Background /Sexual Offender Check Release Authorization

In connection with my application for participation in clinical rotations at Community Medical Center, Kalispell Regional Healthcare, North Valley Hospital and/or St. Patrick Hospital, hereafter referred to as ORGANIZATIONS, and as a condition of acceptance at these ORGANIZATIONS for such rotations, I voluntarily agree that the ORGANIZATIONS, its agents or designees, may request and obtain one or more background checks regarding me; including criminal background check, exclusion database lists and national sexual offender lists; and the information received from the background checks may be shared between these ORGANIZATIONS and my facility. The ORGANIZATIONS can also receive and use for its purposes any such background checks from the facility.

I hereby authorize and release from all liability, without reservation, the ORGANIZATIONS and my facility, and its agents and employees, as well as any law enforcement agency, local, state or federal government agency, institution, information service bureau, or any other person or entity, from liability for requesting, conducting, receiving and communicating the above information.

I further acknowledge that a telephone facsimile (fax), photographic or digital (pdf) copy of this executed release will be as valid as the original.

I understand that I must report to the ORGANIZATION designee, within 48 hours, any criminal charges, arrests or indictments that occur at any time during my rotations at these ORGANIZATIONS. I also understand that I must report any criminal charges, arrests or indictments that have occurred after the background check that was cleared on / / to the ORGANIZATIONS designee before I can begin my rotation.

Date Background Check Infonnation Was Cleared

Failure to do so could lead to termination of the relationship. This reported information may also be shared with my facility.

Print Name_____
Last First Middle

Maiden/Previous Name(s) (if applicable)_____

Name of Facility_____

Program_____ Date of Birth_____

Signature._____ Date Signed._____

*******To be completed by approved facility representative or ORGANIZATION only*******

The cleared records for the background check, exclusion database lists and national sexual offender lists are to be kept and maintained by the facility unless prior arrangements have been made. Records are not to be submitted to the ORGANIZATION unless approved in advance by the ORGANIZATION. By signing below, I am verifying that this information is on file with the ORGANIZATION, facility, and school and/or university system. If requested, we will provide these documents to the ORGANIZATION within one business day of the request. I am verifying the records are clear with no records or discrepancies.

Facility or ORGANIZATJON Representative Signature	Date
Print Name	Title
Phone Number	Email address

Updated 4/20/16