PLEASE FAX APPLICATION TO (949)-715-3995

PERSONAL HISTORY

Last Name__________________________First Name_________________________M.I. ______ DOB____________________________
(Used strictly for Background Checks)

Any Former Names or Maiden Name____

CURRENT ADDRESS

____
Street Name

____
City   State   Zip Code

Name of Emergency Contact______________________ Relationship______________________Phone Number_____________________

Email Address:____

PHONE NUMBERS (circle best contact number)

____
Home

____
Cell

PERSONAL DATA

Social Security Number: ________-________-_________   Are you at least 18 years of age? (Please Circle)   **YES**   **NO**

Driver's License Number____ State_________________________

Technician or Pharmacist (Please circle)   LICENSE#________________   STATE_________   EXPIRES______________

Technician or Pharmacist (Please circle)   LICENSE#________________   STATE_________   EXPIRES______________

Technician or Pharmacist (Please circle)   LICENSE#________________   STATE_________   EXPIRES______________

Do you have an NPI number? ☐ **NO**   ☐ **YES** -If Yes, please provide_____________________________________
Are you authorized for employment in the United States?   ☐ **YES**   ☐ **NO**
If NO, are you interested in being sponsored to work in the U.S.   ☐ **YES**   ☐ **NO**
Note: If Yes, you must commit to 4 years
Enter approximate date you are available to immigrate to the U.S.___________________________________
(Should you become employed by Echelon Medical Support, you will be required to provide the documentation showing your eligibility to work in the US.)

Are you able to perform the essential functions of the job for which you are applying with or without a reasonable accommodation? ☐ **YES**   ☐ **NO**
If not, please describe____
____
____

JOB INFORMATION

✦Check position you are applying for (JOB CLASS): ☐ Pharmacist   ☐ Technician

✦Check areas that you are qualified to work in:

☐ **Hospital:** ☐ Unit Dose ☐ IV' ☐ Chemotherapeutic ☐ Investigational ☐ TPN's ☐ Outpatient
☐ **Retail**   ☐ **Home Health**   ☐ **Long Term Care**   ☐ **Nuclear**   ☐ **Nursing Home**

✦Check your availability: ☐ Full-Time   ☐ Part-Time   ☐ Per Diem   ☐ Open to Travel

✦Check the days of the week you are available to work:
☐ **Sunday**   ☐ **Monday**   ☐ **Tuesday**   ☐ **Wednesday**   ☐ **Thursday**   ☐ **Friday**   ☐ **Saturday**

✦Check the shifts you prefer to work: ☐ **AM Shift**   ☐ **MID Shift**   ☐ **PM Shift**   ☐ **OVERNIGHT Shift**

✦How far are you willing to drive?   ☐ **Miles**______________________ ☐ **Time**__________________________

✦Are you willing to fly to another area or state?   ☐ **Yes**   ☐ **NO**

✦How were you referred to Echelon? ☐ **Newspaper** ☐ **Trade Publication** ☐ **Job Fair** ☐ **Career Day** ☐ **Internet** ☐ **Employee Referral(Name of Employee)**_____________________________________ ☐ **Other(please specify)**________________________

PROFESSIONAL LIABILITY INSURANCE:
Do you carry Professional Liability Coverage? ☐**Yes** ☐**No**

If yes: Provider____ Policy No:____________________________________

Liability Limits: $_______________per occurrence /$_______________aggregate Effective Date___________Expiration Date___________

EMPLOYMENT HISTORY (Start with most recent employer.)

Employer	Dates	Position	Supervisor	Pay rate	Reason for Leaving

CURRENT PAY RATE:____________$/hr (Must be answered) **EXPECTED PAY RATE:_________$/hr (Must be answered)**

LIST LANGUAGES THAT YOU SPEAK, READ AND/OR WRITE: (please check box that best describes your ability to speak the language)

Language	Fluent	Good	Fair

EDUCATION

	School Name	Address	Degree Earned
Professional			
Undergraduate			
High School			

REFERENCES (Please list up to three people of which, ***two people are supervisors*** whom we may contact. *Do NOT list relatives*.)

Name	Relationship	Address	Phone Number

I hereby acknowledge that the information I have provide is accurate to the best of my knowledge.

Signature:____ **Date:_________________________**

CRIMINAL HISTORY

Have you ever been convicted of a misdemeanor crime or felony? (CA ONLY) ☐**Yes** ☐**No**

(You need not identify convictions that have been sealed, dismissed or otherwise eradicated by statue or court order, or information pertaining to referral to any participation in any pre-trial or post-trial diversion program. In CA, you also need not identify any marijuana-related convictions if you have written proof that it is more than 2 years old.)

