

AR920390Z

Arkansas Department of Health
Section of Emergency Medical Service
5800 W. 10th Street Suite 800
Little Rock, AR 72204-1763

EMS/Healthcare Affiliation _____

Name of Supervisor _____

_____ State Check only

_____ State and National Check

Items Needed:

1. This form completed (typed or printed clearly) signed AND notarized (see back)
2. If a National Check is also required, **one** completed fingerprint card.
3. IF YOU HAVE PAID ON LINE DO NOT SEND ADDITIONAL PAYMENT TO ADH.

For State Background Checks ONLY: A check or money order in the amount of \$22.00 payable to Arkansas Department of Health.

DO NOT SEND A CHECK IF YOU PAID ON LINE.

For State AND National Background Checks: A check or money order in the amount of \$37.75 payable to Arkansas Department of Health.

RETURN TO THE SECTION OF EMS AT THE ABOVE ADDRESS

_____	_____	_____	_____	
Last Name	First	Middle	Maiden	
_____	_____	_____	_____	
Date of Birth	Race	Sex	Social Security Number	
_____	_____	_____	_____	
Driver's License Number	State of Issue	County	Email address	
_____	_____	_____	_____	
Current Mailing Address		City	State	Zip Code

The name, address and date of birth appear in the following government issued identification document(s):

_____ Drivers License _____ State Identification Card _____ Other (list) _____

The applicant must list all felony and misdemeanor charge(s) for which he/she was found guilty or pled guilty or nolo contendere to:

Date	Location	Description	Sentencing/Disposition
_____	_____	_____	_____
_____	_____	_____	_____

_____ 82001 Civil Records Check - \$22.00

OFFICE USE ONLY

_____ 80000 FBI Records Check \$15.75

I, the undersigned, hereby give my consent for the Arkansas State Police to conduct the required criminal history check on myself and to release any results to the Arkansas Department of Health. Providing false information on this form is a violation of Arkansas law and is punishable as set forth in Arkansas Code 5-53-1-3.

Statement of Oath (please check one):

_____ I verify that I have been a resident of Arkansas for **MORE** than five (5) years.

_____ I verify that I have been a resident of Arkansas for **LESS** than five (5) years.

I state on oath that the representations made herein are true and correct.

Signature of Applicant

Date

Subscribed and sworn (or affirmed) before me this _____ day of _____, 20__.

At _____
City

State

Signature of Notary

(SEAL)

My commission expires: _____

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FINGER PRINT CARD MUST BE COMPLETED BY LAW ENFORCEMENT. DO NOT LEAVE ANY SPACE BLANK EXCEPT FOR OCA, FBI NUMBER, MISC, NUMBER AND ARMED FORCES NUMBER. THE FINGERPRINT CARD MUST BE A BLUE FBI FINGERPRINT CARD WITH THE PROPER LICENSING ENTITY AND OR NUMBER REPRINTED. THE FBI REQUIRES A CLASSIFIABLE SET OF FINGERPRINT IMPRESSIONS: OTHERWISE THE CARD WILL BE REJECTED, TYPE OR PRINT THE INFORMATION CLEARLY.

FOR RACE: A= ASIAN B=BLACK I=INDIAN W=WHITE U=UNKNOWN **FOR SEX;** 'M' or 'F'

FOR 'HGT': USE FEET AND INCHES SUCH 6'6"

USE THE FOLLOWING THREE CHARACTER CODES FOR EYES AND HAIR

EYES: BLU=BLUE BRO=BROWN BLK=BLACK GRY=GRAY GRN=GREEN HAZ=HAZEL MAR=MAROON
PNK=PINK XXX=UNKNOWN

CITIZENSHIP: IF USA=US; IF MEXICO=MEXICO, ETC

DATE OF BIRTH: USE NUMERICALS SUCH AS 04-29-55

PLACE OF BIRTH: STATE OR COUNTRY

NOTICES:

PRIOR TO THE COMPLETION OF A STATE CRIMINAL HISTORY CHECK, THE ARKANSAS DEPARTMENT OF HEALTH MAY CHOOSE TO DENY AN APPLICANT CERTIFICATION AS AN EMERGENCY MEDICAL TECHNICIAN.

ANY CHALLENGES TO THE ACCURACY OF THE RESULTS SHOULD BE DIRECTED FIRST TO THE STATE IDENTIFICATION BUREAU (PHONE 501-618-8500), #1 STATE POLICE PLAZA DRIVE, LITTLE ROCK AR 72209.