

ADULT



**ST. MARY'S
GENERAL HOSPITAL**

Volunteer Application 18 years and older

Please fill out completely and return to:
SMGH Volunteer Dept., 350 Boulevard, Passaic, NJ 07055

Volunteer Application Process
Application Rec'd: _____
Orientation: _____
Medical Clearance: _____
PPD/TB vaccination: _____
First Assignment: _____

Mr. Mrs. Ms. _____
(Last Name) (First Name) (Middle Initial)

Address _____
(Number & Street) (City, State) (Zip Code)

EMAIL: _____

Home Phone #: _____ Date of Birth: ____/____/____

Cell Phone #: _____ SSN#: _____

Emergency Use Only _____
(Name, Relationship, Phone #)

Family Doctor _____
(Doctor's full name and address)

Physical Restrictions _____

Educational/Special Training:
High School _____ College _____
Business School _____ Other _____

Employment Background _____

List Talents & Skills You Have (Foreign Language, Photography, Computer Skills, Crafts, Etc.)

How did you become interested in our program? _____

Day Preferred _____ Time Preferred _____

References (List full name and address of two people not related to you)

Signature _____ Date _____



350 Boulevard, Passaic, NJ 07055 • 973-365-4300 • www.smh-nj.org

Employee Health Services
Volunteer: Tuberculosis, Measles, Rubella, Varicella and Hepatitis B Screening

Dear Applicant,

Please note that the form Health Certificate must be presented to your physician for the physical exam. It requests an evaluation for **immunity** status for Measles, Rubella, Varicella and Hepatitis B. Proof of Hepatitis B immunity may be established via a titer or date of when 3 vaccine doses were given.

NJDHSS, NJHA, CDC require all hospital healthcare workers and volunteers to be screened for Tuberculosis and other diseases.

The initial **two-step** (two doses, one week apart) PPD/Tuberculin Skin Test for Tuberculosis may be done with your private physician, or at St. Mary's General Hospital Nursing HUB Department, Monday – Friday, 9:00 a.m. – 6:30 p.m. and Saturday – Sunday, 9:00 a.m. – 5:00 p.m. The HUB is located on the 2nd floor of the Main Building, (turn left when exiting the elevator on the 2nd floor). **Please bring this form and your entire Volunteer Application with you when reporting to the HUB for this TB skin test.** There is no fee for this PPD test.

**** Parent or legal guardian of minors must be present for placement of TB skin test ****

The skin test will be placed /injected on the forearm just under the first layer of skin (intra dermal) and must be read 48 hours - 72 hours after. Tuberculin skin tests may be read by a registered nurse in the HUB, a school nurse or a private physician. If the test is administered by St. Mary's, we will provide the form for documentation of off- site readings.

Allergy to eggs or taking large doses of Prednisone must be reported to the HUB.

If the applicant has had a negative PPD/Mantoux/Tuberculin skin test within the last 12 months then please submit the documentation for review. The second one may be given at the St. Mary's Nursing HUB. .

If the applicant has a **past history** of a positive skin test (that of an induration greater than 10mm), documentation of a medical evaluation and **treatment plan** will be requested. A copy of a current chest-x-ray report by a radiologist should also be submitted for review but is not enough by itself. The treatment plan must be documented regardless of declining or accepting treatment. Please bring any past documentation for review to the HUB and/or submit it with your Volunteer Application.

New positives will be followed up as per St. Mary's General Hospital Policy.

I hereby give permission for Tuberculosis skin testing/ screening for:

****Parent or legal guardian must be present for placement of Tb skin test****

Volunteer's Name: _____

Name of parent /legal Guardian (Print): _____

Signature of parent/legal guardian _____ Date ____/____/____

Any questions about this test, may be directed to HUB nursing personnel at 973-365-4379.

