Agency Stamp

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BUREAU OF CHILD CARE

STAFF HEALTH FORM

Initial employment and every 2 years, a health examination is required for all teaching and non-teaching staff members, including volunteers and students who regularly associate with children. Attach any additional documentation to this form.

Date of Employment____/____/____ Date of Exam____/____/____

(Last)	(First)	(Middle)	SEX F M M M	DATE	DATE OF BIRTH ___/___/___
(No.)	(Street)	(City/Boro)	(State)	(Zip)	
TELEPHONE: AC ( )		JOB TITLE		AREA EMPLOYED	

PAST MEDICAL HISTORY
Please check YES or NO

YES	NO	
M	M	Hypertension
M	M	Heart Disease
M	M	Diabetes
M	M	Seizure Disorder
M	M	Chronic Lung Disease
M	M	Mental Illness
M	M	Alcohol Abuse
M	M	Substance Abuse
M	M	Physical Disabilities
M	M	Allergies
M	M	Hepatitis
M	M	OTHER (SPECIFY) __________

Please explain any positive findings, list and explain any chronic medications or therapies: __________

MEDICAL PROVIDER SECTION

PHYSICAL EXAM: *(Please note any conditions or findings considered abnormal or requiring medical follow-up)*

Height__________

Weight __________

Blood Pressure_____/_____

TOBACCO USE	M Current	M Former	M None
If current, referred for cessation services?	M Yes	M No	
Counselled re: No Smoking	M Yes	M No	

Staff Name ______________________ D.O.B.____/____/____

TUBERCULIN TESTING *(Not required for employment)*

TUBERCULIN SKIN TEST: PPD MANTOUX (5 TU)
OR
BLOOD TEST: QUANTEFERON GOLD

DATE TESTED: ______________________

DATE INTERPRETED: ______________________

RESULTS: ______________________

Staff exempt from testing if they
Had a positive reaction to a PPD/Mantoux test or history of TB.

DATE: ______________________

DATE: ______________________

History of BCG vaccine does not exempt a staff member from TB screening.
All positive tuberculin tests in persons whose previous PPD/Mantoux was negative, require a chest X-ray and evaluation if treatment is indicated.
All positive tuberculin tests (PPD Mantoux 10 mm or over) require a report of one chest X-ray, (H.C. 49.06).

CHEST X-RAY: DONE AT: ______________________

DATE: ____________ RESULTS: ______________________

TREATMENT: ______________________

IMMUNIZATION RECORD
Staff are required to have evidence of immunity to the diseases below through either documented vaccines, blood test documenting immunity, or provider-documented history of illness (except where shaded in grey). Records should be kept in the staff person's file.

Documentation of Immunity	Vaccine Name	Vaccine Date 1	Vaccine Date 2	Blood Test Documenting Immunity (Yes / No)	Provider-Documented History of Illness (Yes / No)
Tdap (Tetanus-diphtheria-acellular pertussis)					
Rubella					
Measles*					
Mumps*					
Varicella*					

*Two doses of vaccine are required at least 28 days apart

LABORATORY TESTS *(Optional) (Specifytests ordered)*	**DATE**	**RESULTS**

DIAGNOSIS/PROBLEM	**PLAN/FOLLOW-UP** *(For each diagnosis)*
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

On the basis of my findings as indicated above and my knowledge of the staff member, I find that the above person is fit to give adequate child care to children in a day care setting at this time.

Provider's Name *(Print)*______________________License No.____________Telephone No.

(Of Supervisor if NP or PA)

Address:______________________Date of Exam ______________________

Provider's Signature______________________Staff Signature ______________________

NOTE TO THE DAY CARE CENTER: Staff Health Records are confidential and must be kept separate from all other records. Records of required medical examinations must be kept on file at the day care center as long as staff members are employed. They must be returned to them upon their request when their employment is terminated. In cases where chest x-rays are required, x-ray reports must be kept on file at the day care center as long as the person is employed and two years thereafter.
(New York City Health Code Section 45.09)

Staff or Volunteer (Applicant) Instructions for a Comprehensive Background Check (CBC) Request

(Give this to applicant)

Dear Applicant:

Please follow the steps below to complete your application for a new comprehensive background check (CBC) or request to add/transfer programs to your current CBC clearance.

