CITY OF FRUITA

AUTHORIZATION TO RELEASE INFORMATION PRE-EMPLOYMENT BACKGROUND WAIVER

I hereby authorize any representative of the City of Fruita bearing this release to obtain any information pertaining to my personal background and activities from schools, residential management agents, employers, criminal justice agencies, retail business establishments, and other sources of information. This information may include, but is not limited to my academic, residential, achievement, performance, attendance, disciplinary, employment history, criminal record information, medical/mental health, substance abuse, and credit history.

I hereby direct you to release this information upon request to the bearer. This release is executed with full knowledge and understanding that the information is for official use of the City of Fruita to furnish such information as is described above, to third parties in the course of the City fulfilling their official responsibilities with regard to my application for employment.

I hereby release you the institution or establishment you represent, including its officers, employees and related personnel, both individually and collectively, from any and all liability for damages of whatever kind, which may at any time result to me, my heirs, family, or associates because of compliance with this authorization and request to release information or any attempt to comply with it.

If a criminal records investigation reveals criminal charges without disposition, I will provide a court order or similar legal document which stipulates what disposition was made of the charge(s).

Acknowledgement and Authorization

By signing below, I voluntarily and knowingly authorize the City of Fruita or its authorized agents to obtain or prepare consumer reports or investigative consumer reports about me.

			TODAY'S DATE	
Signature				
LAST NAME	FIRST	NAME	MIDDLE NAME/INITIAL	-
HOME ADDRESS				_
	_ COUNTY			
SSN	D/L or STATE I	D	STATE ISSUE)
EMAIL ADDRESS				
For identification purpo	ses only, please provide	FULL DOB:		
Please List Other Nam	es lised			

Copies of this authorization that show my signature are as valid as the original release signed by me. This authorization is valid for two (2) years from the date signed.

This fo	rm m	ust be	notarized.
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Signed	Print Name		
Date			
Social Security Number			
State of Colorado, County			
Signed in the presence of			
Address			
Day of	20		
My commission expires		Notary Public	