

# Background Check Release Form

Traverse Health Clinic

## Personal Data

Name (Last, First, Middle Initial)

\_\_\_\_\_

Other Names Used

\_\_\_\_\_

Date of Birth

\_\_\_\_\_

Sex

M

F

Home Address (Street, City, State, Zip)

\_\_\_\_\_

\_\_\_\_\_

Home Phone

\_\_\_\_\_

I agree that the above information is true and correct to the best of my knowledge. BY signing this form, I give THClinic permission to conduct a criminal record check.

Signature

\_\_\_\_\_

Date

\_\_\_\_\_