



CRIMINAL HISTORY INFORMATION CONSENT FORM

As a current or prospective **INNOVATIONS'** employee, I understand that it is this agency's policy to secure conviction criminal history information as part of their investigation or screening process using the information provided below. I also understand that continued employment, or an offer of employment, is contingent upon the satisfactory results of this investigation.

NAME: _____
Last First Middle

MAIDEN NAME/NAMES PREVIOUSLY USED: _____

BIRTHDATE: _____ RACE: _____ SEX: _____

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____
Street City State Zip

COUNTY: _____ NUMBER OF YEARS AT THIS ADDRESS: _____

PRIOR ADDRESS IF LESS THAN 2 YEARS AT ABOVE:

ADDRESS: _____
Street City State Zip

COUNTY: _____ NUMBER OF YEARS AT THIS ADDRESS: _____

Without reservation, I authorize Health Care **INNOVATIONS** or any party or agency contacted by this employer to procure my consumer report and/or to obtain or furnish information concerning my credit, criminal, motor vehicle and other history. I understand that inquiries may be made to various federal and state agencies, employers, references, acquaintances and others seeking information as to my personal characteristics, credit worthiness, employment status, general reputation and mode of living.

MEDICAL RELEASE FORM

I, _____, hereby authorize all pertinent medical records and/or medical information to be released to Health Care **INNOVATIONS**. This information will be retained in an **INNOVATIONS'** personnel file and used exclusively for the purposes of employment. This information may be released to any institution that requires fulfillment of medical requirements prior to employment.

Signature Of Employee

Date