Salt Lake Regional Medical Center
A STEWARD FAMILY HOSPITAL

VOLUNTEER APPLICATION

Today's Date: _____ E-Mail Address: _____

Name: _____
(First) (Middle) (Last)

Mailing Address: _____
(Street) (City) (Zip)

Phone: Day: _____ Best Time to Call: _____

Evening: _____ Best Time to Call: _____

Contact In Case Of Emergency:

Name: _____ Relationship to You: _____

Address: _____ Phone: _____

Name of relatives/friends currently employed by Salt Lake Regional Medical Center:
_____

Employment Experience (List current or recent experience first)

Job Title	Company	Dates	Phone

Volunteer Experience (List current or most recent experience first)

Company	Duties	Dates	Phone

VOLUNTEER DUTIES DESCRIPTION: Helps to create and promote a caring, compassionate, environment for patient, families and visitors. Greets, guides, and offers assistance to those who come in or call with questions. The goal is to help make interactions with the hospital a positive experience. The volunteer may offer elbow assistance for persons with mobility concerns, and offer wheelchair transport as needed. The volunteer will adhere to HIPAA and Infection Prevention standards.

Volunteers may be needed for the following Dates/Time/Areas

AREA	SUNDAY	MONDAY - FRIDAY	SATURDAY
Main Lobby Desk 1st Floor	8:30 AM to 12:30 PM	8:30 AM to 12:30 PM	8:30 AM to 12:30 PM
	12:30 PM to 4:30 PM	12:30 PM to 4:30 PM	12:30 PM to 4:30 PM
	4:30 PM to 8:30 PM	4:30 PM to 8:30 PM	4:30 PM to 8:30 PM
Surgery Waiting Room Ground Level		8:30 AM to 12:30 PM	
		12:30 PM to 4:30 PM	

WHEN ARE YOU AVAILABLE TO VOLUNTEER?

SHIFTS	SUN	MON	TUES	WED	THURS	FRI	SAT
8:30 AM - 12:30 PM							
12:30 PM - 4:30 PM							
4:30 PM - 8: 30 PM							

How long are you planning to volunteer? (6 months, 1 year, etc.): ________________________________

References: List two persons not related to you who have definite knowledge of your qualifications.

Name	Address, City, ST, ZIP	Phone

Volunteer positions require the ability and physical capability to walk see and hear. Must be able to lift twenty (20) pounds and have the capacity to push a normal size person in a wheelchair. (Reasonable accommodations may be available in certain volunteer areas). Some reaching and bending may be required. Must be able to read, write, and communicate effectively in English; Professional appearance with good personal hygiene. There will be minimal exposure to hazardous materials.

Opportunities for volunteers are provided without regard to religion, creed, race, national origin, age or sex

+ +

I authorize contact of the listed references. I understand that misrepresentation or omission of facts requested is cause for non-appointment as a Salt Lake Regional Medical Center Volunteer. If appointed as a volunteer, I agree to abide by the philosophies of Salt Lake Regional Medical Center. I will fulfill the volunteer responsibilities to the best of my abilities and agree to a thirty-day probationary period.

Salt Lake Regional Medical Center is not obligated to provide a volunteer position placement, nor am I obligated to accept the volunteer position offered. I understand that the only way to receive paid employment is to apply through the Hospital Human Resources office.

Volunteer Signature: ______________________________ **Date:** _________________________

Parent or Guardian Signature: ______________________________ **Date:** __________________

Parental Signature Indicates Approval For Salt Lake Regional Medical Center To Perform A Background Check, Including References And A Drug Screen. Parental Signature Also Gives Approval For Minors To Obtain Emergency Medical Attention Deemed Necessary, In The Event Of An Illness Or Accident While Minor Is On Duty At Salt Lake Regional Medical Center When Reasonable Attempts To Contact Parent/Guardian Have Been Unsuccessful.

Salt Lake Regional Medical Center
A STEWARD FAMILY HOSPITAL

Steward

VOLUNTEER APPLICATION

AUTHORIZATION AND RELEASE FOR THE PROCUREMENT OF POST-OFFER/PRE-PLACEMENT VOLUNTEER DRUG SCREEN

I, the undersigned, do hereby authorize Salt Lake Regional Medical Center to procure a pre-placement drug screen test. I understand that my ability to volunteer is contingent upon the successful passing of the drug-screening test. The test will be administered at the facility's expense and will require me to provide a urine specimen for analysis. The urine specimen will be analyzed for the presence of marijuana, cocaine, phencyclidine (PCP) opiates and amphetamines.

