# OMV MEDICAL, INC.

6940 CARROLL AVENUE •TAKOMA PARK, MD 20912 • PHONE 301-270-9212 •FAX 301-270-9335

**Welcome to the OMV Medical application process.**

**Who We Are…**

OMV Medical, Inc. (OMV) has successfully provided diversified health care services since 1987. The Company was founded with the vision of providing the most professional health care workers, in the timeliest manner, while representing the best value to the customer. This vision continues to be the primary motivation of OMV today. Currently, a cadre of OMV health care professionals delivers quality patient care throughout the United States. To date the company has supplied over 2,500 health care professionals to our customers across the United States at JCAHO-accredited hospitals, outpatient treatment facilities, the Veterans Administration Medical Center, military treatment facilities, occupational health centers, FEMA, university affiliated medical centers, hospitals, and rehabilitation centers.

OMV stands above the rest, rising to any challenge by demonstrating an unfailing capability to adapt itself to the unique needs of each facility. The Company has an excellent track record of meeting all contractual obligations and going above and beyond our customer expectations when necessary. OMV has positioned itself to meet the requirements of any medical facility. We can provide any service needed by our customers in an efficient manner.

OMV's senior executives are experienced health care professionals with varied backgrounds in education and training. With over eighty years combined experience in direct patient care, health care administration, and procurement of health care services, OMV has all the necessary tools and experience to support our customers and the needs of their eligibility beneficiaries in a timely manner. OMV is headquartered in the historic district of Takoma Park, Maryland with regional offices in San Antonio, Texas, San Diego, California and three additional satellite offices in North Carolina. OMV is available 24 hours a day, seven days a week to meet the needs of our customers and employees.

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# Pre- Employment Application

Our Company is an equal opportunity employer and will consider all applicants for all positions equally without regard to race, sex, age, color, religion, national origin, veteran status or any disability as provided in the Americans with Disabilities Act.

This application will be given every consideration, but its receipt does not imply that the applicant will be employed. Each question should be answered in a complete and accurate manner as no action can be taken on this application until all questions have been answered.

Date_____________________

## PERSONAL:

Name______________________________ Home Phone (___ )______Cell Phone (____)______________
LAST FIRST MIDDLE

Address ________________________________________________________________________________
STREET CITY STATE ZIP CODE

Email Address_________________________________ Date of Birth _____________________________

Social Security No ___________________ Are you over 18 ? Yes ❑ No ❑

Are you a citizen of the U.S. or do you have the legal right to be employed in the United States?

Yes ❑ No ❑

Have you ever been convicted of any crime (excluding minor traffic violations) including driving under the influence of alcohol and/or drugs? Yes ❑ No ❑
If yes, state the offense, location, date and disposition.
NOTE: A Conviction will not necessarily disqualify you from employment.

You must have a **MINIMUM** of two years current experience.
Clinical experience or Specialty ________ Shift Preferred_____________Full time or Part time________

Position applying for ______________________ Salary Desired $________________

Date Available to start __________________________

How did you learn about our company and/or the position? __________ Who referred you to us? ________

## EDUCATION:

College: __________ ________ ________________ _____________ ________________
NAME/ LOCATION MONTH/YEAR GRAD DEGREE/DIPLOMA

Graduate School: ______________________________________ ______________ ________________
NAME/LOCATION MONTH/YEAR GRAD DEGREE/DIPLOMA

Other: ______________________________________ ______________ ________________
NAME/LOCATION MONTH/YEAR GRAD DEGREE/DIPLOMA

## LICENSURE/CERTIFICATIONS:

| LICENSE/CERTIFICATION # | STATE | TYPE | EXPIRATION |
|---|---|---|---|
| ________________________ | __________ | _______________ | _________________________________ |
| ________________________ | __________ | _______________ | _________________________________ |
| ________________________ | __________ | _______________ | _________________________________ |
| ________________________ | __________ | _______________ | _________________________________ |

## CONTINGENCY TRAINING:

| TRAINING | C/T | EXPIRATION (MM/YY) |
|---|---|---|
| BLS | | |
| ACLS | | |
| PALS | | |
| NALS | | |

## MILITARY:

Have you ever served in the military? Yes ❑ No ❑ Service Branch ___________________________

## EMPLOYMENT HISTORY: (Most recent first. If employed by an agency, state "Agency" as "Employer", and state place of employment)

1. Employer: Supervisor's Name:

Address: Contact number:

City, State, Zip code: Dates Employed: to

Job Title: Salary May we contact them?

