

# CHOP Irradiator Access Request Form

This form must be completed by Children's Hospital faculty, employees, or students requesting access to an irradiator.

## Section 1. Employee Information (to be filled out by ALL applicants)

Location of Irradiator Requested _____	
Name _____	Job title _____
Department _____	Phone # _____
<i>By signing the application I attest that all the information I have provided is true and complete I also agree to follow all the required rules and requirements when accessing and/or using irradiators I also agree to access and operate the irradiator only for approved activities and will not access or use this device in any unauthorized manner</i>	
_____ Signature of Applicant	_____ Date

## Section 2. To be completed by employees with greater than 3 years experience.

<b><u>If you have &gt; 3 years of experience at your current institution, have your supervisor sign below. Submit this page to EHRS</u></b>	
<i>I reviewed the applicant's request for irradiator access and confirm their need to use this device They have been employed by Penn, HUP, CHOP, Wistar (circle one) for more than 3 years. I have reviewed their employment history and believe that this individual is trustworthy and reliable I have no information that would indicate that access to the device requested should not be approved</i>	
_____ Signature of Supervisor	_____ Date
_____ Print name	_____ Phone Number

Submit completed request forms to EHRS by fax at 215-898-0140.

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The above individual has meet the required elements to be deemed trustworthy and reliable.

\_\_\_\_\_  
EHRS signature

\_\_\_\_\_  
Date







**THE CHILDREN'S HOSPITAL *of* PHILADELPHIA**

Applicants for positions at The Children's Hospital of Philadelphia are required to undergo certain pre-employment screens and checks. Accordingly, enclosed is a Fair Credit Reporting Act Job Applicant Disclosure and Authorization form ("Disclosure and Authorization form") for you to complete so that we can complete the application and/or pre-employment process.

By signing the Disclosure and Authorization form, you are authorizing a third party to conduct certain screens and checks and to provide the results of those screens and checks to CHOP. CHOP may use the results of any screens and checks for any purpose permitted under the Fair Credit Reporting Act and other applicable law, and may condition your employment upon our receiving satisfactory results for all screens and checks that are conducted

Sincerely,

The Human Resources Department

**FAIR CREDIT REPORTING ACT  
EMPLOYEE DISCLOSURE AND AUTHORIZATION**

TO: \_\_\_\_\_  
Name of Employee

The Children's Hospital of Philadelphia ("CHOP") will perform a review of your background to determine your suitability for continued employment. The review may include an investigation of your background, such as current and/or past employment history, references, driving record, criminal history, credit history and other information bearing on your character, reputation, personal characteristics and/or mode of living.

The Federal Fair Credit Reporting Act protects certain types of background information contained in "consumer reports." To the extent that CHOP procures information on employees in "consumer reports" furnished by "consumer reporting agencies," it will comply with all applicable provisions of the Fair Credit Reporting Act.

Under that Act, CHOP is required to disclose in writing that it may procure information about you from "consumer reports" for purposes of evaluating your suitability for employment. As a condition of employment, you will be required to authorize CHOP to obtain such information. This authorization will remain in effect for the duration of your employment. If you have questions about the Fair Credit Reporting Act or your rights as a covered "consumer," you may contact the Federal Trade Commission.

By signing below, you certify that CHOP has provided you with a copy of this Disclosure, that you have read it and understand its terms and that you consent to the procurement of "consumer reports" by CHOP containing information about you.

\_\_\_\_\_  
Signature

Date:

*The Children's Hospital of Philadelphia*  
*Background Screening Form*

Application Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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Last Name	First Name	Middle Initial
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Other Name Used	Last/First	Middle Initial
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Address ( <b>current</b> )	City	State/Zip
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Previous Address	City	State/Zip
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(Provide all addresses where you have lived/practiced in the last seven years)

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Previous Address	City	State/Zip
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(Provide all addresses where you have lived/practiced in the last seven years)

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Previous Address	City	State/Zip
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(Provide all addresses where you have lived/practiced in the last seven years)

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Social Security Number

**FOR LICENSED PROFESSIONALS:**

List each state in which you have held a license to practice, the license number and the dates you held each license:

State	License Number	Dates