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 12 months. Applicant shall submit this request form to the facility or respective Central Office moderator. Use additional sheets if necessary.*

SECTION "A" (CANDIDATE) (Check one)

- _____ I am requesting a Single Facility Clearance Identify Facility _____
- _____I am requesting a Multi-Facility Clearance (*Circle all facilities that you require access to during clearance period)*

ALB CAM CBS CEN CHS COA CRE DAL FRA FRS FYT GRA GRE GRN
(Camp Hill) *(Greene)*
HOU HUN LAU MAH MER MUN PIT PNG QBC RET ROC SMI SMR TRA WAM

- _____ I am requesting a Statewide Clearance (Access required at every DOC facility within the clearance period)

*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** (Construction, Food delivery, Service, Repairs, etc)
_____ **CONTRACT SERVICE PROVIDER** (CSP)
_____ **VOLUNTEER PROGRAM**
_____ **PUBLIC VISITOR** (Religious Ministry)
_____ **PUBLIC VISITOR** (Government, Criminal Justice Agency, etc)
_____ **PUBLIC VISITOR** (Entertainment, Activities, Sports, Guest Speaker)
_____ **COMMONWEALTH EMPLOYEE**
_____ **OFFICIAL VISITOR** (PA Prison Society only)
_____ **MENTOR PROGRAM**
_____ **ORGANIZATION**
_____ **INMATE VISITOR** (provide inmate # in purpose of visit field)
_____ **OTHER** (identify) _____

Initial Clearance Request: ☐
Renewal Request: ☐

Purpose of Visit _____

Organization/Agency/Company/Program Name:_____ **Abbreviation if applicable (_____)**

Subcontracted to:_____ **Title or Position**_____

Last Name _____ **First Name** _____ **Complete Middle Name** _____

List all previously used names :_____ _____ _____

Date of Birth: _____ _____ _____ **Social Security Number:** _____ - _____ - _____ **or**

Passport # _____ **Alien Registration #**_____ **Visa #** _____

Sex _____ **Race** (*circle*) **W B I A** **Height** ____ **ft** ____ **in** **Weight** _____ **lbs** **Eye Color** _____ **Hair Color** _____

Current Address: _____, _____, _____

Prior Address: _____, _____, _____

Place of Birth _____, _____ **E-mail Address** _____@_____ . _____

Home Phone: ( ) _____ -_____ **Alternate Phone:** ( ) _____ - _____

Current Driver's License Info: State _____ ☐ **Operator** ☐ **ID only license** **List OLN 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: _____ **Emp #:**_____ **Date of Request** _____

Specific Event or Access: _____ **Period of Access Required** _____

Security Office approving staff member signature_____ **Facility** _____ **Date** _____