



Bassett Healthcare Network Valley Health Services

690 West German Street
Herkimer, New York 13350
www.valleyhealthservices.org
315-866-3330

VALLEY HEALTH SERVICES INFORMATION RELEASE FORM

I certify that answers given are true and complete to the best of my knowledge. I understand that the employer will thoroughly investigate my work and personal history and verify all data given on this application, resume, related papers or interviews. I authorize all individuals, schools, and firms named therein, except my current employer if so noted, to provide any information requested about me, and I release them from all liability for damage in providing this information.

I understand that unless otherwise defined by applicable law, any employment relationship with this organization is of an “**at will**” nature, which means that the employee may resign at any time and the employer may discharge the employee at any time with or without cause. It is further understood that this “**at will**” employment relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization.

I understand Valley Health Services, Inc. keeps applications on file for one (1) year; after which time, if I wish to be considered for employment, I must submit a new application.

I certify all the statements herein are true and understand that any falsification or willful omission shall be sufficient for dismissal or refusal of employment.

Signature of applicant: _____ Date: _____

Name (Please print): _____



Bassett Healthcare Network Valley Health Services

690 West German Street
Herkimer, New York 13350
www.valleyhealthservices.org
315-866-3330

Authorization for Search and Exchange of Information

I, _____, hereby authorize Valley Health Services, Inc. (VHS) to submit a request to the Attorney General of the United States to conduct a search of the records of the Criminal Justice Information Services Division of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints or other identification information between the Attorney General of the United States, the New York State Department of Health and VHS. This information may be used only by VHS and only for the purpose of determining my suitability for employment in a position involved in direct patient care. I understand that I have the right to obtain and explain the information and results contained within the criminal history record check received by VHS. I am aware that I can withdraw my application for employment at any time without prejudice during the provisional employment period, and that VHS has the right to discharge me, without prejudice if the results/findings disqualify me from continued employment in a health care institution under the mandates and article of the applicable laws governing such institutions.

If the employment relationship is severed for reasons stated above, the facility must provide a basis for the withdrawal in writing and provide a copy for me. I am also aware that VHS must destroy my fingerprints and criminal history record.

Name: _____

Signature: _____

Date: _____

For all applicants under the age of 18, Valley Health Services, Inc. requires a parent or guardian's signature for the criminal history record check and fingerprinting process:

I, _____, parent/legal guardian of

_____, do hereby give my permission to Valley Health Services, Inc to conduct the criminal history check and fingerprinting process set forth for the search and exchange on information as conveyed within this notification.

Name of Parent/Guardian: _____

Signature: _____

Date: _____