EAST-CENTRAL DISTRICT HEALTH DEPARTMENT
BACKGROUND INVESTIGATION AUTHORIZATION

I authorize East-Central District Health Department (the "Company) or any of its agents to undertake a verification of the information I have provided, and to make an investigation of my background, references, character, credit history, past employment, education, criminal and police records, and to make other investigative checks, including those maintained by both public and private organizations, and all public records for the purpose of confirming the information contained on my application, resume or other documentation and/or obtaining other information which may be material to my application for employment or continued employment with the company. I authorize all corporations, companies, credit agencies, educational institutions, persons, law enforcement agencies, worker's compensation agencies, criminal, civil and federal courts, former employers and individuals named in my application to release information they may have about me.

I release East-Central District Health Department and/or its agents, and any person or entity which provides information pursuant to this authorization, from any and all liabilities, claims or lawsuits in regard to the information obtained from any and all of the above referenced sources used. I understand that East-Central District Health Department and/or its agents will adhere to any applicable state and federal statutes concerning the securing, handling and release of such information.

I certify that all of the statements I have made and all the information I have provided to East-Central District Health Department are true, including the information on this form, and agree that any false information, misrepresentation or omission of facts may result in cancellation of my application and/or immediate dismissal.

Date: _____ Print Name: _____
First Middle Last Name

Maiden Name and/or any other name used : _____

Present Address: _____
Address City State Zip

Former Address: _____
Address City State Zip

Date of Birth: _____ Social Security Number: _____

Driver's License Number: _____ State Issuing Driver's License: _____

I consent to the disclosure and copying of any Record of Arrest of Prosecution to the above listed persons.

State of _____ _____
Signature of Person of Interest
)ss
County of _____

Subscribed and sworn to before me this _____ day of _____, _____.

(seal) _____
Notary Public