

TYPE OR PRINT ALL INFORMATION CLEARLY IN INK

## ***Fingerprinting Information Form***

**Connecticut Department of Public Health, Long-Term Care Background Search Program**  
**410 Capitol Avenue, MS #12LEG, P.O. Box 340308, Hartford, CT 06134**  
**Phone: (860) 509-8366 Fax: (860) 707-1976**  
**Email: [dph.ABCMS@ct.gov](mailto:dph.ABCMS@ct.gov) Website: [www.ct.gov/dph/ABCMS](http://www.ct.gov/dph/ABCMS)**

You have received this form because you have applied for a position for which a criminal history record search is required pursuant to Section 19a-491c of Connecticut's General Statutes. As a result of the background search, you will be listed in the Health Care Worker Registry.

**THE FOLLOWING INFORMATION IS REQUIRED SOLELY FOR THE PURPOSE OF PROCESSING AND COMPLETING AN ACCURATE CRIMINAL RECORD SEARCH PURSUANT TO SECTION 19A-491C OF CONNECTICUT'S GENERAL STATUTES.**

Last Name	
First Name	
Middle Name	
Suffix	
Maiden or Other Name(s)	
Street Address	
City	
State	
Zip Code	
Social Security Number	<input type="checkbox"/> This is an ITIN

Date of Birth	Hair Color
Race	Height
Gender	Weight
Eye Color	Place of Birth

I understand that the information requested herein regarding race, gender, eye color, hair color, weight, height, place of birth, date of birth and social security number is for the sole purpose of identification. The gathering of this information and the processing of this application is required by the State of Connecticut and Federal Bureau of Investigation for the purpose of a state and national criminal history record check pursuant to section 19a-491c of Connecticut's General Statutes. This information will not be used to discriminate against me in violation of the law.

I certify that the above is true and correct.

Applicant's Name (please print): \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_