

CAPITAL AREA SCHOOL OF PRACTICAL NURSING

Authorization for Release of Criminal Background Information
(School Purposes)

TO BE COMPLETED BY STUDENT
(PLEASE PRINT LEGIBLY OR TYPE)

LAST NAME	FIRST NAME	M.	SUFFIX (JR., SR.)
MAIDEN NAME OR OTHER ALIASES _____			
SOCIAL SECURITY Number ____/____/____			
DATE OF BIRTH ____/____/____ Month Day Year		SEX: FEMALE MALE	
RACE: WHITE ASIAN BLACK HISPANIC PACIFIC ISLANDER UNKNOWN			
CURRENT ADDRESS _____ Street Address			
City	State	Zip	

Student Authorization

Without reservation, I authorize Capital Area School of Practical Nursing (CASPN) to procure my background check to obtain or furnish information concerning my criminal or other history. I understand that inquiries may be made to various federal, and state agencies, employers, references, acquaintances and others seeking information as to my personal characteristics, employment status, and general reputation.

Signature _____ Date _____

Print Full Name _____

This information is requested by CASPN for purposes of insuring accurate retrieval of records for acceptance into the nursing program.

TO BE COMPLETED BY CASPN STAFF ONLY	
Date background received _____	CASPN Staff Initials _____