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: _____

*SSN: _____

*Date of Birth: _____

*US State or Foreign Nation of Birth: _____

*Sex (circle one): Male Female

*Race (circle one): White Black Asian Amer_Indian Other

*Hair Color: _____

*Eye Color: _____

*Height: _____

*Weight: _____

Contact Information

*Address Line 1: _____

Address Line 2: _____

*City: _____

*State: _____

*Zip: _____

*Email: _____

*Phone: _____

*Denotes Required Fields