If yes, please explain and designate whether a felony or a misdemeanor.

____

____

____

(Such convictions may be relevant if job-related, but do not necessarily bar you from employment.)

In the past three years, have you ever knowingly used any narcotics, amphetamines, or barbiturates, other than those prescribed to you be a physician?

☐ **Yes** ☐ **No**

Have you at any time had an application for registration with the Drug Enforcement Agency or a state board of pharmacy denied?

☐ **Yes** ☐ **No**

Have you ever had a DEA registration or state pharmacy license or your own state pharmacist's license revoked and/or suspended?

☐ **Yes** ☐ **No**

Have you ever surrendered a DEA registration or a state pharmacy license or your own pharmacist's license for cause? ☐ **Yes** ☐ **No**

(For cause means a surrender as a consequence or, any federal or state administrative, civil or criminal action resulting from as investigation or your handling of controlled substances or your commitment or fraud or other financial misconduct in the delivery of items or services to a state or federal health care program.) Conviction of a crime will not be an absolute bar to employment.

Has your pharmacist license ever been revoked, suspended or placed on probation by any state board? ☐ **Yes** ☐ **No**

Have you ever been the subject of disciplinary or investigatory proceedings against you as a pharmacist or against your pharmacist's license or reprimanded by an administrative or governmental agency, hospital, retail or professional association?

☐ **Yes** ☐ **No**

Are you now, or have you ever been excluded from participation in federal health care programs such as Medicare or Medicaid or are you currently the subject of any pending exclusive proceedings?

☐ **Yes** ☐ **No**

Signature_______________________________________ **Date**_______________________

DRUG TEST CONSENT

1. **I HAVE READ AND UNDERSTAND** Echelon Medical Support, Inc. Drug Free Workplace Policy and Drug Test Consent Form and understand failure to follow it may result in disciplinary action, up to and including termination

2. **I UNDERSTAND** that I must pass a drug screen/test to be hired by Echelon Medical Support, Inc. **I ALSO UNDERSTAND** that I may have to take a drug and/or alcohol test, including an on-site screen where lawful as outlined in the Drug Free Workplace Policy and Drug Test Consent form.

3. **I AGREE** to provide my urine, breath, blood, hair or other specimen(s) for screening/testing for drugs and/or alcohol whenever deemed necessary by Echelon Medical Support, Inc., a collection site or medical provider.

4. **I CONSENT** to the specimen(s) being collected at the assigned collection site(s) or on-site screening facility and further consent to have my specimen(s) tested as a U.S. Department of Health and Human Services Abuse and Mental Health Services Administration (HHS/SAMHSA)- certified laboratory.

5. **I CONSENT** to the release of the test results to Echelon Medical Support, Inc., to the company's third party administrator, and its Medical Review Officer (MRO) or as otherwise allowed or required by applicable federal, state or local laws.

6. **I UNDERSTAND** I will be given the opportunity to discuss a positive drug test result with the MRO, a licensed physician who will consider any offered legitimate medical explanation for the test result. **I AGREE** to cooperate with the MRO. **I UNDERSTAND** that the MRO is not acting as my physician or health care provider in performing this service and that no physician-patient relationship is formed between us. **I UNDERSTAND** the MRO may contact my health care provider(s) or others to verify any information I have supplied about why the test was positive (such as being on prescription medication.) **I AUTHORIZE** my health care provider or others to give the MRO this information.

7. **I RELEASE** Echelon Medical Support, Inc. or any of its operating companies, the MRO, the laboratory, the collection site, my health care provider(s), or others who verify information I have supplied, and their respective employees, agents, and affiliates from any and all liability in connection with a specimen collection and/or test, or any employment action taken as a result of a specimen collection and/or test.

8. **I AGREE** that information relating to a test (including its results) may be disclosed by Echelon Medical Support, Inc., the MRO, the laboratory, the collection site, my health care provider(s), or others who verify information I have supplied, and their respective employees, agents, and affiliates, if I challenge this test or results, of if I take any action as a result of a test in any kind of administrative, judicial, legal or other proceedings relating to my employment or potential employment, including but not limited to worker's compensation, unemployment compensation or other proceedings**.**

9. **I CONSENT** to Echelon Medial Support, Inc., releasing the background check and drug test results with our business clients in order to fulfill our contractual agreements with our clients.

______________________________	______________________________
Print Name	**SSN**
______________________________	______________________________
Signature	**Date**

RELEASE AND AUTHORIZATION FORM

In accordance with my right to privacy, I have been advised by **Echelon Medical Support** that the information described below is required to assist the same in making an employment advancement determination concerning me and that execution of this form is voluntary.

