APPLICATION TO MEDICAL STAFF

- Complete a "Supplemental Claim Form" for every malpractice claim, suite or incident you have EVER experienced. Please make additional copies of the form as necessary.
- Attach any additional pages where necessary.
- Please make sure to initial and date the bottom of each page.

PERSONAL INFORMATION

Legal First Name*	Legal Middle Name	Legal Last Name*
Suffix	Preferred Name	Previous Surname
Social Security Number*	Birth Date (MM/DD/YYYY)*	Preferred Phone*
Preferred Phone Type ☐ Cell ☐ Home ☐ Office ☐ Other _____	Other Phone	Other Phone Type ☐ Cell ☐ Home ☐ Office ☐ Other _____
Preferred Email Address*	Date Available (MM/DD/YYYY)	Best time/day to be reached

How did you hear about us?	If referred, by whom?

PERMANENT PHYSICAL ADDRESS

Address*	
City*	State/Province*
Zip Code*	Country*

CURRENT MAILING ADDRESS

Maling address*	
City*	State/Province*
Zip Code*	Country*
Current Address Until (MM/DD/YYYY)	

Birth City	Birth Country	Birth State/Province
Languages Spoken Other Than English		

Emergency Contact Name	Relationship to Applicant
Emergency Contact Phone	Emergency Contact Email

I affirm that all information given on this page is true and accurate. Initials _____ Date _____

SPECIALTIES

Discipline*

Primary Specialty*

Additional Specialties

Are you able to work legally in the USA?*

☐ Yes ☐ No

If yes, please indicate the following*:

☐ US Citizen ☐ Visa ☐ Permanent Resident ☐ Work Authorization Card

EDUCATION/TRAINING

Please list all formal healthcare related education/training you have completed.

Institution*

Degree/Certificate*

Address

City*	State*	Zip Code	Country*

Phone	From Date (MM/YYYY)*	To Date (MM/YYYY)*
Graduated* ☐ Yes ☐ No		Date of Graduation (MM/YYYY)*

Institution*

Degree/Certificate*

Address

City*	State*	Zip Code	Country*

Phone	From Date (MM/YYYY)*	To Date (MM/YYYY)*
Graduated* ☐ Yes ☐ No		Date of Graduation (MM/YYYY)*

Institution*

Degree/Certificate*

Address

City*	Sate*	Zip Code	Country*

Phone	From Date (MM/YYYY)*	To Date (MM/YYYY)*
Graduated* ☐ Yes ☐ No		Date of Graduation (MM/YYYY)*

CERTIFICATIONS

Certification*			
Certification Number	Date Issued (MM/YYYY)	Expiration Date (MM/YYYY)	Certification does NOT Expire ☐ Yes ☐ No
Certification*			
Certification Number	Date Issued (MM/YYYY)	Expiration Date (MM/YYYY)	Certification does NOT Expire ☐ Yes ☐ No
Certification*			
Certification Number	Date Issued (MM/YYYY)	Expiration Date (MM/YYYY)	Certification does NOT Expire ☐ Yes ☐ No

MEDICAL SYSTEMS

Machines you are MOST familiar with:
Additional machines with which you are familiar:
Charting systems you are MOST familiar with:
Additional charting systems with which you are familiar:

LICENSES

State*		License Number	
Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Compact ☐ Yes ☐ No	Inactive ☐ Yes ☐ No
State*		License Number	
Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Compact ☐ Yes ☐ No	Inactive ☐ Yes ☐ No
State*		License Number	
Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Compact ☐ Yes ☐ No	Inactive ☐ Yes ☐ No
State*		License Number	
Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Compact ☐ Yes ☐ No	Inactive ☐ Yes ☐ No
State*		License Number	
Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Compact ☐ Yes ☐ No	Inactive ☐ Yes ☐ No
State*		License Number	
Date Issued (MM/DD/YYYY)		Expiration Date (MM/DD/YYYY)	

I affirm that all information given on this page is true and accurate. Initials ________________ Date ___________

WORK HISTORY

List in reverse chronological order, beginning with the most current, all employment affiliations since completion of specialty education.

