iprospectcheck.com
KNOW BEFORE YOU HIRE

AUTHORITY TO RELEASE INFORMATION

To: Any person having knowledge of my conduct or activities, or any past, present or future Employer, Credit Bureau, Bank, Financial Institution, Dean, Registrar, Principal, Counselor, Instructor, or School, Doctor, Hospital, Clinic or Medical Facility, Law Enforcement Agency, Government Agency or Armed Forces:

iprospectcheck.com, LLC has been retained to conduct an appropriate background investigation of me and prepare a consumer report which may be used as a factor in determining my eligibility for employment, promotion or retention as governed by the Fair Credit Reporting Act. I understand this report may include information from personal interviews about my character, general reputation, personal characteristics and mode of living as well as both public and private sources including but not limited to information contained in federal, state and local records, public and private databases and repositories, criminal records, my credit report, employment records, school records, driving records or abstracts, licensing boards and registries, etc. I understand I may be entitled to certain disclosures and have been given access to a copy of "A Summary of Your Rights under the FCRA" available to me at www.iprospectcheck.com .

I hereby authorize all persons who may have information relevant to this investigation to disclose it to iprospectcheck.com, LLC or their agents, and I release all persons from any liability on account of such disclosure. I hereby further authorize that a photocopy of this authorization may be considered as valid as an original.

Signature: _____ Date: _____

Furnished for the purpose of positive identification: (Print Clearly)

First: _____ MI: _____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

Other names you have been known as: (maiden name, etc.):

_____

SSN: _____-_____-_____ DOB: _____/_____/_____

Driver License#: _____ State: _____

Professional License #:_____ State:_____

Address History (Past 7 Years)

_____

_____

_____

Notice to California, Minnesota and Oklahoma Residents

Under California, Minnesota and Oklahoma law, you have a right to receive a free copy of your consumer report upon request. You may obtain a copy of the consumer report upon submitting proper identification and paying the costs of duplication services.

You may call iprospectcheck.com at (888) 808-9997 to make such a request or check this box and a copy will be provided to you. ☐

StaffingEtc.

"Where excellence is our goal"

DRUG TESTING DISCLOSURE

Disclosure:

Prior to testing at the lab, please disclose to Staffing Etc. all prescription and non-prescription drugs used and their purpose during the last 30 days.

Any applicant who waives the disclosure of providing Staffing Etc. with information on any prescription or non-prescription drugs used in the last 30 days and the applicant tests positive, they will not be hired. Any applicant who refuses to submit to a drug test or who interferes with the test will not be hired.

I wish to disclose that I am currently taking the following

Prescription Drugs:

_____

_____

_____

(I understand, for any prescription drugs, I must provide a copy of a current, valid prescription prior to being cleared regarding any positive results.)

Non Prescription Drugs:

_____

_____

_____

Name:_____

Date:_____

StaffingEtc.

REFERENCE RELEASE AUTHORIZATION

I hereby authorize you to release the requested information to Staffing Etc, a prospective employer.

It is expressly understood that any information given is used for the purpose of determining my acceptability for employment. A photocopy of this authorization shall be deemed as effective as the original.

Name of Professional Reference:_____

Telephone number of Professional Reference:_____

Applicant's Name: _____(Please print)

Applicant's Signature:_____

Please list all names under which employed. (Please print)

Social Security Number: _____-_____-_____

Position Held: _____Dates Employed: FROM_____ TO_____

	Excellent	Good	Fair	Poor
Job Knowledge				
Quality				
Quantity				
Attitude				
Dependability				
Punctuality				

Reason for leaving:

Eligible for re-employment: ▫ Yes ▫ No If no, please explain:_____
_____

Salary/Hourly Rate: _____ Comments:_____

Reference Signature/Name:_____Title: _____

Name of Company:_____ Date:_____

Circle the type of reference you are completing. For telephone references, Staffing Etc. representatives should sign when completed.

Telephone

_____

(Completed By)

Mail

A self addressed, stamped envelope is included for your mailing convenience.

StaffingEtc.

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Position Held: _____Dates Employed: FROM_____ TO_____

	Excellent	Good	Fair	Poor
Job Knowledge				
Quality				
Quantity				
Attitude				
Dependability				
Punctuality				

Reason for leaving:

Eligible for re-employment: ◦ Yes ◦ No If no, please explain:_____
_____

Salary/Hourly Rate: _____ Comments:_____

Reference Signature/Name:_____Title: _____

Name of Company:_____ Date:_____

Circle the type of reference you are completing. For telephone references, Staffing Etc. representatives should sign when completed.

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StaffingEtc.

STATEMENT OF GOOD HEALTH

PATIENT'S NAME: _____

DATE OF BIRTH: _____

I have examined the above-named person and certify that he/she is free from disease in communicable form; as of this date, the person appears to be in satisfactory physical and mental condition and able to function in his/her professional capacity with no limitations.

_____ _____

Physician/CNP Signature **Date**

_____

Physicians Printed Name

_____

Address

_____

City, State, Zip Code

_____

Phone Number

6525 Belcrest Road, Suite 526 Hyattsville, MD 20782 • Tel. 301-403-8838, Fax 301-403-8859

StaffingEtc.

HEPATITIS B DECLINATION FORM

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. 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 very serious disease.

_____ _____

Print Name Signature

_____

Date

StaffingEtc.

PPD TUBERCULOSIS SKIN TEST

PATIENT'S NAME: _____

DATE OF BIRTH: _____

PPD

Date Given:_____

Date Read:_____

- ☐ **Negative (non-reactive)**
- ☐ **Positive (reactive)** _____**mm**

Chest X-Ray

Chest Xray Date:_____

Chest Xray Findings:

- ☐ **Negative**
- ☐ **Positive**

_____ _____

Physician/CNP Signature **Date**

9410 Annapolis Road, Suite 200, Lanham, MD 20706 ● Tel. 301-403-8838, Fax 301-403-8859

StaffingEtc.

