

# LEGACY BEHAVIORAL HEALTH SERVICES, INC.

## Background Check Authorization and Consent Form

*Empowering Abilities, Inspiring Legacies*

### APPLICANT INFORMATION

Full Legal Name:	<input type="text"/>	Email Address:	<input type="text"/>
Other Names Used:	<input type="text"/>	License/ID:	<input type="text"/>
Date of Birth:	<input type="text"/>	State of Issuance:	<input type="text"/>
SSN:	<input type="text"/>	Position Applied For:	<input type="text"/>
Phone Number:	<input type="text"/>	Program/Location:	<input type="text"/>

### CURRENT ADDRESS

Street Address:	<input type="text"/>		
City:	<input type="text"/>	State:	<input type="text"/>
		Zip Code:	<input type="text"/>

### DISCLOSURE AND AUTHORIZATION

I authorize Legacy Behavioral Health Services, INC. and/or its designated representatives or third-party vendors to conduct a background investigation for employment, volunteer, contractual, reassignment, promotion, or continued employment purposes. This investigation may include criminal history records, sex offender registry checks, Healthcare Personnel Registry checks, Office of Inspector General exclusion checks, abuse/neglect registry checks, employment verification, education verification, professional license or certification verification, driving record checks, reference checks, and other lawful screenings relevant to determining eligibility.

I authorize all agencies, organizations, employers, educational institutions, licensing boards, references, and other entities having relevant information to release such information to LBHS and/or its authorized representatives. I understand that false statements, omissions, or refusal to authorize required screening may result in denial of employment or termination, as permitted by law.

### FCRA DISCLOSURE

LBHS may obtain a consumer report and/or investigative consumer report for employment purposes in accordance with the Fair Credit Reporting Act. You may request additional information regarding the nature and scope of any investigative consumer report.

### APPLICANT CERTIFICATION

- I certify that the information provided is true and complete to the best of my knowledge.
- I voluntarily authorize LBHS to conduct the background investigation described above.



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### Signatures and Internal Tracking

#### APPLICANT SIGNATURE

Printed Name:

Applicant Signature:

Date:

#### WITNESS / LBHS REPRESENTATIVE

Printed Name:

Signature:

Date:

#### FOR OFFICE USE ONLY

Verification Item	Completed	Date	Staff Initials
Criminal Background Check	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Sex Offender Registry	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
HCPR Check	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
OIG Exclusion Check	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Driver License/MVR Check	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Employment Verification	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Reference Checks	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Education/License Verification	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other:	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>