TRIMED HEALTHCARE, LLC State License Number 24213601

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