


<p><b>NYS Department of Health</b></p> <div style="text-align: center;">  </div> <p style="text-align: center;">CHRC Unit P. O. Box 2607 Albany, NY 12220-0607 Phone: 518.402.5549 Fax: 518.474.7477 <a href="http://www.nyhealth.gov/chrc">www.nyhealth.gov/chrc</a> <a href="mailto:chrc@health.state.ny.us">chrc@health.state.ny.us</a></p>	<p><b>REQUEST FOR CRIMINAL HISTORY RECORD CHECK PAGE 1 INSTRUCTIONS</b></p> <p><b>CRIMINAL HISTORY RECORD CHECK (CHRC) PROGRAM</b></p>	<p style="text-align: right;"><i>For Department use only Leave blank</i></p>
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**This form is to be used to request a criminal history record check (CHRC) for a subject individual from the DOH CHRC Unit.**

For purposes of this form, the term **"Agency"** means residential health care facility, certified home health agency, licensed home care services agency or long term home health care programs that are authorized by law to request a check of criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

**"Authorized Person"** is the individual that is allowed to request, on behalf of the Agency, fingerprints and criminal history record checks.

**"Subject individual"** is an "employee" as defined by Public Health Law Section 2899(3).

**INSTRUCTIONS:**

1. This form is to be completed by the Authorized Person, who will sign and date where indicated in Section 3.
2. Please obtain subject individual information and complete all sections on page 2 of this form prior to or at the time of fingerprinting. This information will be used to conduct both a Federal and State criminal history record check pursuant to State law.
3. If subject individual is employed by a staffing organization with an Agency work location, the Agency is responsible for completing this form and the staffing agency may complete Section 4 if that staffing agency fingerprints the subject individual.
4. Subject individual is required to present two (2) forms of identification (ID) when fingerprinted. One must be a government-issued ID with subject individual's signature. At least one of the two forms of ID must contain a current photograph. Acceptable forms of government-issued IDs are: valid driver's license or Department of Motor Vehicles (DMV) ID, valid passport, valid military identification or valid school identification document. The type of government-issued ID presented is recorded in Section 2 of this form. Refer to the Employment Eligibility Verification Form I-9 for examples of other forms of identification. The second ID must be produced but not recorded in Section 2 of this form.
5. If subject applicant is fingerprinted by other than the Authorized Person, provide this instructional page to that individual for assistance in completing Section 4 of this form.
6. Authorized Person is to ensure that all fields in all sections must be completed for accurate and timely submissions.
7. Authorized Person will forward Page 2 of this Form to the DOH CHRC Unit at the address indicated above.

**FIELD DESCRIPTIONS:**

<p><b><u>SEX FIELD</u></b> M – Male F – Female</p>	<p><b><u>RACE FIELD</u></b> A – Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan or any other Pacific Islander B – African black racial groups I – American Indian, Eskimo, or Alaskan native U – Of indeterminable race W – Caucasian, Mexican, Puerto Rican, Cuban, Central/South American or other Spanish origin</p>
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**BIRTH COUNTRY/PLACE FIELD**  
Enter **United States of America** for those of American birth  
Enter Country of Birth for those not of American birth

**HEIGHT FIELD**  
To be completed as a three (3) character value. If reported in feet and inches, the first (leftmost) digit is used to show feet with the two rightmost digits are used to show the inches between 00 and 11. If reported in inches, the leftmost character is "N" followed by two digits. If height is unknown, 000 is entered.

The allowable range is 400 to 711. Heights shorter than 4 ft. will be recorded as 400 and taller than 7 ft. 11 in. will be recorded as 711.

**WEIGHT FIELD**  
In this field, the subject applicant's weight in pounds is entered (000-499). If weight is unknown, 000 is entered.  
All weight in excess of 499 pounds will be recorded as 499 lbs.

<p><b><u>HAIR FIELD – COLOR CODES</u></b> BAL – Bald BLK – Black BLN – Blonde or Strawberry BLU – Blue BRO – Brown GRN – Green GRY – Gray or Partially Gray ONG – Orange PNK – Pink PLE – Purple RED – Red or Auburn SDY – Sandy WHI – White XXX – Unknown</p>	<p><b><u>EYE FIELD – COLOR CODES</u></b> BLK – Black BLU – Blue BRO – Brown GRY – Gray GRN – Green HAZ – Hazel MAR – Maroon MUL – Multicolored PNK – Pink XXX – Unknown</p>
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## DOH CHRC 103 (9/06) - Page 2

