Health Care Coalition of Lafayette County
DBA Health Care Collaborative of Rural Missouri
825 South Business Highway 13, Lexington, MO 64067 660-259-2440
DBA Live Well Community Health Centers
324 S. Hudson, St., P.O. Box 512, Buckner, MO 64016 816-249-1521
300 E. 9th St., Carrollton, MO 64633 660-329-9005
206 N. Bismark, Concordia, MO 64020 660-463-0234
608 Missouri St., Waverly, MO 64096 660-493-2262

BACKGROUND CONSENT AGREEMENT

Notification

All HCC/LWCHC clinical training students are subject to a series of appropriate criminal background checks as a condition of work. This check includes the following: Criminal history reference searches for felony and misdemeanor convictions at the county and federal levels of every jurisdiction where I currently reside or where I have resided during the past 7 years; and sex offender registry searches at the county and federal levels in every jurisdiction where I currently reside or where I have resided.

Authorization

I hereby authorize HCC/LWCHC to conduct the criminal background check described above. In connection with this, I also authorize the use of law enforcement agencies and/or private background check organizations to assist HCC/LWCHC in collecting this information. Validity Screening Solutions has been secured as a third party vendor (consumer reporting agency) to assist in collecting and verifying information.

I also am aware that records of arrests on pending charges and/or convictions are not an absolute reason to deny my clinical training request. Such information will be used to determine whether the results of the background check reasonably bear on my trustworthiness or my ability to perform the duties of my position in a manner which is safe for HCC/LWCHC patients, employees, and other community members.

Position(s): _____

Please print (for identification purposes):

Full Legal Name:

_____

First Middle Last

Other Names You Have Used in Past Seven Years: _____

Current Address: _____

Previous Address (most recent): _____

Addresses in the 7 years prior to completing this authorization:

_____

_____

Phone Number: _____ **Alternate Phone Number:** _____

Date of Birth: _____ /_____ /_____ **Gender:** Female _____ Male _____

Month / Day / Year

Social Security #: _____ **Driver's License #:** _____

State of Driver's License: _____

Have you ever been convicted of a criminal *offense or have any pending criminal* charges against you?

*This refers only to felonies and misdemeanors; you do not need to include non-criminal traffic violations or municipal ordinance violations.

Yes_____(provide detail on next page) **No**_____

To the best of my knowledge, the information provided in this Notice and Authorization and any attachments thereto is true and complete. I understand that any falsification or omission of information may disqualify me for training with HCC/LWCHC and/or may serve as grounds for the severance of my clinical training agreement with HCC/LWCHC. By signing below I hereby provide my authorization to HCC/LWCHC to conduct a criminal background check and I acknowledge that I have been provided with a summary of my rights under the Fair Credit Reporting Act which is attached. In addition to those rights, I understand that I have a right to appeal an adverse decision made by HCC/LWCHC based on my background check information within three business days of receipt of such notice and that a determination on my appeal will be made in seven working days from HCC/LWCHC's receipt of such appeal.

_____ _____

Signature **Date**

If you have been convicted of a criminal *offense or have any pending criminal* charges against you, please give details here. (This refers only to felonies and misdemeanors; you do not need to include non-criminal traffic violations or municipal ordinance violations.)