RELEASE FOR CRIMINAL BACKGROUND CHECK

Due to the nature of the practice of anesthesia – including continuous responsibility for the lives and well-being of patients and having continual access to scheduled substances – individuals with criminal records generally are not suitable candidates for participating in the Master of Science Program in Anesthesiology, University of Colorado School of Medicine. In so far as students are present and participate in the clinical practice of anesthesia, University of Colorado will perform a criminal background check on each applicant to the Master of Science in Anesthesiology Program. Applicants must complete and submit a release form with their application document. Results from the background check will be used in evaluating the applicant's eligibility for admission.

APPLICANT

- Enter your background check password and full name on the lines below.
- When you print out this application document, have your signature notarized.
- Return the notarized copy with the printed application document.

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Enter your ePass number (When you receive your completed background check) from www.castlebranch.com here:_________________________

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University of Colorado
Consent to Release of Personal Records and History

I, _____________________________ (ENTER FULL NAME), hereby give permission to University of Colorado through http://www.castlebranch.com and its employees and agents to perform a criminal background check in accordance with the laws of Colorado, which background check is required by University of Colorado as a condition of participation in University of Colorado's clinical education programs. Further, I give permission to http://www.castlebranch.com to share the information gained from said background check with University of Colorado's Master of Science Program in the Department of Anesthesiology for use by that Program in evaluating eligibility for admission and participation, and to provide to any of its clinical education sites for the purpose of fulfilling participation requirements with said clinical education sites.

______________________________ ________________

SIGNATURE DATE

________________________________ _________________ __________________

IN WITNESS HEREOF DATE NOTARY SEAL

State of ________________________, County of ________________________________