**APPLICANTS 18 OR OLDER COMPLETE THE FOLLOWING:**

1. Medical and workers’ compensation information will only be requested in compliance with the Federal Americans with Disabilities Act (ADA) and/or any other applicable state laws.
2. I acknowledge that a telephonic facsimile (FAX) or photographic copy shall be as valid as the original.

The following information is required by law enforcement agencies and other entities for positive identification purposes when checking public records. It is confidential and will not be used for any other purposes. I hereby release the employer and agents and all persons, agencies, and entities providing information or reports about me from any and all liability arising out of the requests for or release of these reports.

(Please print your full name) LAST FIRST MIDDLE

(Please print other names you have used)

HOME ADDRESS

CITY STATE ZIP CODE

SOCIAL SECURITY NUMBER DATE OF BIRTH

DRIVER’S LICENSE NUMBER STATE ISSUING LICENSE

NAME AS IT APPEARS ON DRIVER’S LICENSE

SIGNATURE TODAY’S DATE

(This page contains sensitive information. Keep only in secure files, separately from personnel records.)