_____ _____

Applicant/Volunteer PRINTED Name Applicant/Volunteer Signature

Today's Date: _____

If Volunteer Applicant is age 14 – 17, a guardian or parent must sign below:

Parent or Guardian Signature: _____ Date: _____

Parental signature indicates approval for Salt Lake Regional Medical Center to perform a background check, including references and a drug screen.

CONFIDENTIALITY STATEMENT

Information concerning patients, fellow volunteers, employees, physicians, other staff and other Hospital business of a confidential nature must not be discussed with persons not concerned with such information.

I understand and agree that in the performance of my duties as a volunteer at Salt Lake Regional Medical Services, I must hold patient, employee or hospital business in confidence. Further, I understand that intentional or involuntary violation of such confidentiality could result in possible civil action, or Hospital disciplinary action up to and including termination of my volunteer privileges.

_____ _____

Date Signature

VOLUNTEER HEALTH - Please provide the following information to the Volunteer Manager

MMR (Measles, Mumps, Rubella) vaccinations - Two (2)

- *Attach written documentation from your health care provider to this form before you begin volunteering.*

VARICELLA (Chicken Pox)

- **I have had the Chicken Pox: Yes _____ I have been vaccinated for Chicken Pox: Yes _____**
- *Attach written documentation from your health care provider to this form before you begin volunteering.*

FLU SHOT – Required if you are volunteering between OCTOBER 1 and MARCH 31ST

- *If you have had the Flu shot, attach written documentation from your health care provider to this form before you begin volunteering.*
- *If you have not had a Flu shot, you may receive it free of charge from the Hospital Infection Control RN.*

TUBERCULOSIS SKIN TEST (PPD) OR CHEST X-RAY within the past 6 months.

- *Attach written documentation from your health care provider to this form before you begin volunteering.*
- *If it is determined that you have active Tuberculosis, you cannot volunteer at Salt Lake Regional Medical Center.*
- *This test may be done free of charge from the Hospital Infection Control RN.*

Any Medical History/Allergies we should know about: _____
_____

I declare each of the above the answers given to be complete and true to the best of my knowledge. Also, I waive any provisions of law forbidding any physician who has attended me, or hospital where I have been confined from furnishing any information required and I hereby authorize them to make such disclosures as Salt Lake Regional Medical Center may request.

_____ _____
Volunteer Printed Name Volunteer Signature

_____
Date

I hereby give consent and authorize Salt Lake Regional Medical Center to conduct an initial Tuberculosis/TB/PPd Test to my minor child/ward named above. In addition, I hereby consent for Salt Lake Regional Medical Center to conduct an annual TB test on my minor child/ward named above.

_____ _____ _____
Legal Guardian Printed Name Legal Guardian Signature Date

I hereby give consent and authorize Salt Lake Regional Medical Center to place an initial Flu Shot vaccination to my minor child/ward named above. I understand that permission for future Flu shots will be given annually.

_____ _____
Legal Guardian Signature Date

Salt Lake Regional Medical Center
A STEWARD FAMILY HOSPITAL
Steward

HEALTH INFORMATION CONFIDENTIALITY AGREEMENT

This **Health Information Confidentiality Agreement** ("Agreement") applies to all members of **Salt Lake Regional Medical Center (**the "Hospital") workforce including staff, employees, volunteers, independent contractors, trainees and others who, in the performance of work for the Hospital, are under the Hospital's direct control and who have access to protected health information ("PHI") maintained, received, or created by the Hospital and/or its affiliated entities. Please read all sections of this Agreement, before signing below. In addition, it is your responsibility to review and become familiar with the Hospital's privacy and security policies and procedures as these apply to your particular job.

