



APPLICANT INFORMATION RELEASE FORM

I hereby authorize the Laurel Eye Clinic and the Laurel Laser & Surgery Center and/or their authorized agents to gather information regarding the following: All records including criminal, driving, and/or education; written or verbal from previous employers; any other pertinent information relating to the function of my job. I understand that all inquiries on this form are used for identification purposes only in order to conduct a background check, and are asked for legitimate nondiscriminatory reasons. I hereby release the Laurel Eye Clinic and the Laurel Laser & Surgery Center and any of its authorized agents from liability, and understand there is no invasion of privacy.

The following is my complete legal name, and all information is true and correct to the best of my knowledge. This information is used for verification purposes ONLY:

Please Print Clearly:

Name (Last, First, Middle Initial) _____ Maiden Last Name _____

All Former Names Used _____

Social Security Number _____ Date of Birth _____

Driver's License Number _____ State Issued _____

Current Address _____ City _____ State _____ Zip _____

Previous Address (past 7 years) _____

City _____ State _____ Zip _____ Dates _____

Previous Address (past 7 years) _____

City _____ State _____ Zip _____ Dates _____

Previous Address (past 7 years) _____

City _____ State _____ Zip _____ Dates _____

Signature

Date