WHITE COAT HEALTHCARE STAFFING SERVICES, LLC

AMBULATORY SURGICAL CENTER

SURGICAL TECHNOLOGIST STAFFING REQUEST FORM

Please complete this form to help us understand your surgical staffing needs. Fields marked with an asterisk (*) are requested to process your inquiry.

1. FACILITY AND CONTACT INFORMATION

Facility / Surgery Center Name *

Contact Person *

Title / Department

Email Address *

Direct Phone Number *

Facility Street Address

City

State

ZIP Code

2. STAFFING REQUEST

Type of Staffing Requested

Select one

Number of Surgical Technologists Needed

Select one

Position Requested

Select one

3. SURGICAL SPECIALTY / SERVICE LINE

Select all that apply:

- ☐ General Surgery
- ☐ Orthopedics
- ☐ Vascular
- ☐ Podiatry
- ☐ Ophthalmology
- ☐ Urology
- ☐ ENT
- ☐ Pain Management
- ☐ Plastic Surgery
- ☐ Multi-Specialty
- ☐ Other (specify on page 2)

4. SCHEDULE AND ASSIGNMENT DETAILS

Requested Start Date

Requested End Date (if known)

Shift Length

Select one

Days Needed

Select one

Shift Hours (e.g., 7:00 a.m.-3:30 p.m.)

If dates or schedules are not finalized, please provide your best estimate.

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QUALIFICATIONS, FACILITY REQUIREMENTS & AUTHORIZATION

5. EXPERIENCE AND QUALIFICATIONS

Minimum Surgical Technologist Experience

Select one

Certification Requirement

Select one

Required Certifications / Credentials

Required Skills, Equipment or Procedure Experience

6. FACILITY ONBOARDING AND ASSIGNMENT REQUIREMENTS

Please identify any facility-specific requirements (select all that apply):

- ☐ BLS
- ☐ ACLS
- ☐ Drug screening
- ☐ Background check
- ☐ Immunization records
- ☐ TB screening
- ☐ Facility orientation
- ☐ EMR training

Other Facility Requirements / Credentialing Instructions

7. ADDITIONAL INFORMATION

Other Specialty (if applicable)

Additional Comments, Coverage Needs, Call Requirements or Scheduling Details

8. REQUESTOR ACKNOWLEDGMENT

By submitting this request, I confirm that the information provided is accurate to the best of my knowledge and authorize White Coat Healthcare Staffing Services, LLC to contact me about this staffing request. Submission does not guarantee placement or confirm staff availability.

☐ I authorize White Coat Healthcare Staffing Services, LLC to contact me regarding this request.

Name of Authorized Requestor

Date

Signature (type name if completing electronically)

Thank you for considering White Coat Healthcare Staffing Services, LLC.

Please save the completed PDF and email it to info@whitecoathealthcarestaffing.com.