NYS Request for Card Scan Services - Information Form

** Every item marked with an asterisk MUST be completed **

Contributor Agency Section:

ORI: NY922160Z Contributor Agency: NYS Justice Center – Office of Mental Health – HRM

* Staff Exclusion List (SEL): Provider certifies that a Staff Exclusion List check was completed: ☐ check here

(Fingerprint cards cannot be submitted until a SEL check has been completed.)

Reason Fingerprinted: Local Service Applicant

*Job Type: (Select one) ☐ Direct Service Provider ☐ Family Care ☐ Volunteer ☐ Operator

* Agency ID Number: (Available in Justice Center CBC system and online at www.justicecenter.ny.gov on the Pre-Employment Checks tab)

Applicant Information:

** Select one -->* ☐ New Submission ☐ Re-Take

*Name of Applicant:

*Last _____ *First _____ M.I. ____

Maiden Name / Alias: _____

*Street Address: _____

*City, State, & Zip: _____

*Date of Birth: *Age: *Sex: Male ☐ Female ☐ *Race: _____

*Ethnicity: Hispanic ☐ Non Hispanic ☐ *Height: ft. in. *Weight: lbs.

*Skin Tone: _____ *Eye Color: _____ *Hair Color: _____

*State / Country of Birth: _____ * Country of Citizenship: _____

Social Security Number: _____

Social Security Number is not required through MorphoTrust; however, it is useful to process the fingerprint submission in the event an applicant's fingerprint are rejected by the FBI.

Job Description: Please print clearly and include detailed information about the job duties that indicate **how the applicant will have direct and substantial unsupervised contact with service recipients limit 150 characters.*

Applicant Section:

Applicant Affirmation: I hereby affirm that the information contained in the application and supporting documents are true and do not contain any false statements or omissions of any material information or facts. I understand that the making of false written statements in this application is punishable as a class A misdemeanor under Section 175.30 and /or Section 210.45 of the New York Penal Law.

*Applicant Signature_____ *Date :

* Applicant Contact Information where *Applicant* can be reached if there is a question about the fingerprint card:

Phone Number: _____ **or** E-mail Address: _____

Payment Section: Agency Billing Account

Mailing Instructions: This fully completed Card Scan Service Information Form must be mailed along with the fingerprint cards to: **CBC Unit, PO Box 97, Delmar, NY 12054**

Clear Form Print Form