



Central Care Mission Mentor Application

First Name: _____

Middle Name: _____

Last Name: _____

Phone Number: _____

Age: _____ *Date of Birth:* _____

How did you learn about your Mentorship Program?

Friend Speaking Engagement Former Client CCM Graduate

Are you willing to commit to attending 6 Mentor meetings per year? (Meetings are held once monthly, 10x per year) Yes Not sure yet I'm unable

Central Care Mission staff and clients are required to complete a background check for the health and wellbeing of our community. Are you willing to complete a background check to comply with our standards? Yes Not at this time

Are you willing to following the Central Care Mission Mentor Guidelines as provided and outlined in this video?

Consent to Background Check

In connection with your program participation and/or volunteer with Central Care Mission of Orlando, Inc., notice is hereby given that a consumer report and/or investigative consumer report may be obtained from a consumer reporting agency for program participation or employment purposes. These reports may contain information about your character, general reputation, personal characteristics and mode of living, whichever are applicable. They may involve personal interviews with sources such as your neighbors, friends, or associates. The reports may also contain information about you relating to your criminal history, credit history, driving and/or motor vehicle records, education or employment history, or other background checks.

You have the right, upon written request made within a reasonable time after the receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report prepared by contacting Central Care Mission and Protect My Ministry (14499 N. Dale Mabry Hwy., Suite 201 South, Tampa, FL 33618; Phone: 1-800-321-5518). For information about Protect My Ministry's privacy practices, see www.protectmyministry.com. The scope of this notice and below authorization is not limited to the present and, if you are hired or granted residency, will continue throughout the course of your employment and boarding, allowing Central Care Mission to conduct future screenings for retention, promotion, or reassignment, as permitted by law and unless revoked by you in writing.

Acknowledgement and Authorization

By signing below, I hereby authorize the obtaining of consumer reports and/or investigative consumer reports by Central Care Mission at any time after receipt of this authorization and throughout the course of my employment and residency, if applicable.

Print Name: _____

Signature: _____

Last Four Digits of SSN: _____

Date: _____

Background Check Information

(required upon admittance to CCM)

First Name: _____

Middle Name: _____

Last Name: _____

Mother's Maiden Name: _____

Other Names Used: _____

Date of Birth: _____

Gender: Male / Female

Social Security Number: _____

White

Black/African American

Ethnicity (circle one): *Hispanic*

Asian/Pacific Islander

Alaskan Native/American Indian

Driver's License or I.D. #: _____

Date License was Issued: _____

Address: _____

City: _____

State/Zip: _____

E-Mail Address: _____