

Department of Behavioral Health and Developmental Services

**REQUEST FOR CRIMINAL RECORDS INVESTIGATIONS FOR
EMPLOYEES AFFILIATED WITH DBHDS' LICENSED PROVIDERS**

To be completed by the Provider only.

| APPLICANT DATA (Please print or type) | | | | |
|---|--------------------------------|--|------------------------------------|------------------------|
| 1. (a) Last Name | | (b) First Name | | (c) Middle Name |
| | | | | |
| (d) All other names currently or previously used (Maiden, Former Married, Religious, etc.) | | | | |
| | | | | |
| 2. Social Security Number | | 3. Date of Birth (month, day & year) | | 4. Gender |
| | | | | |
| 5. Race* | 6. Height (ft & in) | 7. Weight (lbs) | 8. Eye Color* | 9. Hair Color* |
| | | | | |
| 10. Place of Birth (State or Country) | | | | |
| | | | | |
| 11. Application Date for Employment | | | 12. Hire Date/Transfer Date | |
| | | | | |
| 13. Applicant Status (check one) | | <input type="checkbox"/> Owner <input type="checkbox"/> New Hire <input type="checkbox"/> Transfer <input type="checkbox"/> Foster Parent/Residency | | |
| 14. Applicant hired only for compensated employment at | | <input type="checkbox"/> Adult Substance Abuse Treatment Facility (ASATF) <input type="checkbox"/> Adult Mental Health Treatment Facility (AMHTF) | | |
| *Use Race, Eye and Hair Color codes on Attachment 7 ~ Enter same on fingerprint card | | | | |
| PROVIDER DATA (Please print or type) | | | | |
| 1. Licensed Provider Name and Address | | | | |
| | | | | |
| 2. Provider Number (3 or 4 digit) | | | | |
| 3. Date of Request | | | 4. Contact Person | |
| | | | | |
| 5. Phone Number | | | 6. Email Address | |
| | | | | |

Original – DBHDS' BIU

Copy – Licensed Provider