YOUR COMPANY NAME
Provider of Healthcare Personnel
Your Address
Your Phone number and email address
www.companywebsite.com

Background Check Consent Form

I hereby authorize _____ to receive any criminal history on file pertaining to me from any federal, state or local criminal justice agency.

_____

(Print Full Name)

_____

(Signature) (Date)

_____

(Street Address)

_____

(City) (State) (Zip)

_____

*(Sex) *(Race) *(DOB) *(Social Security Number)

* The above information is necessary to retrieve criminal history information.