correspondence schools and extension classes, provide the address where the records are maintained.

Month/Year #1	Month/Year To	Code	Name of School	Degree/Diploma/Other	Month/Year Awarded
Street Address and City (Country) of School					State
ZIP Code					
Name of Person Who Knew You			Street Address	Apt. #	City (Country)
			State	ZIP Code	Telephone Number ()
Month/Year #2	Month/Year To	Code	Name of School	Degree/Diploma/Other	Month/Year Awarded
Street Address and City (Country) of School					State
ZIP Code					
Name of Person Who Knew You			Street Address	Apt. #	City (Country)
			State	ZIP Code	Telephone Number ()
Month/Year #3	Month/Year To	Code	Name of School	Degree/Diploma/Other	Month/Year Awarded
Street Address and City (Country) of School					State
ZIP Code					
Name of Person Who Knew You			Street Address	Apt. #	City (Country)
			State	ZIP Code	Telephone Number ()

Enter your Social Security Number before going to the next page

11 YOUR EMPLOYMENT ACTIVITIES

List your employment activities, beginning with the present (#1) and working back 7 years. You should list all full-time work, part-time work, military service, temporary military duty locations over 90 days, self-employment, other paid work, and all periods of unemployment. The entire 7-year period must be accounted for without breaks, but you need not list employments before your 16th birthday.

• **Code.** Use one of the codes listed below to identify the type of employment:

- | | | | |
|-----------------------------------|---|--|-----------|
| 1 - Active military duty stations | 5 - State Government (Non-Federal employment) | 7 - Unemployment (Include name of person who can verify) | 9 - Other |
| 2 - National Guard/Reserve | | 8 - Federal Contractor (List Contractor, not Federal agency) | |
| 3 - U.S.P.H.S. Commissioned Corps | 6 - Self-employment (Include business and/or name of person who can verify) | | |
| 4 - Other Federal employment | | | |

• **Employer/Verifier Name.** List the business name of your employer or the name of the person who can verify your self-employment or unemployment in this block. If military service is being listed, include your duty location or home port here as well as your branch of service. You should provide separate listings to reflect changes in your military duty locations or home ports.

• **Previous Periods of Activity.** Complete these lines if you worked for an employer on more than one occasion at the same location. After entering the most recent period of employment in the initial numbered block, provide previous periods of employment at the same location on the additional lines provided. For example, if you worked at XY Plumbing in Denver, CO, during 3 separate periods of time, you would enter dates and information concerning the most recent period of employment first, and provide dates, position titles, and supervisors for the two previous periods of employment on the lines below that information.

	Month/Year	Month/Year	Code	Employer/Verifier Name/Military Duty Location	Your Position Title/Military Rank		
#1	To	Present					
Employer's/Verifier's Street Address				City (Country)	State	ZIP Code	Telephone Number ()
Street Address of Job Location (if different than Employer's Address)				City (Country)	State	ZIP Code	Telephone Number ()
Supervisor's Name & Street Address (if different than Job Location)				City (Country)	State	ZIP Code	Telephone Number ()
PREVIOUS PERIODS OF ACTIVITY (Block #1)	Month/Year	Month/Year		Position Title	Supervisor		
	To						
	Month/Year	Month/Year		Position Title	Supervisor		
To							
PREVIOUS PERIODS OF ACTIVITY (Block #2)	Month/Year	Month/Year		Position Title	Supervisor		
	To						
	Month/Year	Month/Year		Position Title	Supervisor		
To							
	Month/Year	Month/Year	Code	Employer/Verifier Name/Military Duty Location	Your Position Title/Military Rank		
#2	To						
Employer's/Verifier's Street Address				City (Country)	State	ZIP Code	Telephone Number ()
Street Address of Job Location (if different than Employer's Address)				City (Country)	State	ZIP Code	Telephone Number ()
Supervisor's Name & Street Address (if different than Job Location)				City (Country)	State	ZIP Code	Telephone Number ()
PREVIOUS PERIODS OF ACTIVITY (Block #3)	Month/Year	Month/Year		Position Title	Supervisor		
	To						
	Month/Year	Month/Year		Position Title	Supervisor		
To							
	Month/Year	Month/Year	Code	Employer/Verifier Name/Military Duty Location	Your Position Title/Military Rank		
#3	To						
Employer's/Verifier's Street Address				City (Country)	State	ZIP Code	Telephone Number ()
Street Address of Job Location (if different than Employer's Address)				City (Country)	State	ZIP Code	Telephone Number ()
Supervisor's Name & Street Address (if different than Job Location)				City (Country)	State	ZIP Code	Telephone Number ()
PREVIOUS PERIODS OF ACTIVITY (Block #3)	Month/Year	Month/Year		Position Title	Supervisor		
	To						
	Month/Year	Month/Year		Position Title	Supervisor		
To							

