UTAH DEPARTMENT OF HEALTH

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

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

INDIVIDUAL BACKGROUND SCREENING APPLICATION

Version: July 2010

(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 | STAFF POSITION

Have you been in Utah continuously for the last five years? ☐ Yes ☐ No **If no**, complete a fingerprint card, obtained from your employer, to submit for processing of an FBI National Criminal Information Clearance.

Also, list all addresses where you have lived and for how long: (attach additional sheets if necessary). **Include fingerprint card and applicable fee with this application.**

ADDRESS	CITY AND STATE	FROM	TO

Have you ever been convicted of any 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 any pending felony of misdemeanor charges? Attach explanation of charges. ☐ 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 to process this criminal history check pertinent to my application in accordance with Utah Code Annotated 26-21-9.5. The release of any and all information is authorized whether the same is of record or not. I do hereby release all persons, firms, agencies, companies, group, or institutions, whomsoever, from any damages of, or resulting from, furnishing such information to the Department of Health, I SWEAR THE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

APPLICANT SIGNATURE | DATE

COVERED ENTITY/EMPLOYER INFORMATION (Print legibly in black ink or type}

☐ **Application Fee** ☐ **Fingerprint Fee** **Amount Paid:** **Check Number:**

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

MAILING ADDRESS | CITY, STATE, ZIP CODE

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	FEES PAID	CBS ADULT APPROVED	APS APPROVED	FBI COMPLETED
	CHECK NUMBER	CBS JUVENILE APPROVED	CPS APPROVED	APPROVED FACILITY ID