

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"/> Original Employee														
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) <input type="checkbox"/> 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