



CAP REVIVAL CARE

Your Best Health Is Our Greatest Achievement

Local Law Background Check Consent Form

Please: **Print or Type**

Full Name: _____, _____, _____, _____
First Middle Last Suffix

Other Names Used (Maiden, Aliases): _____

Social Security Number: _____ Date of Birth: _____

Driver's License Number: _____ State: _____

Current Address: _____
CITY STATE ZIP CODE

I acknowledge that CAP REVIVAL CARE LLC may utilize an external agency to investigate and confirm the information I provided in my employment application. This agency will provide a report to CAP REVIVAL CARE LLC.

I understand that the external agency will gather relevant information from various sources, including but not limited to credit reporting agencies, current and previous employers, criminal conviction records, Department of Motor Vehicles records, military records, academic records, and both professional and personal references. I hereby authorize, without any reservations, any individual, corporation, or other private or public entity to provide CAP REVIVAL CARE LLC with all information pertaining to me.

This consent, whether in original, faxed, photocopied, or electronic format, shall remain valid for this and any future reports and updates that CAP REVIVAL CARE LLC may request.

Applicant Signature: _____ Date: _____

Please sign and date your full name above with a black pen: wet signatures ONLY (no typed or digital signatures permitted).