UTAH DEPARTMENT OF HEALTH

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UTAH DEPARTMENT OF HEALTH
DIVISION OF FAMILY HEALTH AND PREPAREDNESS
BUREAU OF HEALTH FACILITY LICENSING AND CERTIFICATION

PO BOX 144103
SALT LAKE CITY, UT 84114-4103
(801) 538-6158
(800) 662-4157 toll free
(801) 538-6163 Fax

INDIVIDUAL CLEARANCE FOR DIRECT PATIENTACCESS APPLICATION

(All fields must be complete or form will be returned)

Print Form

APPLICANT INFORMATION (Information must be completed by the applicant - Print legibly in black ink or type)

LAST NAME | FIRST NAME | MIDDLE NAME | DATE OF BIRTH | ☐ Male ☐ Female GENDER

MAIDEN NAME & ALL PREVIOUS MARRIED NAMES/ALIAS | SOCIAL SECURITY NUMBER | DRIVERS LICENSE NUMBER | STATE

CURRENT ADDRESS

CITY | STATE | ZIP CODE | HOME PHONE NUMBER | HIRE DATE

PREVIOUS ADDRESS INFORMATION

CITY AND STATE | MM/YYYY | MM/YYYY | CITY AND STATE | MM/YYYY | MM/YYYY

STAFF POSITION

☐ Executive, Administrative or Managerial ☐ Professional/Licensed Health Care ☐ Food and Dietary Services ☐ Volunteer

☐ Technical, Unlicensed Health Care ☐ Housekeeping and Engineer Services ☐ Laboratory and Radiology Services ☐ Other

POSITION DESCRIPTION

Have you ever been convicted of a felony or misdemeanor as a juvenile or adult? If yes, include a written explanation of the offense(s). ☐ Yes ☐ No

Are you currently awaiting trial on a pending felony or misdemeanor charge? Attach explanation of charge(s). ☐ Yes ☐ No

Have you ever been investigated for abuse or neglect of disabled or vulnerable individuals by the State of Utah? If yes, attach explanation. ☐ Yes ☐ No

I hereby authorize the Utah Department of Health (UDOH) to submit my direct patient access application to the Utah Bureau of Criminal Identification (BCI) for processing in accordance with Utah Code annotated Chapter 26 Title 21 Part 2. I authorize BCI to access and review state and federal criminal history records and provide that information to the UDOH to be used to make a clearance determination. I do herby release UDOH and BCI, all persons, organizations, or government agencies from any damages of, or resulting from, furnishing such information. I have been provided with a copy of this form. I have read and understand the foregoing and my certification is true and correct to the best of my knowledge and belief.

APPLICANT SIGNATURE | DATE

COVERED ENTITY/EMPLOYER INFORMATION

REQUEST TYPE ☐ INITIAL ☐ RENEWAL ☐ CHANGE OF OWNERSHIP

COVERED ENTITY NAME (AS LISTED ON LICENSE IF LICENSED) | LICENSE NUMBER | CHECK NUMBER

MAILING ADDRESS | CITY, STATE, ZIP CODE | BUSINESS TELEPHONE NUMBER

I understand the information received as a result of submission of this Application shall be used only for the purposes of employing the individual listed above.

ADMINISTRATOR/DESIGNEE (PRINT NAME) | SIGNATURE | DATE

****FOR DEPARTMENT OF HEALTH USE ONLY****

DATE RECEIVED	CHECK NUMBER	AMOUNT	DATE APPROVED	APPROVED FACILITY ID