I hereby authorize any qualified agent bearing this document or a copy thereof, to obtain information from all personnel, educational institutions, government agencies, to include The Department of Justice and The Youth Authority, companies, corporations, worker's compensation information, law enforcement agencies or individuals relating to my past activities, to supply any and all information concerning my background, and release same from any liability resulting from providing such information. The information received may include, but is not limited to academic, job performance, attendance, personal history, financial record history, disciplinary, driving (DMV or MVR) records, and criminal or civil records.
I understand that the information released is for consideration of my employment application, resume and possibly for the purpose of determining my qualifications for future assignment.

I further hereby release any individual associated with the compilation of such information to include record custodians, directors, officer, agent, employees, if authorized representatives of the same, from any and all liability for damages of whatever kind of nature, which may at any time accrue to me on account of (1) reliance by such person on the information submitted in my employment application; (2) reliance by such persons on the information obtained pursuant to this authorization; (3) compliance with, or any attempt to comply with, this authorization; and (4) termination of my employment based on information obtained after commencement thereof pursuant to validity of this authorization. If adverse action is taken based in whole or in part on the consumer report, we will provide to you a copy of the consumer report and a summary of the consumer's rights as prescribed by the FCRA. This report will not be used in violation of any federal or state laws and/or equal employment opportunity laws or regulations.

I hereby certify that all the statements and answers set forth on this application form and documents signed are true and complete to the best of my knowledge, and I understand that if, subsequent to employment any of such statements and/or answers are found false or that information has been omitted, such false statements or omissions will be just cause for termination of my employment.

I understand that I have a right to receive a copy of any consumer report created as a result of this release form, by Liberty Alliance Inc.. I have also stated clearly in the boxes listed below as to my desire to receive that report from this company to which I am applying upon its completion. The investigative consumer-reporting agency preparing the report(s) is Liberty Alliance, Inc., 22707 La Palma Ave., Yorba Linda, CA 92887, telephone (800) 630-2880. Their files are available for review by appointment, by certified mail or telephonically with proper identification.

PLEASE PRINT CLEARLY

____
SIGNATURE OF APPLICANT

____
PRINT FULL NAME (First, Middle & Last Name)

____
Street Address

____
DATE

____
City, State & Zip

For purposes of gathering this information, I agree to supply the following information which may be required by law enforcement agencies and other entities for positive identification purposes in checking records. It is confidential and will not be used for any other purpose.

DATE OF BIRTH	DRIVERS LICENSE NUMBER	STATE	SOCIAL SECURITY NUMBER

L*AST NAME* AS IT APPEARS ON LICENSE ________________________
(PLEASE PRINT CLEARLY)

☐ Yes, I would like a copy of any investigative consumer report that is conducted by Liberty Alliance, Inc.
☐ No, I do not need a copy of any investigative consumer report that is conducted by Liberty Alliance, Inc.

RELEASE AND AUTHORIZATION FORM

Authorization to Obtain Credit Information

In accordance with the Consumer Credit Reporting Reform Act of 1996 Section 604 (B), I hereby authorize Echelon Medical Support ____________ and/or its agents to obtain an Employment Insight Credit Report concerning my current credit status. I understand that such an inquiry is relevant to the position for which I am applying. I understand that a credit report will be obtained and that I am entitled to a copy of this report. If adverse action is taken, based in whole or in part on the consumer report, we will provide to you a copy of the consumer report and a summary of the consumer's rights as prescribed by the FCRA. The report will not be used in violation of any federal or state laws and/or equal employment opportunity laws or regulations.

The investigative consumer-reporting agency preparing the report(s) is Liberty Alliance, 22707 La Palma Ave., Yorba Linda, CA 92887, (800-630-2880). Their files are available for review in person, by certified mail or telephonically with proper identification.

______________________________ DATE: ______________________

SIGNATURE OF APPLICANT

______________________________ ______________________

PLEASE PRINT FULL NAME SOCIAL SECURITY NUMBER

ADDRESS: ______________________________________

____

____

CONSENT AND DISCLOSURE

To be a member of Echelon Medical Support, Inc. requires dedication, trust and above all, honesty. It is a commitment we ask of all of our employees and potential employees. As a apart of our hiring process, we will request a consumer and/or investigative report about you, which may include: a background investigation, consistent with applicable federal, state, and local laws, that includes information, and any on convictions and/or pending prosecutions as well as information contained in the Esteem database (admissions of theft), a credit report, Department of Motor Vehicles information, and any other factors that may be relevant to your qualifications to work at Echelon Medical Support, Inc. In addition, we may be asked to provide a copy of these records to any of our clients upon request. To fulfill our client obligations, Echelon Medical Support Inc, may share this background information with our clients.

