Office of Shared Administration
Federal Program Participation Acknowledgment, Authorization, Consent, and Release

No person who is currently excluded, debarred, suspended, or otherwise ineligible to participate in federal health care programs or in federal procurement or non-procurement programs shall be hired by the West Virginia Departments of Health, Health Facilities, or Human Services or the Office of Shared Administration.

I am ☐ am not ☐ currently excluded, debarred, suspended, or otherwise ineligible to participate in federal health care programs or in federal procurement or non-procurement programs.

_____ _____

Signature ***Date***

I authorize and consent to a background check by the Office of Human Resources Management specifically to determine whether I am currently excluded, debarred, suspended, or otherwise ineligible to participate in federal health care programs or in federal procurement or non-procurement programs. If hired, I also agree to periodic conduct of additional such background checks during the course of employment by the Office of Human Resources Management.

I release any persons and the Departments of Health, Health Facilities, and Human Services and their agents, officials, representatives, employees, officers, or related personnel both individually and collectively, from any and all liability for damages of any kind that may result because of compliance with this acknowledgment and authorization.

For positive identification purposes, the following information is required when conducting a background check. This information is confidential (**please print**):

Name _____ _____ _____

Last Name *First Name* *Middle Initial*

Maiden/Other Names _____

This should include other married names by which you have been known

Home Address _____

Street/box#, City, State, Zip

Mailing Address _____

Street/box#, City, State, Zip

NOTE: Your social security card must be presented for verification purposes.

Social Security # _____ **Date of Birth** _____

Month/day/year

Driver's License Number _____ **State of Issue** _____

Employing Unit Information

Department of ☐ Health ☒ Health Facilities ☐ Human Services ☐ Office of Shared Admin

Office/Facility/Region/District: William R Sharpe Jr Hospital Contact Person Kim Flesher

Signature _____ Date _____