

FOUR SEASONS HEALTHCARE CENTER

483 4TH ST. SW FOREMAN, ND 58032 PHONE (701) 724-6211 FAX (701) 724-3061

CONFIDENTIAL BACKGROUND CHECK AUTHORIZATION

Print Name:
(First) (Middle) (Last)

Former Name(s) and Date(s) Used:

Current Address Since:
(Mo/Year) (Street) (City) (State/Zip)

Previous Address Since:
(Mo/Year) (Street) (City) (State/Zip)

Previous Address Since:
(Mo/Year) (Street) (City) (State/Zip)

Social Security Number: Date of Birth:

Telephone Number:

Drivers License Number/State:

This Information contained in this application is correct to the best of my knowledge. I hereby authorize Four Seasons Healthcare Center and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment and/or volunteer purposes. I understand that the scope of the consumer report/investigative consumer report may include, but is not limited to the following areas: verification of social security number; current and previous residences; employment history; education background; civil and criminal history records from any criminal justice agency in any federal, state, county jurisdictions; driving records; and any other public records.

I further authorize any individual, company, firm, corporation, or public agency (including the Social Security Administration and law enforcement agencies) to divulge any and all information, verbal or written pertaining to me, to Four Seasons Healthcare Center or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources.

Signature: _____ Date: _____