UCONN HEALTH

BACKGROUND INFORMATION SHEET

PLEASE COMPLETE ALL SECTIONS AND SIGN AT THE BOTTOM

The following information is being solicited for purposes of conducting pre-employment criminal and/or other background checks only and is not used in employment decisions unrelated to the results of the background check.

Name: _____
Last First Middle (spell out)

Social Security Number: _____

Contact Phone: _____ Home Phone: _____

e-mail: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced

Maiden Name: _____ Aliases: _____

_____ Race _____ Eyes _____ Height Physically Disabled:

_____ Sex _____ Hair _____ Weight ☐ Yes ☐ No

Identifying Scars/marks/tattoos (type & location):

_____

Home Address: _____
Number Street City/Town State Zip

Date of Birth: _____
MM/DD/YYYY

Place of Birth: _____
City and State or Country

Citizenship: _____ Visa Status: _____

Drivers License ☐ Yes ☐ No

State: _____ License #: _____

List the states that you have lived in the last 7 years:

_____

Are you related to, or an unmarried partner of, an employee at UConn Health? ☐ **YES** ☐ **NO**

If "YES" list below. Continue on the reverse side if necessary. Per UConn Health Policy #2002-51 a relative is a spouse, father, mother, sister, brother, child, the spouse of a child, or any relative who is domiciled in the employee's household.

Name	Relationship	Department

Have you ever been CONVICTED of an offense against criminal or military law, or are there criminal charges currently pending against you? Exclude minor traffic violations, or any offense settled in juvenile court or under a youth offender law. ☐ **YES** ☐ **NO**

If "YES" list all cases below, providing details as indicated. Continue on the reverse side if necessary. **Special Note:** Under the provisions of (C.G.S. § 46a-80 a person is not disqualified from state employment solely because of a prior conviction of a crime. The state can deny employment if a person is found unsuitable after considering (1) the nature of the crime, (2) information relating to the degree of rehabilitation, and (3) the time elapsed sine the conviction. You are not required to disclose the existence of any arrest, criminal charge or conviction, the records of which have been erased pursuant to Connecticut General Statutes §46b-146, 54-76o, or 54-142a. If your criminal records have been erased pursuant to one of these statutes, you may swear under oath that you have never been arrested. Criminal records that may be erased are records pertaining to a finding of delinquency or that a child was a member of a family with service needs (C.G.S. § 46b-146), an adjudication as a youthful offender (C.G.S. § 54-76o), a criminal charge that has been dismissed or nolled, a criminal charge for which the person has been found not guilty or a conviction for which the person received an absolute pardon (C.G.S. § 54-142a).

Date	Place	Court Location	Offense(s)	Disposition

Have you ever been excluded, disbarred, restricted, disqualified, or sanctioned from any Federal or State programs or government organizations? ☐ **YES** ☐ **NO** If "YES" list all cases below, providing details as indicated. Continue on the reverse side if necessary. For the CMHC program, fingerprints taken by the Department of Correction will be submitted to the Connecticut State Police and the FBI for a criminal history check.

Date	Place	Agency	Funding	Current Status

Have there ever been any actions against your professional license(s)? ☐ **YES** ☐ **NO** ☐ **N/A**

If "YES" list all cases below, providing details as indicated. Continue on the reverse side if necessary.

Date	Place	Agency	Funding	Current Status

Have you brought or will you be bringing (or having transported) to UConn Health ANY biological materials that are pathogenic in humans, animals or plants, including but not limited to viable organisms or genetic elements of pathogenic viruses, bacteria, biological toxins, fungi, rickettsia, mycoplasma or parasitic organisms? ☐ **YES** ☐ **NO**

If "YES", IMPORTANT NOTE: You must contact Research Safety 860/679-2723 or rwallace@uchc.edu before transporting any biological, chemical or radioactive materials to UConn Health.

I certify that the information provided by me in the Background Information sheet is COMPLETE and TRUE to the best of my knowledge and is made in good faith. I understand that if I knowingly make any misstatement of facts or fail to provide required information I am subject to disqualification or dismissal and other penalties as they may be prescribed by law, policy, or regulation. This sheet is not complete without a wet signature. Digital signatures are not acceptable.

