



SOUTHWEST HEALTHCARE SERVICES
802 2ND ST NW
BOWMAN, ND 58623

I hereby authorize Southwest Healthcare Services to do a criminal background check prior to my employment.

I understand that the following information will be used solely for that purpose.

Date of Birth: _____

Social Security Number: _____

States You Currently and Previously Resided: _____

Type of Professional License or Certification (Example: CNA, RN, etc.): _____

Professional License or Certification Number: _____

(Do Not Use Driver's License)

Expiration Date: _____

Maiden Name: _____

Other Names Used: _____

(Currently or in the Past): _____

Signature: _____

Print Name: _____

Date: _____