Enter your Social Security Number before going to the next page →

YOUR EMPLOYMENT ACTIVITIES (CONTINUED)

#4	Month/Year	Month/Year	Code	Employer/Verifier Name/Military Duty Location	Your Position Title/Military Rank			
	To							
	Employer's/Verifier's Street Address				City (Country)	State	ZIP Code	Telephone Number ()
	Street Address of Job Location (if different than Employer's Address)				City (Country)	State	ZIP Code	Telephone Number ()
Supervisor's Name & Street Address (if different than Job Location)				City (Country)	State	ZIP Code	Telephone Number ()	

PREVIOUS PERIODS OF ACTIVITY (Block #4)	Month/Year	Month/Year	Position Title	Supervisor
	To			
	Month/Year	Month/Year	Position Title	Supervisor
To				
Month/Year	Month/Year	Position Title	Supervisor	
To				

#5	Month/Year	Month/Year	Code	Employer/Verifier Name/Military Duty Location	Your Position Title/Military Rank			
	To							
	Employer's/Verifier's Street Address				City (Country)	State	ZIP Code	Telephone Number ()
	Street Address of Job Location (if different than Employer's Address)				City (Country)	State	ZIP Code	Telephone Number ()
Supervisor's Name & Street Address (if different than Job Location)				City (Country)	State	ZIP Code	Telephone Number ()	

PREVIOUS PERIODS OF ACTIVITY (Block #5)	Month/Year	Month/Year	Position Title	Supervisor
	To			
	Month/Year	Month/Year	Position Title	Supervisor
To				
Month/Year	Month/Year	Position Title	Supervisor	
To				

#6	Month/Year	Month/Year	Code	Employer/Verifier Name/Military Duty Location	Your Position Title/Military Rank			
	To							
	Employer's/Verifier's Street Address				City (Country)	State	ZIP Code	Telephone Number ()
	Street Address of Job Location (if different than Employer's Address)				City (Country)	State	ZIP Code	Telephone Number ()
Supervisor's Name & Street Address (if different than Job Location)				City (Country)	State	ZIP Code	Telephone Number ()	

PREVIOUS PERIODS OF ACTIVITY (Block #6)	Month/Year	Month/Year	Position Title	Supervisor
	To			
	Month/Year	Month/Year	Position Title	Supervisor
To				
Month/Year	Month/Year	Position Title	Supervisor	
To				

12 YOUR EMPLOYMENT RECORD	Has any of the following happened to you in the last 7 years? If "Yes," begin with the most recent occurrence and go backward, providing date fired, quit, or left, and other information requested.		Yes	No

- Use the following codes and explain the reason your employment was ended:
- 1 - Fired from a job
 - 2 - Quit a job after being told you'd be fired
 - 3 - Left a job by mutual agreement following allegations of misconduct
 - 4 - Left a job by mutual agreement following allegations of unsatisfactory performance
 - 5 - Left a job for other reasons under unfavorable circumstances

Month/Year	Code	Specify Reason	Employer's Name and Address (Include city/Country if outside U.S.)	State	ZIP Code

Enter your Social Security Number before going to the next page

16 YOUR MILITARY HISTORY	Yes	No
a Have you served in the United States military?		
b Have you served in the United States Merchant Marine?		

List all of your military service below, including service in Reserve, National Guard, and U.S. Merchant Marine. Start with the most recent period of service (#1) and work backward. If you had a break in service, each separate period should be listed.

•Code. Use one of the codes listed below to identify your branch of service:

1 - Air Force 2 - Army 3 - Navy 4 - Marine Corps 5 - Coast Guard 6 - Merchant Marine 7 - National Guard

•O/E. Mark "O" block for Officer or "E" block for Enlisted.

