NORTHWEST HOSPITAL & MEDICAL CENTER
UW Medicine

CRIMINAL BACKGROUND AUTHORIZATION

Instructions for completing this form on reverse side.
Please print clearly and use BLACK INK.

Northwest Hospital Human Resources
Northgate Plaza
9709 Third Ave NE, Suite 509
Seattle, WA 98115
Phone: (206) 368-1785
Fax: (206) 368-1990

SECTION 1. AGENCY INFORMATION (COMPLETED BY CONTRACTOR)

1 NAME (TRADE NAME) OF HOSPITAL	2. THE LOCATION (STREET) ADDRESS
Northwest Hospital & Medical Center	**9709 Third Ave NE, Suite 509 Seattle, WA 98115**
3 TELEPHONE NUMBER (INCLUDE AREA CODE) **(206) 368-1785**	4 FAX NUMBER (INCLUDE AREA CODE) **(206) 368-1990**

SECTION 2. ALL QUESTION IN THIS SECTION MUST BE COMPLETED BY THE APPLICANT (PERSON TO BE CHECKED)

5. SOCIAL SECURITY NUMBER	6. DATE OF BIRTH	7. GENDER ☐ Male ☐ Female	8. RACE (OPTIONAL)

CURRENT LEGAL NAME	OTHER NAMES YOU HAVE BEEN KNOWN BY
9. LAST NAME	12. BIRTH NAME LAST FIRST MIDDLE
10. FIRST NAME	13. OTHER MARRIED NAME(S) (WRITE NONE IF NONE)
11. MIDDLE NAME (WRITE NONE IF NONE)	14. NICKNAME(S)/OTHER NAME(S) (WRITE NON IF NONE)

	YES	NO
15. Have you **ever** been **convicted of**, or do you have **charges** pending for any crime? ..... If yes, give the crime, the conviction date or charge status and the state where it occurred. Note, this includes all convictions and charges	☐	☐
16. Have you ever been found to have sexually abused, physically abused, neglected, abandoned or exploited a child or adult? ..... If yes, give name of court, state licensing board, disciplinary board, or dependency action, details of the finding, and the state where it occurred.	☐	☐
17. Have you ever had a contract and/or license to care for children or adults denied, terminated, revoked, or suspended? ..... If yes, give date, contract and/or license type, name of contracting and/or licensing agency, and the state where it occurred.	☐	☐
18. Has a court ever issued an order of protection against you for abuse, neglect, financial exploitation, or abandonment? ..... If yes, give date, court, and the state where it occurred.	☐	☐

19. DRIVER'S LICENSE OR STATE IDENTIFICATION NUMBER	20. LENGTH OF TIME LIVED IN WASHINGTON STATE YEARS: MONTHS:

21. **I understand that this authorization form and the background check is the result of Washington State Laws and Regulations and if any of the information provided above is found to be false, it may result in the loss of my employment/contract.**

I understand that I am signing this under penalty of perjury. By signing this form, I state that the information above is true and correct to the best of my knowledge. I understand untruthful or misleading answers, or deliberate omissions are cause for denial or immediate termination of my employment/contract. My signature below authorizes Northwest Hospital to obtain now and on a periodic basis conviction records from Washington State including **Washington State Patrol** and other states, and to obtain from Washington and other states licensing information and any determination or finding of abuse, neglect, exploitation or abandonment. I understand that the result of this background check(s) will be released to the agency, the facility or my employer/contractor named above. I understand I may contact Northwest Hospital to receive a copy of my WSP record, ten (10) days after signing this form.

22. SIGNATURE OF PERSON TO HAVE BACKGROUND CHECK'	23. DATE

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FORM

This form will be returned if any portion of the required information necessary to conduct a background check is not entered or is not legible.

SECTION 2: To be completed by the applicant (person to be checked).

