Exhibit C
Background Screening Information

Name as it appears on Social Security Card: ___________________________________

Social Security Number: _____________________

Date of Birth: ___________________

School: ___________________________________ Major: ______________

Instructor for this semester: ________________________________

Attach a clear copy of school photo I.D. If school does not issue photo I.D.'s, a clear copy of driver's license must be attached.

Authorization

This Disclosure and Authorization form, in original, faxed, photocopied or electronic form, will be valid for any reports that may be requested by Brookwood Medical Center or Tenet.

Signature: ___________________________________ Date: ______________

Printed Name: ___________________________________

School has conducted a retrospective background check on all students assigned to the program and members of staff/faculty responsible for supervision and/or instruction prior to their participation in clinical activities. Unless Hospital is notified in writing, all background checks are negative.

The background check included in the following:
1. Social Security number verification.
2. Criminal Search (7 years)
3. Violent Sexual Offender and Predator registry
4. HHS/OIG/GSA
5. Other: _________________________

School acknowledges this information will be available to all Tenet affiliates as reasonably necessary.

School: ___________________________________

Name: (Please Print) ____

Signature: ________________________________ Title: __________________________