AUTHORIZATION FORM

I hereby authorize Donalsonville Hospital, Inc. to have background checks conducted and reports received pertaining to me from national criminal file search, social security verification search, and State of Georgia sexual offender search.

The following personal information is furnished for this purpose.

Full name PRINTED_____

Address_____

City, State, Zip _____

How long at this address _____

Sex_____ *Birth Date_____ * Social Security No._____

Previous Names, if any (printed)

_____

Signature_____Date_____

*Providing social security number and date of birth is necessary to perform the search, and they will be used with you consent for this purpose.

If an adverse employment, scholarship, or licensing decision is made against the person whose record is obtained, he/she shall be informed

(1) that a record was obtained;
(2) the specific content of the record;
(3) the effect the record had upon decision