



# Background Check Authorization

Hospice of Salina is required to complete background checks on all employees and volunteers prior to their service with the organization. Please complete this form and return it to the Volunteer Coordinator, as soon as possible. This information will be sent to Salina Regional Health Center for processing of the background check.

Thank you for your assistance in keeping our records complete and accurate!

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

Other Names You Have Used: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Home Address: \_\_\_\_\_

States You Have Lived In: \_\_\_\_\_

\_\_\_\_\_

I understand that this personal information will be used to perform my background check. The results of this background check will be kept with my employee/volunteer record with Hospice of Salina.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Date Emailed to SRHC HR \_\_\_\_\_

Date Returned to VC by HR \_\_\_\_\_