You must complete and submit the following to your permittee:

- ☐ Statewide Central Register (SCR) Database Check Form – download form, complete, sign and date
- ☐ Affirmation and Authorization Form - sign and date
- ☐ Applicant Worksheet

Federal law requires child care staff and volunteers to submit a new CBC every five years or if there is break in service longer than 180 days. If you need a new CBC:

- ☐ You or the permittee should schedule a fingerprint appointment
- ☐ You get fingerprinted at an IdentoGO center
- ☐ You submit the fingerprint receipt to the permittee

Instructions for Completing the Statewide Central Register Database Check Form LDSS-3370, DCCS version

ALL information on the **LDSS-3370**, DCCS version must be easily read so that data entry and results are accurate. Each *Statewide Central Register Database Check* form **LDSS-3370**, DCCS version submitted should be reviewed for completeness and legibility by the program/agency liaison. If the form is incomplete or illegible, it will be returned to the agency for corrections.

HOW TO COMPLETE THE FORM:

AGENCY INFORMATION

TOP LINE OF FORM

- The three-digit agency code must be placed in the top left-hand box, followed by the Resource I.D. (RID) in the next box to the right. (Contact the licensing agency if there are any questions about these.)
- Day Care providers must place their Child Care Facility System (CCFS) Number in the box next to Resource ID (RID), in lieu of RID number. (Contact your licensing agency/regional office if you have any questions).
- Clearance Category letter code (see the back of form **LDSS-3370**, DCCS version) must be placed in the middle box.
- Phone number (with area code) enables the SCR to contact the agency liaison if this becomes necessary.
- The Request ID Box is for SCR use only.

AGENCY ADDRESS AREA

- Agency Name: Please use full name, no abbreviations
- Agency Liaison is the contact person at the inquiring agency. (The SCR response will be addressed to the liaison.) **The liaison cannot be the applicant or a relative of the applicant.**
- Agency Address: **Must** include street and city

APPLICANT INFORMATION

APPLICANT/HOUSEHOLD MEMBER AREA

ALL HOUSEHOLD MEMBERS, ADULTS AND CHILDREN, WHETHER RELATED TO THE APPLICANT OR NOT, ARE TO BE LISTED IN THIS AREA OF THE FORM.

Remember to **write clearly** or **type** all information to assist in obtaining an accurate response. Record all names with the last name first, then the first name, and middle name.

- First line: Applicant's name. If there is more than one applicant place the additional name(s) on the lines below the maiden name line.
- Second line: Any maiden names, previous married names, or aliases by which the applicant is or has been known. Use additional lines if there is more than one maiden/married/alias name to be listed.
- Remaining lines: Names of all other household members. (Attach an additional page if needed.)

IF THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK BOX FOR NO OTHER HOUSEHOLD MEMBERS.

- First column: indicate the relationship to the applicant of each person listed. (Spouse, son, daughter, mother, father, friend, etc.)
- Sex M/F/Non-Binary column: check either M (Male) or F (Female) or Non-Binary for every person listed.
- Date of Birth column: fill in complete date of birth (mm/dd/yyyy) for everyone listed on the form.

ADDRESS AREA

The information required varies depending on the category (see the back of the form for categories).

- For Adoption, Foster Care and Family and Group Family Day Care, provide addresses for the applicant and any household member who is 18 years of age or older. **This information must date back to the last 28-years**. Attach supplemental pages if necessary, but **do not use** another **LDSS-3370,** DCCS version form to list this additional information. Be sure to associate address histories with individuals (i.e., indicate which addresses are for which household member).
- For all other categories, only the applicant's address history is required – for the **last 28-years**.
- Complete addresses are required. Include street name, street number, apartment number and city/town/village. **Post Office Box numbers are not acceptable.** If the applicant has lived abroad, indicate country and dates *(months/years)* of residence. If the applicant has spent time in the military, list base names and locations along with dates *(months/years)*.
- **Be sure that there are no periods of time unaccounted for.**
- The top line is for the current address. The previous address should be listed on the second line downward, and so on, to the back of the form for the last 28-years. Staple the attached supplemental page to the form if more space is needed, but **do not use** another copy of the **LDSS-3370,** DCCS version for this additional information.

SIGNATURE AREA

- Signatures required depend upon the category (see the back of the form for categories).
- For Adoption, Foster Care and Family and Group Family Day Care, signatures are needed from the applicant and any household member who is 18 years of age or older.
- For all other categories, only the applicant's signature is required.
- All signatures must correspond to the names recorded in the Applicant/Household Member Area. For example: Mary Smith should not sign Mary Ann Smith. Victoria Smith should not sign Vicki.
- Applicants must sign in the boxes marked Applicant's Signature; household members over 18 years of age who are not applicants must sign in the boxes at the extreme bottom of the page marked Signature.
- All signatures must be dated (mm/dd/yyyy). The SCR **will not accept** a form with a signature date more than six-months old.