**BRING THIS FORM
TO YOUR DOCTOR**



ST. MARY'S

GENERAL HOSPITAL

350 Boulevard, Passaic, NJ 07055 • 973-365-4300 • www.smh-nj.org

Volunteer Department
HEALTH CERTIFICATE

Volunteer Applicant Name: _____ SS#: _____
(Last, First, MI)

Address: _____
(Street, City, State, Zip)

Telephone Number: (____) _____ DOB: ____/____/____

1. **Measles, Mumps, Rubella, and Varicella:** The CDC defines immunity to these viruses as one of the following: (1) Appropriate immunization*, (2) positive titer, diagnosed case of the illness. Given the above definition of immunity, please complete the following information for this individual.

VACCINE: Dates of each injection or exposure.

Measles:	Yes _____	No _____	Mumps:	Yes _____	No _____
Rubella:	Yes _____	No _____	Varicella:	Yes _____	No _____

*Measles, Mumps, and Rubella Vaccine (MMR): Two doses of live measles (or MMR) vaccine, at least one month apart, on or after his/her first birthday.
Varicella Vaccine: Individuals who receive the vaccine between 12 months and 12 years of age are required to only receive one dose of the vaccine. Individuals over the age of 13 should receive two doses of the vaccine 4 to 8 weeks apart. If unsure of immune status, please have titers done.

2. **Hepatitis B Vaccine:** If you have given this patient the Hepatitis B vaccine, please record the dates that it was given.

1st dose ____/____/____ 2nd dose ____/____/____ 3rd dose ____/____/____

3. **Tuberculosis Testing:** If you have ever placed a Mantoux Test (PPD) on this patient, please record the two most current test dates and results. If positive, please provide documentation of a chest x-ray.

Date: mo/date/yr	Amount	Result (mm)
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1. _____

2. _____

4. **Health Status:** To my knowledge this applicant:

a. Is free from contagious disease and capable of performing all volunteer assignments.

Yes _____ No _____

b. If no, please list what precautions need to be taken and if the volunteer has any restrictions in her or his activities: _____

5. Doctor's Name: _____ Doctor's signature: _____

6. Doctor's Address: _____

NOTIFICATION / AUTHORIZATION / RELEASE OF INFORMATION

NAME: _____ DATE: _____

~~PLEASE PRINT~~

In connection with my application for employment with **St. MARY'S HOSPITAL** (hereafter referred to as **COMPANY**), I hereby understand and acknowledge that the **COMPANY** utilizes the services of an investigative consumer reporting agency, **TABB INC.**, to verify the information I have provided on the employment application. I am hereby notified that the **COMPANY** intends to procure an investigative consumer report and I authorize the procurement of this investigative consumer report. I understand that the report will contain information about my background, character, general reputation, credit worthiness, mode of living and job performance. The investigative consumer report may consist of, but not be limited to, an interview with all listed employers to verify my employment, references, supervisors, criminal history, educational records, licensing agencies, governmental databases, address databases, credit history and driving history records. This authorization is valid during the course of my employment to the extent permitted by law. I certify that I have made true, correct, and complete answers and statements on my employment application, any supplements to it and in any interview in the knowledge that they will be relied upon in considering my application for employment. I understand that, upon written request within a reasonable period of time, I am entitled to a copy of the report and additional information concerning the nature and scope of this investigation. I understand that pursuant to the Fair Credit Report Act (FCRA), I have the right to know if adverse action is being considered against me as a result of information contained in this report. I have the right to a copy of this report prior to any adverse action taken against me and to dispute the accuracy of any information in the report by contacting the consumer reporting agency, **TABB, INC.**, at the address and telephone number listed on the bottom of this form. The **COMPANY** has provided a copy of A Summary of Your Rights Under the FCRA. I understand that I may have additional rights under State law which I may determine by contacting my state or local consumer protection agency. I hereby release the **COMPANY** and **TABB, INC.**, their officers, agents, employees, and servants from any liability arising from the preparation of this report or investigations relating thereto. I understand that any offer of employment from the above named **COMPANY** will be contingent upon the results of a number of factors including this background investigation.

