# From: hr@universalmedicalrecord.com

# Fax: 914-940-6860

# ALL INFORMATION MUST BE COMPLETED PRIOR TO PAYROLL RECEIVING THIS FACE SHEET

# \*\*\* PLEASE TYPE OF PRINT CLEARLY\*\*\*

EFFECTIVE DATE: \_\_ \_\_ /\_\_ \_\_/\_\_ \_\_ \_\_ \_\_

APPLICANT NAME: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

SOCIAL SECURITY #: \_\_ \_\_ \_\_ - \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_

PHONE (H) (\_\_ \_\_ \_\_) - \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_

PHONE (C) (\_\_ \_\_ \_\_) - \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_

E-MAIL ADDRESS: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

D.O.B. \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_

RACE: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ SEX: Circle One: Male Female

STREET ADDRESS: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

CITY OR TOWN: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ STATE: \_\_ \_\_ ZIP CODE \_\_ \_\_ \_\_ \_\_ \_

JOB TITLE/POSITION: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

LICENSE/CERTIFICATION NUMBER \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

EXPIRATION DATE: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_ Please attach Copy of License/Certification

TERMINATION DATE: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_

AUTHORIZED BY:\_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ DATE: \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_

FACILITY NAME: \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

Please submit 3 reference letters - 2 Professional Recommendations

2 Personal Recommendation