REQUEST, AUTHORIZATION, CONSENT AND RELEASE FOR BACKGROUND INFORMATION

PLEASE TYPE OR PRINT

I: ____

LAST NAME FIRST NAME MIDDLE NAME (PLEASE INCLUDE Jr., Sr., II, III Etc.)

understand that in conjunction with my application to provide temporary allied healthcare services to Therapeutic Resources, Inc. Therapeutic Resources will use the services of an outside agency to research and verify the information I have provided on my application which relates to my work, educational history, professional standing and qualifications. Therapeutic Resources uses consumer-reporting agencies, to perform its background investigations. These agencies will provide a written report of their findings to Therapeutic Resources. I understand and agree that the background check will include a criminal background check and I hereby consent to the performance of the same.

The consumer reporting agencies will utilize various sources of information they deem appropriate including but not limited to: criminal conviction records, current and former employers, military records, education records, professional and personal references. I request, authorize and consent to the release and disclosure of any and all information relating to my background including but not limited to the above to Therapeutic Resources. In compliance with the Fair Credit Reporting Act, I understand that I will be notified by Therapeutic Resources if my application is denied because of information obtained from a consumer reporting agency. Additionally, I understand that if requested within 60 days, I will be given a full and accurate disclosure as to the nature and substance of all information provided to Therapeutic Resources. I further understand that I may request a copy of the report, and that when doing so, proper identification will be required. I understand that Therapeutic Resources will send to me a copy of the report if an adverse action is taken as a result of information contained in the report, or upon my request as outlined herein.

FOR POSITIVE IDENTIFICATION PURPOSES, THE FOLLOWING INFORMATION IS REQUIRED. THE INFORMATION YOU PROVIDE WILL BE TREATED AS STRICTLY CONFIDENTIAL AND WILL NOT BE USED FOR ANY OTHER PURPOSES. PLEASE PRINT CLEARLY.

______________________ **Signed**	______________________ **Today's Date**
______________________ - **Name as it appears on your driver's license**	- / / **Social Security Number** **Date of Birth**
______________________ **Driver's License Number** **State**	______________________ **Other Names You Have Used**

PLEASE PROVIDE ALL RESIDENTIAL ADDRESSES FOR THE PAST 7 YEARS:

	Street	Apt.#	City	State	Zip Code	Mo./Yr. / Mo./Yr From / To?
Current Address:						/
Former Address:						/
Former Address:						/
Former Address:						/
Former Address:						/
Former Address:						/