

AUTHORIZATION FOR RELEASE OF REFERENCE AND BACKGROUND INFORMATION FOR
THE BIG BEND REGIONAL HOSPITAL DISTRICT

As a potential candidate for the position of Director of the Big Bend Regional Hospital District Board of Directors, I authorize the release and giving of any information requested by the Big Bend Regional Hospital District for a background check/screening and/or driving record whether such information is favorable or unfavorable to me.

I release any person, organization, or company from any and all liability, claims or damages that may directly or indirectly result from the use, disclosure, or release of any such information by any person or party, whether such information is favorable or unfavorable to me.

I further waive the right to ever personally view any references given to the Big Bend Regional Hospital District.

I further certify that I have carefully read and do understand the above statements.

NAME

Please PRINT full name (including maiden name or other names used)

BIRTHDATE (mm/dd/yyyy) _____

DRIVER'S LICENSE # _____ STATE _____

PERMANENT ADDRESS _____

CITY _____ STATE _____ ZIP _____

_____ DATE _____

Signature