MedTrust Staffing Co

(Print and complete form, scan, and send the completed and scanned document to infor@medtruststaffingcompany.com)

Authority to Release Information

For Medical Staffing Partners, Inc. to effectively process my employment application **I understand and authorize the following actions**: Medical Staffing Partners may conduct an investigation in which information is obtained and verified through: personal interviews, review of information held by government, review of information held by law enforcement, past employment and education, professional licensure and certifications. This may include potential disciplinary actions, criminal records including sexual and predatory offenses, personal references, motor vehicle records, and other job related data provided on this application or in the interview process.

In addition, I agree that I waive my right of privacy in this investigation and release and hold harmless Medical Staffing Partners, Inc. and its agent, Corporate Security Solutions, Inc. I have a right under the FCRA to obtain a copy of this report by directing a written request to Corporate Security Solutions, Inc.

I authorize the appropriate individuals, companies, institutions or agencies to release information and I release them from any liability as a result of such inquiries or disclosures.

I understand that a 'consumer report' may be generated summarizing this information. I authorize Medical Staffing Partners, Inc. to disclose this 'consumer report' to any company, facility, or healthcare provider where I am, or could be, assigned to provide services.

I understand and agree that a photocopy of this authorization would be accepted with the same authority as the original. I understand that any decision to offer employment by Medical Staffing Partners, Inc. is contingent upon the results on the 'consumer report'.

I affirm that all statements and answers on my application, resume, or interview are true and complete. I understand if any are false or misleading this will be cause for immediate disqualification and termination of my employment by Medical Staffing Partners, Inc.

As a condition of employment I authorize Medical Staffing Partners, Inc. to check my conviction record, license or any applicable piece of information as needed, and on a continuous basis, as related to my employment.

First Name: _____ Middle Name: _____ Last Name: _____

Previous Name (i.e.: maiden name, aka's, etc.…) _____

Social Security Number: _____ Date of Birth: _____

Location of Birth: _____

Current Address:

Street Address: _____

City: _____ State: _____ Zip: _____

Previous Address (if you moved in the past 7 years):

Street Address: _____

City: _____ State: _____ Zip: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Drivers License Number: _____ State Issued: _____

Signature: _____ Date: _____