ALPHA HOME HEALTH SERVICES, LLC
CRIMINAL BACKGROUND CHECK RELEASE OF INFORMATION AUTHORIZATION FORM

By my signature below, I authorize the **Virginia State Police** through the State Bureau of Investigation, Division of Criminal Information to perform a **Virginia** criminal history record information check relative to my application for employment or volunteer services with **Alpha Home Health Services, LLC** .

Please print legibly or type the following information:

Name: _____
Last First Middle Maiden

Previous Name(s) including previous married name(s) and aliases: _____

_____

Address: _____

_____

If applicant has lived at the above address for less than two (2) years, please list previous address(es) below:

_____

_____

Social Security #: _____ Date of Birth: _____ Sex: _____

Place of Birth: _____
City County State Country

I understand that the Virginia Bureau of Investigation, Division of Criminal Information and its official and employees shall not be held legally accountable in any way for providing this information to the above named healthcare provider, and I hereby release said Agency and persons from any and all liability which may be incurred as a result of furnishing such information. I further understand that the healthcare provider cannot provide me with a copy of the results of this criminal history record check.

Applicant's Signature: _____ Date: _____

This request form must be accompanied by a transmittal letter from the authorized official or individual requesting criminal history record information. This request must be mailed to:

VIRGINIA STATE POLICE