If you have questions regarding completion of this form, **please call the SCR at 518-474-5297.**

SUBMIT YOUR COMPLETED **LDSS-3370,** DCCS VERSION TO THE PERSON REFERENCED IN **OCFS-6000**
BE SURE TO INCLUDE THE REQUIRED FEE - **FEE REQUIRED FOR EACH APPLICANT**

TO ORDER A SUPPLY OF FORM, LDSS-3370, DCCS version**:**

Please access the **OCFS-4627,** *Request for Forms and Publications*, from the Intranet: http://ocfs.state.nyenet/admin/forms/Management_Services/ Internet http://ocfs.ny.gov/main/documents/forms_keyword.asp and mail the completed **OCFS-4627**, *Request for Forms and Publications* to: **THE NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES, FORMS AND PUBLICATIONS UNIT, 52 WASHINGTON ST. ROOM 116 SOUTH BLDG., RENSSELAER, NY 12144.**

LDSS-3370 (Rev. 08/2019) DCCS version FRONT

SCR USE ONLY
REQUEST I.D.:

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STATEWIDE CENTRAL REGISTER DATABASE CHECK

Agency Use Only

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE:	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY (Use alpha codes on reverse):	PHONE NUMBER (Area Code): ( ) -

PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER:

AGENCY NAME:

AGENCY LIAISON:

STREET ADDRESS:

CITY: **STATE:** **ZIP CODE:**

The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box above, are also on the reverse side of this form.

FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS/MARRIAGE SECTIONS THAT APPLY. IF NONE, STATE "NONE" *List RELATIONSHIP in the fields below.*

(see reverse side for instructions) Attach additional page if necessary.

The purpose of collecting the demographic data on *other persons in your household* who are not screened pursuant to Section 424-a of the Social Services Law is to enable the NYS Office of Children and Family Services to identify with the greatest degree of certainty whether the person(s) being screened is the subject of an indicated child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA **PLEASE TYPE OR PRINT CLEARLY**

☐ **IF THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK THIS BOX.**

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	Sex M/F	DATE OF BIRTH
APPLICANT			☐ M ☐ F	
APPLICANT MAIDEN/ALIAS/ MARRIED NAME			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	

Please provide your current address and any other addresses at which you have resided for the last 28-years, including street, street number, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 years of age or older.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /

I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE	DATE / /	APPLICANT'S SIGNATURE	DATE / /

EIGHTEEN-YEARS OF AGE OR OLDER:

I understand that as a person 18 years of age or older in a home of an applicant to become an Adoptive or a Foster Parent or a Family or Group Family Day Care provider, the information I have provided will be used to inquire of the Statewide Central Register to determine if I am the subject of an indicated report of child abuse or maltreatment.

SIGNATURE	DATE / /	SIGNATURE	DATE / /

AGENCY LIAISON INSTRUCTIONS

Please verify that each form is completed. Incomplete forms will be returned to the sender. For ADOPTION, FOSTER CARE, and FAMILY and GROUP FAMILY DAY CARE, if both spouses are applicants, both are to sign. Persons 18 years of age or older residing in the home of applicants for ADOPTION, FOSTER CARE and FAMILY AND GROUP FAMILY DAY CARE also must sign the form.

AGENCY CODE: Record your three-digit agency code. NOTE: Day Care, Family and Group Family Day Care and Camps must provide the agency code of the agency or office which issues your license or certificate. Verify your Alpha or Alpha/Numeric three-digit code with your licensing agency.

DAYCARE PROVIDERS: Must place their Child Care Facility System (CCFS) Number in the box next to Resource ID (RID), in lieu of RID number. (Contact your licensing agency/regional office if you have any questions).

RESOURCE I.D. (RID): Record your RID in this field. OCFS, OMH, OMRDD, DOH, OASAS and SED licensed agencies and programs and local departments of social services, have RIDs as of 9/2001. Verify your RID with your licensing agency. If you need assistance, email: ocfs.sm.conn_app@ocfs.ny.gov

CLEARANCE CATEGORIES: Record the appropriate alpha code in the category box.

A– Adult Services/Family Type Home for Adults

D- Prospective employee *(Local DSS district - bill against reimbursement)***

E- Current employee

F- Prospective/new employee other than day care employees. (fee required - see below)*

G-This is a provider, employee, volunteer, or household member 18 years of age or older not related to any child in care, at legally-exempt family child care. No checks required when provider is a legally-exempt relative-only family child care provider.
(This category is only to be used by Enrollment Agencies)

I- This is a provider, employee, or volunteer at a legally-exempt in-home care. No checks required when provider is a legally-exempt relative-only in-home child care provider.
(This category is only to be used by Enrollment Agencies)

J- Age 18 or Older Household Member (with no child care role)

L- This is a director, employee, or volunteer at legally exempt group child care. (this category is only to be used by Enrollment Agencies).

