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)

(Check one)

- _____ I am requesting a Single Facility Clearance — Identify Facility _____
- _____ I am requesting a Multi-Facility Clearance — *(Circle all that apply)*

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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-Facilty 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: Rick DAVIS **Title/Emp #:** CAS/481511 **Facility** SCI Rockview

Telephone Number: (814) 355-4874 X229 **FAX Number:** _____

Date of Request: _____

Reason for Access or Comments: Community Powerlifting Meet

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