This authorization for release of information includes, but is not limited to, matters of opinion relating to my character, ability, reputation and past performance. I authorize all persons, schools, organizations, companies, corporations, credit bureaus, law enforcement agencies, state agencies and courts for the purpose of criminal record research and motor vehicle agencies for the acquisition of a driving record or abstract if required to release such information without restriction or qualification to **TABB, INC.**, and any of its officers, agents, employees and servants. I voluntarily waive all recourse and release any sources of information including individuals, companies, organizations, researchers, government agencies and firms, including the above named **COMPANY** and **TABB INC.**, from liability for complying with this authorization. I hereby hold the **COMPANY** and **TABB INC.** harmless and agree to indemnify them from and against all third party claims, losses, lawsuits, settlements, demands, causes, judgments, expenses and costs including reasonable attorney fees arising under or in connection with this agreement to the extent that such costs and liabilities are proximately caused by the gross negligence or willful misconduct of **COMPANY** or **TABB INC.**

SIGNATURE: _____ OTHER NAME(S) USED: _____

SOCIAL SECURITY NO.: _____ DATE BIRTH: _____

TABB INC.
P.O. Box 10; 555 E. Main St., Chester, NJ 07930
Phone (908) 879-2323 (800) 877-8222 Fax (908) 879-8675

Social Security Administration
Authorization for the Social Security Administration (SSA)
To Release
Social Security Number (SSN) Verification

Printed Name _____ Date of Birth _____ SSN _____ - ____ - ____

I am conducting the following business transaction:

EMPLOYMENT APPLICATION

with the following company (“the Company”):

Company Name:

Address:

I authorize the Social Security Administration to verify my name and SSN to the Company and/or the Company’s Agent, if applicable, for the purpose I identified.

The name and address of the Company’s Agent is:

TABB INC. 555 E. Main St., Chester, NJ 07930

I am the individual to whom the Social Security number was issued or that person’s legal guardian. I declare and affirm under the penalty of perjury that the information contained herein is true and correct. I acknowledge that if I make any representation that I know is false to obtain information from Social Security records, I could be found guilty of a misdemeanor and fined up to \$5,000.

This consent is valid only for 90 days from the date signed, unless indicated otherwise by the individual named above. If you wish to change this timeframe, fill in the following:

This consent is valid for _____ days from the date signed. _____ (Please initial.)

Signature _____ Date Signed _____

Contact information of individual signing authorization:

Address _____

City/State/Zip _____

Phone Number _____

A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness and privacy of information in the files consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.ftc.gov/credit or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment-or to take another adverse action against you-must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer-reporting agency (your “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
 - A person has taken adverse action against you because of information in your credit report;
 - You are the victim of identity theft and place a fraud alert in your file;
 - Your file contains inaccurate information as a result of fraud;
 - You are on public assistance;
 - You are unemployed but expect to apply for employment within 60 days.

In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.ftc.gov/credit for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create score or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.
- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer-reporting agency, the agency must investigate unless your dispute is frivolous. See www.ftc.gov/credit for an explanation of dispute procedures.
- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete, or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

- **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer-reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.
- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need—usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer-reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.ftc.gov/credit.
- **You may limit “prescreened” offers of credit and insurance you get based on information in your credit report.** Unsolicited “prescreened” offers for credit and insurance must include a toll-free number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt out with the nationwide credit bureaus at 1-800-XXX-XXXX.
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.ftc.gov/credit.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:

