



RELEASE OF LIABILITY

I hereby release from liability any and all individuals and organizations who, in good faith and without malice, provide any and all information to representatives of COASTAL CLINICAL & MANAGEMENT SERVICES, INC. concerning my work competence, ethics, character, education, and other qualifications, and I hereby consent to the release of any and all such information to COASTAL CLINICAL & MANAGEMENT SERVICES, INC. You are specifically authorized to accept a photocopy of this signed release form in lieu of an original signed form.

Applicant's Signature

Date

Print or Type Name

Maiden Name (if applicable)

EMPLOYMENT BACKGROUND INVESTIGATION AUTHORIZATION

I understand that in connection with my application for employment, Coastal Clinical and Management Services, Inc. will be performing a background check on me. This background check may include an inquiry into my employment history, education, general character or reputation, work experience, financial and/or credit history, criminal history records from any criminal justice agency in any or all federal, state, city and county jurisdictions, and/or state Department of Motor Vehicle Drivers License Records.

According to the Fair Credit Reporting Act (FCRA), I am entitled to know if the considerations for which I am applying are denied because of information obtained from a consumer-reporting agency. If so, I will be notified and be given the name of the agency providing that report.

I agree that a photocopy or telephonic facsimile of this authorization shall be valid as the original. This release is valid for most federal, state and county agencies.

I release Coastal Clinical and Management Services, Inc. and /or their agent ScreenNow, LexisNexis Risk & Information Analytics Group and any person or entity, which provides information pursuant to this authorization, from any and all liabilities, claims or law suits in regards to the information obtained from any and all of the above referenced sources used.

I have read this Pre-Employment Disclosure and by signing below, hereby authorize investigators to conduct a background check as described herein in conjunction with my application for employment.

COMPLETE THE FOLLOWING:

Signature

Today's Date

Please print full name

The following information is required by law enforcement agencies and other positive identification purposes when checking public records. It is confidential and will not be used for any other purposes.

Maiden name (if applicable)

Social Security Number - Your Social Security Number will only be used in order to confirm your identity for purposes of completing an accurate background investigation.

Date of Birth - Your date of birth is required on this form in order to confirm your identity for purposes of completing an accurate background investigation, and is not provided to the hiring official for any purpose in connection with consideration of your application for employment.

Home Address

City

State

Zip

Driver's License Number and State

Name as it appears on License

Have you ever been convicted of, plead guilty, or "no contest" to a crime that has or has not been expunged or removed from your record? No Yes **If yes, please explain:** (Make sure to include the city/state/county and the year the crime occurred for each conviction.)



EDUCATIONAL STATEMENT

I, _____, do attest to having attended and
Applicant's Name (Print)

graduated from an accredited education program:

Name of Institution: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: _____

Type of Degree: _____

Date Awarded: _____

Social Security Number: _____

Due to circumstances beyond my control, I am unable to locate or receive a duplicate copy of my original diploma/degree.

Applicant's Signature

Date

Maiden Name (if applicable)



CERTIFICATE OF AVAILABILITY

To Whom It May Concern:

I, _____ am available to work at _____,
(Name) (Name of Facility)

for Coastal Clinical & Management Services, Inc. starting on _____.
(Date)

Signature