UTAH DEPARTMENT OF HEALTH

Version: November 2010

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

Print Form

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

REQUEST FOR RENEWAL OF INDIVIDUAL BACKGROUND SCREENING APPLICATION

COVERED ENTITY/EMPLOYER INFORMATION

COVERED ENTITY NAME (AS LISTED ON LICENSE)	MAILING ADDRESS	CITY, STATE, ZIP CODE	BUSINESS TELEPHONE NUMBER

I certify this request is made pursuant to UCA 26-21-9.5, for employment with health care facilities, and that all information provided on this form is true and accurate. I understand that further dissemination or other use of any criminal history information is prohibited by law. I further certify that Disclosure Statements have been signed by all applicants and are on file with the facility. I understand that the signed statements must be furnished upon request for verification. Only include individuals that have been previously cleared through the Individual Background Screening Application.

ADMINISTRATOR/DESIGNEE (PRINT NAME)	SIGNATURE	DATE	STATE HEALTH FACILITY LICENSE NUMBER

Include additional pages as necesary Page ____ of ____

APPLICANT INFORMATION

SEX	LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DRIVERS LICENSE NUMBER	PRIOR CLEARANCE DATE	**STATE USE ONLY**

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

DATE RECEIVED	FEES PAID	CHECK NUMBER	APS APPROVED	CPS APPROVED	CBS ADULT APPROVED	CBS JUVENILE APPROVED	COMPLETED BY	APPROVED FACILITY ID