TYPE OF BUSINESS:	CONTACT:
Consumer reporting agencies, creditors and others not listed below	Federal Trade Commission Consumer Response Center-FCRA Washington, DC 20580 1-877-382-4357
National banks, federal branches/agencies of foreign banks (word “National” or initials “N.A.” appear in or after bank’s name)	Office of the Comptroller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219 (800) 613-6743
Federal Reserve System member banks (except national banks and federal branches/agencies of foreign banks)	Federal Reserve Board Div. of Consumer & Community Affairs Washington, DC 20551 (202) 452-3693
Savings associations and federally chartered savings banks, (word “Federal” or initials “F.S.B.” appear in federal institution’s name)	Office of Thrift Supervision Consumer Complaints Washington, DC 20552 (800) 842-6929
Federal credit unions (words “Federal Credit Union” appear in institution’s name)	National Credit Union Administration 1775 Duke St. Alexandria, VA 22314 (703) 518-6360
State chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Division of Compliance & Consumer Affairs Washington, DC 20429 (800) 934-FDIC
Air, surface or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	Department of Transportation Office of Finance Management Washington, DC 20590 (202) 366-1306
Activities subject to the Packers and Stockyards Act, 1921	Department of Agriculture Office of Deputy Administrator-GIPSA Washington, DC 20250 (202) 720-7051



350 Boulevard, Passaic, NJ 07055 • 973-365-4300 • www.smh-nj.org

Employee Health Services
Volunteer: Tuberculosis, Measles, Rubella, Varicella and Hepatitis B Screening

Dear Applicant,

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**** Parent or legal guardian of minors must be present for placement of TB skin test ****

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Allergy to eggs or taking large doses of Prednisone must be reported to the HUB.

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New positives will be followed up as per St. Mary's General Hospital Policy.

I hereby give permission for Tuberculosis skin testing/ screening for:

****Parent or legal guardian must be present for placement of Tb skin test****

Volunteer's Name: _____

Name of parent /legal Guardian (Print): _____

Signature of parent/legal guardian _____ Date ____/____/____

Any questions about this test, may be directed to HUB nursing personnel at 973-365-4379.

**BRING THIS FORM
TO YOUR DOCTOR**



ST. MARY'S

GENERAL HOSPITAL

350 Boulevard, Passaic, NJ 07055 • 973-365-4300 • www.smh-nj.org

Volunteer Department
HEALTH CERTIFICATE

Volunteer Applicant Name: _____ SS#: _____
(Last, First, MI)

Address: _____
(Street, City, State, Zip)

Telephone Number: (____) _____ DOB: ____/____/____

1. **Measles, Mumps, Rubella, and Varicella:** The CDC defines immunity to these viruses as one of the following: (1) Appropriate immunization*, (2) positive titer, diagnosed case of the illness. Given the above definition of immunity, please complete the following information for this individual.

VACCINE: Dates of each injection or exposure.

Measles:	Yes _____	No _____	Mumps:	Yes _____	No _____
Rubella:	Yes _____	No _____	Varicella:	Yes _____	No _____

*Measles, Mumps, and Rubella Vaccine (MMR): Two doses of live measles (or MMR) vaccine, at least one month apart, on or after his/her first birthday.
Varicella Vaccine: Individuals who receive the vaccine between 12 months and 12 years of age are required to only receive one dose of the vaccine. Individuals over the age of 13 should receive two doses of the vaccine 4 to 8 weeks apart. If unsure of immune status, please have titers done.

2. **Hepatitis B Vaccine:** If you have given this patient the Hepatitis B vaccine, please record the dates that it was given.

1st dose ____/____/____ 2nd dose ____/____/____ 3rd dose ____/____/____

3. **Tuberculosis Testing:** If you have ever placed a Mantoux Test (PPD) on this patient, please record the two most current test dates and results. If positive, please provide documentation of a chest x-ray.

Date: mo/date/yr	Amount	Result (mm)
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1. _____

2. _____

4. **Health Status:** To my knowledge this applicant:

a. Is free from contagious disease and capable of performing all volunteer assignments.

