



100 Madison Avenue  
P.O. Box 1956  
Morristown, NJ 07962-1956  
P: 973-971-5475  
F: 973-290-7259

PATIENT ID  
HERE

**BACKGROUND REQUEST INFORMATION**

<b>LAST NAME</b>		<b>FIRST NAME</b>		<b>MIDDLE</b>
<b>DATE OF BIRTH</b>		<b>GENDER</b>	<b>SOCIAL SECURITY NUMBER</b>	
		M F <small>CIRCLE ONE</small>		
<b>CURRENT ADDRESS</b>				
<b>NUMBER</b>	<b>STREET</b>			<b>APT. #</b>
<b>TOWN</b>			<b>STATE</b>	<b>ZIP CODE</b>
<b>DRIVER'S LICENSE NUMBER</b>			<b>STATE OF ISSUE DLN</b>	

**Written Disclosure to Applicant and Consent to Request Consumer Report Information**

I understand that Atlantic Health will utilize the services of a consumer reporting agency as part of the procedure for processing my application for volunteering. I also understand if my application for volunteering is granted, Atlantic Health may obtain further information through subsequent investigations by a consumer reporting agency so as to update, renew or extend my volunteering.

I understand a consumer reporting agency's investigation may include obtaining information covering up to the last seven years, regarding my credit background, references, character, past employment, work habits, education, general reputation, personal characteristics, mode of living, civil judgments, and liens. I understand a consumer reporting agency's investigation also may include any information about my criminal conviction background consistent with federal state law.

I understand such information may be obtained by direct or indirect contact with former employers, volunteer organizations, financial institutions, landlords and public agencies or other persons who may have such knowledge.

I also understand that before I am denied a volunteer position based, in whole or part, on information obtained in the report, I will be provided a copy of the report and a description in writing of my rights under the Fair Credit Reporting Act.

I understand if I disagree with the accuracy of any information in the report, I must notify Atlantic Health within two days of my receipt of the report. If I notify Atlantic Health within two days of the receipt of the report that I am challenging information in the report, Atlantic Health, will not make a final decision on my volunteer status until I have had a reasonable opportunity to address the information contained in the report.

I hereby consent to this investigation and authorize Atlantic Health to procure a report on my background as stated above from a consumer reporting agency.

Signature of applicant \_\_\_\_\_ Date \_\_\_\_\_

<b>INTERNAL USE ONLY:</b>				
<i>CIRCLE ONE</i>	REQUESTING SITE:	MMH	OH	AH
	REQUESTING DEPT:	HR	S&S	VOLS



**AUTHORIZATION FOR THE SOCIAL SECURITY ADMINISTRATION (SSA) TO RELEASE SOCIAL SECURITY-NUMBER (SSN) VERIFICATION**

PATIENT ID  
HERE

Printed Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

I am conducting the following business transaction: **Volunteer Services**

with the following company \_\_\_\_\_

Company Name

Address

**Atlantic Health**

**100 Madison Avenue, Morristown, NJ 07960**

I authorize the Social Security Administration to verify my name and SSN to the Company and/or the Company's Agent, if applicable, for purpose I identified.

The name and address of the Company's Agent is \_\_\_\_\_

**TABB INC., 555 E. Main St., Chester, NJ 07930**

I am the individual to whom the Social Security number was issued or that person's legal guardian. I declare and affirm under the penalty of perjury that the information contained herein is true and correct. I acknowledge that if I make any representation that I know is false to obtain information from Social Security records, I could be found guilty of a misdemeanor and fined up to \$5,000.

**This consent is valid only for 90 days from the date signed, unless indicated otherwise by the individual named above. If you wish to change this timeframe, fill in the following.**

**This consent is valid for \_\_\_\_\_ days from the date signed. \_\_\_\_\_ (Please initial.)**

Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Contact information of individual signing authorization:

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone Number \_\_\_\_\_