Type of Employment* ☐ Permanent ☐ Per Diem ☐ Traveler ☐ Volunteer		Facility/Worksite*	
Position Held*		Phone	Agency Contracted Through
Address			
City*	State*	Zip Code*	Country*
From Date (MM/YYYY)*	To Date (MM/YYYY)*	Currently Employed ☐ Yes ☐ No	
Reason for Leaving:			
Unit Type*	Sub-Specialty	Unit Size/Number of Beds ☐ 0-5 ☐ 6-15 ☐ 16-24 ☐ 25+	Nurse/Patient Ratio
Float To:		Shift (e.g. 8 HR day, 12 HR day, 8 HR Day/Night Rotation)	
Clinical Supervisor Name	Clinical Supervisor Title	Clinical Supervisor Phone	
May we contact for a reference?* ☐ Yes ☐ No	Teaching Facility? ☐ Yes ☐ No	Trauma Center ☐ Level I ☐ Level II ☐ Level III ☐ Not Applicable	Worked as a Charge Nurse? ☐ Yes ☐ No
Notes (Facility Size, Types of Patients, Floating Experience)			

Type of Employment* ☐ Permanent ☐ Per Diem ☐ Traveler ☐ Volunteer		Facility/Worksite*	
Position Held*		Phone	Agency Contracted Through
Address			
City*	State*	Zip Code*	Country*
From Date (MM/YYYY)*	To Date (MM/YYYY)*	Currently Employed ☐ Yes ☐ No	
Reason for Leaving:			
Unit Type*	Sub-Specialty	Unit Size/Number of Beds ☐ 0-5 ☐ 6-15 ☐ 16-24 ☐ 25+	Nurse/Patient Ratio
Float To:		Shift (e.g. 8 HR day, 12 HR day, 8 HR Day/Night Rotation)	
Clinical Supervisor Name	Clinical Supervisor Title	Clinical Supervisor Phone	
May we contact for a reference?* ☐ Yes ☐ No	Teaching Facility? ☐ Yes ☐ No	Trauma Center ☐ Level I ☐ Level II ☐ Level III ☐ Not Applicable	Worked as a Charge Nurse? ☐ Yes ☐ No
Notes (Facility Size, Types of Patients, Floating Experience)			

I affirm that all information given on this page is true and accurate. Initials _____ Date _____

WORK HISTORY CONTINUED

Type of Employment* ☐ Permanent ☐ Per Diem ☐ Traveler ☐ Volunteer		Facility/Worksite*	
Position Held*		Phone	Agency Contracted Through
Address			
City*	State*	Zip Code*	Country*
From Date (MM/YYYY)*	To Date (MM/YYYY)*	Currently Employed ☐ Yes ☐ No	
Reason for Leaving:			
Unit Type*	Sub-Specialty	Unit Size/Number of Beds ☐ 0-5 ☐ 6-15 ☐ 16-24 ☐ 25+	Nurse/Patient Ratio
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Notes (Facility Size, Types of Patients, Floating Experience)			

Type of Employment* ☐ Permanent ☐ Per Diem ☐ Traveler ☐ Volunteer		Facility/Worksite*	
Position Held*		Phone	Agency Contracted Through
Address			
City*	State*	Zip Code*	Country*
From Date (MM/YYYY)*	To Date (MM/YYYY)*	Currently Employed ☐ Yes ☐ No	
Reason for Leaving:			
Unit Type*	Sub-Specialty	Unit Size/Number of Beds ☐ 0-5 ☐ 6-15 ☐ 16-24 ☐ 25+	Nurse/Patient Ratio
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Notes (Facility Size, Types of Patients, Floating Experience)			

I affirm that all information given on this page is true and accurate. Initials _____ Date _____

WORK HISTORY CONTINUED

Type of Employment* ☐ Permanent ☐ Per Diem ☐ Traveler ☐ Volunteer		Facility/Worksite*	
Position Held*		Phone	Agency Contracted Through
Address			
City*	State*	Zip Code*	Country*
From Date (MM/YYYY)*	To Date (MM/YYYY)*	Currently Employed ☐ Yes ☐ No	
Reason for Leaving:			
Unit Type*	Sub-Specialty	Unit Size/Number of Beds ☐ 0-5 ☐ 6-15 ☐ 16-24 ☐ 25+	Nurse/Patient Ratio
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Notes (Facility Size, Types of Patients, Floating Experience)			

