St. Clair County Community Mental Health Authority

Background Check Notice

This notice is to inform you that St. Clair County Community Mental Health Authority will be conducting a criminal background check at the time of potential hire, and annually thereafter. This will be done in accordance with the Authority's Background Check Policy, #06-001-0015. Additionally, driving records will also be done for all employees using agency vehicles and their supervisors.

Any questionable results will be reviewed by the Chief Executive Director and kept in a separate administrative file.

First Name: _____ Middle: _____ Last Name: _____

Other Names Used (Aliases, Maiden Name, etc.): _____

Phone #: _____ Race: _____ Sex: ☐ Male ☐ Female ☐ Non-Binary

Date of Birth: _____ Social Security Number: _____

Driver's License Number: _____ Driver's License State of Issue: _____ Expiration Date: _____

Note: Date of Birth, Sex, and Race are being requested for the sole purpose of identification and the accurate gathering of criminal history record.

Acknowledgement/Authorization:

I have read and understand this notice. I understand that by signing this form, I am certifying the information I have provided is true, accurate, and complete. I also understand that by signing, I am giving permission to SCCCMHA to conduct an initial background check as well as any subsequent background checks deemed necessary during the length of my employment with SCCCMHA.

_____ _____

Signature Date