•Status. "X" the appropriate block for the status of your service during the time that you served. If your service was in the National Guard, do not use an "X"; use the two-letter code for the state to mark the block.

•Country. If your service was with other than the U.S. Armed Forces, identify the country for which you served.

Month/Year	Month/Year	Code	Service/Certificate No.	Status				Country
				O	E	Active	Inactive Reserve	
To								
To								

17 YOUR SELECTIVE SERVICE RECORD	Yes	No
a Are you a male born after December 31, 1959? If "No," go to 18. If "Yes," go to b.		
b Have you registered with the Selective Service System? If "Yes," provide your registration number. If "No," show the reason for your legal exemption below.		

Registration Number _____ Legal Exemption Explanation _____

18 YOUR INVESTIGATIONS RECORD	Yes	No
a Has the United States Government ever investigated your background and/or granted you a security clearance? If "Yes," use the codes that follow to provide the requested information below. If "Yes," but you can't recall the investigating agency and/or the security clearance received, enter "Other" agency code or clearance code, as appropriate, and "Don't know" or "Don't recall" under the "Other Agency" heading, below. If your response is "No," or you don't know or can't recall if you were investigated and cleared, check the "No" box.		

Codes for Investigating Agency 1 - Defense Department 4 - FBI 2 - State Department 5 - Treasury Department 3 - Office of Personnel Management 6 - Other (Specify)	Codes for Security Clearance Received 0 - Not Required 3 - Top Secret 6 - L 1 - Confidential 4 - Sensitive Compartmented Information 7 - Other 2 - Secret 5 - Q
--	--

Month/Year	Agency Code	Other Agency	Clearance Code	Month/Year	Agency Code	Other Agency	Clearance Code

b To your knowledge, have you ever had a clearance or access authorization denied, suspended, or revoked, or have you ever been debarred from government employment? If "Yes," give date of action and agency. Note: An administrative downgrade or termination of a security clearance is not a revocation.	Yes	No
---	-----	----

Month/Year	Department or Agency Taking Action	Month/Year	Department or Agency Taking Action

19 FOREIGN COUNTRIES YOU HAVE VISITED	Yes	No
--	-----	----

List foreign countries you have visited, except on travel under official Government orders, beginning with the most current (#1) and working back 7 years. (Travel as a dependent or contractor must be listed.)

•Use one of these codes to indicate the purpose of your visit: 1 - Business 2 - Pleasure 3 - Education 4 - Other

•Include short trips to Canada or Mexico. If you have lived near a border and have made short (one day or less) trips to the neighboring country, you do not need to list each trip. Instead, provide the time period, the code, the country, and a note ("Many Short Trips").

•Do not repeat travel covered in items 9, 10, or 11.

Month/Year	Month/Year	Code	Country	Month/Year	Month/Year	Code	Country
#1	To			#5	To		
#2	To			#6	To		
#3	To			#7	To		
#4	To			#8	To		

Enter your Social Security Number before going to the next page →

20 YOUR POLICE RECORD (Do not include anything that happened before your 16th birthday.)					Yes	No
In the last 7 years, have you been arrested for, charged with, or convicted of any offense(s)? (Leave out traffic fines of less than \$150.)						
If you answered "Yes," explain your answer(s) in the space provided.						
Month/Year	Offense	Action Taken	Law Enforcement Authority or Court (City and county/country if outside the U.S.)	State	ZIP Code	

21 ILLEGAL DRUGS					Yes	No
The following questions pertain to the illegal use of drugs or drug activity. You are required to answer the questions fully and truthfully, and your failure to do so could be grounds for an adverse employment decision or action against you, but neither your truthful responses nor information derived from your responses will be used as evidence against you in any subsequent criminal proceeding.						
a In the last year, have you <u>illegally</u> used any controlled substance, for example, marijuana, cocaine, crack cocaine, hashish, narcotics (opium, morphine, codeine, heroin, etc.), amphetamines, depressants (barbiturates, methaqualone, tranquilizers, etc.), hallucinogenics (LSD, PCP, etc.), or prescription drugs?						
b In the last 7 years, have you been involved in the illegal purchase, manufacture, trafficking, production, transfer, shipping, receiving, or sale of any narcotic, depressant, stimulant, hallucinogen, or cannabis, for your own intended profit or that of another?						
If you answered "Yes" to "a" above, provide information relating to the types of substance(s), the nature of the activity, and any other details relating to your involvement with illegal drugs. Include any treatment or counseling received.						
Month/Year	Month/Year	Controlled Substance/Prescription Drug Used		Number of Times Used		
To						
To						
To						

