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)	☐ Owner ☐ New Hire ☐ Transfer ☐ Original Employee
14. Applicant hired only for compensated employment at	☐ Adult Substance Abuse Treatment Facility (ASATF) ☐ Adult Mental Health Treatment Facility (AMHTF) ☐ Not Applicable

***Use Race, Eye and Hair Color codes on Attachment 7 ~ Enter same on fingerprint card**

PROVIDER DATA
(Please print or type)

1. Licensed Provider Business 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**