Carolinas HealthCare System
Carolinas College of Health Sciences

Consent for Release

The purpose of this release is to provide documentation of drug screen results, immunizations, and background checks to clinical facilities and educational programs which are part of Carolinas HealthCare System, or which are clinical partners thereof.

Background Verification Disclosure

In connection with my admission to an educational program, I understand that Carolinas HealthCare System (CHS) may obtain a consumer or investigative consumer report which may contain public record information, criminal record, driving record, credit standing, credit capacity, education, prior employer verification, character, general reputation, personal characteristics, or mode of living. This report may be compiled with information from various federal, state and local agencies, credit bureaus, past or present employers and educational institutions, business or personal references, or any other source necessary to verify information. Upon written request, additional information as to the nature and scope of the report will be provided in the event the report contains information regarding your character, general reputation, personal characteristics, or mode of living. If negative information contained in the report should result in a change of status in regards to my admission to or enrollment in an educational program, I understand that I will be notified. I understand that I may request a complete and accurate disclosure of the nature and scope of the background verification to the extent such investigation includes information bearing on my character, general reputation, personal characteristics, or mode of living.

Drug Screen Results and Immunization Records

In connection with my enrollment in an educational program, CHS and/or the educational program may release my drug screen results, immunization records, or any related information to agencies providing clinical experiences in the normal course of business.

Authorization, Acknowledgement, and Release

During the application process or at any time during my affiliation with CHS or during my enrollment in a CHS educational program, I authorize CHS to procure, through a third-party vendor, a consumer or investigative consumer report which may include information as described above. I further authorize CHS and its agents to provide the information obtained from such report, as well as my drug screen results, immunization records, or any related information, to any agency providing clinical experiences for the purpose of evaluating acceptance into or continued participation in an internship, preceptorship, or clinical experience. I understand that I must report any charge, conviction, plea of no contest, or prayer for judgment in writing to school or program officials according to policy. Failure to do may result in termination of my participation in the clinical experience and dismissal from the educational program.

I hereby release those individuals or companies, CHS and its agents and educational programs, employees and officers, from any liability that may arise from the disclosure of such information or from my termination of participation in a clinical experience as described above. This authorization and release is in effect until my program of study is complete unless previously revoked in writing.

For identification purposes, please print all information clearly:

First Name	Middle Name	Last Name	
	Maiden Name		
Social Security Number		Employee ID: *If employed by Carolinas HealthCare System*	
Gender		Date of Birth	
Home Phone		Cell Phone	
Circle Program	Clinical Laboratory Science	Continuing Education	Nursing
Radiation Therapy	Radiological Technology	Surgical Technology	Nurse Anesthesia (CRNA)

List all addresses for the past seven (7) years starting with most current (continue on back if necessary):

Street Address	City	State	Zip	Dates
				MM/YR to MM/YR
				MM/YR to MM/YR
				MM/YR to MM/YR
				MM/YR to MM/YR
				MM/YR to MM/YR
				MM/YR to MM/YR
				MM/YR to MM/YR

Signature: __________________________________ Date: ______________________________

Parent or Guardian (if applicant is under 18):
____ Date: _______________________________

Please return to:
Admissions Office, Carolinas College of Health Sciences, 1200 Blythe Blvd., Charlotte, NC 28203