22 YOUR FINANCIAL RECORD					Yes	No
a In the last 7 years, have you, or a company over which you exercised some control, filed for bankruptcy, been declared bankrupt, been subject to a tax lien, or had legal judgment rendered against you for a debt? If you answered "Yes," provide date of initial action and other information requested below.						
Month/Year	Type of Action	Name Action Occurred Under	Name/Address of Court or Agency Handling Case	State	ZIP Code	
b Are you now over 180 days delinquent on any loan or financial obligation? Include loans or obligations funded or guaranteed by the Federal Government.					Yes	No
If you answered "Yes," provide the information requested below.						
Month/Year	Type of Loan or Obligation and Account #	Name/Address of Creditor or Oblige	State	ZIP Code		

After completing this form and any attachments, you should review your answers to all questions to make sure the form is complete and accurate, and then sign and date the following certification and sign and date the release on Page 8.

Certification That My Answers Are True

My statements on this form, and any attachments to it, are true, complete, and correct to the best of my knowledge and belief and are made in good faith. I understand that a knowing and willful false statement on this form can be punished by fine or imprisonment or both. (See section 1001 of title 18, United States Code).

Signature (Sign in ink)	Date

Enter your Social Security Number before going to the next page

UNITED STATES OF AMERICA

AUTHORIZATION FOR RELEASE OF INFORMATION

Carefully read this authorization to release information about you, then sign and date it in ink.

I Authorize any investigator, special agent, or other duly accredited representative of the authorized Federal agency conducting my background investigation, to obtain any information relating to my activities from individuals, schools, residential management agents, employers, criminal justice agencies, credit bureaus, consumer reporting agencies, collection agencies, retail business establishments, or other sources of information. This information may include, but is not limited to, my academic, residential, achievement, performance, attendance, disciplinary, employment history, criminal history record information, and financial and credit information. I authorize the Federal agency conducting my investigation to disclose the record of my background investigation to the requesting agency for the purpose of making a determination of suitability or eligibility for a security clearance.

I Understand that, for financial or lending institutions, medical institutions, hospitals, health care professionals, and other sources of information, a separate specific release will be needed, and I may be contacted for such a release at a later date. Where a separate release is requested for information relating to mental health treatment or counseling, the release will contain a list of the specific questions, relevant to the job description, which the doctor or therapist will be asked.

I Further Authorize any investigator, special agent, or other duly accredited representative of the U.S. Office of Personnel Management, the Federal Bureau of Investigation, the Department of Defense, the Defense Investigative Service, and any other authorized Federal agency, to request criminal record information about me from criminal justice agencies for the purpose of determining my eligibility for assignment to, or retention in a sensitive National Security position, in accordance with 5 U.S.C. 9101. I understand that I may request a copy of such records as may be available to me under the law.

I Authorize custodians of records and other sources of information pertaining to me to release such information upon request of the investigator, special agent, or other duly accredited representative of any Federal agency authorized above regardless of any previous agreement to the contrary.

I Understand that the information released by records custodians and sources of information is for official use by the Federal Government only for the purposes provided in this Standard Form 85P, and that it may be redisclosed by the Government only as authorized by law.

Copies of this authorization that show my signature are as valid as the original release signed by me. This authorization is valid for five (5) years from the date signed or upon the termination of my affiliation with the Federal Government, whichever is sooner.

Signature (<i>Sign in ink</i>)	Full Name (<i>Type or Print Legibly</i>)	Date Signed
Other Names Used		Social Security Number
Current Address (<i>Street, City</i>)	State	ZIP Code
		Home Telephone Number (<i>Include Area Code</i>) ()

UNITED STATES OF AMERICA

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Carefully read this authorization to release information about you, then sign and date it in black ink.

Instructions for Completing this Release

This is a release for the investigator to ask your health practitioner(s) the three questions below concerning your mental health consultations. Your signature will allow the practitioner(s) to answer only these questions.

