***CROZER-KEYSTONE HEALTH SYSTEM***

***CRIMINAL BACKGROUND CHECK DISCLOSURE FORM***

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| --- | --- | --- |
| **Full Name (Last, First, Middle)** | Date of Birth | |
| **Other Names Known By (Maiden, Alias)** | **Social Security Number** | |
| **Street Address** | **Race** | **Sex** |
| **City, State** | **Zip Code** | |

**Have you ever been convicted of a crime, excluding a traffic offense? YES( ) NO( )**

# Have you resided in Pennsylvania for the past two consecutive years? YES( ) NO( )

(If you have not resided in PA for the past two consecutive years, you are required to submit to the Federal Criminal Background Check)

I authorize Crozer-Keystone Health System to conduct a criminal background check with either the Pennsylvania State Police or the Federal Bureau of Investigation, as applicable. In addition, I authorize Crozer-Keystone Health System to conduct a Patient Abuse and/or Child Abuse Clearance Check.

I certify that the information provided in this disclosure is true and correct and I understand that any falsification, misrepresentation or omission on this application is grounds for refusal to hire or if hired, grounds for immediate dismissal.

SIGNATURE DATE

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