VERIFIED

A Criminal Background Investigation Program of the Metropolitan Chicago Healthcare Council

APPLICANT INFORMATION ***PLEASE PRINT CLEARLY***

X NAME ____

Last Name | First Name | Middle Initial

X ADDRESS ____

Street Address | City | State | Zip Code

X If you may be known by another name, please indicate:

____

Last Name | First Name | Middle Initial

DATE OF BIRTH ________/_______/________	Social Security No. ___________________________
SEX _______________ RACE ______________	Information in this box is required for a background check in the state of Illinois by the Uniform Criminal Information Act.

Valid Codes for Sex
- Male -------- M
- Female ----- F
- Unknown--- U

Valid Codes for Race
- White ---------------------- W
- Black ----------------------- B
- Asian/ Pacific Islands --- A
- American Indian/Alaskan----------- I
- Hispanic ------------------------------ H
- Unknown ----------------------------- U

I certify that the information provided above is true and complete. I understand that false or misleading information given in my employment application, interview(s) or this form will render my application void and will be just cause for termination of my employment. I also authorize you to make a criminal background investigation and other such investigations as are necessary in arriving at an employment decision. I further authorize the Illinois State Police to release criminal background information to the VERIFIED program as part of the criminal background investigation.

X ________________________________ **X** ________________________

Applicant Signature | Date

REQUESTOR INFORMATION **PARTICIPANT CODE** 0890

ORGANIZATION Loyola Medical Center FAX No. 707-216-4918

REQUESTOR NAME ____________________________ PHONE No. ____________________

APPLICANT/EMPLOYEE NAME ____

Last Name/First Name (PLEASE PRINT CLEARLY IN BLOCK LETTERS)

POSITION SOUGHT/OFFERED ____

IS POSITION SUBJECT TO THE HEALTH CARE WORKER BACKGROUND INFORMATION ACT __________ Y/N

____ ____________________

Requestor Signature | Date

Please Check appropriate box if verification requested:

(__) Social Security Verification (__) Department of Motor Vehicles (__) Cumulative Sanctions

NOTICE REGARDING BACKGROUND INVESTIGATION

IMPORTANT – PLEASE READ CAREFULLY BEFORE SIGNING ACKNOWLEDGEMENT

______Loyola Medical Center______may, upon execution of this authorization, investigate the information contained in your employment application and/or other background information, the results of which will be requested by the company from an outside agency. These reports may be obtained at any time after receipt of your authorization and through your employment.

A "consumer report" may contain information obtained from an outside agency on your credit standing, credit capacity, character, general reputation, personal characteristics, and mode of living which will be used to establish your eligibility for employment.

In the event that information from the report is utilized in whole or in part in making an adverse employment decision, before making the adverse decision, we will provide you with a copy of the consumer report and a description in writing of your rights under the Fair Credit Reporting Act.

ACKNOWLEDGEMENT AND AUTHORIZATION

I acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION and certify that I have read and understand this form.

I hereby authorize ___Loyola Medical Center______ to obtain a "consumer report" at any time after receipt of this authorization and throughout my employment.

Printed Name _____________________ **X** Social Security Number _____________________ **X**

Signature ________________________ **X** Date ____________________ **X**