1. Required.
2. Required.
3. Required.
4. Optional.
5. Required. Must write NONE if none.
6. Required. Must write NONE if none.
7. Required. Must write NONE if none.
8. Required. Must include complete name at birth. If same as #9 through #11, must write SAME.
9. Required. Must list all married names used (male or female); must write NONE if none.
10. Required. Must list all nicknames used (male or female); must write NONE if none.
11. Required.
12. Required.
13. Required.
14. Required.
15. Required. Must list drivers license number or state identification number; must write NONE if none.
16. Required. Indicate number of consecutive years and/or months lived in Washington State.
17. Read prior to moving to block #22.
18. Required signature of applicant.
19. Required. Date signed by applicant.

UW Medicine

NORTHWEST HOSPITAL
& MEDICAL CENTER

Confidentiality Agreement

Northwest Hospital & Medical Center (NWHMC) is affiliated with the UW Medicine Health System. NWHMC is comprised of owned-clinics and affiliated entities which include The Sports Medicine Clinic, Neurosurgical Consultants of Washington, The Seattle Arthritis Clinic, Richmond Internal Medicine, The Bone & Joint Center of Seattle, and Primary Care Partners Northwest.

With appropriate authorization from their manager, certain individuals may be granted access to confidential information and/or the computer systems owned and operated by NWHMC, for business use. The individuals granted access may include employees of Northwest Hospital, its owned clinics, employees of affiliated entities described above, contractors, students, observers, visitors, and others. "Confidential information" is defined as any data that NWHMC considers confidential, protected, or sensitive. Confidential information may be heard (verbally transmitted) or viewed on paper, in computer applications, networks or laptops, or recorded on storage media such floppy disks, CDs, or tapes.

If given access to confidential information and/or NWHMC computer systems, the individual must agree to abide by NWHMC's confidentiality agreement below. For more information, please refer to the Administration policy on Privacy and the Information Management Services Use Policy.

Northwest Hospital & Medical Center (NWHMC) considers it everyone's responsibility to respect and maintain the confidentiality of patients, physicians, fellow employees, visitors and volunteers.

I acknowledge that I may have access to confidential information that is managed and protected by NWHMC. I understand that all individually identifiable patient information is considered protected health information (PHI) and must be treated as confidential as prescribed by the policies and procedures of NWHMC. Additionally, personal employee information such as home address, telephone numbers, and work schedules are confidential. Retrieving and/or discussing confidential information for any purpose other than required by my job (or required by my authorized assignment or visit in the case of students, visitors or observers) is prohibited, and may be considered grounds for dismissal and/or legal action.

Further, if I have been granted access to the NWHMC computer network in order to perform my job duties (or to complete my authorized assignment, if I am a student, visitor, or observer), I understand that the passwords assigned to me are confidential. I understand the information to which I have access within the computer system is also confidential. Any disclosure of such information or use of the data or computer systems for any purpose other than that required by my job duties (or my authorized assignment) will be considered grounds for immediate dismissal and/or legal action.

_____

Printed Name _____

Signature _____

Date: _____

Please fax completed forms to Human Resources: (206) 368-1990

Cc: File in NWHMC Human Resources

NORTHWEST HOSPITAL & MEDICAL CENTER
UW Medicine

Student Information Form

PLEASE PRINT

Contact Information

Last _____ First _____ MI _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Other (type): _____

School Email Address: _____

Personal Email Address: _____

Anticipated Graduation Date: _____

Emergency Contact

Last Name _____ First Name _____ Relationship _____

Address _____ City _____ State _____ Zip Code _____

Telephone: The best way to reach this person is at: Home ☐ Work ☐ Other ☐

Home Phone: (___) _____ Check one: Day ☐ Eve ☐

Work Phone: (___) _____ Ext # _____ Check one: Day ☐ Eve ☐

Other Phone: (___) _____ Check one: Cell ☐ Pager ☐ Fax ☐

Please fax completed forms to Human Resources: (206) 368-1990