Carolinas HealthCare System

Medical Students Program

STUDENT INFORMATION AND RELEASE AUTHORIZATION

Name: _____
Last, First, Middle (Please Print)

Maiden or Other Name(s) Used: _____

College attending and address: _____

Social Security Number: _____ Date of Birth: _____ Gender: _____

Current Address: _____ Telephone Number (s): _____
_____ _____

How long have you lived at this residence? _____
(If less than 7 years, please indicate all previous addresses during this period below. Please attach an additional sheet if needed.)

Address: _____

Address: _____

BACKGROUND VERIFICATION DISCLOSURE

In order to complete the student's criminal background, Carolinas HealthCare System may obtain a Consumer Report and/or an Investigative Consumer Report. The Fair Credit Reporting Act as amended by the Consumer Reporting Reform Act of 1996, requires that we advise you that for purposes of complying with JCAHO standards, a Consumer Report may be made which may include information about your criminal record, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided in the event the report contains information regarding you character, general reputation, personal characteristics, or mode of living. During the application process and at any time during my affiliation with CHS, I hereby authorize BIB – Background Investigation Bureau, on behalf of CHS to procure a Consumer Report which I understand may include information as described above. This report may be compiled with information from credit bureaus, courts record repositories, departments or motor vehicles, past or present employers and education institutions, governmental occupational licensing, or registration entities, business or personal references, and any other source required to verify information that I have voluntarily supplied. I understand that I may request a complete and accurate disclosure of the nature and scope of the background verification; to the extent such investigation includes information bearing on my character, general reputation, personal characteristics or mode of living.

AUTHORIZATION, ACKNOWLEDGEMENT, AND RELEASE

I authorize CHS to provide the information obtained from such records CHS – Medical Students Program for the purposes of evaluating acceptance into or continued participation in an internship or field/clinical placement. I understand that I must report, in writing, any charge to CHS – Medical Students Program designee the next day after the charges are filed. I further acknowledge that failure to report a charge will be grounds for immediate exclusion or termination of my participation in the internship or field/clinical placement. I understand that I must report, in writing, any plea of no contest, prayer for judgment, or conviction to CHS – Medical Students Program designee within five days of the occurrence. I further acknowledge that failure to report a plea of no contest, prayer for judgment, conviction will be grounds for immediate termination of my participation in the internship or field/clinical placement.

I hereby release CHS, its agents, employees and officers, from any liability that may arise from the disclosure of any information contemplated by this form or from CHS terminating me from an internship or field/clinical placement as described above. I understand that this form is in effect until my program of study is complete at CHS unless I revoke it in writing and provide such revocation to CHS. I further understand that if I choose to revoke this form, I may not be able to participate in an internship or field/clinical placement.

_____	_____	_____
Printed Name	**Signature**	**Date**

Please sign above and return this form:
CHS – Medical Students Program

Charlotte, NC

03/30/2004