Healthcare Worker Background Screening Form

Personal Information

Full Name

Date of Birth

Phone Number

Email Address

Address

Employment Details

Job Title

Department / Facility

Start Date

Background Screening

Have you ever been convicted of a criminal offense?

If yes, please provide details

Professional License Number

License Expiry Date

Have you ever been subject to disciplinary action by a licensing authority?

If yes, please provide details

Declaration

I confirm that the above information is accurate to the best of my knowledge.

Date

Signature (Type full name)