1. Complete this form in its entirety & leave the top copy with your advisor when you register.
2. Pay the $30 fee at the Accounting counter in Student Services.
3. Take your payment receipt & the bottom copy of this form to the Health Career division office, W102 to schedule your fingerprinting appointment.

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Illinois Department of Public Health

Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761 Phone: (217) 785-5133

Health Care Worker Background Check

Disclosure and Authorization for Criminal History Records Check

I hereby authorize the Illinois Department of Public Health (IDPH), IDPH's designee that train or test health care workers, staffing agency, or the health care employer to request a criminal history records check and I further authorize the Illinois State Police (ISP) to release information relative to the existence or non existence of any criminal record which it might have concerning me to the requestor solely to determine my suitability for employment or continued employment. I further authorize any agency which maintains records relating to me to provide same on request to the ISP or IDPH. I certify that the ISP and any agency, including IDPH, their employees or officers who furnish this information shall be held harmless from any and all liability which may be incurred as a result of releasing such information. I further acknowledge that a health care employer shall not be liable for the failure to hire or to retain an applicant or employee who has been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25)

I understand that any false statements or deliberate omissions on this document may be grounds for disqualification from employment or, if discovered after employment begins, could result in discipline up to and including my termination of employment.

I understand that the information requested below regarding sex, race, height, eye color, and date of birth is for the sole purpose of identification and the gathering of the above-mentioned information about me accurately, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my social security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

First Name _____ Full Middle Name _____ Last Name _____

Other Names Used: (Nicknames) _____ (Maiden Name) _____ Telephone ____ - ____ - ____

Mailing Address _____ City _____ State_____ Zip Code_____

States Where You Have Lived? _____

☐ Male ☐ Female Height _____ Weight _____ Date of birth _____ Social Security Number ____ - ____ - ____

Race _____ (choose from below) Original Hair Color _____ Eye Color _____ Place of Birth (State only) _____

A Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
B Black or African American (Not Hispanic or Latino)
H Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander.
I American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
U Of undeterminable race. Of Untold mixture.
W Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of Abuse, Neglect, or Theft? ☐ Yes ☐ No If "Yes", give full details and state. Continue on back if more space is needed.

Have you ever been convicted of a criminal offense other than a minor traffic violation (do not include convictions that have been expunged, sealed or adjudicated delinquent)? ☐ Yes ☐ No If "Yes", give full details of each offense and the state in which convicted. Continue on back if more space is needed.

I certify that the above is true and correct and give my consent for my name to appear on IDPH's Health Care Worker Registry as a result of this criminal history records check:

_____ _____
(Signature) (Date)

As the parent or guardian of the above named individual, who is under the age of seventeen, I give my consent for this named individual to have a criminal history records check.

_____ _____
(Signature of Parent or Guardian when applicable) (Date)

All fields must be completed or application will not be processed