



Authority to Release Information

<p>I understand that in processing my application with @WORK Medical Services, an investigation may be made in which information is obtained through personal interviews, and a review of information held by law enforcement or other government agencies.</p> <p>I authorize you to verify my past employment and education, professional licensure and certifications (including potential disciplinary actions), criminal records (including sexual/predatory offenses), credit history, motor vehicle records, personal references, and other job related data provided on this application, or via the interview process.</p> <p>I authorize the appropriate individuals, companies, institutions or agencies to release information, and I release them from any liability as a result of such inquiries or disclosures. A consumer report may be generated summarizing this information. I also authorize @WORK Medical Services to disclose any consumer report to any company, facility, or healthcare provider where I am, or could be, assigned to provide services.</p>		
First, Middle, Last Name (as appears on identification)		
Previous Name/Maiden Name/A.K.A.s	Date of Change	
Previous Name/Maiden Name/A.K.A.s	Date of Change	
Previous Name/Maiden Name/A.K.A.s	Date of Change	
Street Address		
City	State	Zip Code
Please list the cities and states you have lived in, if the above address does not encompass 7 years:		
Former Complete Address #1	Dates Lived at this Address	
Former Complete Address #1	Dates Lived at this Address	
Social Security Number	Drivers License Number	State Issued

I UNDERSTAND THAT A PHOTOCOPY OF THIS AUTHORIZATION WOULD BE ACCEPTED WITH THE SAME AUTHORITY AS THE ORIGINAL.

Signature

Date