



HEALTHCARE NETWORK

20042 19th Avenue NE, Shoreline, WA 98155

CONSENT FOR RELEASE OF MEDICAL RECORDS

TO: _____

Address: _____

I, _____ hereby authorize the release of my immunization records to Healthcare Network, Inc. in conjunction with my application for employment. I have been assured that my records will be kept confidential and there will be no further disclosure of my information to other organizations or agencies without my prior written consent.

Applicant (Signature)

Witness (Signature)

Date: _____

Date: _____



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AUTHORIZATION TO RELEASE EMPLOYEE INFORMATION

EMPLOYEE NAME: _____ DOB: _____

STATE ID # _____ SSN # : _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____

I request and authorize _____ **HEALTHCARE NETWORK, INC.** _____ to

release the credentialing profile of the employee named above to below named facility(ties)

Initial _____ I authorize Healthcare Network to release my employment information, updated

Yes No

Credential records, Immunization records, Washington State Patrol background check and Drug, Alcohol screen results whether negative or positive to the facility (ties) listed above. I Understand that the facility (ties) listed above will be notified and that I must give specific written permission before disclosure of these information to anyone not included on this list. Healthcare Network, Inc. will not be held liable for any release of information authorized by the specified facility to those listed.

Employee Signature _____ Date Signed: _____

phone 206 546 2966
fax 206 546 4210



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APPLICANT DISCLOSURE STATEMENT

Pursuant to the requirements of RCW 43.43.8534, Healthcare Network, Inc. must ask you to complete the following Applicant Disclosure Statement. Please answer fully and accurately.

*Please note: Healthcare Network, Inc. will confirm your answers to these questions by:

- (1) Running a Washington State Patrol check for criminal convictions;
- (2) Searching the Washington Courts database for civil adjudications as listed below; and
- (3) For licensed personnel, checking the Department of Health credentials database for disciplinary actions.

*You will be notified of the State Patrol's response within ten days after we receive the report of the report contains anything of concern to us as an Agency employer. Whether it does or not, we will make a copy of the report available to you upon your request.

1. Have you ever been convicted of a crime?

_____ Yes _____ No

If the answer is yes, please identify the offense(s), provide the date(s) of the conviction(s), the name of the court(s) (e.g., King County Superior Court) and the sentence(s) imposed:

2. Have you ever had findings made against you for domestic violence, abuse, sexual abuse, neglect, exploitation or financial exploitation of a child or a vulnerable adult in any civil adjudicative proceeding? Civil adjudicative proceeding includes judicial or administrative proceedings as well as findings by DSHS or the Department of Health that you have not administratively challenged or appealed.

_____ Yes _____ No

If the answer is yes, please identify the specific finding(s), which agency or court made the finding(s), the date(s) of the finding(s) and The penalty (ies) imposed:

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct. I understand that if I am hired I can be discharged for any misrepresentation or omission in the above statement. I also understand that my employment is conditioned upon satisfactory results of the background checks listed above. I have signed this Disclosure Statement on the date shown below.

Signature: _____

Print Name: _____

Date: _____