THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

ROUTE TO HR SERVICE CENTER UNIVERSITY REHAB CLINIC (URC)

MARCH 2020

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SCALE IN FEET

CONSENT AND FULL RELEASE FOR FINGERPRINTING AND CRIMINAL BACKGROUND CHECK

Fingerprints you submit will be used to check the criminal history records information of the FBI. You have the right to challenge the accuracy of the information on the FBI record. Should you choose to challenge the accuracy of your record, you will be afforded a reasonable amount of time to correct or complete the record before you are denied a job, license, or other benefit based on the information in the criminal history. If you decline to do so, you need do nothing. To challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency (See 28 CFR 16.30 through 16.34). This report will be used for authorized purposes only, and will be processed by the University of Mississippi Medical Center Human Resources Department, 2500 North State Street, Jackson, MS 39216-4505. You may request a copy of your FBI criminal history record information. Such information will be provided to you at no cost within 30 days after receiving your request in writing. *You are not required to share your criminal history record information with any private entity or other third-party.* This information will be provided by University of Mississippi Medical Center Human Resources where you were fingerprinted. Upon your request, the University of Mississippi Medical Center will provide additional details regarding your screening report, including the names of specific resources used to gather information, such as courts, schools, public record databases, previous employers, commonly accepted data sources and individuals.

PRINT Name ______________________________ Date of Birth ____________________

Other Last Name(s) Used____

Social Security Number ________________________ Phone ________________________

Physical Address ____

City ____________________ State __________ Zip Code____________________

PRINT Active Email Address ____

By signing below I authorize UMMC to conduct a criminal background check as may be required. <u>I acknowledge that I have been informed of the Non-Criminal Justice Applicant Privacy Rights and I understand my fingerprints will be run through the criminal history records of the FBI.</u> I acknowledge that this disclosure is available online and that I may request a paper copy. I hold harmless any person or entity providing information about me in response to UMMC's request. I understand that correspondence, including any Criminal History Record Information and "Clearance Letter", if issued, may be sent to me by UMMC email. The email address I have provided is an active email address. Only I have access to that mailbox content. I also understand that I am responsible for checking the email account I provided, including my SPAM folder for any UMMC related correspondence.

Signature ______________________________________ **Date** ____________________

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For HR Use Only

Reason: ◯Pre-Employment ◯UMMC Student ◯Non-Employee ◯Volunteer ◯Affiliated Student

Group/Department/School:____

Payment: ◯N/A ◯Cash ◯Credit/Debit ◯Billed to:__________________ ◯IDI from:__________________

Background Check Acknowledgement and Consent

Section 1: This is to let you know that we conduct a comprehensive background review

By this document, the University of Mississippi Medical Center (UMMC) discloses to you that a consumer report, including an investigative consumer report containing information as to your character, general reputation, personal characteristics and mode of living, may be obtained for employment purposes as part of the pre-employment background investigation and at any time during your employment. Should an investigative consumer report be requested, you will have the right to request a complete and accurate disclosure of the nature and scope of the investigation requested and a written summary of your rights under the Fair Credit Reporting Act.

Section 2: This will give your permission to conduct a comprehensive background review by consumer report

Pursuant to the federal Fair Credit Reporting Act, I hereby authorize the University of Mississippi Medical Center (UMMC) and its designated agents and representatives to conduct a comprehensive review of my background through a consumer report and/or an investigative consumer report to be generated for employment, promotion, reassignment or retention as an employee. I understand that the scope of the consumer report/investigative consumer report may include, but is not limited to, the following areas: verification of Social Security number; current and previous residences; employment history, including all personnel files; education; references; credit history and reports; criminal history, including records from any criminal justice agency in any or all federal, state or county jurisdictions; birth records; motor vehicle records, including traffic citations and registration; and any other public records.

I authorize the complete release of these records or data pertaining to me that an individual, company, firm, corporation or public agency may have. I hereby authorize and request any present or former employer, school, police department, financial institution or other persons having personal knowledge of me to furnish the University of Mississippi Medical Center or its designated agents with any and all information in their possession regarding me in connection with an application of employment. I am authorizing that a photocopy of this authorization be accepted with the same authority as the original.

I understand that, pursuant to the federal Fair Credit Reporting Act, if any adverse action is to be taken based upon the consumer report, a copy of the report and a summary of the consumer's rights will be provided to me.

By signing below I acknowledge receipt of and consent to sections 1 and 2.

Full Legal Name_____

Signature _____ Date_____

Revised: 09/2019

Consent for Drug Screen and Employment Qualification Testing

THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

I understand that it is the policy of the University of Mississippi Medical Center (UMMC) to prohibit the use, possession, transportation or sale of illegal or non-prescribed drugs and alcoholic beverages on the premises of the Medical Center. Further, that under Mississippi Law I am required to submit to fingerprinting and a criminal background investigation. I understand that it is violation of Medical Center policy for an employee to be under the influence of drugs or alcohol while at work and it is prohibited to report for, or work while impaired. I acknowledge that UMMC is a tobacco free campus and the use of all tobacco products is prohibited at work.