Salt Lake Regional Medical Center has a legal and ethical responsibility to safeguard the privacy of the Hospitals' patients and to protect the confidentiality of their health information. In the course of your employment, whether or not you are directly involved in providing patient services, you may hear information that relates to a patient's health, read or see computer or paper files containing PHI and/or create documents containing PHI. Because you may have contact with PHI, the Hospital requests that you agree to the following as a condition of your employment:

1. **Confidential PHI**.
   I understand that all health information which may in any way identify a patient or relate to a patient's health must be maintained confidentially. I will regard confidentiality as a central obligation of patient care.

2. **Prohibited Use and Disclosure**.
   I agree that, except as required under my job responsibilities or as directed by the Hospital, I will not at any time during or after my work for the Hospital speak about or share any PHI with any person or permit any person to examine or make copies of any PHI maintained by the Hospital. I understand and agree that personnel who have access to health records must preserve the confidentiality and integrity of such records, and no one is permitted access to the health record of any patient without a necessary, legitimate, work-related reason. I shall not, nor shall I permit any person to, inappropriately examine or photocopy a patient record or remove a patient record from the Hospital.

3. **Safeguards.**
   When PHI must be discussed with other healthcare practitioners in the course of my work for the Hospital, I shall make reasonable efforts to avoid such conversations from being overheard by others who are not involved in the patient's care.

   I understand that when PHI is within my control, I must use all reasonable means to prevent it from being disclosed to others, except as otherwise permitted by this Agreement. I will not at any time reveal to anyone my confidential access codes to the Hospital's information systems, and I will take all reasonable measures to prevent the disclosure of my access codes to anyone. I also understand that the Hospital may, at any time, monitor and audit my use of the electronic/automated patient record and information systems.

   Protecting the confidentiality of PHI means protecting it from unauthorized use or disclosure in any form: oral, fax, written, or electronic. If I keep patient notes on a handheld or laptop computer or other electronic device, I will ensure that my supervisor knows of and has approved such use. Should I need to send patient identifiable health information in an email, or email attachment, I agree that it will be sent in compliance with the Hospital's policies and procedures.

4. **Training and Policies and Procedures.**
I agree that I will read the Hospital's policies and procedures as they relate to my job responsibilities, will complete the training courses offered by the Hospital, and shall abide by the Hospital's policies and procedures governing the protection of PHI.

5. **Return or Destruction of Health Information.**
If, as part of my job responsibilities, I must take PHI off the premises of the Hospital, I shall ensure that I have the Hospital's permission to do so, I shall protect the PHI from disclosure to others, and I shall ensure that all of the PHI, in any form, is returned to the Hospital or destroyed in a manner that renders it unreadable and unusable by anyone else.

6. **Termination.**
At the end of my employment with the Hospital, or when my assignment for the Hospital is otherwise terminated, I will make sure that I take no PHI with me, and that all PHI in any form is returned to the Hospital or destroyed in a manner that renders it unreadable and unusable by anyone else. Discharge or termination, whether voluntary or not, shall not affect my ongoing obligation to safeguard the confidentiality of PHI and to return or destroy any such PHI in my possession.

7. **Sanctions.**
I understand that my unauthorized access or disclosure of PHI may violate state or federal law and cause irreparable injury to the Hospital and harm to the patient who is the subject of the PHI and may result in disciplinary and/or legal action being taken against me, including termination of my employment.

8. **Reporting of Non-Permitted Use.**
I agree to immediately report to the Hospital any unauthorized use or disclosure of PHI by any person. The person to whom I report unauthorized uses and disclosures at the Hospital is the Regional Privacy Officer. The person to whom I report unauthorized uses and disclosures at the Steward corporate office is the Chief Privacy Officer, Steward Healthcare LLC, 111 Huntington Avenue Suite 1800 Boston, Massachusetts 02199, 617-419-4700.

9. **Disclosure to Third Parties.**
I understand that I am not authorized to share or disclose any PHI with or to anyone who is not part of the Hospital's workforce, unless otherwise permitted by this Agreement.

10. **Agents of the Department of Health and Human Services.**
I agree to cooperate with any investigation by the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any agent or employee of HHS or other oversight agency, for the purpose of determining whether the Hospital is in compliance with federal or state privacy laws.

11. **Disclosures Required by Law.**
I understand that nothing in this Agreement prevents me from using or disclosing PHI if I am required by law to use or disclose PHI

By my signature below, I agree to abide by all the terms and conditions of this Agreement.

