

CENTRALIZED CLEARANCE CHECK INFORMATION REQUEST

Please type the following information. Enter N/A in any space that does not apply. All information will be maintained confidentially, but **must be provided in order to complete a clearance check.** Falsification or omission of pertinent information will be considered as justification for disapproval or possible criminal prosecution. It is the responsibility of the requestor to initiate renewal of all clearances. Applicant shall submit this request form to the facility or respective Central Office moderator. Use additional sheets if necessary.

SECTION "A" (CANDIDATE)

Have you ever worked in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution? Yes No
 Have you ever been adjudicated, convicted, or otherwise disciplined for committing an act of sexual abuse or sexual harassment in the workplace or community? Yes No

- Type of Clearance:** Initial Clearance Request Renewal Request
- Category:** Agency Temp Services Contract Service Provider Intern/Extern Organization
 Reentry Services Vendor Volunteer Program
 Official Visitor (please select one):
 Government PA Prison Society
 Public Visitor (please select one):
 Ministry Criminal Justice Agency Entertainment, Sports, Activities, Guest Speaker
 Other (please explain):

Purpose of Visit:			Primary Facility:		
Organization/Agency/Company/Program Name:			Abbreviation (if applicable):		
Subcontracted to:			Title or Position:		
Last Name:		First Name:		Middle Name:	
List all previous names:					
Date of Birth:			Social Security Number:		
Passport #:		Alien Registration #:		Visa #:	
Sex:	Race:	Height:	Weight:	Eye Color:	Hair Color:
Current Address:			City:	State:	Zip Code:
Prior Address:			City:	State:	Zip Code:
Place of Birth:			Email Address:		
Home Phone:			Alternate Phone (cell):		
Current Driver's License Information:		State:	Operator: <input type="checkbox"/>	ID Only license: <input type="checkbox"/>	OLN Number:
Valid: Yes <input type="checkbox"/> No <input type="checkbox"/>					
Previous Licenses (List all states & #'s that apply):		State:	Operator/Non-Operator #:		
Professional/Medical Licenses:			DEA Number:	NPI Number:	
Identify names, relationships, and locations of any relatives or close friends in any DOC facility:					

I confirm that all information contained on this clearance request has been verified by me to be complete and accurate. I also agree to abide by all Department rules and assume all risks which may result from the normal operation of a Department facility.

Signature:	Date:
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SECTION "B" (REQUESTING DOC STAFF MEMBER)

Requesting Staff Member:	Employee #:	Date of Request:
Describe Specific Event or Access:		Specific Period of Access Required:

