

# Background Verification Agreement

Student Name \_\_\_\_\_

School \_\_\_\_\_

I, \_\_\_\_\_ do consent and verify that  
\_\_\_\_\_ has received a criminal  
background check, and that his or her record meets the Fairfield Medical  
Center permissible standards. Fairfield Medical Center honors the  
partnerships and maintains that integrity with all programs and students  
who use the Fairfield Medical Center facilities.

\*\*If the school program cannot verify that this student has received a  
criminal background or that he or she meets our permissible standards, then  
the student must provide Fairfield Medical Center with a copy of his or her  
background.

Signature and Title \_\_\_\_\_

Date \_\_\_\_\_