



## Care Provider Background Screening Clearinghouse Background Screening Request Form



You have applied for a position with a health care and/or service provider regulated by a specified agency in the Care Provider Background Screening Clearinghouse (Clearinghouse) that requires a fingerprint-based background check. As a health care and/or service provider regulated by a specified agency in the Clearinghouse we may conduct a search for an existing background screening result or submit a new background screening request through the Clearinghouse results website on your behalf.

In order to complete the search and/or background screening request we must collect the following information. This information is required by the Clearinghouse, the Florida Department of Law Enforcement, and the Federal Bureau of Investigation.

Please provide the following information:

### Applicant Information

\*First Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_

\*Last Name: \_\_\_\_\_

Aliases: \_\_\_\_\_

\*SSN: \_\_\_\_\_

\*Date of Birth: \_\_\_\_\_

\*Place of Birth: \_\_\_\_\_

### Demographics

\*Sex: \_\_\_\_\_

\*Race: \_\_\_\_\_

\*Hair Color: \_\_\_\_\_

\*Eye Color: \_\_\_\_\_

\*Height: \_\_\_\_\_

\*Weight: \_\_\_\_\_

### Contact Information

\*Address Line 1: \_\_\_\_\_

Address Line 2: \_\_\_\_\_

\*City: \_\_\_\_\_

\*State: \_\_\_\_\_

\*Zip: \_\_\_\_\_

County \_\_\_\_\_

Prior States: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_

\*Denotes Required Fields