



## INTERN BACKGROUND CHECK CONSENT STATEMENT

**Please read and mark the following statements:**

\_\_\_\_\_ I understand that a condition of my internship, I will be required to submit background checks/clearances as per the instructions provided to me and at my own expense. I understand that my consent will apply throughout my internship with WellSpan Health to the extent permitted by law.

\_\_\_\_\_ There are no charges against me in any other state that would prohibit my selection as an Intern with WellSpan.

\_\_\_\_\_ I understand that falsifying this information will result in my immediate termination as an Intern with WellSpan.

\_\_\_\_\_ I understand that WellSpan can require additional information as part of the clearance process, and I will be notified if additional information is required.

\_\_\_\_\_ I understand that my name and other information such as date of birth and address will be reported to the Office of Inspector General to determine if I have been involved with Medicare or Medicaid fraud and/or sanctions.

\_\_\_\_\_ I understand that if my conviction status changes after I begin my internship that would affect my intern status, I must report this information to Volunteer Engagement within 72 hours of the change. Failure to do so could result in charges filed by the state of Pennsylvania and termination of my intern position.

Have you been a resident of Pennsylvania for the last consecutive 10 years?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

I have carefully read and understand this Background Check Consent Statement and, by my signature below, consent to the release of the investigative reports to WellSpan within the terms of this statement.

INTERN NAME (Print):

\_\_\_\_\_

(First) (Middle) (Last)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_