My signature below constitutes my consent to provide a sample of my blood, breath, hair, urine or other related sample for alcohol and/or drug testing analysis and to submit to fingerprinting and a criminal background check. I understand that failure to timely cooperate with any pre-employment testing and/or qualification procedure will be construed as a withdrawal of my application for employment. I understand that I may be requested to submit an observed 2nd sample for drug screening within 24 hours if the original sample is too dilute to yield results. I understand that I may, upon request, review the University of Mississippi Medical Center Drug and Alcohol Testing - Fingerprinting and Tobacco policies. As an inducement to persuade UMMC to consider me for employment, I hereby authorize the University of Mississippi Medical Center to conduct the qualification testing/procedures indicated.

Upon employment, I agree to a physical assessment and examination which will include blood test, TB skin test and may include a chest x-ray and/or other testing medically or otherwise indicated.

AFTER PRESENTING FOR TESTING DO NOT LEAVE THE RECEPTION AREA.

_____I **HAVE** taken the following prescription medication(s) or drug(s) during the last **two months**:

_____

_____

_____

_____

_____I have **NOT** taken **any** prescription medication(s) or other drug(s) during the last **two months**.

List any medical conditions that might cause your urine to be dilute: _____

Approximately how much liquid have you consumed in the last 12 hours? _____

PRINT NAME: _____

SOCIAL SECURITY NUMBER: _____ TODAY'S DATE: _____

APPLICANT SIGNATURE: _____

---------- **For Office Use Only**----------

Employee/Student Health Representative_____Date_____

Chain-of-Custody Verified_____Date_____

CONFIDENTIAL

UMMC EMPLOYEE ID NUMBER: _____

STUDENT-EMPLOYEE HEALTH
NEW EMPLOYEE PATIENT REGISTRATION FORM

Each new employee will be scheduled for an employment physical. Please complete and submit form to Student Employee Health (or during new employee orientation).

☐ Temporary

☐ New Employee

☐ Former Employee

PLEASE PRINT OR TYPE

Patient Information:

Birth Date: _____ Hire Date: _____ Your Gender: _____ Soc Sec #: _____

Last Name: _____ Maiden Name: _____

First Name: _____ Middle Name: _____

Street Address: _____
(**NO** P.O. Box or RR #) City State Zip

Daytime Telephone: _____ Evening Telephone: _____

Marital Status: _____ M. S. W. D. Mother's Maiden: _____

Religion: _____ Ethnicity: _____ Primary Language: _____

Emergency Contact:

Relationship to Patient: _____

Last Name: _____ First Name: _____

Address: _____
Street Address City State Zip

Home Telephone: _____ Other Telephone: _____

UMMC History Information:

Previous UMMC Employee? Yes No If so, under what name? _____

Year employment ended: _____

UMMC student? Current Previous If so, under what name? _____

Year of graduation or last date of attendance? _____

Employment Information:

Title: _____ Department: _____

Supervisor Name: _____ Phone _____

PRE-PLACEMENT EMPLOYEE PHYSICAL EXAMINATION
STUDENT EMPLOYEE HEALTH

Date _____

LAST NAME FIRST NAME MIDDLE NAME DATE OF BIRTH

HOME ADDRESS (Street, City, & State) HOME PHONE WORK PHONE

GENDER RACE MARITAL STATUS (M, S, W, D) WHICH FOREIGN COUNTRIES HAVE YOU VISITED IN THE PAST 5 YEARS?

STATEMENT OF YOUR PRESENT HEALTH IN YOUR OWN WORDS (If ill health currently exists, please explain. Additional space provided on page 2.)

WILL YOU BE ABLE TO PERFORM ALL THE ESSENTIAL FUNCTIONS OF YOUR JOB? NO YES (If no, please explain on page 2)

LIST OF ALL MEDICATIONS YOU ARE TAKING _____

_____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATION? NO YES

WHAT:_____

DO YOU HAVE ANY OTHER ALLERGIES? NO YES

WHAT:_____

DO YOU HAVE A LATEX ALLERGY? NO YES

DO YOU USE TOBACCO? NO YES

WHEN DID YOU HAVE THE FOLLOWING?

