UW Medicine

CRIMINAL BACKGROUND AUTHORIZATION

UWMC - MONTLAKE 1959 NE Pacific Street Seattle, WA 98195

Instructions for completing this form on reverse side.

SECTION 1. AGENCY INFORMATION (COMPLTETED BY CONTRACTOR)						
1. NAME (TRADE NAME) OF HOSPITAL				2. THE LOCATION (STREET) ADDRESS		
UW MEDICAL CENTER - MONTLAKE				1959 NE Pacific Street Seattle WA 98195		
	3. HOSPITAL PHONE 3a. HOSPITAL FAX NUM 206.598.4909 206.598.2800			4. HOSPITAL EMAIL hospsec@uw.edu		
SECTION 2. ALL QUESTIONS IN THIS SECTION MUST BE COMPLETED BY THE APPLICANT (PERSON TO BE CH						ON TO BE CHECKED)
5. SOCIAL SECURITY NUMBER			6. DATE OF BIRTH		7. GENDER	8. RACE (OPTIONAL)
CURRENT LEGAL NAME 9. LAST NAME			OTHER NAMES YOU HAVE BEEN KNOWN BY 12. BIRTH NAME			
7. LAST NAME			12, bik	LAST	FIRST	FULL MIDDLE NAME
10. FIRST NAME			13. OTH	IER MARRIED O Last	PR LEGAL NAME(S) (OR V FIRST	VRITE NONE) FULL MIDDLE NAME
11. FULL MIDDLE (OR WRITE NONE)			14. NICKNAME(S)/OTHER KNOWN NAME(S) (OR WRITE NONE)			
15. HOME ADDRESS			APT/U	UNIT	CITY	STATE/ZIP
16. HAVE YOU EVER BEEN CONVICTED OF, OR DO YOU HAVE CHARGES PENDING FOR ANY CRIME? ☐ YES ☐ NO If yes, give the crime, the conviction date or charge status and the state where it occurred. Note, this includes all convictions and charges: 17. HAVE YOU EVER BEEN FOUND TO HAVE SEXUALLY ABUSED, PHYSICALLY ABUSED, NEGLECTED, ABANDONED OR EXPLOITED A CHILD OR ADULT? If yes, give name of court, state licensing board, displinary board, or dependency action, details of the finding, and state where it occurred:						
18. HAVE YOU EVER HAD A CONTRACT AND/OR LICENSE TO CARE FOR CHILDREN OR ADULTS DENIED, TERMINATED, REVOKED, OR SUSPENDED? If yes, give date, contract and/or license type, name of contracting and/or licensing agency, and the state where it occurred:						
1	D. HAS A COURT EVER ISSUED AN ORDER OF PROTECTION AGAINST YOU FOR ABUSE, NEGLECT, ☐ YES ☐ NO FINANCIAL EXPLOITATION, or ABANDONMENT? If yes, give date, court, and the state where it occurred:					
20. DI	20. DRIVER LICENSE OR STATE IDENTIFICATION NUMBER 2				OF TIME LIVED IN WA	ASHINGTON STATE
Nu	Number: State:			Years:	Months:	
22. I understand that this authorization form and the background check is the result of Washington State Laws and Regulations and if any of the information provided above is found to be false, it may result in the loss of my employment/contract. I understand that I am signing this under penalty of perjury. By signing this form, I state that the information above is true and correct to the best of my knowledge. I understand untruthful or misleading answers, or deliberate omissions are cause for denial or immediate termination of my employment/contract. My signature below authorizes UW Medicine to obtain now and on a periodic basis conviction records from Washington State including Washington State Patrol and other states; and to obtain from Washington and other states licensing information and any determination or finding of abuse, neglect, exploitation or abandonment. I understand that the result of this background check(s)will be released to the agency, the facility or my employer/contractor named above. I understand I may contact UW Medicine to receive a copy of my WSP record, ten (10) days after signing this form. 23. SIGNATURE OF PERSON TO HAVE BACKGROUND CHECK 24. DATE SIGNED						
23. SIG	INATURE OF PERSON I	O HAVE BACKGROUNL			INED	

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FORM

This form will be returned if any portion of the required information necessary to conduct a background check is not entered or is not legible.

SECTION 2:

To be completed by the applicant (person to be checked).

- 1. Completed by UWMC
- 2. Completed by UWMC
- 3. Completed by UWMC
- 3a. Completed by UWMC
- 4. Completed by UWMC
- 5. Required.
- 6. Required.
- 7. Required.
- 8. Optional.
- 9. Required.
- 10. Required.
- 11. Required.
- 12. Required. Must include complete name at birth. If same as #9 #11, must write SAME.
- 13. Required. Must list all married names used (male or female); must write NONE if none.
- 14. Required. Must list all nicknames used (male or female); must write NONE if none.
- 15. Required.
- 16. Required.
- 17. Required.
- 18. Required.
- 19. Required.
- 20. Required. Must list driver lic. number or state ID number; must write NONE if none.
- 21. Required. Indicate number of consecutive years and/or months lived in WA State.
- 22. Read prior to moving to block #23.
- 23. Required signature of applicant.
- 24. Required. Date signed by applicant.