TO: West Carroll Parish Sheriff Dept.
305 East Main Street
P.O. Box 744
Oak Grove, LA. 71263

FROM: West Carroll Memorial Hospital
REQUESTING NAME OF FACILITY/AGENT/ETC.

706 Ross Street, Oak Grove, LA. 71263
MAILING ADDRESS, CITY, STATE, ZIP

Amanda Grey, RHIT, CCS — 318-428-3237
Corporate Compliance Officer — Facility Phone Number

RE: **Authorization to Disclose Criminal History Records Information**

As a new or prospective employee of the above facility or agency, I understand a thorough investigation of any record of past criminal activities will be conducted by the West Carroll Parish Sheriff Department.

By my signature below, I hereby authorize such an investigation and further authorize the West Carroll Parish Sheriff Department to release all criminal record information maintained in their files which may confirm or deny my eligibility for employment with the facility or agency named above.

APPLICANT'S FULL NAME(Printed)____

APPLICANT'S SIGNATURE____

APPLICANT'S SOCIAL SECURITY #____________________ **DATE OF BIRTH**______________

APPLICANT'S JOB TITLE____

APPLICANT'S DRIVERS LICENSE # ____

RACE______________________________ **SEX**______________________________

DATE______________________________ **WITNESS**______________________________

PLEASE CHECK ONE:

WORKING WITH CHILDREN: _________ **HEALTH PROVIDER:** _________ **OTHER:**_________

NOTE: THERE IS A $20 FEE FOR THIS SERVICE

*Department Heads: Please give this sheet to Mandy Hibbard.