



Information Needed for Background Screening

OCA Number 04162263Z

ORI Number-DCF General

EDCFGN10Z

Name (First, Middle, & Last Name) _____

Alias(es) _____

SS # _____

Birthdate _____

Place of Birth _____

Sex _____

Race _____

Eye Color _____

Hair Color _____

Height _____

Weight _____

Address _____

City / Zip _____

County _____

Any other states you've lived in the past 5 years _____

Email _____ Phone _____

Please be sure to sign the privacy policy acknowledgement on the back of this paper as well.



PRIVACY POLICY ACKNOWLEDGEMENT FORM

I acknowledge that I have received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, which describe the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

I understand and agree that I will read and comply with the guidelines contained in the privacy policies.

Employee / Contractor Name (Printed)

Employee / Contractor Signature

Date