Yes _____ No _____

b. If no, please list what precautions need to be taken and if the volunteer has any restrictions in her or his activities: _____

5. Doctor's Name: _____ Doctor's signature: _____

6. Doctor's Address: _____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

DATE: _____ NAME OF PATIENT: _____

DATE OF BIRTH: _____

I hereby authorize **MY DOCTOR** to release protected health information of the above-named patient to:

**VOLUNTEER SERVICES
ST. MARY'S GENERAL HOSPITAL
350 BOULEVARD
PASSAIC, NJ 07055**

The purpose of such release is _____

The type and amount of information requested is as follows:

- Discharge Summary from (date) _____ to (date) _____
- H&P from (date) _____ to (date) _____
- Consultation Record from (date) _____ to (date) _____
- Lab Reports from (date) _____ to (date) _____
- Radiology Reports from (date) _____ to (date) _____
- Abstract from (date) _____ to (date) _____
- Entire Record from (date) _____ to (date) _____
- Other _____

I understand that Federal law protects the confidentiality of health information contained in alcohol/drug abuse related patient records; these regulations (42 CFR, Part 2) prohibits the further disclosure of health information without the specific written consent of the patient or as otherwise permitted by such regulations. A general authorization for; the release of information ("any and all") is NOT sufficient for this purpose.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ Date

If I fail to specify an expiration date, event or condition, this authorization will expire within 6 months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization I need not sign this form in order to assure treatment or payment I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may be protected by federal confidentiality rules.

Signature of Patient or Authorized Representative

Date

If Signed by Representative, Relationship to Patient
7910-05B IH Rev. 9/11

Signature of Witness

IF UNDER 18 PARENT MUST SIGN

NOTIFICATION / AUTHORIZATION / RELEASE OF INFORMATION

NAME: _____ DATE: _____

~~PLEASE PRINT~~

In connection with my application for employment with **St. MARY'S HOSPITAL** (hereafter referred to as **COMPANY**), I hereby understand and acknowledge that the **COMPANY** utilizes the services of an investigative consumer reporting agency, **TABB INC.**, to verify the information I have provided on the employment application. I am hereby notified that the **COMPANY** intends to procure an investigative consumer report and I authorize the procurement of this investigative consumer report. I understand that the report will contain information about my background, character, general reputation, credit worthiness, mode of living and job performance. The investigative consumer report may consist of, but not be limited to, an interview with all listed employers to verify my employment, references, supervisors, criminal history, educational records, licensing agencies, governmental databases, address databases, credit history and driving history records. This authorization is valid during the course of my employment to the extent permitted by law. I certify that I have made true, correct, and complete answers and statements on my employment application, any supplements to it and in any interview in the knowledge that they will be relied upon in considering my application for employment. I understand that, upon written request within a reasonable period of time, I am entitled to a copy of the report and additional information concerning the nature and scope of this investigation. I understand that pursuant to the Fair Credit Report Act (FCRA), I have the right to know if adverse action is being considered against me as a result of information contained in this report. I have the right to a copy of this report prior to any adverse action taken against me and to dispute the accuracy of any information in the report by contacting the consumer reporting agency, **TABB, INC.**, at the address and telephone number listed on the bottom of this form. The **COMPANY** has provided a copy of A Summary of Your Rights Under the FCRA. I understand that I may have additional rights under State law which I may determine by contacting my state or local consumer protection agency. I hereby release the **COMPANY** and **TABB, INC.**, their officers, agents, employees, and servants from any liability arising from the preparation of this report or investigations relating thereto. I understand that any offer of employment from the above named **COMPANY** will be contingent upon the results of a number of factors including this background investigation.