Signature: _____ Printed Name: _____

Title/Position: _____ Date: _____

Para informacion en espanol, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20006.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20006.**

• **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.

• **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:

• A person has taken adverse action against you because of information in your credit report;
• You are the victim of identity theft and place a fraud alert in your file;
• Your file contains inaccurate information as a result of fraud;
• You are on public assistance;
• You are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

• **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.

• **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.

• **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

• **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

• **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

• **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.

• **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8688.

• **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
• **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS	CONTACT
1.a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates.	a. Bureau of Consumer Financial Protection 1700 G Street NW Washington, DC 20006
b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the Bureau:	b. Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above:	
a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks	a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050
b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and insured state branches of foreign banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act	b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480
c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations	c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106
d. Federal Credit Unions	d. National Credit Union Administration Office of Consumer Protection (OCP) Division of Consumer Compliance and Outreach (DCCO) 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Department of Transportation 400 Seventh Street SW Washington, DC 20590
4. Creditors Subject to Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 1925 K Street NW Washington, DC 20423
5. Creditors Subject to Packers and Stockyards Act	Nearest Packers and Stockyards Administration area supervisor
6. Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 406 Third Street, SW, 8th Floor Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F St NE Washington, DC 2054
8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
9. Retailers, Finance Companies, and All Other Creditors Not Listed Above	FTC Regional Office for region in which the creditor operates or Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357

DISCLOSURE AND RELEASE

I hereby authorize Salt Lake Regional Medical Center and Steward Healthcare Corporation (collectively, "Steward") and their agents or assigns to request and receive access to consumer reports and/or investigative consumer reports on me from any consumer reporting agency.

I understand that a "consumer reporting agency" is a person or organization paid to regularly engage in the practice of assembling or evaluating consumer credit information or other information about consumers for the purpose of furnishing consumer reports to third parties. I also understand and agree that Steward is not itself a "consumer reporting agency."

I understand that a "consumer report" includes, but may not be limited to, information collected by a consumer reporting agency that may bear on my creditworthiness, credit standing, character, and general reputation. A "consumer report" may include a criminal background check and a review of driving records, professional credentials, and educational transcripts.

I understand that an "investigative consumer report" may include information collected by a consumer reporting agency through personal interviews with neighbors, friends, and associates. In seeking employment from Steward, I understand and agree that Steward may commission an investigation through which information may be obtained through personal interviews with my neighbors, friends, associates, and others with whom I may be acquainted. These inquiries may seek information as to my character, general reputation, personal characteristics, and mode of living.

I understand that if Steward elects to request an investigative consumer report, I have the right to make a request, within a reasonable period of time, for a complete and accurate disclosure of additional information concerning the nature and scope of this investigation.

I also understand that, before taking any adverse decision based on information contained in a "consumer report" or "investigative consumer report," Steward will provide me with a copy of the report and the telephone number of the agency providing the report. I understand that I will have a right to dispute with the agency the accuracy or completeness of any information in a "consumer report" or "investigative consumer report."

I acknowledge, with my signature below, that I have read and understood the information on this disclosure and release. Furthermore, I understand and agree that Steward may use the information contained in a "consumer report" or "investigative consumer report" to evaluate my candidacy to volunteer, for employment, or for participation in any program or event associated with Steward.

Volunteer Signature _____

Volunteer Name (printed) _____

Date _____

Salt Lake Regional Medical Center - BackgroundCheck & Drug Screen # 8993

VOLUNTEER INFORMATION

APPLICANT'S FULL NAME _____

Any Other Names Used _____

Social Security No. _____ /_____ / _____ Date of Birth[1] _____

Email address: _____ (Provide if you prefer to receive information via email)

Current Address _____

City _____ State _____ Zip _____

Driver's License State _____ D.L. Number _____

Address on D.L.: _____

Name of High School, College, University or Institution of Professional Training where you completed the highest level

(☐ GED – provide state)_____

Campus Name _____Campus City _____Campus State _____

Name on GED or under which you graduated _____

Year(s) Attended _____Year Graduated/GED Completed_____

Please provide any current professional licenses, certifications, or registries you may hold:

