

REQUEST FOR CHILD ABUSE OR NEGLECT / CRIMINAL RECORD

TYPE OF SERVICE (Check ALL that apply) See reverse side for further instructions. <input checked="" type="checkbox"/> (1) CD Central Registry Child Abuse Search Only - No Charge <input type="checkbox"/> (2) Name Search - \$9.00 (Criminal record, child abuse, or neglect, central registry search) <input type="checkbox"/> (3) Fingerprint Search <input type="checkbox"/> \$14.00 (Authorized Statute 210.487) <input type="checkbox"/> \$20.00 (All other request)	TYPE OF DAYCARE PROVIDER <input type="checkbox"/> (1) License <input type="checkbox"/> (2) License Exempt <input type="checkbox"/> (3) Registered
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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 found guilty to or been convicted of any criminal act in this state or any state?

YES (Complete section below) NO, I have not been found 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 Children's Division 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 REQUESTOR (Required in ink)	DATE
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TITLE OF CHILD CARE PROVIDER Park University School for Education	TELEPHONE (816) 584-6335
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STATE AGENCY	STATE VENDOR OR CONTACT NO. (if applicable)
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CHECK APPROPRIATE BOX

<input type="checkbox"/> CHILD CARE RELATED EMPLOYMENT	<input type="checkbox"/> DOH / CCB CHILD CARE BUREAU	<input checked="" type="checkbox"/> SCHOOLS / PUBLIC AND PRIVATE
<input type="checkbox"/> CHILD CARE RELATED VOLUNTEER	<input type="checkbox"/> DMH / DMH VENDOR	<input type="checkbox"/> CD CONTRACT PROVIDER
<input type="checkbox"/> CD LICENSURE	<input type="checkbox"/> HEALTH CARE	<input type="checkbox"/> OTHER _____

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

AGENCY NAME Park University
ATTENTION School for Education
ADDRESS 8700 NW River Park Drive
CITY, STATE, ZIP CODE Parkville, MO 64152