HCA Criminal Background Check Request Form

A criminal history background check must be conducted to be considered for enrollment in the *Healthcare Careers for All* program. The Washington State Child & Adult Abuse Information Law (RCW 43.43.830 -.842) requires disclosure of specific information about any convictions for crimes against persons and/or crimes relating to financial exploitation and findings in related actions and proceedings. This conviction information must be disclosed before consideration for employment in any position which may involve unsupervised access to children, developmentally disabled persons or vulnerable adults as defined by law. **A conviction / criminal history record does not necessarily disqualify an individual from enrollment.**

The information you provide is private and confidential. It may be shared among the Workforce Development Council (WDC) and other partners only to facilitate the delivery of employment and training-related services to you. Such partners include: community colleges, community-based organizations, the Employment Security Department (ESD), and the Department of Social & Health Services (DSHS). By contract and state and federal law (42CFR, Part 2), WDC partners are prohibited from further disclosing this information.

The data we may share includes: personal information such as your name, address, and Social Security Number; other relevant identifying information; and your criminal history record information (CHRI). Sharing of this information among interested partners allows you to receive services from them without having to give the same information to each of the partners.

I understand my rights and responsibilities as outlined above. TRAC Associates has permission to conduct a criminal history background check required for consideration for my enrollment in the *Healthcare Careers for All* program.

_____ _____

Signature: *Healthcare Careers for All* Customer Date

Participant Name: _____ DOB: _____

Request Amount: $12.95 Vendor: US Criminal Checks, Inc. SSN: _____

Staff Signature: _____ Date: _____

[ ] Full payment authorized [ ] Payment not authorized

Authorizing Staff Signature: _____ Date: _____

Contract No: _____ Paid By Visa#: _____ Chg Date: _____

Order Number: _____ Initial: _____

I certify that $12.95 has been issued on my behalf and that I cannot pay for this item.

Participant Signature: _____ Date: _____

Updated: April 17, 2013