

AUTHORIZATION FOR BACKGROUND CHECK for Day Care

READ INSTRUCTIONS ON PAGE 2. PRINT ALL INFORMATION ON PAGE 1. SIGN PAGES 1, 3 AND 4

CHECK ONE BOX IN EACH COLUMN IN EITHER ROW A or B:			
	Category of Facility	Specific Type of Application	Person in the Home/Facility
1	A	Day Care in a Home <input checked="" type="checkbox"/> Day Care Home <input type="checkbox"/> Group Day Care Home	<input type="checkbox"/> Applicant <input type="checkbox"/> Member of Household (age 13 and over) <input checked="" type="checkbox"/> Employee/Volunteer (includes household member under age 18 who is also an employee/volunteer)
	B	Day Care/Child Care Facility (other than a home) <input type="checkbox"/> Day Care Center <input type="checkbox"/> Day Care Agency	<input type="checkbox"/> Applicant/Operator/Owner <input type="checkbox"/> Executive Director/Day Care Center Director <input type="checkbox"/> Employee/Volunteer

PERSONAL INFORMATION (Please see additional instructions on page 2)

Last Name/First Name/Middle Initial <u>Doe John A</u>		Social Security or ITIN Number <u>3 8 8 - 6 5 - 6 4 7 9</u>	
Maiden and/or Any Names Formerly Used (Last/First/Middle Initial) <u>Jones Michael B</u>		Have you lived outside of Illinois in the past 5 years? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
CURRENT ADDRESS, TELEPHONE (when applicable): Street/Apt.#: <u>543 North Street</u> City: <u>Chicago</u> State: <u>IL</u> Zip Code: <u>9 1 2 3 4</u> County: <u>Cook County</u> Home Telephone (<u>3 2 1</u>) <u>4 5 6 - 7 8 9 1</u> Cell Phone (<u>3 4 3</u>) <u>4 1 4 - 3 9 7 7</u>		List all complete addresses for the past five (5) years, including those outside of Illinois. (Street/Apt.#/City/State/Zip Code) <u>487 S. Elm Washington</u> <u>11/5/21-3/4/25</u> <u>New York 12345</u>	
Date of Birth (Month/Date/Year) <u>63-25-2004</u>	Age <u>21</u>	Place of Birth (City and State) <u>Seattle Washington</u>	Citizenship (Country) <input checked="" type="checkbox"/> USA <input type="checkbox"/> Other (Specify) _____
Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		Height Ft. In. <u>7 5</u>	Weight (lbs.) <u>150</u>
Race (Check all that apply) <input checked="" type="checkbox"/> Native American/Alaskan (Indian or Eskimo) Tribal Affiliation: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander	<input checked="" type="checkbox"/> Asian <input checked="" type="checkbox"/> White <input type="checkbox"/> Unknown
Ethnicity (see codes on Page 2) <u>HA</u>		Declined to Identify Could not be Verified	

AUTHORIZATION /CERTIFICATIONS BELOW AND ON PAGES 2 AND 3 MUST BE SIGNED AND DATED

3	Have you ever been indicated as a perpetrator in a child abuse/neglect investigation?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	Have you ever been convicted of a criminal offense, other than a minor traffic violation?		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	I certify that I have read and understood the Authorization/Certification box on the back page of this form.		
Signature <u>my Name</u>		Date <u>6/25/25</u>	
Parent/Guardian Signature (if applicable) <u>Parent Signature</u>		Date <u>6/25/25</u>	

TO BE COMPLETED BY SUPERVISING AGENCY	
This authorization will not be processed without completion of this section. The licensing representative must complete the following	
Date Fingerprinted: _____ Probationary Start Date (New Candidate/Probationary Employee): _____ Full Name of Provider: _____ Provider ID #: _____ Street Address: _____ City: _____ IL ZIP: _____	Supervising Agency Name: _____ Provider ID# _____ Or DCFS Region/Site/Field _____ Name of Worker _____ Worker ID#/Phone Number _____ Name of Supervisor _____ Supervisor ID#/Phone Number _____
5 BACKGROUND CHECK RESULTS-BACKGROUND CHECK UNIT USE ONLY Sex Offender Clearance: _____ CANTS Clearance: _____ Illinois State Police Clearance: _____ FBI Clearance: _____ Transfer Clearances: SO/CANTS: _____ ISP: _____	FOR CENTRAL OFFICE OF LICENSING USE ONLY SID# _____ Clear _____ Record _____ BC-03 Registered: _____ FBI Sent Out: _____

PRINT: Last Name/First Name/Middle Initial

Provider ID #

Doe John A

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