INSTRUCTIONS
(For completing forms)

Fax cover sheet

1. Print your name under "From" in the upper right section of the page.
2. In Section 1, enter the date and check the appropriate department in which you are a student.
3. Disregard Section 2
4. Add any comments in Section 3.

Disclosure and Authorization

1. Read form carefully and fill out all available lines
2. Sign and date form at bottom.
3. Please print your name legibly and enter your email address at bottom.

Disclosure & Authorization by Student Regarding Sharing Information

1. Read form carefully.
2. Sign and date only one of the two options at the bottom of the page.
3. Print full name legibly.

Authorization for Release of Dependant Adult Abuse Information

1. Fill out your personal information in section labeled: The information concerns:
2. Sign and date the section that states "To be completed by the person authorizing....

Authorization for Release of Child Abuse Information

1. Fill out your personal information in Part A that is labeled, This information concerns:
2. Sign and date Part B

Please fax or email all forms to Inquirehire
(563) 323-5441 or inbox@inquirehire.com

ST. AMBROSE UNIVERSITY

TO: inquirehire

FROM:

FAX NUMBER: 563-323-5441

TOTAL NO. OF PAGES INCLUDING COVER:

PHONE NUMBER: 563-323-5922

RE: BACKGROUND FORMS

Section 1

PLEASE INDICATE THE REQUESTING DEPARTMENT

INITIAL BACKGROUND:

DATE: _____

- ☐ OCCUPATIONAL THERAPY (Shelli Engelbrecht)
- ☐ PHYSCIAL THERAPY (Susan Hartung)
- ☐ NURSING (Carol Shoemaker)
- ☐ SPEECH & LANGUAGE PATHOLOGY (Elisa Huff)
- ☐ MASTERS IN SOCIAL WORK (Katie VanBlair)
- ☐ HUMAN PERFORMANCE & FITNESS (Mike Orfitelli)
- ☐ OTHER_____

Section 2

State where student will have placement, if known _____

UPDATED BACKGROUND – DATE: _____

(An update is the additional background that needs to be completed prior to placement in a facility and in accordance with instructions of the facility.)

PLEASE DETAIL SPECIFIC REQUIREMENTS OF PLACEMENT AGENCY

Section 3

OTHER COMMENTS:

518 WEST LOCUST STREET
DAVENPORT, IOWA 52803

St. Ambrose University and InquireHire
DISCLOSURE and AUTHORIZATION

This notice is to inform you that in preparation for clinical/fieldwork/practicum experiences we will be obtaining and reviewing a consumer report or an investigative consumer (Background Check) report on you. By signing this, you are affirmatively acknowledging you understand you are not to be considered an employee of any clinical site or practicum but have been notified that this report may be considered a consumer report used for employment purposes as defined in the Fair Credit Reporting Act, section 603 (h). "Employment purpose" shall mean to include volunteer work, internship, clinical affiliation, practicum, or other position to fulfill educational requirements.

I, _____, hereby consent and authorize St. Ambrose University or its agents to prepare a consumer report consisting of criminal record checks, sanctioned lists check, as well as a search to determine all previous addresses within the last 7 years. This consumer report will be used for employment purposes as defined in the Fair Credit Reporting Act, section 603 (h), or in particular including employment as defined above. **In using a consumer report for employment purposes, before taking any adverse action based in whole or in part on the report, the person intending to take such adverse action shall provide to the consumer to whom the report relates, a copy of the report and a description in writing of the rights of the consumer under the FCRA, as prescribed by the Federal Trade Commission, section 609(c)(3).**

I am providing the following information for the preparation and proper verification of the consumer report.

Have you used another name such as but not limited to a maiden name or other married name? Yes____No____

If yes, list names and corresponding years:_____

Drivers License number: _____State of issuance (DL):_____

Date of Birth: _____ Social Security Number: _____

List all past **counties** of residence **and** corresponding years: (i.e. Scott, IA 2001 - 2008)
County_____ Years: from _____through _____
County_____ Years: from _____through _____
County_____ Years: from _____through _____

☐ For Minnesota, Oklahoma and California check here if you would like a copy of the consumer report.

New York students or employees: You have the right to inspect and receive a copy of any investigative consumer report requested by employer by contacting Inquirehire at 800-494-5922 or inbox@inquirehire.com.

Current Address, City, State, & Zip

_____

Permanent Address, City, State, & Zip

_____

_____ _____

Signature Date email address

revised 10/2008

_____

Print Last Name First Name Middle Name (please print legibly)

ST. AMBROSE UNIVERSITY
DISCLOSURE and AUTHORIZATION by STUDENT REGARDING
SHARING INFORMATION WITH POTENTIAL PLACEMENT SITES

CRIMINAL BACKGROUND CHECKS and ABUSE CHECKS

In preparation for required clinical/fieldwork/practicum experiences, I understand clinical/fieldwork/ practicum facilities ("sites") routinely require criminal background checks and abuse checks. These sites often want assurances from St. Ambrose University that these checks were done and the results satisfy the site's requirements. I understand sharing information with these sites is necessary to obtain placement(s) for me. I may either authorize St. Ambrose University to share this information or opt out of such process and share this information directly with the site.

