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: *Vendor Company Name: _____

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

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