

Missouri State Highway Patrol / Missouri Department of Social Services
REQUEST FOR CHILD ABUSE OR NEGLECT / CRIMINAL RECORD

TYPE OF SERVICE (Check only one) See reverse side for further instructions

(1) Name Search - \$5.00

(2) Fingerprint Search - \$14.00

(3) DFS Central Registry Screening Only – No Charge

IDENTIFYING DATA (Please type or print information legibly in ink.) The subject of the request must complete the next section and sign.

APPLICANT'S NAME (Last, first, MI, Jr., Sr., III)

MAIDEN NAME	DATE OF BIRTH (MM/DD/YY)	STATE OF BIRTH	SEX	RACE
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ALIAS NAME(S)	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER / STATE
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ADDRESSES FOR PAST 5 YEARS					
STREET	CITY	STATE	STREET	CITY	STATE

Have you ever been charged / pled guilty to or been convicted of any criminal act in this state or any state?

YES (Complete section below) NO, I have not been charged / pled guilty to or been convicted of any criminal offense in this state or any state.

DATE	CITY	STATE	COUNTY	CIRCUMSTANCES (Identify charges, attach separate page, if necessary)

Have you ever been substantiated as a perpetrator in any child abuse or neglect report made to the Division of Family Services in this state or any state?

YES (Complete section below) NO, I have not been substantiated as a perpetrator in any child abuse or neglect report

DATE	CITY	STATE	COUNTY	CIRCUMSTANCES (Attach separate page, if necessary)

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant permission to the Department of Social Services to obtain any and all information needed to process my request and to use the information as permitted by law.

SIGNATURE OF APPLICANT (REQUIRED IN INK.)	DATE
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SIGNATURE OF CHILD CARE PROVIDER (Required in Ink.)	DATE
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TITLE OF CHILD CARE PROVIDER	TELEPHONE
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STATE AGENCY	STATE VENDOR OR CONTRACT NO. (if applicable)
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CHECK APPROPRIATE BOX

<input type="checkbox"/> CHILD CARE RELATED EMPLOYMENT	<input type="checkbox"/> DOH / CCS CHILD CARE BUREAU	<input type="checkbox"/> SCHOOLS / PUBLIC AND PRIVATE
<input type="checkbox"/> CHILD CARE RELATED VOLUNTEER	<input type="checkbox"/> DMH / DMH VENDOR	<input type="checkbox"/> DYS
<input type="checkbox"/> DFS LICENSURE	<input type="checkbox"/> HEALTH CARE	<input type="checkbox"/> OTHER _____

RETURN ADDRESS (REQUIRED ON EACH APPLICATION)
 Complete your mailing label below
 Confidential Mail

AGENCY NAME
ATTENTION
ADDRESS
CITY, STATE, ZIP CODE