REQUEST FOR RENEWAL OF CBS/MIS CRIMINAL HISTORY INFORMATION

FOR HEALTH FACILITY EMPLOYMENT PURPOSES

DEPARTMENT OF HEALTH – HEALTH FACILITY LICENSING, CERTIFICATION AND RESIDENT ASSESSMENT

PO BOX 144103 - Salt Lake City, UT 84114-4103

REQUESTING FACILITY **(MARK ONE)** **ADULTS ONLY FACILITY 9 ADULTS & CHILDREN 9**

Facility Name _____ Mailing Address _____ City/State/Zip Code _____

Requestor=s Name _____ Title _____ Area Code & Phone 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 this facility. I understand that signed statements must be furnished upon request for verification.

2. APPLICANT NAMES

PRINT OR TYPE

Sex M/F	Last Name	First	Middle	Date of Birth	Social Security #	Drivers License #

*****FOR DEPARTMENT USE ONLY -USE ADDITIONAL SHEETS AS NEEDED*****

DATE RECEIVED	MIS APPROVAL STAMP	CBS APPROVAL STAMP