Type of Employment* ☐ Permanent ☐ Per Diem ☐ Traveler ☐ Volunteer		Facility/Worksite*	
Position Held*	Phone	Agency Contracted Through	
Address			
City*	State*	Zip Code*	Country*
From Date (MM/YYYY)*	To Date (MM/YYYY)*	Currently Employed ☐ Yes ☐ No	
Reason for Leaving:			
Unit Type*	Sub-Specialty	Unit Size/Number of Beds ☐ 0-5 ☐ 6-15 ☐ 16-24 ☐ 25+	Nurse/Patient Ratio
Float To:		Shift (e.g. 8 HR day, 12 HR day, 8 HR Day/Night Rotation)	
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May we contact for a reference?* ☐ Yes ☐ No	Teaching Facility? ☐ Yes ☐ No	Trauma Center ☐ Level I ☐ Level II ☐ Level III ☐ Not Applicable	Worked as a Charge Nurse? ☐ Yes ☐ No
Notes (Facility Size, Types of Patients, Floating Experience)			

I affirm that all information given on this page is true and accurate. Initials _____ Date _____

MILITARY SERVICE

Branch

☐ Air Force ☐ Air Force National Guard ☐ Army ☐ Army National Guard
☐ Marine Corps ☐ Navy ☐ US Public Health Services

From Date (MM/YYYY)*	To Date (MM/YYYY)

Status

☐ Honorable Discharge ☐ Dishonorable Discharge ☐ Active ☐ Reserve ☐ Other_____

Branch

☐ Air Force ☐ Air Force National Guard ☐ Army ☐ Army National Guard
☐ Marine Corps ☐ Navy ☐ US Public Health Services

From Date (MM/YYYY)*	To Date (MM/YYYY)

Status

☐ Honorable Discharge ☐ Dishonorable Discharge ☐ Active ☐ Reserve ☐ Other_____

GAPS IN HISTORY

Please explain any gaps in your work history that are greater than 60 days in the last 7 years. Work gaps prior to 7 years ago are not required but recommended.

From Date (MM/YYYY)*	To Date (MM/YYYY)*

Explain Gap History*:

From Date (MM/YYYY)*	To Date (MM/YYYY)*

Explain Gap History*:

From Date (MM/YYYY)*	To Date (MM/YYYY)*

Explain Gap History*:

From Date (MM/YYYY)*	To Date (MM/YYYY)*

Explain Gap History*:

PROFESSIONAL REFERENCES

Please list at least two (2) professional references within your specialty who have provided CLNICAL supervision for you within the past ONE YEAR. Appropriate professional references include but are not limited to Nurse Manager, Supervisor, and/or Charge Nurse.
Verbal references will be kept confidential. Please let the references know in advance that RNnetwork will be in contact with him/her.

Facility/Worksite*	Name*

Position/Relationship	Specialty

Home/Cell Phone	Work Phone	Fax

Email	Address

City	State	Zip Code

Country	Worked With From (MM/YYYY)*	Worked With To (MM/YYYY)*

I affirm that all information given on this page is true and accurate. Initials _____ Date _____

PROFESSIONAL REFERENCES CONTINUED

Facility/Worksite*		Name*
Position/Relationship		Specialty
Home/Cell Phone	Work Phone	Fax
Email		Address
City	State	Zip Code
Country	Worked With From (MM/YYYY)*	Worked With To (MM/YYYY)*

PROFESSIONAL LIABILITY

Do you have your own professional liability insurance coverage?*	☐ Yes ☐ No
If yes, please list the name of all carriers and amounts of coverage.*	
Have you ever been involved in any malpractice claim(s) (including dismissed actions)?* If yes, how many? _____	☐ Yes ☐ No
Has any monetary payment ever been made by your or on your behalf because of alleged medical malpractice?*	☐ Yes ☐ No
Are there currently any pending medical malpractice claims or settlements involving yourself?*	☐ Yes ☐ No
If yes, please explain.*	
Has your professional liability insurance coverage ever been denied, limited or canceled by the action of any insurance company?*	☐ Yes ☐ No
Explain Insurance Coverage Denied.*	

ACTIONS, LIMITS, SANCTIONS, AND DISCIPLINARY ACTIONS

Have any of the following been, or are any currently, in the process of being investigated, denied, revoked, suspended, refused, limited, placed on probation or placed under other disciplinary action?

