



## LINDA HEALTHCARE CONTRACTOR APPLICATION

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### PERSONAL INFORMATION

NAME \_\_\_\_\_  
FIRST MIDDLE LAST

PRESENT ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

PERMANENT ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

PHONE #HOME \_\_\_\_\_ &ALTERNATE \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

DOB \_\_\_\_\_ SOC SEC # \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_  
NAME PHONE#

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### CONTRACT POSITION DESIRED

POSITION \_\_\_\_\_ DATE AVAILABLE TO START \_\_\_\_\_ SALARY DESIRED \_\_\_\_\_

IF YOU ARE EMPLOYED, MAY WE INQUIRE OF YOUR PRESENT EMPLOYER? YES NO

PRESENT EMPLOYEER \_\_\_\_\_ PHONE # \_\_\_\_\_

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EDUCATION	NAME & LOCATION	#YRS ATTENDED	COMPLETED	DEGREE OBTAINED
HIGH SCHOOL				
COLLEGE				
OTHER				



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LIST SUBJECTS OF SPECIAL STUDY OR TRAINING \_\_\_\_\_

FORMER EMPLOYERS (LIST LAST THREE EMPLOYERS, STARTING WITH MOST RECENT/CURRENT)

DATES OF EMPLOYMENT	NAME & ADDRESS OF EMPLOYER	SALARY	POSITION	REASON FOR LEAVING
FROM TO				
FROM TO				
FROM TO				

REFERENCES (LIST THREE PROFESSIONAL REFERENCES NOT RELATED TO YOU)

NAME	ADDRESS	TELEPHONE #	# YRS KNOWN

### AUTHORIZATION AND CERTIFICATION

BY SIGNING BELOW I ACKNOWLEDGE THE FOLLOWING:

1. THE INFORMATION IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.
2. IF ACCEPTED AS A CONTRACTOR, FALSE STATEMENTS SHALL BE GROUNDS FOR TERMINATION OF THIS CONTRACT.



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3. THE CONTRACT IS FOR AN INDEFINITE PERIOD.
4. THERE IS NO MINIMUM GUARANTEE AS TO HOURS OR DAYS WORKED.
5. UPON REGISTERING WITH HANDS ON SURGICAL ASSISTANTS, APPLICANT MAY NOT SEEK OR ACCEPT EMPLOYMENT OR CONTRACT SERVICES TO ANY CLIENT, COMPANY OR INDIVIDUAL DOING BUSINESS WITH HOSA, FOR A PERIOD OF 180 DAYS FROM THE DATE OF LAST CONTACT WITH THAT CLIENT.

APPLICANT'S SIGNATURE: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ACCEPTED BY: \_\_\_\_\_ DATE \_\_\_\_\_