SIGNATURE: _____ **DATE SIGNED:** _____

OFFICIAL USE ONLY

MUST BE COMPLETED BY HIRING DEPARTMENT

submitted by: ☐ Abromaitis D ☐ Duggal J ☐ Hobson M ☐ Leone M ☐ Logan N
☐ Rucker P ☐ Seklecki D ☐ Smith J ☐ Stockwell L ☒ Other: Mark Siraco

return to: ☐ Abromaitis D ☐ Duggal J ☐ Hobson M ☐ Leone M ☐ Logan N
☐ Rucker P ☐ Seklecki D ☐ Smith J ☐ Stockwell L ☒ Other: Mark Siraco

area: ☐ CMHC ☐ Clinical Operations ☒ Clinical Faculty ☐ Day Care
☐ Dental Clinics ☐ IT ☐ Non-Clinical ☐ Research

employee type: ☐ Paid ☐ Volunteer ☐ Grad Assistant ☐ Dental Resident/Non-Surgical
☒ Unpaid ☐ Student ☐ Contractor: Medical Resident

job title: Visiting Medical Resident the dept of _____

PUBLIC SAFETY USE ONLY

Result/Date

___ Cleared

___ Rejected - failure to disclose ____/____/____

___ Rejected - criminal history ____/____/____

___ Administrative Review Pending ____/____/____

___ Administrative Review Complete ____/____/____

Form Approved
OMB No. 0960-0760

Authorization for the Social Security Administration (SSA) To Release Social Security Number (SSN) Verification

Printed Name:	Date of Birth:	Social Security Number:

I want this information released because I am conducting the following business transaction:
Employee/Contractor/Vendor/Volunteer/Student - Background Screening

Reason (s) for using CBSV: (Please select all that apply)

- ☐ Mortgage Service
- ☐ Banking Service
- ☒ Background Check
- ☐ License Requirement
- ☐ Credit Check
- ☐ Other

with the following company ("the Company"):

Company Name: Security Services of CT, Inc. (SSC, Inc.)

Company Address: 25 Controls Dr, Shelton, CT 06484

I authorize the Social Security Administration to verify my name and SSN to the Company and/or the Company's Agent, if applicable, for the purpose I identified.

The name and address of the Company's Agent is:
Computer Information Development LLC
713 West Duarte Road #106, Arcadia, CA 91007

I am the individual to whom the Social Security number was issued or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare and affirm under the penalty of perjury that the information contained herein is true and correct. I acknowledge that if I make any representation that I know is false to obtain information from Social Security records, I could be found guilty of a misdemeanor and fined up to $5,000.

This consent is valid only for 90 days from the date signed, unless indicated otherwise by the individual named above. If you wish to change this timeframe, fill in the following:

This consent is valid for _____ days from the date signed. _____ (Please initial.)

Signature _____ Date Signed _____

Relationship (if not the individual to whom the SSN was issued): _____

Contact information of individual signing authorization:

Address _____

City/State/Zip _____

Phone Number _____

Privacy Act Statement

SSA is authorized to collect the information on this form under Sections 205 and 1106 of the Social Security Act and the Privacy Act of 1974 (5 U.S.C. § 552a). We need this information to provide the verification of your name and SSN to the Company and/or the Company's Agent named on this form. Giving us this information is voluntary. However, we cannot honor your request to release this information without your consent. SSA may also use the information we collect on this form for such purposes authorized by law, including to ensure the Company and/or Company's Agent's appropriate use of the SSN verification service.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U. S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to complete the form. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401*. ***Send to this address only comments relating to our time estimate, not the completed form***.

---TEAR OFF ---

NOTICE TO NUMBER HOLDER

The Company and/or its Agent have entered into an agreement with SSA that, among other things, includes restrictions on the further use and disclosure of SSA's verification of your SSN. To view a copy of the entire model agreement, visit http://www.ssa.gov/cbsv/docs/SampleUserAgreement.pdf