<b>NYS Department of Health</b>		<b>CRIMINAL HISTORY RECORD CHECK</b>	
Resubmission <input type="radio"/>	<b>Type or print all information - USE CAPITAL LETTERS.</b> <b>Inaccurate, incomplete or illegible information will delay processing.</b>		DOH use only. Leave blank
<b>SECTION 1 - SUBJECT INDIVIDUAL INFORMATION</b>			
Social Security Number* <input type="text"/> - <input type="text"/> - <input type="text"/>		Date of Birth mm/dd/yyyy <input type="text"/> / <input type="text"/> / <input type="text"/>	
LAST Name <input type="text"/>		FIRST Name <input type="text"/> M.I. <input type="text"/>	
Maiden Name <input type="text"/>		Alias (AKA) <input type="text"/>	
Street Nbr <input type="text"/>	Street Name <input type="text"/>		Apt # <input type="text"/>
City <input type="text"/>	St <input type="text"/>	Zip <input type="text"/>	Home Phone <input type="text"/> - <input type="text"/> - <input type="text"/>
Sex <input type="text"/>	Birth Country/Place <input type="text"/>	Cell Phone <input type="text"/> - <input type="text"/> - <input type="text"/>	
Race <input type="text"/>	Height (ft-inch) <input type="text"/> - <input type="text"/>	Weight (lbs) <input type="text"/>	Hair <input type="text"/> Eyes <input type="text"/>
<b>SECTION 2 - SUBJECT INDIVIDUAL IDENTIFICATION</b>			
Please Select the Type of <b>PICTURE IDENTIFICATION</b> (select one):			
<input type="radio"/> Drivers License/DMV ID <input type="radio"/> Passport <input type="radio"/> Military <input type="radio"/> School <input type="radio"/> Other Identify: <input type="text"/>			
Issuing State/Country/Armed Force/School: <input type="text"/>		ID Number <input type="text"/>	ID Expire Date mm/dd/yy <input type="text"/> / <input type="text"/> / <input type="text"/>
<b>SECTION 3 - AGENCY IDENTIFICATION</b>			
<input type="radio"/> Nursing Home <input type="radio"/> CHHA <input type="radio"/> LTHHCP            PFI# <input type="text"/> <input type="radio"/> LHCSA LICENSE # <input type="text"/>			
Full name of Agency where applicant will be working <input type="text"/>		Telephone number with area code <input type="text"/> - <input type="text"/> - <input type="text"/>	
Authorized Person LAST Name <input type="text"/>		FIRST Name <input type="text"/>	
Agency's Street Nbr <input type="text"/>		Street Name <input type="text"/>	
City <input type="text"/>		State <input type="text"/>	Zip <input type="text"/>
Authorized Party's e-mail: <input type="text"/>			
The subject individual, whose identification I have confirmed, will provide direct care or supervision to individuals receiving care and/or services and is a subject individual concerning whom a criminal history record check is required by law (Article 28-E of the Public Health Law and Section 845-B of the Executive Law). I understand that the results of the criminal history record check will be used solely for purposes authorized by law and I will abide by the confidentiality requirements set forth in law. Informed consent (DOH CHRC Form 102) has been given by the subject individual and is on file.			
Signature of Agency Authorized Person: <input type="text"/>		Date: <input type="text"/> / <input type="text"/> / <input type="text"/> MM DD YY	
<b>SECTION 4 - FINGERPRINTING METHOD/IDENTIFICATION</b>			
Fingerprint Method: <input type="radio"/> Ink & Roll <input type="radio"/> Live Scan	Name & Address of Location where fingerprint services were performed <input type="text"/> <input type="text"/> City <input type="text"/> State <input type="text"/> Zip <input type="text"/>		
Identification verified before fingerprinting: (refer to Instruction #4) <input type="radio"/> Yes <input type="radio"/> No	The subject individual, whose identification I have confirmed, appeared before me for fingerprinting. I secured his/her fingerprints via the method indicated. Signature: <input type="text"/>	First Name: <input type="text"/> Last Name: <input type="text"/> Title: <input type="text"/>	Date Fingerprinted <input type="text"/> / <input type="text"/> / <input type="text"/> MM DD YYYY

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\*The Authorized Person shall inform the subject individual that disclosure of the Social Security Number (SSN) is voluntary and not mandatory and that it will be used to assist DOH-CHRC Unit in performing criminal history record checks.

**NYS Department of Health**  
**ACKNOWLEDGEMENT AND CONSENT FORM FOR FINGERPRINTING AND DISCLOSURE OF CRIMINAL HISTORY RECORD INFORMATION**

**THIS FORM IS TO BE RETAINED BY THE AGENCY- DO NOT FORWARD TO THE DOH CHRC UNIT.**

[chrc@health.state.ny.us](mailto:chrc@health.state.ny.us)

**The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.**

**SECTION 1 – SUBJECT INDIVIDUAL INFORMATION**

LAST Name	FIRST Name	M.I.	
Date of Birth (mm/dd/yyyy)	Mother's Maiden Name	Alias: AKA	
Mailing Address (street)	City	State	Zip

**SECTION 2 - ATTESTATION**

1. I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).
2. I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.
3. I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary to be provided to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, as maintained by DCJS or the FBI, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. I have been advised that by law, DOH is authorized and may be required to provide the results of the criminal history record check through a criminal history record summary to the agency. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law.
4. I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.
5. I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI.
6. I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.
7. I certify to the best of my knowledge and belief that I (check as appropriate):
 

☐ **Have**    ☐ **Have not been convicted of a crime in New York State or any other jurisdiction**  
☐ **Do**      ☐ **Do not have a final finding of patient or resident abuse**

If you have checked either "Have" and/or "Do", please provide a brief explanation. (Optional)

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8. My current mailing or home address is indicated in Section 1 of this form.

9. I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the redisclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own (not applicable for Expedited Review submitted pursuant to CHRC Form 104).

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent or Legal Guardian \_\_\_\_\_ Date: \_\_\_\_\_  
 (if subject individual is under 18 years of age)

**SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION**

Agency Name:	PFI/Operating License Number:
Print Name of Authorized Person:	Title:
Signature of Authorized Person:	Date: