YOUR COMPANY NAME

Provider of Healthcare Personnel

Your Address

Your Phone number and email address

www.companywebsite.com

Employment Check List

Name _____

Emergency Contact _____ Phone No. _____

Application Filled	_____	
Current License	_____	Date Verified ____
Current CPR	_____	
Reference Check	_____	
I-9 Documentation	_____	
Social Security	_____	
W-9 if they are Independent Contractor)	_____	
W-4 if they are your Employee	_____	
Hepatitis Form		
TB Form	_____	