I have completed an Authorization and Disclosure form authorizing criminal background checks (including healthcare-related list checks, e.g., such as but not limited to OIG) and abuse checks to be conducted by InquireHire. I know I am entitled to a copy of the report(s) upon a written request. I also know if there is adverse information contained in these checks, St. Ambrose or its agent will notify me.

I may authorize St. Ambrose University to share the results of these checks with potential clinical/fieldwork/practicum sites and in rare instances be required to contact the site to discuss placement potential OR I may opt out of allowing this sharing by St. Ambrose University and take on the sole responsibility of providing a potential site with my information for placement pursuant to its specific requirements.

I have signed **ONE OF THE SECTIONS BELOW** indicating whether, for potential placements pursuant to the site's specific requirements, I authorize St. Ambrose University to share that information or I "opt out" of its sharing that information and will share such information myself.

SIGN EITHER NUMBER 1 OR NUMBER 2 BELOW:

1. I hereby consent to and authorize subsequent disclosure of any information regarding the results of these criminal background checks, health care related list checks and abuse checks to potential placement sites. Additionally, I authorize St. Ambrose University through its clinical/fieldwork/practicum coordinator and its other agents to discuss any adverse results with the site, or if necessary, the Department of Human Services.

_____ _____
Student Signature Date

_____
PRINT Last Name First Name Middle Name

OR

2. I opt out and <u>DO NOT</u> consent to and authorize St. Ambrose University to share the results of these criminal background checks, health care related list checks and abuse checks with potential placement sites. I understand I will be responsible for providing a site with information it requires for placement.

_____ _____
Student Signature Date

Revised 10/08

_____
PRINT Last Name First Name Middle Name

Iowa Department of Human Services

Authorization for Release of Dependent Adult Abuse Information

This form must be used to authorize release of dependent adult abuse information when the person requesting the information does not have independent access to it in Iowa law. Complete a separate form for each person about whom information is requested. Send the original to the Central Abuse Registry, Iowa Department of Human Services, 1305 E Walnut Street, 5th Floor, Des Moines, IA 50319-0114 or fax to 515-242-6884.

To be completed by the person requesting information:

Requester			
INQUIREHIRE			
Address			
320 LECLAIRE ST.			
City	State	Zip Code	Phone Number
DAVENPORT	IA	52801	563-323-5922

The information concerns:

Name (first, middle initial, last)			
Maiden Name or Alias (if applicable)	Birth Date		Social Security Number
Address			
City	State	Zip Code	County

What is the purpose of your request for dependent adult abuse information?
CLEARANCE FOR STUDENTS TO PARTICIPATE IN FIELD WORK/CLINICAL EXPERIENCES IN HEALTHCARE SETTINGS.

I have read and understand the legal provisions for handling dependent adult abuse information that are printed on the second page of this form.

Signature	Date
James M. Sweeney	

To be completed by the person authorizing the Department of Human Services to release dependent adult abuse information:

Signature	Date

To be completed by the Central Abuse Registry or designee:

- ☐ The person named above is listed on the Dependent Adult Abuse Registry as having abused a dependent adult.
- ☐ The person named above is not listed on the Dependent Adult Abuse Registry as having abused a dependent adult.
- ☐ This request for information is denied because the form is incomplete.

Signature	Date

Comments:

Iowa Department of Human Services

AUTHORIZATION FOR RELEASE OF CHILD ABUSE INFORMATION

This form must be used to authorize release of child abuse information when the person requesting the information does not have independent access to it under Iowa law. Complete a separate form for each person about whom information is requested. Send the original to the Central Abuse Registry, Iowa Department of Human Services, 1305 E Walnut Street, Fifth Floor, Des Moines, Iowa 50319-0114.

PART A: ***To be completed by the person requesting information.***

1. Requester: INQUIREHIRE
   Address: 320 LECLAIRE ST.
   City: DAVENPORT | State: IA | Zip Code: 52801 | Phone Number: (563) 323-5922
2. The information concerns:
   Name (first, middle initial, last):
   Maiden Name or Alias (if applicable): | Birth Date: | Social Security Number:
   Address:
   City: | State: | Zip Code: | County:
3. What is the purpose of your request for child abuse information?
   CLEARANCE FOR students to PARTICIPATE in FIELD WORK/CLINICAL EXPERIENCES in HEALTHCARE SETTINGS.
4. I have read and understand the legal provisions for handling child abuse information which are printed on the back of this form.
   Signature: James M. Sweeney | Date:

PART B: ***To be completed by the person authorizing the Department of Human Services to release child abuse information.***

I understand that my signature authorizes the requester to receive information to verify whether I am named on the Child Abuse Registry in a child abuse report as having abused a child (Iowa Code 235A.15). To the best of my knowledge, all or part of the information contained in Part A of this form is correct.

Signature: | Date:

PART C: ***To be completed by the Central Abuse Registry or designee.***

1. ☐ The person named in item A-2 is listed on the Child Abuse Registry as having abused a child.
2. ☐ The person named in item A-2 is not listed on the Child Abuse Registry as having abused a child.
3. ☐ This request for information is denied because the form is incomplete.

Signature: | Date:

Comments: