

**CERTIFICATION AND AUTHORIZATION  
FOR VOLUNTEERS**

(Please read the following paragraph carefully before signing)

I certify that the information that I have provided is true and correct to the best of my knowledge and belief. I authorize Community Health Systems (the "Company") to investigate my employment and personal history, including an inquiry concerning information on my criminal, credit and driving history, if appropriate. In connection with this investigation, I authorize all corporations, companies, credit agencies, educational institutions, persons, law enforcement agencies and former employees to release information they may have about me and release them from any liability or responsibility from doing so. This authorization, in original or copy form, shall be valid for this and any future investigation conducted by the Company. I am aware that if I am denied employment based on a report by a consumer-reporting agency, the Company will furnish the name and address of such agency upon my written request.

\_\_\_\_\_

Date

\_\_\_\_\_

Print legal first, middle and last name

\_\_\_\_\_

Social Security Number

\_\_\_\_\_

DOB

\_\_\_\_\_

Driver's License # & State Issued

\_\_\_\_\_

Street Address

\_\_\_\_\_

City, State, Zip