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Phone (413) 447-2784 Fax (413) 447-2091

**BERKSHIRE MEDICAL CENTER/BERKSHIRE HEALTH SYSTEMS  
BACKGROUND INVESTIGATION POST-OFFER CONSENT FORM**

I, \_\_\_\_\_, hereby authorize Berkshire Health Systems, and/or its agents to make an independent investigation of my background, references, character, past employment, education, credit history, criminal or policy records, including those maintained by both public and private organizations and all public records for the purpose of confirming the information contained on my Application/Resume and/or obtaining other information which may be material to my qualifications for employment/clinical internship now and, if applicable, during the tenure of my employment/training with Berkshire Medical Center/Berkshire Health Systems.

**Continuation of employment/clinical training will be contingent until the results of the background checks are completed and there are no discrepancies. An offer may be rescinded based on the information received as a result of a background check.**

I release Berkshire Health Systems and/or its agents and any person or entity, which provides information pursuant to this authorization, from any and all liabilities, claims or law suits in regards to the information obtained from any and all of the above referenced sources used.

The following is my true and complete legal name and all information contained herein is true and correct to the best of my knowledge:

\_\_\_\_\_  
Applicant Signature Date

Social Security Number \_\_\_\_\_ Other names used for work or school \_\_\_\_\_

**NOTE:** The above information is required for identification purposes only and is in no manner used as qualifications for employment. Berkshire Medical Center/ Berkshire Health Systems is an Equal Opportunity Employer and does not discriminate on the basis of Sex, Race, Religion, Age, Handicap or National Origin.

Name \_\_\_\_\_

PLEASE PRINT

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**FOR EMPLOYER USE ONLY – DO NOT COMPLETE ITEMS BELOW THIS LINE**

**Employer Section**

**Employer Contact Person:** \_\_\_\_\_ **Date** \_\_\_\_\_

**DOB:** \_\_\_\_\_