Have you ever been employed where your employment was terminated by the employer?*	☐ Yes ☐ No
If yes, please explain.*	
Has your professional license in any state been or is it currently being investigated, denied, revoked, suspended, refused, limited, placed on probation or placed under disciplinary action?*	☐ Yes ☐ No
If yes, please explain.*	
Have you ever been the object of an administrative or civil complaint, or investigation regarding sexual misconduct?*	☐ Yes ☐ No
If yes, please explain.*	
Have you ever been placed on probation, terminated, or placed under any disciplinary action during your training program?*	☐ Yes ☐ No
If yes, please explain.*	

HEALTH STATUS

Do you currently have any chemical substance abuse dependency?*	☐ Yes ☐ No
If yes, please explain.*	
Are there any reasons that would prevent you from being able to perform competently the job-related functions of your specialty?*	☐ Yes ☐ No
If yes, please explain.*	

SUPPLEMENTAL CLAIMS

Supply the following information regarding any instance of claim, suit, or incident which may give rise to a claim whether dismissed, settled-out-of-court, judgement or pending. Answer all questions completely. A form must be filled out separately for each claim. Please type or print clearly.

SUPPLEMENTAL CLAIM FORM 1

GENERAL INFORMATION

Applicant (Defendant's) Name*			Claimant (Plaintiff's) Name*
Date of Alleged Error (MM/YYYY)*			Date of Claim (MM/YYYY)*
Indicate whether ☐ Claim ☐ Suit ☐ Incident that has been reported to your insurance carrier			
Name of Insurer	Agent		Phone
Location of court where complaint was filed			Case number
Defendant's legal representative			Phone
Address	City	State	Zip Code
Plaintiff's legal representative			Phone
Address	City	State	Zip Code

STATUS OF COMPLAINT

If closed, indicate:

☐ Court judgement	Finding for ☐ You ☐ Plaintiff	Date (MM/YYYY)	Determined by ☐ Judge ☐ Jury
☐ Out-of-court settlement	Date of settlement (MM/YYYY)		Amount paid on your behalf $
Compensation $	Punitive Damages $		Total Settlement Amount $
☐ Case dismissed	Against YOU Against ALL DEFENDENTS		Date (MM/YYYY)*

If pending, indicate:

Claimant's settlement demand $	Defendant's offer for settlement $	Insurer's loss reserve $
Defense reserve $	Deductible $	Claim in suit ☐ Yes ☐ No
If yes, amount in summons $	Compensation $	Punitive Damages $

DESCRIPTION OF CLAIM Provide enough Information to allow evaluation

Incident Location*	Alleged act, error, or omission upon which Claimant bases claim*
Description of type of extent of injury or damage allegedly sustained*	
Patient's condition at point of your involvement*	
Patient's condition at end of treatment*	
Give a complete narration of the case, relating events in chronological order emphasizing the dates of service and stating in detail what was done at each time the patient was seen professionally (treatment and procedures provided). Attach a separate sheet if additional space is needed.*	

I affirm that all information given on this page is true and accurate. Initials _____ Date _____

SUPPLEMENTAL CLAIM FORM 2

GENERAL INFORMATION

Applicant (Defendant's) Name*			Claimant (Plaintiff's) Name*
Date of Alleged Error (MM/YYYY)*			Date of Claim (MM/YYYY)*
Indicate whether ☐ Claim ☐ Suit ☐ Incident that has been reported to your insurance carrier			
Name of Insurer	Agent		Phone
Location of court where complaint was filed			Case number
Defendant's legal representative			Phone
Address	City	State	Zip Code
Plaintiff's legal representative			Phone
Address	City	State	Zip Code

STATUS OF COMPLAINT

If closed, indicate:			
☐ Court judgement	Finding for ☐ You ☐ Plaintiff	Date (MM/YYYY)	Determined by ☐ Judge ☐ Jury
☐ Out-of-court settlement		Date of settlement (MM/YYYY)	Amount paid on your behalf $
Compensation $		Punitive Damages $	Total Settlement Amount $
☐ Case dismissed	Against YOU Against ALL DEFENDENTS		Date (MM/YYYY)*
If pending, indicate:			
Claimant's settlement demand $		Defendant's offer for settlement $	Insurer's loss reserve $
Defense reserve $		Deductible $	Claim in suit ☐ Yes ☐ No
If yes, amount in summons $		Compensation $	Punitive Damages $

DESCRIPTION OF CLAIM
Provide enough Information to allow evaluation

Incident Location*	Alleged act, error, or omission upon which Claimant bases claim*
Description of type of extent of injury or damage allegedly sustained*	
Patient's condition at point of your involvement*	
Patient's condition at end of treatment*	
Give a complete narration of the case, relating events in chronological order emphasizing the dates of service and stating in detail what was done at each time the patient was seen professionally (treatment and procedures provided). Attach a separate sheet if additional space is needed.*	