If employed, consistent with applicable federal, state and local laws, echelon Medical Support may request additional background investigations to evaluate you for retention as an employee or otherwise in the event o a promotion or transfer. upon request, you will be informed whether a report was subsequently requested from Liberty Alliance. Liberty Alliance conducts all background investigations:

LIBERTY ALLIANCE
22707 La Palma Ave.
Yorba Linda, CA 92887
1-800-630-2880

☐ If you would like a copy of the consumer report to be mailed directly to you, check this box.

For all applicants:
Should you at anytime, without authorization, take cash, merchandise or property from Echelon Medical Support, Inc., our clients, employees or customers, our Company may report this action to Liberty Alliance.
In turn, Liberty Alliance will report this to prospective employers who are members of its organization. and as a result, your ability to be employed may be affected.

For CA Applicants only
You may contact the agency to review, by phone, mail, or in person the contents of the agency's investigative reporting file about you; and the agency will explain any of the information in the report and will provide written explanation of any coded information. You may also make a written request for a copy of the agency's file. For applicants in California, the specific nature an scope of the requested investigative consumer report includes: A criminal background check and Liberty Alliance Verification.

By signing this form, you are doing the following, so please read carefully:

- Authorizing our Company to Request and get a consumer report and/or investigative consumer report about you from Liberty Alliance.
- Authorizing our Company to contact law enforcement and other government agencies and other private consumer reporting agencies including credit bureaus, mutual associations and any other person or agency which may have information about you. you further authorize such agencies and parties to issue applicable reports and provide information to the Company;
- Authorizing our Company to investigate all the statements you have provided on your application to other persons in order to conduct this investigation and to verify the truthfulness and completeness of the information you have provided; and

You also understand that before any adverse action is taken, based in whole or part, or information obtained in the consumer or investigative consumer report, you will be provided a copy of the report and a description in writing of your rights under the Fair Credit Reporting Act and where applicable, state and local laws. You understand if you disagree with the accuracy of any information in the report, you must notify Echelon Medical Support within five business days of your receipt of the report. You hereby consent to this investigation and authorize our Company to procure a consumer report and/or investigative consumer report on your background.

Please Note: You are NOT creating a "contract of employment" with our Company by signing this form. If hired, both you and our Company have the right to end your employment at any time or for any reason. You agree that:
•You have read this form carefully and understand it. •Your signature below indicates your voluntary agreement with the above statements.

The existence of a criminal record will not automatically disqualify you from receiving a conditional job offer.

I have read and signed the RELEASE AND AUTHORIZATION form . I understand that in requesting a consumer report, Echelon Medical Support, Inc. may provide this information to a third party so that they may verify the truthfulness and completeness of the information I am providing. In addition, Echelon Medical Support, may be asked to share this background information with our business clients to fulfill our contractual agreements with our clients.

Please fill out this form completely and honestly without omitting any information. If you fail to do this, and you are hired, you could lose your job, regardless of how long you have worked for Echelon Medical Support.

Print Name______________________________ Signature______________________________________

Date__________________________________

ACKNOWLEDGMENT OF PART-TIME AT-WILL EMPLOYMENT

I am aware that Echelon Medical Support, Inc. is a Temporary Service Company. I understand that Echelon Medical Support, Inc. fills short term, temporary assignments for its clients using a registry of pharmacists and pharmacy technicians.

1. I am aware that Echelon Medical Support, Inc. is a Temporary Service Company. I understand that Echelon Medical Support, Inc. fills short term, temporary assignments for its clients using a registry of pharmacists and pharmacy technicians.

2. I am aware that Echelon Medical Support, Inc. doe s NOT have a goal of finding permanent jobs for pharmacists or pharmacy technicians.

3. I understand and agree that Echelon Medical Support, Inc. makes no guarantees or assurances, either expressed or implied, that a pharmacist or pharmacy technician will receive any minimum or maximum number of work assignments or be paid any minimum or maximum amount of compensation.

4. I understand and agree that my employment with the Company is voluntarily entered into, and the employee is free to resign at will at any time, with or without cause or notice. Similarly, the Company may terminate the employment relationship at any time, with or without notice or cause. These terms of employment are referred to as "at will" as stated in California Labor Code Section 2922. The employment at will relationship may not be modified be any conduct or statements or writings with the sole exception that the President of the Company may enter a written agreement signed by an employee and the President, specifically designed to modify your at will status. You should not rely on verbal or written comments, made by anyone at the Company as a promise of special privileges, working conditions or length of employment. If you have any questions regarding the significance of this paragraph, please contact Human Resources.