CHEST X RAY _____ WHERE _____

T.B. SKIN TEST DATE _____ Result_____

TB BLOOD TEST DATE: _____ Result_____

MMR IMMUNIZATION DATES: 1. _____ 2. _____

VARICELLA IMMUNIZATION DATES: 1. _____ 2. _____

TETANUS(Td) IMMUNIZATION DATES_____

Tdap IMMUNIZATION DATES _____

HEPATITIS B VACCINATION 1. _____2._____3._____

HAVE YOU BEEN SCREENED FOR HEPATITIS C? NO YES

DO YOU HAVE ANY CONTRAINDICATIONS TO THE FLU VACCINE? NO YES

HAVE YOU EVER HAD OR HAVE NOW (Place check at RIGHT of each item). ANSWER ALL QUESTIONS.

(Check each item)	Present	Past	NA*	(Check each item)	Present	Past	NA*	(Check each item)	Present	Past	NA*	(Check each item)	Present	Past	NA*
Appendicitis				Chronic cough				Heart disease				Paralysis			
Alcohol abuse				Chronic kidney disease				Hemorrhoids				Recent weight loss/gain			
Anxiety disorder				Coughed up blood				Hepatitis B or C				Rheumatic fever			
Arthritis				Depression				Hernia				Rheumatoid Arthritis			
Asthma				Diabetes mellitus				High blood pressure				Seizure disorder			
Attempted suicide				Dizziness or fainting spells				HIV/AIDS				Schizophrenia			
Back injury				Ear, nose, throat trouble				Insomnia				Shortness of breath			
Bipolar disorder				Eye infection				Joint pain				Sinusitis			
Bleeding Disorders				Foot pain				Kidney stones				Stuttered or stammered			
Bled excessively after injury or tooth extraction				Frequent indigestion				Leg cramps				night sweats			
Boils				Frequent or painful urination				Measles				Substance abuse			
Bursitis				Gall stones				Memory loss				Thyroid disease			
Cancer				German measles (Rubella)				Motion Sickness				Tuberculosis			
Carpal Tunnel Syndrome				Glaucoma				Mumps				Syphilis			
Chest pain				Hay fever				Other GI Complications				Whooping Cough			
Chicken pox				Headaches				Palpitations				an artificial eye			
Chronic back pain				Hearing loss				Panic attack				glasses or contact lenses			
												hearing aids			

Are You (Check one) Right Handed Left Handed

Females only

No. of previous pregnancies _____ Date of last menses _____

Are you, or do you think you might be pregnant now? _____

*Not Applicable (NA)

PRE-PLACEMENT EMPLOYEE PHYSICAL EXAMINATION
STUDENT EMPLOYEE HEALTH

CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED "YES" MUST BE FULLY EXPLAINED BELOW.

Have you been unable to hold a job because of: A. Sensitivity to chemicals, dust, sunlight, etc.	YES	NO	Have you been hospitalized within the past 5 years? (If yes, please elaborate below.)	YES	NO
B. Inability to perform certain motions			Have you ever had any illness or injury other than those already noted? (If yes, specify when, where and give details.)		
C. Inability to assume certain positions					
D. Other medical reasons (If yes, give reasons)			Have you ever been hospitalized for a mental disorder? (If yes, specify when, where, why, and name of doctor.)		
Have you ever been exposed to hazardous drugs?					
Have you ever worked with radioactive substance?			Is there any reason you cannot perform strenuous physical activity?		
Have you ever been refused employment because of your health? (If yes, stat reason and give details.)			Have you had, or have you been advised to have any operations? (If yes, describe and give age at which occurred.)		
Have you ever been denied life or health insurance? (If yes, state reason and give details.)			Will you perform CDC Category I surgery (i.e., cardiothoracic, orthopedic, OB-GYN, oral/maxillofacial or general surgery)?		
Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.)			Will you be working with live animals? (If yes, what kind of animals?)		

Summary and elaboration of all significant data (indicate "yes" responses and describe.)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I hereby consent and authorized my attending physician and/ or their designee to release any and a medical records or medical information arising from any of my prior medical examinations, to Student Employee Health, in order that a complete diagnosis of my condition may be had. I further consent to authorize Student Employee Health physicians and/or their designee to furnish to the relevant human resources personnel, the results of their findings if such is pertinent to my employment or education.

Printed name	Signature

PHYSICAL EXAMINATION (To be completed by physician)

Wt. Ht. B.P. Pulse Temp.

✓ = Normal
X = Abnormal
O = Omitted

1. General appearance				
2. Skin				
3. Nails				
4. Head Scalp				
5. Neck	Thyroid	Nodes	Vessels	
6. Nose	Sinuses			
7. Mouth	Tongue	Throat		
8. Teeth				
9. Ears Drums				
10. Eyes	Disc	Fundi	Vessels	
11. Thorax				
12. Lungs				
13. Heart				
14. Peripheral vessels				
15. Abdomen				
16. Rectum				
17. Genitalia				
18. Hernia				
19. Extremities				
20. Feet				
21. Nerves				
22. Back				
23. Lymphatics				

Typed or printed name of physician or examiner	Date	Physician's signature	Number of attached sheets

Statement of your present health continued: