Foundation Medical Staffing

TRAVELER AFFIRMATION

Last Name	First Name	Social Security Number	Discipline

I attest that I am the applicant and the information provided in this application is complete and correct and that it can be relied upon by CHG Medical Staffing Inc., dba Foundation Medical Staffing ("FMS") for evaluating my potential as a traveler. Providing incomplete or inaccurate information may constitute grounds for termination of employment. It is my obligation to notify FMS of any material change affecting my professional status. I authorize FMS to obtain information from my current and previous employers, references, and any individuals and institutions familiar with my ability, character and employment records. I release all such persons from liability for furnishing said information.

I authorize FMS to release to their client facilities any information contained in this application or discovered by FMS which may be relevant to my employment, generally, but not limited to: criminal background checks, drug screening results, communicable disease information, school transcripts, personal and professional references, and government licensing documentation. I release FMS and its client facilities from all liability for any damages from disclosure of this information. This document shall be interpreted according to the laws of the state of Oklahoma.

Signature: _____ Date: _____

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