REQUEST FOR RENEWAL OF INDIVIDUAL BACKGROUND SCREENING APPLICATION

Print Form

ADDITIONAL FORM PAGES

Include additional pages as necessary. Page ____ of ____

COVERED ENTITY/EMPLOYER INFORMATION

COVERED ENTITY NAME (AS LISTED ON LICENSE)

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

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