

LOGAN HEALTH STUDENT AFFILIATIONS

BACKGROUND/SEXUAL OFFENDER CHECK RELEASE AUTHORIZATION

This form must be completed by **BOTH** the Student/Faculty and School before uploading to myClinicalExchange.

STUDENT/FACULTY SECTION:

- In connection with my application for participation in educational experiences at Logan Health System ("LH"), and as a condition of acceptance for such experiences, I voluntarily agree that LH, its agents or designees, may request and obtain one or more background checks regarding me including criminal background check, exclusion database lists, and national sexual offender lists. The information received from the background checks may be shared between LH and my School or employer facility. LH may also receive and use for its purposes any such background checks from my School or employer facility.
- I hereby authorize and release from all liability, without reservation, LH and my School/employer facility, and their agents and employees, as well as any law enforcement agency, local, state, or federal government agency, institution, information service bureau, or any other person or entity from liability for requesting, conducting, receiving, and communicating the above information.
- I further acknowledge that a telephone facsimile (fax), photographic, or digital copy of this executed release will be as valid as the original.
- I understand that I must report to the LH designee, within 48 hours, any criminal charges, arrests, or indictments that occur at any time during my experience(s) at LH. I understand that before I begin my experience(s), I must report to the LH designee any criminal charges, arrests, or indictments that have occurred since my most recent background check. Failure to do so could lead to termination of the experience(s). This reported information may also be shared with my School.

Last Name: _____ First Name: _____

Middle Name: _____ Date of Birth: _____

Maiden/Previous Names(s) (if applicable): _____

Name of School: _____

School Program: _____

Student/Faculty Signature: _____ Date Signature: _____



Below to be completed by approved School representative ONLY!

SCHOOL SECTION:

By signing below, I attest that the above-listed person (Student / Faculty) has evidence of completion of all of the registries listed below, and confirmation that such individual is not found on any of these registries. The report of such evidence is dated within six months before the Student/Faculty enrollment/employment as a Student/Faculty at the School. The reports include the past 7 years.

- **National Criminal Background**
- **National Sexual Offender Registry**
- **Federal General Services Administration and Federal Health and Human Services Office of Inspector General (OIG)**
The search of the excluded person registry and debarred person registry.

If requested, the School or facility will provide these documents to Logan Health within **one business day** of the request.

By signing below, I attest that I have verified the person listed above records: (Check ONE Box)

- Person is clear with no records, discrepancies, offenses, or pending charges.
- Record, offenses, or pending charges found; background check has been shared with Logan Health.

School/Facility Representative Name: _____

Phone Number: _____ E-mail Address: _____

Signature: _____ Date Signature: _____