

CENTRALIZED CLEARANCE CHECK INFORMATION REQUEST

Please print the following information legibly. 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. It is the responsibility of the requestor to initiate renewal of all clearances every 6 months. Use additional sheets if necessary. Applicant shall submit this request form to the facility or respective Central Office moderator.

SECTION "A" (CANDIDATE) • I am requesting a Single Facility Clearance Identify Facility _____

(Check one) I am requesting a Multi-Facility Clearance (Circle all that apply)

**ALB CAM CBS CEN CHS COA CRE DAL FRA FRS FYT GRA GRE GRN
HOU HUN LAU MAH MER MUN PIT PNG QBC RET ROC SMI SMR WAM**

• I am requesting a Statewide Clearance (Access required at all DOC facilities)

*If requesting a Multi-Facility or Statewide Clearance, identify a single facility as your preference for your primary assignment. Attempts will be made to accommodate your first choice. PREFERRED FACILITY _____

Category: (Check one) _____
_____ **VENDOR**
_____ **CONTRACT SERVICE PROVIDER**
_____ **VOLUNTEER**
_____ **ORGANIZATION**
_____ **PUBLIC VISITOR** (Govt, Criminal Justice, Education, Entertainment, etc)
_____ **OFFICIAL VISITOR** (PA Prison Society only)
_____ **DOC APPLICANT**
_____ **MENTOR PROGRAM**
_____ **INMATE VISITOR** (provide inmate # in Reason for Access field below)
_____ **COMMONWEALTH EMPLOYEE**
_____ **OTHER** (Identify) _____

Name of Organization/Group/Agency/Company/Program Name: _____

Approved Vendor Subcontractor for: _____ Reason for Access Request: _____ Title or Position _____

Last Name _____ First Name _____ Complete Middle Name _____

List all previous names (AKA's): _____

Date of Birth: _____ Social Security Number: _____ - _____ - _____ or

Passport # _____ Alien Registration # _____ Visa # _____

Sex _____ Race (circle) W B I A Height _____ Weight _____ Eye Color _____ Hair Color _____

Current Address: _____

Prior Address: _____

POB _____ Home Phone: () _____ - _____ Alternate Phone: () _____ - _____

Current Driver's License Info: State _____ Operator/Non-Operator Number _____ Valid: Yes No

Previous Licenses (list all states & #'s that apply) State _____ Operator/Non-Operator Number _____

Identify names, relationships and locations of any relatives or close friends confined in any DOC Facility _____

I confirm that all information contained on this clearance request has been verified by me to be complete and accurate

Signature _____

Date _____

SECTION "B" (REQUESTING DOC STAFF MEMBER)

Requesting Staff Member: _____ Title/Emp #: _____ Facility _____

Telephone Number: _____ FAX Number: _____

Date of Request: _____

Reason for Access or Comments: _____

Referring DOC staff member for Statewide/Multi Clearance: _____ Facility _____