M- Director of a summer camp, overnight camp, day camp or traveling day camp.

N- Applying for a license to operate a day care center. (To be submitted by authorized licensing agency only.) (fee required - see below)*

P- Applying to be a family day care provider. *(fee required - see below)* Provide address history for all household members 18-years old or over.*

Q- Applying to be group family day care provider. *(fee required see below)* Provide address history for all household members 18 years old or over.*

R- Applying to be kinship foster parents.

S- Provider of goods/services

U- Universal Pre-K Teacher *(fee required - see below)**

W- Applying to be foster parents or family care home providers.

X- Applying to be adoptive parents pursuant to an application pending before the inquiring agency.

Y- Prospective Day Care employee *(fee required - see below)**
- Applying to be a Group Family Day Care Assistant. (Fee required - See below)*

Z- Prospective volunteer/consultant.

AGENCY LIAISON: Record the name of the person to whom the response should be sent (cannot be the same as applicant or related to the applicant**).**

APPLICANT/HOUSEHOLD MEMBER AREA INSTRUCTIONS: This information is to be provided by the applicant/employee/ provider. (*See front of form).*

APPLICANT(S): -USE FIRST LINE (at least one person must be so designated)

MAIDEN NAME/ALTERNATIVE/AKA: MUST be completed for every applicant. Record **ALL** previous names used. Start with second line. Use as many lines as needed (one last name per line)

OTHER HOUSEHOLD MEMBERS: describe relationship to applicant, e.g., son, daughter, father, mother, friend, etc. on remaining lines (ATTACH ADDITIONAL PAGE IF NECESSARY)

IF THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK BOX FOR NO OTHER HOUSEHOLD MEMBERS.

*Social Services Law 424-a requires the collection of a **$25.00 fee** for certain categories. A certified check, postal or bank money order, teller's check, cashier's check or agency check made payable to *"New York State Office of Children and Family Services"* in the amount of twenty-five dollars, is to accompany the form. The check must also include the applicant's name and the agency code.
N.B.: a separate check must accompany each form.

**Social Services Law 424-a, allows local DSS to bill against their reimbursement the charge collected for screening prospective employees.

If you have questions, please call the SCR at 518-474-5297.

SUBMIT YOUR COMPLETED FORM, **LDSS-3370,** DCCS VERSION TO THE PERSON REFERENCED IN **OCFS-6000**
BE SURE TO INCLUDE THE REQUIRED FEE – **FEE REQUIRED FOR EACH APPLICANT**

STAPLE TO LDSS-3370, DCCS version *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM ADDITIONAL PAGE

(Use only if the space on the form, **LDSS-3370,** DCCS version is not sufficient)

APPLICANT NAME: ______________________________

Print clearly, all dates must be consecutive *(month/year)*. Be sure to associate address histories with particular individuals.

Previous Street Address	City	State	Zip	From (Mo/Yr)	To (Mo/Yr)
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STAPLE TO LDSS-3370, DCCS version *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM

ADDITIONAL PAGE

(Use only if the space on the form, **LDSS-3370,** DCCS version is not sufficient)

APPLICANT NAME: ______________________________

Other Household Members are: (please print clearly):

☐ **IF THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK THIS BOX.**

SCR Use Only	Relationship To Applicant	Last Name	First Name	Sex	Date of Birth		
				M/F	M	D	Y
				☐ M ☐ F			
				☐ M ☐ F			
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Staff or Volunteer (Applicant) Authorization and Affirmation Form for a Comprehensive Background Check

Each applicant must complete and sign this form. By signing this form, you authorize the New York City Department of Health and Mental Hygiene (NYC Health Department) to conduct the required background checks, and you are affirming that all the information you have provided to the group child care program is true and accurate.

