Updated: February 2014

SOUTHEAST GEORGIA HEALTH SYSTEM
Application Form for Criminal Background Check (CBC)

All requested information in Sections I and II must be legibly completed

SECTION I – Personal Information

DATE: _____

NAME: _____ **MAIDEN NAME**: _____

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **COUNTY:** _____

DOB: _____ **SS#:** _____ **RACE:** _____ **SEX: M F**
(Circle One)

DRIVERS LICENSE #: _____ **STATE ISSUED:** _____

(List the county and state of your most recent previous places of residence and employment)

County & State	Length of Time (Years & Months)
1. _____	_____
2. _____	_____
3. _____	_____

SECTION II - Authorization and Release

I hereby give permission to Southeast Georgia Health System and its agent to verify the information submitted by me and to obtain a criminal history. Neither the Health System nor its' agent shall be violating my right to privacy in any manner and I release them from all liability whatsoever for actions related to the background investigation. I authorize release of this information to the appropriate representative(s) of Southeast Georgia Health System.

AFFILIATION NAME: _____
(Name of Hospital Department, Company, Organization, Agency, Contractor, Vendor, Service Provider, Educational Institution/Organization, other entity, etc...)

SIGNATURE: _____ **DATE:** _____

SECTION III - Safety & Security/Police Department Use Only

☐ State Criminal Check: _____ ☐ County (Name & State):_____

☐ Other Check: _____ ☐ Phone Results: _____

☐ Fax Results: _____ Results Entered in Database By: _____ Date:_____

Terminal Agency Coordinator/Operator: _____ Date: _____

☐ Note additional information on reverse side