Attachment B - Consent to Conduct Background Investigations

In connection with my application for Credentialing/Re-Credentialing and Privileges, I hereby authorize Mid-State Health Network to obtain a record of my conduct a criminal background check from official law enforcement agencies.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name (Last, First, Middle): | | | DOB: | |
| Others Names Used: | | | SS#: | |
| Race: | | | Gender: Male Female | |
| Driver’s License #: | | | State Issued: | |
| **List below all addresses for the last seven (7) years starting with the most current** (attach additional page if needed) | | | | |
| Street Address | City | State | Zip | Dates (MM/YY-MM/YY) |
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My signature below indicates that the information that I have furnished is true and correct to the best of my knowledge.

**Applicant Signature:**  **Date:**