



Applicants employed under the TriMED Healthcare - AGENCY: FBI Facility ID: 13263

Applicants employed under the TriMED Healthcare - REGISTRY: FBI Facility ID: 13264

PRE-EMPLOYMENT BACKGROUND CHECK AUTHORIZATION

I, _____, understand that as part of the employment process, **TRIMED HEALTHCARE, LLC** needs to complete a background check on me regarding:

- | | |
|--------------------------------------|---|
| 1. Criminal record; State / FBI | 10. Reference Verification; |
| 2. Sex and Violent Offenders Record; | 11. Medical Suitability |
| 3. Employment Verification; | 12. Drugs/Alcohol |
| 4. Education Verification; | 13. Social Security Verification |
| 5. License Verification; | 14. (LEIE) Excluded Individuals/Entities |
| 6. Motor Vehicle Records; | 15. Medicheck |
| 7. FBI Finger printing | http://oig.hhs.gov/fraud/exclusions.asp |
| 8. 2 Step PPD or Chest XRay | 16. Excluded Parties List System |
| 9. Personal/Professional | (EPLS) |

- **For Finger Printing go to: https://www.pa.cogentid.com/index_dpwNew.htm Use Facility ID: 13263 for TriMED Healthcare Agency or Facility ID: 13264 for TriMED Healthcare Registry (1099).**
- I authorize all federal and state agencies, persons and organizations that may have information relevant to this research to disclose such information to **TRIMED HEALTHCARE, LLC** or its authorized agent(s).
- I understand that this authorization is to be part of the written and signed employment application.
- I also understand that I do not have to give authorization for a background check but if I don't give permission, my employment application will not be processed further.
- I understand that I have specific rights under the federal Fair Credit Reporting Act (FCRA) and may have additional rights under relevant State law.
- I further authorize that a photocopy of this authorization may be considered as valid as the original.
- I hereby certify that all statements on this form are true and correct to the best of my knowledge and belief. I understand that employment with **TRIMED HEALTHCARE, LLC** is contingent upon successful completion of a background check.
- I authorize to have the applicable cost of background check, motor vehicle check and Motor vehicle driving record check paid by TirMED deducted from my payroll a appropriate.
- **Medicheck Website (<http://www.oig.nsf.gov/debarment>).**

_____ Applicant's Signature _____ Date

Full Name _____ Telephone No. _____

Former Name(s) and Date(s) used: _____

Current Address _____ From ___/___/___ To: ___/___/___

Date of Birth _____ Social Security Number: _____

Current Driver's License: _____ State: _____ **Date PA Residence Commenced:** ___/___/___

Residence in PA 2 years? Y/N . FBI ? Y/N . Note: If Residence in PA for less than 2 years. FBI Check is required.

List any other cities, states and dates of residency during last 10 years (Use back of sheet, if necessary.)

City	State	From: Month/Year	To: Month/Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____