CABARRUS COLLEGE of HEALTH SCIENCES

Carolinas Medical Center NorthEast

BACKGROUND CHECK RELEASE

In connection with my acceptance into and participation in the Clinical Internship in Lactation Program ("Internship") at Charlotte-Mecklenburg Hospital Authority dba Carolinas Medical Center - NorthEast (CMC-NorthEast), I understand that consumer or investigative consumer reports which may contain public record information, may be requested or made about me including criminal records, driving record, education, prior employer verification, workers compensation claims and others. Further, I understand that CMC-NorthEast will request information from various Federal, State and Local agencies regarding my past activities. I also understand that the information below regarding sex, race and date of birth is requested for the sole purpose of gathering the above information, and will not be used to discriminate against me in violation of any law. I further understand and acknowledge that such requests for information may be made by Cabarrus College of Health Sciences on behalf of CMC-NorthEast.

If negative information resulting in a change of my status with the Internship is contained in any report, I understand that I will be notified of such information by the Chief Mentor. I understand that information contained in the criminal background report might result in the termination of my Internship status. I also understand that any such termination may be appealed to the Lactation Nurse Manager and Women's and Children's Services Director. I understand that I am obligated to inform the Chief Mentor of any activities that may change the results of my criminal background report. I understand that I have a right to review the information that CMC-NorthEast and its designee receives in this criminal background investigation by written request. I understand that all reasonable efforts will be made by CMC-NorthEast to protect the confidentiality of this information.

I hereby release those individuals or companies from any liability or damage in providing such information. I hereby further release CMC-NorthEast and Cabarrus College of Health Sciences and its agents and employees from any and all claims, including but not limited to claims of defamation, invasion of privacy, wrongful termination, negligence or any other damages from or pertaining to the collection and/or dissemination of this information. I hereby authorize without reservation, any party or agency to furnish the above-referenced information.

I understand I have the right to make a request of the Consumer Reporting Agency, upon proper identification and the payment of any authorized fees, the information in its files on me at the time of my request. I further authorize ongoing procurement of the above-referenced reports at any time during my enrollment in the Internship.

Signature _____ Date _____

FOR IDENTIFICATION PURPOSES: PLEASE <u>PRINT</u> ALL INFORMATION CLEARLY

_____

Last Name First Name Middle Name

Other Names; Maiden, Aliases, etc.: _____

Date of Birth: Month: _____ Day _____ Year _____ Race: _____ Gender: _____

Social Security #: _____ - _____ - _____ Driver's License # _____ State: _____

LIST ALL ADDRESSES FOR THE PAST TEN (10) YEARS STARTING WITH THE MOST CURRENT:

STREET	CITY	STATE	ZIP	DATES (MM/YYYY)	
				FROM	TO
1.					
2.					
3.					
4.					
5.					
6.					
7.					

Return to:

Cabarrus College of Health Sciences - 401 Medical Park Drive, Concord NC – 28025