Duties:

Reason for Leaving:

2. Employer: Supervisor's Name:

Address: Contact number:

City, State, Zip code: Dates Employed: to

Job Title: Salary May we contact them?

Duties:

Reason for Leaving:

3. Employer: Supervisor's Name:

Address: Contact number:

City, State, Zip code: Dates Employed: to

Job Title: Salary________ May we contact them?

Duties:

Reason for Leaving:

## REFERENCES:

1. NAME ________________________________________ POSITION_______________
   ADDRESS _____________________________________________________________
   TELEPHONE ____________________________________________

2. NAME ________________________________________ POSITION_______________
   ADDRESS _____________________________________________________________
   TELEPHONE ____________________________________________

3. NAME ________________________________________ POSITION_______________
   ADDRESS _____________________________________________________________
   TELEPHONE ____________________________________________

## AFFIDAVIT:

I certify that my answers to the foregoing questions are true and correct without any consequential omissions of any kind whatsoever. I understand that if I am employed, any false, misleading or otherwise incorrect statements made on this application form or during any interviews may be grounds for my immediate discharge.

I hereby authorize OMV Medical, Inc. to contact any company or individual it deems appropriate to investigate my employment history, character and qualifications, and I give my full and complete consent to their revealing any and all information they wish as a result of this investigation. In addition, I hereby waive my right to bring any cause of action against these individuals for defamation, invasion of privacy, or any other reason because of their statements.

I agree that, if I am employed, I will abide by all the rules and regulations of the company. I understand that the taking of a drug and alcohol test, when given pursuant to company policy, are a condition of continued employment and refusal to take such tests when asked will be grounds for my immediate termination. I further understand that nobody in the company is authorized to enter into any written or verbal employment contracts with me for any definite period of time without the express written consent of the President of the company. I also understand that my employment is "at-will" and may be terminated by myself or by the company at any time for any reason or no reason at all, with or without prior notice.

SIGNATURE ___________________________________ DATE __________________________

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# RELEASE/CONSENT STATEMENT

## PRIVACY ACT STATEMENT

| | |
|---|---|
| **Authority:** | 42 USC 13041 and 10 USC 3013 |
| **Principal Purpose:** | To comply with requirements of Public Law 101-647, Section 231 (Crime Control Act, 1990) |
| **Routine Uses:** | To perform the background check requirement of the statute |
| **Disclosure:** | Mandatory. Failure to disclose the information precludes consideration of an application for employment in a child care workers position, or may form the basis for removal from a child care workers position if you are a current incumbent of a child care worker position |

## EMPLOYEE STATEMENT

I have been advised that my being hired will be based upon successful completion of a criminal history background check. I understand that the background check includes both a fingerprint check by the FBI's Identification Division and a name check against a State Criminal History Repository in each state where I have resided 5 years prior to hire. I authorize OMV Medical, Inc to forward the information for the purpose of conducting the required check(s)

NAME (Last, First, MI) ______________________________________________

DATE __________________________________________________________

SIGNATURE _____________________________________________________

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# APPLICANT ACKNOWLEDGEMENT OF EMPLOYER OBLIGATION

## EMPLOYEE STATEMENT

My signature below acknowledges that I have been advised that pursuant to Section 231(d) of the Crime Control Act of 1990, my prospective employer is required to obtain this information. As an employee or prospective employee of the Federal government, I understand that if the report contains adverse information. I have a right to challenge the accuracy or completeness of the report.

Have you ever been arrested for or charged with a crime involving a child?
If so, describe the disposition of the arrest or charge. (Under Public Law 101-647, Section 231, this statement is made under penalty of perjury, with the applicable Federal punishment of perjury.)

