

**South Carolina Law Enforcement Division
Records Check**

PLEASE PRINT LEGIBLY

Name: _____

AKA and Maiden Names: _____

DOB: _____ Race: _____ Sex: _____ HGT: _____ WGT: _____

SSN: _____

Present Address: _____

City: _____ State: _____ Zip: _____

County: _____

I understand that the above information will be used to conduct a criminal records check and I hereby authorize all law enforcement agencies including the South Carolina Law Enforcement Division (SLED) and/or the Federal Bureau Investigation (FBI) to release any and all records regarding me to Columbia Hands of Hope. I further agree to release SLED and any law enforcement agency from liability for providing information to Columbia Hands of Hope in response to this authorization.

Signature

Date

I give Columbia Hands of Hope permission to release a copy of the results of this SLED/FBI check to the clinical rotation facility. I understand that a copy of my SLED/FBI check will be kept on file at Columbia Hands of Hope and may be shared with other clinical facilities, as South Carolina law and/or clinical contracts require. I further agree to release Columbia Hands of Hope from liability for sharing this information with clinical sites or any lawful use of the information acquired as a result of a criminal records check.

Signature

Date