



EXHIBIT C
RELEASE STATEMENT CERTIFICATION

I hereby authorize HEALTHSOUTH and/or its agents to make an independent investigation of my background for the purpose of confirming information provided to the School and/or obtaining other information which may be material to my qualification for a clinical affiliation rotation, and to conduct pre-placement or other placement related inquiries (to the extent allowed by law). This investigation may access records maintained by both public and private organizations. Information requested may include, but is not limited to:

- Professional and personal references
Criminal and police records
Public records
Professional credentials
Education
Urine or blood tests to determine drug or alcohol use.

I authorize any individuals or entities contacted during this investigation to give you any and all pertinent information they may have, personal or otherwise, and release all parties from any and all liabilities, claims or law suits in regard to the information obtained.

I understand that the complete and final results of HEALTHSOUTH's investigation of my background may not be available to HEALTHSOUTH before employment, if any, with the Company commences. I also understand that the results of HEALTHSOUTH's investigation into my background may affect my employability, continuing employability or participation in a clinical rotation.

The following is my true and complete legal name and all information is true and correct to the best of my knowledge.

Signed: _____ Date: _____
(Applicant)

PLEASE PRINT THE FOLLOWING INFORMATION. FILL IN ALL BLANKS COMPLETELY:

Last Name: _____ First Name: _____ Middle Name: _____

Other names you have used in the past 5 years. (Maiden name, nickname, alias, etc.): _____

Present Address: _____

Previous: _____

Provide the following information on places you have worked or lived during the past five years:

City State From: Month/Year To: Month/Year City State From: Month/Year To: Month/Year

City State From: Month/Year To: Month/Year City State From: Month/Year To: Month/Year

Driver's License #: _____ State of License: _____ * Date of Birth: _____

Social Security Number: _____

* Date of birth is used only for purposes of record identification when requesting the above mentioned reports.

FOR FACILITY USE ONLY

The following information must be completed by the facility in order to process this request. Please PRINT clearly

Facility Name: _____ Phone Number: _____
Facility Number: _____ Secured Fax Number: _____
Requested By: _____ E-mail address: _____
Job Title: _____
(Must be Supervisor or above)

Please indicate the type of background check requested:

- Criminal Result: _____ Date: _____ Source: _____
Drug/Alcohol Screen Result: _____ Date: _____ Source: _____
Cornerstone Search date verified: _____ Result: _____ Date: _____

Fax form to: 205-802-7896 To obtain results call: 1-800-417-4669 or check your e-mail address.