I am seeking assignment to or retention in a position of public trust with the Federal Government as a(n)

(Investigator instructed to write in position title.)

As part of the investigative process, I hereby authorize the investigator, special agent, or duly accredited representative of the authorized Federal agency conducting my background investigation, to obtain the following information relating to my mental health consultations:

Does the person under investigation have a condition or treatment that could impair his/her judgment or reliability?

If so, please describe the nature of the condition and the extent and duration of the impairment or treatment.

What is the prognosis?

I understand that the information released pursuant to this release is for use by the Federal Government only for purposes provided in the Standard Form 85P and that it may be redisclosed by the Government only as authorized by law.

Copies of this authorization that show my signature are as valid as the original release signed by me. This authorization is valid for 1 year from the date signed or upon termination of my affiliation with the Federal Government, whichever is sooner.

Signature (<i>Sign in ink</i>)	Full Name (<i>Type or Print Legibly</i>)		Date Signed
Other Names Used			Social Security Number
Current Address (<i>Street, City</i>)	State	ZIP Code	Home Telephone Number (<i>Include Area Code</i>) ()



PERSONAL QUALIFICATIONS SHEET – DENTAL ASSISTANT

1. Every item on the Personal Qualifications Sheet must be addressed. Please sign and date where indicated. Any additional information required may be provided on a separate sheet of paper (indicate by number and section the question(s) to be addressed).
2. The information you provide will be used to determine your technical acceptability. In addition to the Personal Qualifications Sheet, please submit two letters of recommendation as described in Item V.
3. After contract award, all of the information you provide will be verified. At that time, you will be required to provide the following documentation verifying your qualifications: Professional Training Certification, Personal and Professional Information Sheet, continuing education certificates, and U.S. citizenship documentation. If you submit false information, your contract may be terminated for default. This action may initiate the suspension and debarment process, which could result in the determination that you are no longer eligible for future Government contracts.
4. Health Certification. Individuals providing services under Government contracts are required to undergo a physical exam 60 days prior to beginning work. The exam is not required prior to award but is required prior to the performance of services under this contract. By signing this form, you have acknowledged this requirement.
5. Practice Information:

	Yes	No
1. Have you ever been the subject of a malpractice claim?	___	___
2. Have you ever been a defendant in a felony or misdemeanor case?	___	___
3. Has your license or certification to practice ever been revoked or restricted in any state?	___	___
4. Have you ever been arrested for or charged with a crime involving a child?	___	___
5. a. Are you a U.S. Citizen?	___	___
b. If yes, do you hold dual citizenship or a passport from a foreign country?	___	___

If any of questions 1 through 4 and 5b above is answered "yes" attach a detailed explanation. Specifically address the disposition of the claim or charges for numbers 1 through 4 above, and the State of the revocation for number 3 above. If you hold a dual citizenship or have a passport issued from a foreign country, address which country the dual citizenship is held and/or which foreign country has issued you a passport.

PRIVACY ACT STATEMENT

Under 5 U.S.C. 552a and Executive Order 9397, the information provided on this page and the remainder of the Personal Qualifications Sheet is requested for use in consideration of a contract; disclosure of this information is voluntary; failure to provide this information may result in the denial of the opportunity to enter into a contract.

_____ (mm/dd/yy)
 (Signature) (Date)



I. General Information

Name: _____ SSN _____
 First Middle Last

Address: _____

Phone: (___) _____

II. Professional Education:

Requirements: You must meet one of the following 7 categories of training and/or experience.	Address and Training Dates: Provide the name and address of the school where you received training and the date of completion.
(1) Certificate or Associate Degree as a dental assistant/technician from a state accredited program and 12 months experience within the preceding 36 months.	
(2) Certification from a dental technician or dental assistant "A" school and 12 months experience within the preceding 36 months.	
(3) Certification from a Red Cross Dental Assistant Course and 12 months experience within the preceding 36 months.	
(4) Certification from a Military Dental Assistant Course within the preceding 6 months.	
(5) 36 months experience within the preceding 60 months as a dental assistant in a private practice or a military clinic.	Document dates of experience under Item IV. of this form.
(6) Membership in good standing with the American Dental Assistants Association with required continuing education and 12 months experience within the preceding 36 months.	
(7) Graduation from a state accredited program for dental assisting or dental technology within the preceding 12 months	