Name as it appears on license/Certification/Registry_____

Type _____State/Region or Issuing Organization _____ Country _____ Number_____

Type _____State/Region or Issuing Organization _____ Country _____ Number_____

*Have you ever been convicted of a crime? Yes ☐ No ☐ (Please attach a separate sheet of paper to provide additional entries)

Offense _____ County _____ State _____ When_____

Offense _____ County _____ State _____ When_____

Please provide all locations where you have resided for the past seven (7) years, starting with your current residency.
(Please attach a separate sheet of paper to provide additional entries)

1. **City:**_____**State:**_____**Date From:**_____**Date To:**_____
2. **City:**_____**State:**_____**Date From:**_____**Date To:**_____
3. **City:**_____**State:**_____**Date From:**_____**Date To:**_____
4. **City:**_____**State:**_____**Date From:**_____**Date To:**_____

STATE LAW NOTICES

Minnesota or **Oklahoma** applicants or employees only: Please mark an X in the designated field if you would like to receive a free copy of a consumer report if one is obtained by the Company. The report will be mailed to the current address you indicated on this form. _____

California applicants or employees only: Please mark the following field if you would like to receive a copy of an investigative consumer report or consumer credit report at no charge if one is obtained by the Company whenever you have a right to receive such a copy under California law. The report will be mailed to the current address indicated above. _____

California applicants or employees only: By marking an X in the designated field, you will receive and are acknowledging receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. _____

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by the Client by directly contacting PreCheck Inc. Additionally, please mark this field to receive and acknowledge receipt of a copy of Article 23-A of New York Correction Law. _____

Maine applicants or employees only: Under Chapter 210 Section 1314 of Maine Revised Statutes, you have the right, upon request, to be informed within 5 business days of such request of whether or not an investigative consumer report was requested. If such report was obtained, you may contact the Consumer Reporting Agency and request a copy.

Massachusetts applicants or employees only: If you ask, you have the right to a copy of any background check report concerning you that the Company has ordered. You may contact the Consumer Reporting Agency for a Copy.

Washington State applicants or employees only: You have the right, upon written request made within a reasonable period of time after your receipt of this disclosure, to receive from the Company a complete and accurate disclosure of the nature and scope of the investigation we requested. You also have the right to request from the consumer reporting agency a written summary of your rights and remedies under the Washington Fair Credit Reporting Act.

I have read and understand the above information and assert that all information provided by me is true and accurate.

Signature: _____ **Date** _____

[1] The Age Discrimination in Employment Act of 1967 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age. This information is necessary for the proper processing of a consumer report.

Nevada Private Investigator License # 1618

Salt Lake Regional Medical Center - BackgroundCheck & Drug Screen # 8993

VOLUNTEER DISCLOSURE & AUTHORIZATION

APPLICANT'S FULL NAME _____

Any Other Names Used _____

Social Security No. _____ /_____ / _____ Date of Birth[1] _____

Current Address _____

City _____ State _____ Zip _____

Driver's License State _____ D.L. Number _____

Address on D.L.: _____

DISCLOSURE REGARDING BACKGROUND INVESTIGATION

The prospective organization ("the Company") may obtain information about you from a consumer reporting agency made in connection with your application to volunteer with the Company. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living, and which can involve personal interviews. These reports may contain information regarding your credit history, criminal history, social security verification, motor vehicle records ("driving records"), verification of your education or employment history, or other background checks. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment is an investigation into your education and/or employment history conducted by PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888)PreCheck [1-888-773-2432] or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing the Company to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and throughout the course of your volunteering with the Company to the extent permitted by law.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the DISCLOSURE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" by the Company at any time after receipt of this authorization and throughout the term of my volunteering, if applicable. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by PreCheck, Inc., 3453 Las Palomas Rd. Alamogordo, NM 88310; 1(888) PreCheck [1-888-773-2432] another outside organization acting on behalf of the Company, and/or the Company itself. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

My present employer may be contacted for a job reference. Yes ☐ No ☐

By signing below, I confirm that I have read and understand the above information and that I provide my consent.

Signature: _____ Date _____

www.PreCheck.com info@precheck.com
ph: 800-999-9861 fax: (800) 207-2778

Nevada Private Investigator License # 1618

Ver0813