This authorization for release of information includes, but is not limited to, matters of opinion relating to my character, ability, reputation and past performance. I authorize all persons, schools, organizations, companies, corporations, credit bureaus, law enforcement agencies, state agencies and courts for the purpose of criminal record research and motor vehicle agencies for the acquisition of a driving record or abstract if required to release such information without restriction or qualification to **TABB, INC.**, and any of its officers, agents, employees and servants. I voluntarily waive all recourse and release any sources of information including individuals, companies, organizations, researchers, government agencies and firms, including the above named **COMPANY** and **TABB INC.**, from liability for complying with this authorization. I hereby hold the **COMPANY** and **TABB INC.** harmless and agree to indemnify them from and against all third party claims, losses, lawsuits, settlements, demands, causes, judgments, expenses and costs including reasonable attorney fees arising under or in connection with this agreement to the extent that such costs and liabilities are proximately caused by the gross negligence or willful misconduct of **COMPANY** or **TABB INC.**

SIGNATURE: _____ OTHER NAME(S) USED: _____

SOCIAL SECURITY NO.: _____ DATE BIRTH: _____

TABB INC.
P.O. Box 10; 555 E. Main St., Chester, NJ 07930
Phone (908) 879-2323 (800) 877-8222 Fax (908) 879-8675

Social Security Administration
Authorization for the Social Security Administration (SSA)
To Release
Social Security Number (SSN) Verification

Printed Name _____ Date of Birth _____ SSN _____ - -

I am conducting the following business transaction:

EMPLOYMENT APPLICATION

with the following company (“the Company”):

Company Name:

Address:

I authorize the Social Security Administration to verify my name and SSN to the Company and/or the Company’s Agent, if applicable, for the purpose I identified.

The name and address of the Company’s Agent is:

TABB INC. 555 E. Main St., Chester, NJ 07930

I am the individual to whom the Social Security number was issued or that person’s legal guardian. I declare and affirm under the penalty of perjury that the information contained herein is true and correct. I acknowledge that if I make any representation that I know is false to obtain information from Social Security records, I could be found guilty of a misdemeanor and fined up to \$5,000.

This consent is valid only for 90 days from the date signed, unless indicated otherwise by the individual named above. If you wish to change this timeframe, fill in the following:

This consent is valid for _____ days from the date signed. _____ (Please initial.)

Signature _____ Date Signed _____

Contact information of individual signing authorization:

Address _____

City/State/Zip _____

Phone Number _____

A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT

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- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment-or to take another adverse action against you-must tell you, and must give you the name, address, and phone number of the agency that provided the information.
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 - A person has taken adverse action against you because of information in your credit report;
 - You are the victim of identity theft and place a fraud alert in your file;
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- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need—usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer-reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.ftc.gov/credit.
- **You may limit “prescreened” offers of credit and insurance you get based on information in your credit report.** Unsolicited “prescreened” offers for credit and insurance must include a toll-free number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt out with the nationwide credit bureaus at 1-800-XXX-XXXX.
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.ftc.gov/credit.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:

TYPE OF BUSINESS:	CONTACT:
Consumer reporting agencies, creditors and others not listed below	Federal Trade Commission Consumer Response Center-FCRA Washington, DC 20580 1-877-382-4357
National banks, federal branches/agencies of foreign banks (word “National” or initials “N.A.” appear in or after bank’s name)	Office of the Comptroller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219 (800) 613-6743
Federal Reserve System member banks (except national banks and federal branches/agencies of foreign banks)	Federal Reserve Board Div. of Consumer & Community Affairs Washington, DC 20551 (202) 452-3693
Savings associations and federally chartered savings banks, (word “Federal” or initials “F.S.B.” appear in federal institution’s name)	Office of Thrift Supervision Consumer Complaints Washington, DC 20552 (800) 842-6929
Federal credit unions (words “Federal Credit Union” appear in institution’s name)	National Credit Union Administration 1775 Duke St. Alexandria, VA 22314 (703) 518-6360
State chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Division of Compliance & Consumer Affairs Washington, DC 20429 (800) 934-FDIC
Air, surface or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	Department of Transportation Office of Finance Management Washington, DC 20590 (202) 366-1306
Activities subject to the Packers and Stockyards Act, 1921	Department of Agriculture Office of Deputy Administrator-GIPSA Washington, DC 20250 (202) 720-7051