III. Certification or Permit for use of Dental X-Ray Equipment:

Date: _____
 Certification or Permit Number: _____

IV. Professional Employment: List your current and preceding employers. Provide dates as month/year. If more space is required, please use a separate sheet of paper:

Name and Address of Present Employer From To

1) _____



 Work Performed: _____

<u>Names and Addresses of Preceding Employers</u>	<u>From</u>	<u>To</u>
2) _____	_____	_____

Work Performed: _____

<u>Names and Addresses of Preceding Employers</u>	<u>From</u>	<u>To</u>
3) _____	_____	_____

Work Performed: _____

Are you are currently employed on a Navy contract? If so, where is your current contract and what is the position? _____

V. Professional References

Provide two letters of recommendation from either practicing dentists or, if you graduated from a dental training program within the preceding 12 months, letters may be provided by faculty members where you received your dental assistant training. The letters must attest to your clinical skills, patient rapport, etc. Recommendation letters must include name, title, phone number, date of reference, address and signature of individual providing the letter. Reference letters must have been written within the preceding three years.

VI. Continuing Education

<u>Title Of Course</u>	<u>Course Dates</u>	<u>CE Hrs</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

VII. Basic Life Support: Certification in American Heart Association Basic Life Support (BLS) for Healthcare Providers; American Heart Association Healthcare Provider Course; American Red Cross CPR (Cardio Pulmonary Resuscitation) for the Professional Rescuer; or equivalent.

Training Type listed on Card:
 Expiration Date: _____ (mm/dd/yy)

VIII. I hereby certify the above information to be true and accurate:

 (Signature)

 (Date)



Hepatitis B Declination Statement*

The following statement of declination of hepatitis B vaccination must be signed by an employee who chooses **not to accept** the vaccine. The statement can only be signed by the employee following appropriate training regarding hepatitis B, hepatitis B vaccination, the efficacy, safety, method of administration, and benefits of vaccination, and that the vaccine and vaccination are provided free of charge to the employee. The statement is not a waiver; employees can request and receive the hepatitis B vaccination at a later date if they remain occupationally at risk for hepatitis B.

Declination Statement

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to me; however, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee Signature: _____ Date: _____



Rep: _____

Fax to 404-257-9500

**BACKGROUND CHECK
AUTHORIZATION AND RELEASE FORM**

**** THIS FORM CANNOT BE PROCESSED IF INCOMPLETE, ILLEGIBLE OR INACCURATE!!!!****

I, _____, having applied for employment,
(PLEASE PRINT FULL LEGAL NAME)

do hereby authorize ALL FACTS, INC. to obtain any information regarding my credit, traffic information, including history of violations and status of Driver's License, education history and employment history including evaluations. Said information is to be released to ALL FACTS, INC., for dissemination to _____. I further release and hold harmless any employee of ALL FACTS, INC., and any business or individual who supplies said information, from any liability resulting from dissemination of said information.

Dr.Lic.# or ID# _____ State _____

Name as it appears on Driver's License _____

SSN#: _____ Place of Birth _____

Other Names used since 2001: 1) _____ Dates: From _____ To _____
(maiden name/aliases) month/year month/year
2) _____ Dates: From _____ To _____
month/year month/year

How many consecutive years have you lived in Georgia? _____

Please print addresses (including city/State/zip code/dates) for **PAST 10 YEARS**.
(If any additional space is needed, please use separate sheet.)

1. _____ Dates: From _____ To _____
month/year month/year
2. _____ Dates: From _____ To _____
month/year month/year
3. _____ Dates: From _____ To _____
month/year month/year
4. _____ Dates: From _____ To _____
month/year month/year
5. _____ Dates: From _____ To _____
month/year month/year

Date of active military service (if applicable or write N/A): From _____ To _____ (Mo/Yr)

=====

The following is required for criminal record identification purposes only:

Date of Birth _____
Race _____
Sex _____

CONSENT FORM

I hereby authorize ALL FACTS, INC./ _____ to receive any criminal history record information pertaining to me which may be in the files of any State or local criminal justice agency in Georgia or any other State.