Please circle the appropriate response: YES NO
Comments:

**NAME (PRINTED) (LAST, FIRST, MI)** ________________________________________________

**DATE** ________________________________________________________________________

**SIGNATURE** ____________________________________________________________________

**NEE (NAME AT BIRTH)** _________________________________________________________

**ALIASES** ______________________________________________________________________

**SOCIAL SECURITY NUMBER** _____________________________________________________

**DATE IF BIRTH** _________________________________________________________________

**PLACE OF BIRTH** ________________________________________________________________

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# DIRECT DEPOSIT AUTHORIZATION

- Complete ALL the information below, including signature and date.
- Attach a voided check to this form - **NOTE: REQUEST CANNOT BE PROCESSED WITHOUT A VOIDED CHECK**
- New requests/changes require AT LEAST one full pay period to take effect.

| Check one of the following:<br>___New Request ___Change an existing request ___Request to discontinue | | |
|---|---|---|
| Name (Last, First, Middle Initial) | | |
| Name of Financial Institution (Bank, Credit Union etc.) | | |
| City | | State |
| ABA Bank Routing Number (Must be 9 numbers) | Account Number | Deposit Amount |
| Account Type: ____Checking ____Savings | | |

To make a deposit to a second account, please complete the following:

| Name of Financial Institution (Bank, Credit Union etc.) | | |
|---|---|---|
| City | | State |
| ABA Bank Routing Number (Must be 9 numbers) | Account Number | Deposit Amount |
| Account Type: ____Checking ____Savings | | |

I authorize OMV Medical, Inc. and the financial institution(s) named above to automatically deposit funds to my account(s). This includes my authorization to reverse any entries in error, under the condition that I am notified of said judgment. This authority will remain in effect until I give written notice to cancel it.

SIGNATURE ________________________________________ DATE_________________

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# PERSONNEL DATA SHEET

## EMPLOYEE TO COMPLETE THIS SECTION:

NAME (Last, First, MI) ____________________________________________________

DATE OF BIRTH __________________________________ SSN ____________________

ADDRESS ______________________________________________________________

CITY ____________________________ STATE _____________ ZIP ________________

HOME PHONE ________________________ CELL PHONE ________________________

EMAIL ADDRESS _________________________________________________________

EMERGENCY CONTACT ______________________________RELATIONSHIP ___________

PHONE NUMBER ________________________________ALTERNATE PHONE __________

## OMV USE ONLY:

POSITION/TITLE ________________________ DATE OF HIRE _________________

CONTRACT/WORK SITE ___________________________WORK STATE __________

EMPLOYMENT STATUS ____FT ____PT ____PRN RATE $ _______________

BENEFITS _____YES ____NO

________________________________________________

________________________________________________

________________________________________________

________________________________________________

________________________________________________

W4 ___ State Withholding ___ Direct Deposit ___ Employee # ___ I9 ___

# Memorandum

**TO:** All Applicants

**FROM:** Olga E. James
President

**SUBJECT:** Affirmative Action Policy Statement

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OMV Medical, Inc. is an Equal Opportunity Employer. It is the Corporation's continuing policy to recruit, hire, train, and promote qualified individuals in all job categories without regard to race, color, religion, sex, age, national origin, handicap or veteran status. In addition, OMV Medical continues to be committed to Affirmative Action Programs regarding the recruitment, employment, development, and promotion of minorities, females, the handicapped, and Vietnam-era veterans. It is our commitment to provide a work environment free from discrimination and sexual harassment.

Our policy of equal employment opportunity applies to all phases of the employment process, including compensation, benefits, training, transfers, layoffs, educational assistance and social and recreational programs. It is constructed and implemented to assist in achieving equality of opportunity in all aspects of employment at OMV MEDICAL and, as a Federal Government contractor, in complying with Executive Orders.

Each decision maker, manager, or supervisor within OMV MEDICAL is responsible for the achievement of Affirmative Action Program objectives in his/her respective area of responsibility. OMV Medical's Human Resource Director is designated, as the Equal Employment Officer of the Company and will be responsible for communicating and implementing this policy at the corporate office and all OMV branches as well as monitoring related OMV policies and programs. The Human Resource Director can be reached at 301-270-9212.

In carrying out this corporate policy, the Human Resource Department will also review all personnel policies and procedures to insure nondiscrimination as it applies to qualified handicapped persons, disabled veterans and veterans of the Vietnam era.

In order to accomplish this goal, job qualification requirements will be reviewed to insure relevance and consistency with the physical and mental demands of the job. Reasonable accommodations will be made to the physical and mental limitations of employees and applicants who are otherwise qualified to perform a job unless such an accommodation would impose an undue business hardship or impair the safe performance on the job.

It is the responsibility of all OMV staff members to cooperate and participate in fulfilling the objective of this policy.

*Olga E James*
**President & CEO**

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## AFFIRMATIVE ACTION QUESTIONNAIRE

All information is to be provided on a voluntary basis.
OMV Medical will use this information only as a basis of statistical reporting.
No employment decisions are made on the information provided in this form.

