LOCUMCARE

NEW HIRE AUTHORIZATION AND RELEASE
PLEASE TYPE OR PRINT

Last Name	**First Name**	**Middle Name**	**Suffix**

I hereby affirm that the information I have provided on this application and attachments is true and correct and that it can be relied upon Locum Care, LLC for evaluating my potential as a locum tenens provider. By applying for membership to, or when evaluating retention with Locum Care, LLC, I hereby authorize Locum Care, LLC, its affiliates and successors, to obtain any information that may be relevant to an evaluation of my professional qualifications, including but not limited to information about disciplinary actions or other confidential or privileged information, and other credentials. I agree to provide and authorize the release by Locum Care, LLC to Locum Care, LLC clients of the following: a) vaccination records; b) reasonable documentation evidencing that I am in good health and free of communicable diseases; c) the result of and/or a copy of my criminal background check, if any; d) the result of and/or a copy of my drug screen, if any; e) National Practitioner Data Bank request and report. I authorize Locum Care, LLC to disclose to and receive from current, prior, or potential employers and Locum Care, LLC clients making a reasonable inquiry, information relating to my qualifications, ability, and character to practice medicine, including information from the following sources: all medical schools, colleges, universities, transcript offices, medical institutions, or organizations, hospitals, employers, personal references, physicians, attorneys, companies or agencies who may furnish my criminal background history, companies that perform drug screens, medical malpractice carriers or organizations, business and professional associates, all government agencies and instrumentalities, the National Practitioner Data Bank, the Federation of State Medical Boards, the American Medical Association, American Osteopathic Association, American Board of Medical Specialties, DEA, state licensing boards, specialty boards, and any other pertinent source. This is a continuing authorization until such time as I have specifically revoked the same in writing which shall apply to all information received at any time by Locum Care, LLC relating to my qualifications, ability, and character to practice medicine. I hereby forever waive and release Locum Care LLC, its officers, employees, agents and third parties which provide or receive information regarding my credentials, including but not limited to the Federation of State Medical Boards and those entities listed above, from any claims, causes of action, damages and expenses, including reasonable attorney's fees arising from or relating to the provision, collection, verification, and dissemination of information about me. Further, I agree to hold Locum Care, LLC harmless from any and all claims, causes of action, damages, judgments and expenses, including reasonable attorney's fees, arising from or related to the collection, verification and dissemination of credentialing information provided by me. I understand that this does not contemplate a duty to hold Locum Care, LLC harmless from claims, causes of action and damages which may arise as a result of information provided about me from sources other than myself. I understand that I have the burden of providing accurate and adequate information to Locum Care, LLC, its affiliates or successors, to demonstrate my qualifications. I understand that any misstatement in this form may constitute grounds for denial of referral to practice opportunities, grounds for civil damages, grounds for reporting the same to the NPDB or state licensing boards or cancellation of contract. If any material changes occur affecting my professional status, it is my obligation to notify Locum Care, LLC or the appropriate affiliate or successor as soon as possible. I attest that the information contained in this application is correct and complete. I understand that the decision to refer me to practice opportunities by Locum Care, LLC is solely at the discretion of Locum Care, LLC. I understand that any information received from references by Locum Care LLC, including but not limited to quality evaluations, is confidential and may not be released to me without the consent of the reference. A copy or facsimile of this document shall have the same effect as the original. This document shall be interpreted according to the laws of the State of Georgia.

Signature	Today's Date

Printed Name (**as it appears on your Driver's License**)	Social Security No.	Date of Birth

PLEASE PROVIDE ALL RESIDENTIAL ADDRESSES FOR THE PAST SEVEN (7) YEARS:

	Street	Apt.#	City, State, Zip	From	To
Current Address:					present
Former Address:					
Former Address:					

LOCUMCARE

AUTHORIZATION OF BACKGROUND INVESTIGATION

I have carefully read and understand this Disclosure and Authorization form and the attached summary of rights under the Fair Credit Reporting Act. By my signature below, I consent to preparation of background reports by a consumer reporting agency such as HireRight, Inc. ("HireRight"), and to the release of such background reports to the Company and its designated representatives and agents, for the purpose of assisting the Company in making a determination as to my eligibility for employment (including independent contractor assignments, as applicable), promotion, retention or for other lawful employment purposes. I understand that if the Company hires me or contracts for my services, my consent will apply, and the Company may, as allowed by law, obtain additional background reports pertaining to me, without asking for my authorization again, throughout my employment or contract period from HireRight and/or other consumer reporting agencies.

I understand that information contained in my employment or contractor application, or otherwise disclosed by me before or during my employment or contract assignment, if any, may be used for the purpose of obtaining and evaluating background reports on me. I also understand that nothing herein shall be construed as an offer of employment or contract for services.

I hereby authorize all of the following, without limitation, to disclose information about me to the consumer reporting agency and its agents: law enforcement and all other federal, state and local agencies, learning institutions (including public and private schools, colleges and universities), testing agencies, information service bureaus, credit bureaus, record/data repositories, courts (federal, state and local), motor vehicle records agencies, my past or present employers, the military, and all other individuals and sources with any information about or concerning me. The information that can be disclosed to the consumer reporting agency and its agents includes, but is not limited to, information concerning my employment and earnings history, education, credit history, motor vehicle history, criminal history, military service, professional credentials and licenses.

By my signature below, I also certify the information I provided on and in connection with this form is true, accurate and complete. I agree that this form in original, faxed, photocopied or electronic (including electronically signed) form, will be valid for any background reports that may be requested by or on behalf of the Company.

☐ **California, Minnesota or Oklahoma applicants only: Please check this box if you would like to receive (whenever you have such right under the applicable state law) a copy of your background report if one is obtained on you by the Company.**

Last Name **First Name** **Middle Name**

Driver's License Number | Issuing State | Expiration Date

Signature | Today's Date