AUTHORIZATION FORM

I hereby authorize Donalsonville Hospital, Inc. to have background checks conducted and reports received pertaining to me from national criminal file search, social security verification search, and State of Georgia sexual offender search.

The following personal information is furnished for this purpose.

Full name PRINTEDAddress	
How long at this address	
Sex*Birth Date	* Social Security No
	_Date
Zigiluturo	
*Providing social security number search, and they will be used with	and date of birth is necessary to perform the you consent for this purpose.

If an adverse employment, scholarship, or licensing decision is made against the person whose record is obtained, he/she shall be informed

- (1) that a record was obtained;
- (2) the specific content of the record;
- (3) the effect the record had upon decision