Position Applying for: ______________________________ Date: __________________________

Please check all that apply to you:

Male _____ Female _____
Veteran _____ Non-Veteran _____

Check One:

Asian ____ African American____
Hispanic ____ Native American ____
Caucasian ____ Other ____

How did you learn of our Company and/or the position? _________________________________

Do you wish to state a federally recognized handicap or medical impairment? If so, please describe below:

***Thank you for completing this questionnaire.***

***Your efforts will ensure that OMV Medical maintains our proud reputation of being an Equal Opportunity Employer.***

# PHYSICAL ASSESSMENT

**Employee Name:**_______________________________________________

**Blood Pressure:**_______________ **Weight:**___________________

| BODY SYSTEM | WNL | ABNORMAL |
|---|---|---|
| Skin | | |
| Head/EENT | | |
| Neck | | |
| Lungs | | |
| Heart | | |
| Breast | | |
| Abdomen | | |
| Back | | |
| Neurologic | | |
| Musculoskeletal | | |

**TB Screen**

**PPD: Date:**______________ **Results:**_________________

**CXR: Date:**______________ **Results:**_________________

**Hepatitis B Vaccine Dates**

**#1**______________ **#2**_______________ **#3**_______________

**Hepatitis B Titer Date:**________________ **Positive:**_______ **Negative:**_______

**H/O Chicken Pox** **Yes:**___________ **No:**____________

**Vaccine Date:**__________

**Varicella Titer Date:**_____________ **Positive:**_______ **Negative:**_______

**MMR Vaccine Dates**

**#1**______________ **#2**_______________

**MMR Titer Date:**________________ **Positive:**_______ **Negative:**_______

**Rubella Titer Date:**______________ **Positive:**_______ **Negative:**_______

**Rubeola Titer Date:**_____________ **Positive:**_______ **Negative:**_______

**I have examined the above named person and certify that he/she is free of communicable diseases and in a satisfactory physical condition**

**Physician Signature**__________________________ **Date:**__________________

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## REFERENCE RELEASE

I, _____________________ have given OMV Medical, Inc. permission to request and receive reference evaluations. I, therefore authorize you to issue OMV information regarding my services and character. I also unconditionally release you or your company from any and all liability that may result from furnishing such information.

**SIGNATURE**:______________________ **DATE**:___________

**REFERENCE EVALUATION FOR:**

Applicant Name:______________________________________

Social Security #:______________________________________

Position Applying for:__________________________________

Employed by/with from:_____________ to:_____________

**MANAGER OR SUPERVISOR NAME**:______________________

**COMPANY**:___________________________________________

**ADDRESS:**___________________________________________

**CONTACT NUMBER**:___________________________________

This applicant wishes to work as a health care provider through OMV Medical, Inc. and has given your name as a reference. Please complete the reference form and return it to OMV Medical, Inc. via fax, email or US Mail. The information that you provide will be held in confidence.

How long have you known this applicant?_________________________

What is/was your association with this applicant?___________________ Unit:____________

Do you recommend this person for the position applied for?___________________________

Is the above information (date of employment, position, etc.) consistent with your records?_____________________________________________________________________

Reason for leaving:____________________________________________________________

Is applicant eligible for rehire with your organization?_________________________________

| | Excellent | Good | Fair | Unsatisfactory |
|---|---|---|---|---|
| **Integrity** | | | | |
| **Dependability** | | | | |
| **Quality of work** | | | | |
| **Clinical Competence** | | | | |
| **Professional Knowledge** | | | | |
| **Safety Oriented** | | | | |
| **Self Motivation** | | | | |
| **Punctuality** | | | | |
| **Attendance** | | | | |

**Comments:**_____________________________________________________________________

**Signature:**__________________________ **Title:**________________________ **Date**_______

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**COMPANY**:____________________________________________

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| | Excellent | Good | Fair | Unsatisfactory |
|---|---|---|---|---|
| Integrity | | | | |
| Dependability | | | | |
| Quality of work | | | | |
| Clinical Competence | | | | |
| Professional Knowledge | | | | |
| Safety Oriented | | | | |
| Self Motivation | | | | |
| Punctuality | | | | |
| Attendance | | | | |

**Comments:**_______________________________________________________________________

**Signature:**_________________________ **Title:**_______________________ **Date**_______