

# UH Talent Management Background Request Form



Date \_\_\_\_\_

Location – **UHCMC Graduate Medical Education**  
Open Case Under – **Will Rebello**

**Return completed form to Graduate Medical Education –**  
Fax 216-844-1949 or email [GME@uhhospitals.org](mailto:GME@uhhospitals.org)

FOR UHCMC RESIDENT AND FELLOW USE ONLY

Applicant Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Drivers License Number: \_\_\_\_\_ State: \_\_\_\_\_

## Background checks to be conducted:

Social Security Number Trace  
Office of Inspector General (OIG)  
General Services Administration (GSA)  
Office of Foreign Asset Control (OFAC)  
CrimeSweep National Criminal Record Search

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If you have received this communication in error, or if any problems occur with this transmission, please immediately notify Corporate Screening Services, Inc. at the telephone number listed at the bottom of this form.

**NOTICE REGARDING BACKGROUND INVESTIGATION  
IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING ACKNOWLEDGMENT**

University Hospitals may obtain information about you from a consumer reporting agency. Thus, you may be the subject of a "consumer report" and/or an "investigative consumer report" which may include information about your character, general reputation, personal characteristics, and/or mode of living. The report conducted for University Hospitals shall include a social security number trace, a national criminal database search, an OIG list search, a GSA list search as well as an OFAC search. These reports may be obtained at any time after receipt of your authorization and, if you become affiliated, throughout your affiliation. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report is an investigation into your education and/or employment history conducted by Corporate Screening Services, Inc., 16530 Commerce Court, Cleveland, OH 44130, Phone: 800-229-8606, Fax: (440) 243-4204 or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing University Hospitals obtain from any outside organization all manner of consumer reports and investigative consumer reports now and, if you become affiliated, throughout the course of your affiliation to the extent permitted by law. As a result, you should carefully consider whether to exercise your right to request disclosure of the nature and scope of any investigative consumer report.

The summary of Rights under the Fair Credit Reporting Act (FCRA) can be found at:  
[www.ftc.gov/sites/default/files/documents/one-stops/credit-reporting/pdf-0096-fair-credit-reporting-act.pdf](http://www.ftc.gov/sites/default/files/documents/one-stops/credit-reporting/pdf-0096-fair-credit-reporting-act.pdf)

**ACKNOWLEDGMENT AND AUTHORIZATION**

I acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" at any time after receipt of this authorization and, if I am hired, throughout my employment. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by Corporate Screening Services, Inc., another outside organization acting on behalf of Employer, and/or Employer itself. I agree that a facsimile ("fax") or photographic copy of this Authorization shall be as valid as the original.

Name: \_\_\_\_\_  
Please Print

Social Security Number\* \_\_\_\_\_ DOB\*\* \_\_\_\_\_

Current Address \_\_\_\_\_

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

Drivers License Number \_\_\_\_\_ State \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**RETURN COMPLETED FORM TO GRADUATE MEDICAL EDUCATION  
FAX 216-844-1949/gme@uhhospitals.org**

**TAXPAYER ID # OR PASSPORT # FOR NON-U.S. RESIDENTS**

\*\*Date of Birth is being requested in order to obtain accurate retrieval of records.