I affirm that all information given on this page is true and accurate. Initials _____ Date _____

SUPPLEMENTAL CLAIM FORM 3

GENERAL INFORMATION

Applicant (Defendant's) Name*			Claimant (Plaintiff's) Name*
Date of Alleged Error (MM/YYYY)*			Date of Claim (MM/YYYY)*
Indicate whether ☐ Claim ☐ Suit ☐ Incident that has been reported to your insurance carrier			
Name of Insurer	Agent		Phone
Location of court where complaint was filed			Case number
Defendant's legal representative			Phone
Address	City	State	Zip Code
Plaintiff's legal representative			Phone
Address	City	State	Zip Code

STATUS OF COMPLAINT

If closed, indicate:			
☐ Court judgement	Finding for ☐ You ☐ Plaintiff	Date (MM/YYYY)	Determined by ☐ Judge ☐ Jury
☐ Out-of-court settlement	Date of settlement (MM/YYYY)	Amount paid on your behalf $	
Compensation $	Punitive Damages $	Total Settlement Amount $	
☐ Case dismissed	Against YOU Against ALL DEFENDENTS	Date (MM/YYYY)*	
If pending, indicate:			
Claimant's settlement demand $	Defendant's offer for settlement $	Insurer's loss reserve $	
Defense reserve $	Deductible $	Claim in suit ☐ Yes ☐ No	
If yes, amount in summons $	Compensation $	Punitive Damages $	

DESCRIPTION OF CLAIM
Provide enough Information to allow evaluation

Incident Location*	Alleged act, error, or omission upon which Claimant bases claim*
Description of type of extent of injury or damage allegedly sustained*	
Patient's condition at point of your involvement*	
Patient's condition at end of treatment*	
Give a complete narration of the case, relating events in chronological order emphasizing the dates of service and stating in detail what was done at each time the patient was seen professionally (treatment and procedures provided). Attach a separate sheet if additional space is needed.*	

I affirm that all information given on this page is true and accurate. Initials _____ Date _____

RELEASE AND AUTHORIZATION INFORMATION

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 by CHG Medical Staffing, Inc. and its affiliates (collectively, "CHG") for evaluating my potential as a healthcare provider.

By applying for employment to, or when evaluating retention with CHG, I hereby authorize CHG, 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 CHG to CHG clients of the following: a) vaccination records; b) reasonable documentation evidencing that I am in good health and free from communicable diseases; c) the result of and/or a copy of my criminal background check, if any; and d) the result of and/or a copy of my drug screen, if any.

I authorize CHG to assist me in the completion of this application and to disclose to and receive from current, prior, or potential employers and CHG clients making a reasonable inquiry, information relating to my qualifications, ability, and character to provide healthcare services, including information from the following sources: all professional schools, colleges, universities, transcript offices, healthcare institutions, or organizations, hospitals, employers, professional 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, DEA, 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 CHG relating to my qualifications, ability, and character to provide healthcare services.

I hereby forever waive and release CHG, its officers, employees, agents and third parties which provide or receive information regarding my credentials, including but not limited to 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 CHG harmless from any and all claims, causes of action, damages, judgements and expenses, including reasonable attorney's fees, arising from or related to the collection, verification, dissemination of credentialing information provided by me. I understand that this does not contemplate a duty to hold CHG 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 CHG, 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, 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 CHG 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 CHG is solely at the discretion of CHG.

I understand that any information received from references by CHG, including but not limited to quality evaluations, is confidential and may not be released to me without 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 Utah.

Full Name Signature*	Date*

Consent to Request Consumer Report Information

I understand that CHG Medical Staffing, Inc. dba RNnetwork, ('COMPANY') will use **Sterling InfoSystems Inc., 249 West 17th Street, New York, NY 10011**, **(877) 424-2457** to obtain a consumer report ("Report") as part of the hiring process. I also understand that if hired, to the extent permitted by law, COMPANY may obtain further Reports from STERLING so as to update, renew or extend my employment.