Applicant Information

Applicant First and Last Name (print or type):

____

Authorization and Affirmation

By signing below, I affirm the following:

1. I authorize the NYC Health Department to conduct a comprehensive background check (CBC) on me.
2. The information provided for this application is true and accurate to the best of my knowledge.
3. I understand that if I knowingly give false statements, such action could be grounds for denial of approval to work in a child care program.
4. I voluntarily agree to the disclosure of any and all information sought in a CBC pursuant to 42 USC §9859f and New York State Social Services Law §390-b.
5. I acknowledge that this CBC will be processed through registries that maintain arrest and criminal histories, sex offender statuses, record of child abuse or maltreatment and mistreatment of the disabled throughout the U.S. These include:
    - FBI and NYS Criminal History Check
    - Statewide Central Register of Child Abuse and Maltreatment
    - NYS Justice Center for the Protection of People with Special Needs
    - NYS Sex Offender Registry
    - National Crime and Information Center - National Sex Offender Registry Check
6. I understand that any information revealed in this CBC will be used solely for the purpose of determining my eligibility to work in a child care program.

____ __________________________

Signature of Applicant Date

Comprehensive Background Check (CBC) Information Worksheet

- Program can use this worksheet however it is helpful to gather information for each staff or volunteer that needs CBC clearance.
- This worksheet is for program purposes only and should not be submitted to the NYC Health Department.

Applicant Information – Note: When completing the online form, the applicant's name must match the identification provided at their fingerprint appointment.	
First Name	Middle Name or Initial
Last Name	
Date of Birth (MM/DD/YYYY)	
Social Security Number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___	If no SSN, Alien Registration Number
Email Address	
Phone Number	

Applicant Home Address
Address Line 1: ____
Address Line 2: ____
City: ____________________ State: __________ ZIP Code: ______________

Applicant Mailing Address (if different than home address)
Address Line 1: ____
Address Line 2: ____
City: ____________________ State: __________ ZIP Code: ______________

The following is only required when submitting a new CBC application.
Has applicant been known by any other names, including maiden name, previous married name(s), or aliases?
☐ Yes
☐ No

If yes, list all other names:
____

Has applicant lived in a state other than New York or in a U.S. territory in the past five years?
☐ Yes. If yes, list addresses and dates applicant lived there, below.
☐ No

In the following table, list the addresses and dates applicant lived in a state other than New York State or in a U.S. territory in the past five years.

Previous Street Address	City	State	ZIP Code	Start Date (MM/DD/YY)	End Date (MM/DD/YY)

FINGERPRINTING IDENTIFICATION AND AUTHORIZATION FORM

(FPIA/DOHMH)

1. Section **A** of this form must be completed by the employee or applicant being fingerprinted by the New York City Department of Investigation (DOI).
   Section **B** must be completed by the Clearance Liaison or Alternate Liaison of the Child Care Service.
   Section **C** will be completed by Department of Investigation (DOI).
2. DOI fingerprints are by appointment only and will provide the applicant a copy of the completed FPIA.
   To schedule an appointment, log onto https://www1.nyc.gov/site/doi/offices/fingerprint-unit.page or call 212-825-5960.
3. The applicant must provide the completed FPIA to the Clearance Liaison or the Alternate Liaison who will retain the form on file at the Child Care Service.
4. To be fingerprinted, applicants must bring one photo identification from the approved list found on DOI's website at https://www1.nyc.gov/site/doi/offices/fingerprint-unit.page .
5. The fingerprint processing fee can be paid by credit card (plus credit card processing fee) or by Postal Money Order from the United States Post Office made payable to the New York City Department of Investigation (other types of money orders will not be accepted).

A. APPLICANT INFORMATION (all fields are required)

Social Security #: ______________________ ______________________________
(Signature of Applicant)

Name:____ ______________________________
(Last) (First) (Middle) (Alias or Maiden Name)

Address:____
(Street Number) (City/State) (Borough) (Zip Code)

Phone: ___________________________ ____________________________ _________________
Job Title/Role Start Date

Date of Birth: _________________ Age: _____ Place of Birth: _______________________
(State and Country)

Sex: _____ Race: _____ Skin Tone: _______ Hair: _____ Eyes: _____ Weight:________Height:_________
(Lbs) (Ft.) (In.)

B. CHILD CARE SERVICE / PROGRAM INFORMATION (all fields are required)

Program Type: **(Select One)** Direct Head Start Non-DOE Group Child Care Non-DOE School Based Child Care
- Summer Youth Public Service Other: _______________

Child Care Service / Provider Name: Young Minds in Motion Permit # / DC#: DC32971

Child Care Service Address: 556 Richmond Rd, Staten Island NY Zip Code: 10304

Child Care Director / Liaison Name: Priscilla James Phone: 347.709.9646

Child Care Director/ Liaison Signature: Priscilla James Date: ___________________

C. DEPARTMENT OF INVESTIGATION INFORMATION (**FOR DOI USE ONLY**)

DOI#: ______________________

Date Applicant Fingerprinted: ____________________

Signature of DOI Staff Member: __________________________