



Care Provider Background Screening Clearinghouse Background Screening Request Form

You have applied for a position with a health care and/or service provider regulated by a specified agency in the Care Provider Background Screening Clearinghouse (Clearinghouse) that requires a fingerprint-based background check. As a health care and/or service provider regulated by a specified agency in the Clearinghouse we may conduct a search for an existing background screening result or submit a new background screening request through the Clearinghouse results website on your behalf.

In order to complete the search and/or background screening request we must collect the following information. This information is required by the Clearinghouse, the Florida Department of Law Enforcement, and the Federal Bureau of Investigation.

Please provide the following information:

Applicant Information

*First Name: _____
Middle Name: _____
*Last Name: _____
Aliases: _____
*SSN: _____
*Date of Birth: _____
*Place of Birth: _____

Demographics

*Sex: _____
*Race: _____
*Hair Color: _____
*Eye Color: _____
*Height: _____
*Weight: _____

Contact Information

*Address Line 1: _____
Address Line 2: _____
*City: _____
*State: _____
*Zip: _____
County _____
Prior States: _____
Email: _____
Phone: _____

*Denotes Required Fields