I understand **Sterling InfoSystems Inc.'s** ("STERLING") investigation may include obtaining information regarding my driving record and criminal record, subject to any limitations imposed by applicable federal and state law. I understand such information may be obtained through direct or indirect contact and public agencies or other persons who may have such knowledge. I acknowledge receipt of the attached summary of my rights under the Fair Credit Reporting Act and, as required by law, any related state summary of rights (collectively "Summaries of Rights").

The nature and scope of the investigation sought is as follows: Criminal History Report and Social Security Trace
This consent will not affect my ability to question or dispute the accuracy of any information contained in a Report. I understand if COMPANY makes a conditional decision to disqualify me based all or in part on my Report, I will be provided with a copy of the Report and another copy of the Summaries of Rights, and if I disagree with the accuracy of the purported disqualifying information in the Report, I must notify COMPANY within five business days of my receipt of the Report that I am challenging the accuracy of such information with STERLING.

I hereby consent to this investigation and authorize COMPANY to procure a Report on my background.

In order to verify my identity for the purposes of Report preparation, I am voluntarily releasing my date of birth, social security number and the other information and fully understand that all employment decisions are based on legitimate non-discriminatory reasons.

The name, address and telephone number of the nearest unit of the consumer reporting agency designated to handle inquiries regarding the investigative consumer report is:

Sterling Infosystems, Inc. | 249 W 17th St. 6th Floor, New York, NY 10011 | 877-424-2457 | or | 5750 West Oaks Boulevard, Ste. 100 Rocklin, CA 95765 | 800-943-2589 | or | 629 Cedar Creek Grade, Winchester, VA 22601 | 866-266-3444

California, Maine, Massachusetts, Minnesota, New Jersey & Oklahoma Applicants Only: I have the right to request a copy of any Report obtained by COMPANY from STERLING by checking the box. (Check only if you wish to receive a copy)

NY Applicants Only: I also acknowledge that I have received the attached copy of Article 23A of New York's Correction Law. I further understand that I may request a copy of any investigative consumer report by contacting STERLING. I further understand that I will be advised if any further checks are requested and provided the name and address of the consumer reporting agency.

California Applicants and Residents: If I am applying for employment in California or reside in California, I understand I have the right to visually inspect the files concerning me maintained by an investigative consumer reporting agency during normal business hours and upon reasonable notice. The inspection can be done in person, and, if I appear in person and furnish proper identification; I am entitled to a copy of the file for a fee not to exceed the actual costs of duplication. I am entitled to be accompanied by one person of my choosing, who shall furnish reasonable identification. The inspection can also be done via certified mail if I make a written request, with proper identification, for copies to be sent to a specified addressee. I can also request a summary of the information to be provided by telephone if I make a written request, with proper identification for telephone disclosure, and the toll charge, if any, for the telephone call if prepaid by or directly charged to me. I further understand that the investigative consumer reporting agency shall provide trained personnel to explain to me any of the information furnished to me; I shall receive from the investigative consumer reporting agency a written explanation of any coded information contained in files maintained on me. "Proper identification" as used in this paragraph means information generally deemed sufficient to identify a person, including documents such as a valid driver's license, social security account number, military identification card and credit cards. I understand that I can access the following website - http://sterlinginfosystems.com/privacy - to view STERLING'S privacy practices, including information with respect to STERLING'S preparation and processing of investigative consumer reports and guidance as to whether my personal information will be sent outside the United States or its territories.
FOR POSITIVE IDENTIFICATION PURPOSES, THE FOLLOWING INFORMATION IS REQUIRED.* THE INFORMATION YOU PROVIDE WILL BE TREATED AS STRICTLY CONFIDENTIAL AND WILL NOT BE USED FOR ANY OTHER PURPOSES. PLEASE PRINT CLEARLY.

Signed*			Today's Date*	
Name as it appears on your driver's license*	Social Security Number*	Date of Birth*	Driver's License Number*	State*
Other Names You Have Used*			Country*	
PLEASE PROVIDE ALL RESIDENTIAL ADDRESSES FOR THE PAST 7 YEARS:				
Current Address*		City*	State*	Zip Code*
Country*	From Date (MM/YYYY)*		To Date (MM/YYYY)*	
Former Address*		City*	State*	Zip Code*
Country*	From Date (MM/YYYY)*		To Date (MM/YYYY)*	
Former Address*		City*	State*	Zip Code*
Country*	From Date (MM/YYYY)*		To Date (MM/YYYY)*	

I affirm that all information given on this page is true and accurate. Initials _____ Date _____