WorkFitMedical
Occupational Health Services

Background Investigation Authorization Form

In connection with my employment or application for employment, I understand that background inquiries are requested by you, or on your behalf that seek information as to my criminal background record. I hereby authorize WorkFit Medical LLC to make all such inquiries. Further, I understand and agree that you may request information from various federal, state, and other agencies, including public sources that maintain records concerning my post activities relating to my criminal conviction record.

I acknowledge that a telephone facsimile or copy of this release shall be as valid as the original. This authorization is valid for any consumer report requested at any time during the tenure of my employment. This release is valid for all federal, state, county, and local agencies. I understand that I have the right to make a written request within a reasonable period of time for complete and accurate disclosure of the information concerning the nature and scope of any investigation into my background.

Print Name _____ Telephone _____
Soc Sec # _____ Date of Birth _____
Gender Male Female
Company Name _____
Current Address _____
City _____ State _____ Zip Code _____
Email _____

List of previous addresses and names (maiden and/or aliases) used during the past 7 years:

Name (if applicable)	Address	City, State, Zip	County

Applicant Signature _____ Date _____

1160 Chili Avenue, Suite 200
Rochester, NY 14624
(585) 426-4990 Phone
(585) 426-4997 Fax
frontdeskroc@workfitmedical.com

1881 Western Avenue, Suite 130
Albany, NY 12203
(518) 452-2597 Phone
(518) 556-3191
frontdeskalb@workfitmedical.com