Printed Name____

Signature____ Date__________________________

PLEASE READ CAREFULLY

We are glad that you are interested in Echelon Medical Support. Our Company complies with federal, state and local laws regarding equal employment opportunity. Qualified applicants are considered for all positions without regard to race, color, national origin, religious beliefs, sex (including pregnancy), age disability, sexual orientation, citizenship status, military status or any other basis protected by federal, state and/or local fair employment laws.

We believe in integrity, honesty at all times. It is a commitment we ask of all of our associates and potential associates. Please answer every question on this application completely and accurately without omitting any information. If you don't answer every question completely and accurately of if you make false statements or misrepresentations during the interview or during the application process, and you are hired, you could lose your job, regardless of how long you have been employed.

This application is just that, an application. It is NOT an offer, promise or contract of employment, either expressed or implied. All of our associates are **"AT WILL",** meaning associates may terminate the employment relationship at any time, for any or no reason. Our company reserves the right to change and/or terminate an associate's employment, compensation and benefits, with or without notice or cause at any time. I further agree and understand that my employment can be terminated at will, at any time, by either the company, or myself for any or no cause. Our company will not, and associates and applicants should not, interpret any verbal or written statements, policies, practices or procedures as altering their "AT WILL" status. "AT WILL" status can only be altered with the advance written approval from the President or Chief Executive Officer.

You understand that our Company has a vital interest in maintaining a drug free workplace and in most locations a job offer is conditional upon passing a drug test and a criminal background check.

Any person duly authorized by this company, may at anytime, ask that I submit to a reasonable search of my person, purses, and/or packages in my possession, including, but not limited to, any locker, desk or files assigned to me. I also understand and agree that, if I refuse to submit to any such request to such may result in my termination. I hereby waive andy and all claim for damages, which may rise from any such search conducted by the Company.

I may be asked and required to take a physical examination, including blood, urine, or hair test, at the Company's expense, at any time, to determine if I am alcohol or drug free and physically able to perform my job responsibilities. I understand and agree that my failure to submit to any such testing may result in my termination. I hereby authorize any physician to release any information to the Company, which may be necessary to determine my ability to perform my assigned job duties.

Echelon, at its sole discretion can change wages, benefits and/or working conditions at any time, and I may be asked or required to work overtime or on weekends, depending upon the demands of my job responsibilities.

You understand that Echelon Medical Support, Inc. may investigate the information provided on your application. You also understand that our Company may use an outside vendor to compile and process electronically the information you provide on this application during the hiring process. You release our Company, previous employers, any vendor our Company may use, and other persons from all claims and liabilities in connection with any investigation into information provided on your application (including the making of inquiries and the furnishing of information) or in connection with furnishing information for the purpose of electronic compilation or processing of this information.

Echelon Medical Support, Inc. may request an investigative consumer report, including information on my character, general reputation, personal characteristics, and mode of living, if applicable, pursuant to the Fair Credit Reporting Act. In addition to the above, I understand a consumer' reporting agency's investigation may include obtaining information regarding my credit background, references, past employment, education, civil judgments, and liens as well as any information about my criminal background consistent with federal and state law. I understand that such information many be obtained by direct or indirect contact with former employers, schools, financial institutions, landlords and public agencies or other persons who may have such knowledge. I have the right to request in writing disclosure of the nature and scope of the investigative consumer report requested by the Company.

I also understand that before I am denied employment based, in whole or part, on information obtained in the report, I will be provided a copy of the report and a description in writing of my rights under the Fair Credit Reporting Act. I understand that if I disagree with the accuracy of any of the information in the report, I must notify Echelon Medical Support, Inc. within five days of my receipt of the report. If I notify Echelon Medical Support within five days of the receipt of the report that I am challenging information in the report, Echelon Medical Support Inc., will not make a final decision on my employment status until I have had a reasonable opportunity to address the information contained in the report. Signing this document states that you consent to this investigation and authorizes Echelon Medical Support Inc., to procure a report on my background as stated from the consumer reporting agency.

If you are employed by our Company, you agree to read, understand and comply with our Company's policies and procedures that may change from time to time. I understand and agree that any such rules, policies, regulations, and/or disciplinary guidelines are not intended by the company to create any obligation of continued employment.

APPLICANT SIGNATURE____ DATE_______________________________________

WITNESSED BY____ DATE____________________________________-

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