Signature of Applicant

Date

**DISCLOSURE TO EMPLOYMENT APPLICANT
REGARDING PROCUREMENT OF
CONSUMER REPORT**

In connection with your application for employment, we may procure, or cause to be procured, a consumer report on you as part of the process of considering your candidacy as an employee. In the event that information from the report is utilized in whole or in part in making an adverse decision with regard to your potential employment, before making the adverse decision we will provide you with a copy of the consumer report and a description in writing of your rights under the law.

By your signature below, you hereby authorize us to obtain a consumer report about you in order to consider you for employment.

Applicant's Name

Social Security Number

Address

City, State, Zip

Applicant's Signature

Welcome to FormFire!

Southern Crescent Personnel Inc. is using FormFire in conjunction with Paychex Insurance Agency, Atlanta Office to ensure you're getting the best possible medical coverage at the best price. With FormFire, you'll enter your information online one time rather than filling out multiple paper applications. Since your information is stored securely from year to year, next time, you'll only have to verify your information and make any updates.

Creating your account:

To get started, visit <http://www.formfire.com> and click "Sign Up". You will need the employer code listed below:

68D2798

Southern Crescent Personnel Inc.'s Employer Code

Frequently Asked Questions

Will this take long?

No. If you don't have many changes to make, updating your FormFire account shouldn't take more than five or ten minutes.

What if I'm waiving coverage?

Even if you're waiving coverage, you must still create an account unless directed otherwise. However, you will not be required to enter any medical information about you or your dependents. On average, it takes someone waiving coverage about 10 minutes to create an account and sign.

What if I have more questions?

After logging in, additional help and answers to frequently asked questions are provided throughout the site, including multiple ways to contact us or your benefits broker.

Please have the following information ready prior to starting:

Information about yourself

- Date of birth (please use MM/DD/YYYY format)
- Date of marriage, if married
- Home address and phone number
- Height and weight
- Name and phone number of your primary care physician
- Your employer's name, your occupation, date of hire, and number of hours worked per week
- If electing Life Insurance coverage, whether your income is reported by W2 or 1099

Information about any dependents

- Full legal name of individuals
- Dates of birth
- Social Security Numbers
- Heights and weights
- Names and phone numbers of primary care physicians

If you have prior or existing medical coverage

- Policy holder's name and Social Security Number
- If the coverage is current, whether or not it will expire or continue when the new coverage becomes effective
- Name, address, and telephone of insurance carrier
- Policy number
- Effective/End dates of coverage
- Coverage type (medical, dental, etc.) and who is covered (e.g., employee only, employee and spouse, etc.)
- Names of covered individuals (e.g., you and your dependents)

Information about any medical conditions

- Condition Name
- Treatment Dates
- Medications and Dosages
- Any other relevant details



FORMFIRE 



Privacy and Your Health Information

Your Privacy Is Important to All of Us

Most of us feel that our health and medical information is private and should be protected, and we want to know who has this information. Now, Federal law

- ▶ Gives you rights over your health information
- ▶ Sets rules and limits on who can look at and receive your health information

Your Health Information Is Protected By Federal Law

Who must follow this law?

- ▶ Most doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other health care providers
- ▶ Health insurance companies, HMOs, most employer group health plans
- ▶ Certain government programs that pay for health care, such as Medicare and Medicaid

What information is protected?

- ▶ Information your doctors, nurses, and other health care providers put in your medical record
- ▶ Conversations your doctor has about your care or treatment with nurses and others
- ▶ Information about you in your health insurer's computer system
- ▶ Billing information about you at your clinic
- ▶ Most other health information about you held by those who must follow this law

The Law Gives You Rights Over Your Health Information

Providers and health insurers who are required to follow this law must comply with your right to

- ▶ Ask to see and get a copy of your health records
- ▶ Have corrections added to your health information
- ▶ Receive a notice that tells you how your health information may be used and shared
- ▶ Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as for marketing
- ▶ Get a report on when and why your health information was shared for certain purposes
- ▶ If you believe your rights are being denied or your health information isn't being protected, you can
 - ▷ File a complaint with your provider or health insurer
 - ▷ File a complaint with the U.S. Government

You should get to know these important rights, which help you protect your health information. You can ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint, from the website at www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748; the phone call is free.

