

Background Study Information

First Name: _____

Middle Name: _____

Last Name: _____

Date of Birth: _____ Male _____ Female _____

Driver License Number: _____ & Expiration Date: _____
OR

State I.D. Number: _____ & Expiration Date: _____
OR

Passport Number: _____ & Expiration Date: _____

Height: _____

Weight: _____

Hair Color: _____

Eye Color: _____

- Race : Asian _____
- Pac.Islander _____
- African American _____
- White _____
- Unknown Other _____
- Hispanic/Latino _____
- Two or more Races _____

Social Security No. _____

Phone No. _____

Street Address _____

City: _____

Zip Code _____

Email _____

Other First Names Used _____ Other Last Names Used _____

Have you lived outside of Minnesota in the last 5 years? _____ If so, where and years _____

What state were you born in? _____

CONSENT TO COMPLETE BACKGROUND STUDY

I have been informed of the 1995 Legislature amended Statutes, Chapter 144, requiring background studies to be completed on all individuals providing direct contact services in facilities licensed by the Minnesota Department of Health. Therefore, I understand that a background study will be done on all individuals providing direct contact services within Oak Hills Living Center, and that the results of the study will be communicated by DHS to the facility and to the person studied. The results shall be kept confidential and will not be released without written authorization. I have also been informed that future convictions for disqualifying crimes will be reported to DHS by the corrections system.

I have read the Privacy Notice and consent to the completion of the background study.

Signature: _____

Date: _____

Position: Professional—RN or LPN Unlicensed—Nurse Aide or Nurse Aid in Training
Food—cook or other