EMPLOYEE HEALTH
TUBERCULOSIS (TB) SCREENING

EMPLOYEE NAME: (Print) DATE:

SECTION EMPLOYEE COMPLETES THE FOLLOWING QUESTIONS:

Do you currently have any of the following that has lasted three (3) weeks or longer?

	Yes	No
1. Unexplained productive cough?	☐	☐
2. Unexplained weight loss?	☐	☐
3. Unexplained appetite loss?	☐	☐
4. Unexplained fever?	☐	☐
5. Night sweats?	☐	☐
6. Shortness of breath?	☐	☐
7. Chest pain?	☐	☐
8. Increased fatigue?	☐	☐
9. Bloody sputum?	☐	☐

Have you:

	Yes	No
1. Ever been told you have TB?	☐	☐
2. Lived with anyone with TB?	☐	☐
3. Had a positive TB skin test?	☐	☐
4. Had a BCG vaccination?	☐	☐
5. Date of last negative PPD skin test result: ___		
6. Do you have documentation of a negative TB skin test within the last 12 months?	☐	☐

Employee Signature: _____ **Date:** _____

Physician's Signature: _____ **Date:** _____

SECTION II OFFICE COMPLETES: Check the appropriate statements below)

Signs and Symptoms Suggestive of TB:

The above questionnaire indicates symptoms suggestive of infectious tuberculosis. A statement of a medical evaluation is required prior to resumption of work indicating the employee is free from infectious TB. Refer employee for a medical evaluation. (Send a copy of this form to the health care practitioner.)

Previous TB Infection OR
Prior Positive Reaction:

☐ Presents documentation of previously reacting **(+)** positive to a TB skin test on:_____/_____/_____or the employee reports having previously been infected with TB and has a medical statement that they were treated and free of infectious TB at this time. The employee does not report any signs and symptoms suggestive of TB. Do not administer PPD skin test. Schedule the employee in a tickler system indicating when the next periodic TB screening needs to be administered. A chest x-ray for TB is not indicated at this time.

☐ The employee reports a previously reacting (+) positive to a TB skin test or reports having previously been ***infected*** with TB and has no medical documentation that they are free of infectious TB at this time. The employee must provide medical documentation that they are free of infectious TB prior to any work assignment.

Prior BCG Vaccination:

☐ If the employee has had a BCG vaccination, the BCG vaccination may produce a PPD reaction than cannot be distinguished reliably from a reaction caused by infection with M. tuberculosis. During the initial evaluation, employees with a history of BCG vaccination and no prior positive reaction have a baseline PPD Mantoux TB skin test performed and periodically thereafter.. -

Negative TB Skin Test in the Last Three (3) Months:

☐ **The employee** has documentation of a negative TB skin test within the last 3 months. Schedule the employee in a tickler system that indicates the next periodic time point that TB screening needs to be administered.
Upon hire, the employee does not have or is not able to produce documentation of a negative TB skin test within the last 3 months. Administer the PPD skin test.

Negative TB Skin Test in the Last Twelve (12) Months:

☐ Upon hire, the employee has documentation of a negative TB skin test within the last 12 months but not within the last 3 months. Administer the PPD TB skin test.

☐ The employee does not have or is not able to produce documentation of a negative TB skin test within the last 12 months. Administer the PPD two-step method TB skin test.

I understand that if I am pregnant, I will consult with my physician who will determine if it is safe for me (and the fetus) to receive the tuberculosis skin test. If my physician decides or I refuse to have a PPD TB skin test while pregnant, I will submit a medical statement indicating that I am free of infectious TB.

I understand that if I am immunosuppressed, l must make my own educated decision as to the acceptance of an assignment where there may be exposure to TB. I understand that I may be unable to react to skin test antigens due to a suppressed immune system. Instead of a PPD TB skin test, I can be referred to the local health department for testing and evaluation.

I do not have known hypersensitivity to the PPD skin test or its components.

I understand that vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons and will report such adverse events to my usual healthcare provider immediately and will also notify Staffing Etc.

I understand that pain, pruritus, and/or discomfort may occur at the test site.

I_____, consent to have a PPD tuberculosis skin test. I will return to have the test
Employee Name (Print)

read on _____ at_____. I understand if I do not return at this time, I must have the test repeated.
Date *Time*

Employee Signature:_____ Date:_____

Witness:_____ Date:_____

SECTION IV PPD TUBERCULOSIS SKIN TEST

❑ This employee reacted **(+) positive** to his/her PPD TB skin test. This is a new reaction. Prior to resumption of work, written documentation of a medical evaluation stating the employee is free of infectious TB is required.

□ This employee reacted **(-) negative** to his/her TB skin test. No further follow-up is required for this TB screening.

❑ This employee reacted **(-) negative** to his/her TB skin test. Because this employee did not present documentation that they had a negative TB skin test in the last 12 months, a two-step PPD TB skin test is required The employee ***is scheduled for the next PPD TB skin test in one to three (1 - 3) weeks on*** / /

SECTION V

Other: (e.g.,State specific health requirements)

Date and Time Given: □ Left Forearm □ Right Forearm

Administered By:_____ Title_____

Lot#_____ Expiration Date: _____

Date and Time Read: _____

Read By:_____

Reading Results:

Negative (non-reactive) □ Positive (reactive) _____ mm

Description:_____

READ 48 -72 HOURS AFTER INJECTION