

BACKGROUND INVESTIGATION AUTHORITY

I hereby authorize Miami Children's Hospital or its agent, SINGLESOURCE SERVICES CORPORATION, to investigate my background to determine any and all information of concern to my record, whether same is of record or not, and I release employers and persons named in my application from all liability for any damages resulting from his/her furnishing said information.

Additionally, I hereby authorize any investigation of my personal history, including, but not limited to a credit history, driving history, educational background, military record, criminal records and I also authorize previous employers, and any references provided by me or ascertained by investigation, to release information about my performance, integrity, general character, and any other job specific information requested. I authorize the release of this information by the appropriate agencies to the investigating service. I understand this may include a workers compensation claims search after a conditional job offer has been made. I also understand I may be required to take a drug test before or during employment.

This authorization, in original or copy form, shall be valid for this and for any future reports and updates that may be requested.

PLEASE PRINT CLEARLY

Full Name: _____ SSN: _____ - _____ - _____

Other Names or SSN Used: _____

Current Street Address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____

Driver's License#: _____ State: _____ *DOB: ____/____/____

**DOB is optional and is only used for identification purposes in screening inquiries*

LIST ALL ADDRESSES FOR PAST 7 YEARS: (check here if more on reverse)

Street Address _____ City _____ State _____ Zip _____ DATES: _____ - _____
from to

Street Address _____ City _____ State _____ Zip _____ DATES: _____ - _____
from to

MAY WE CONTACT YOUR CURRENT EMPLOYER? YES NO

HAVE YOU EVER BEEN CONVICTED OF A CRIME? YES NO

This includes but is not limited to pleas of guilty, nolo contendere, no contest, adjudication withheld, and pre-trial intervention programs. If YES show details including date, charge, county, disposition on reverse.

Signature: _____ DATE: ____/____/____

Client Ref: _____ **For** **Miami Children's Hospital** **Office Use ONLY** **Date**
Requested: _____

Fax to: 904.241.0601 or 877.835.5787
 Please carry out the services indicated below:

	Extensive Employee Screening		
	Basic Employee Screening		