


DOH CHRC 100 (9/06)

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| <p>NYS Department of Health</p>  <p>CHRC Unit P. O. Box 2607 Albany, NY 12220-0607 Phone: 518.402.5549 Fax: 518.474.7477 www.nyhealth.gov/chrc chrc@health.state.ny.us</p> | <p>AGENCY REQUEST FORM</p> <p>CRIMINAL HISTORY RECORD CHECK (CHRC) PROGRAM</p> | <p><i>For Department use only Leave blank</i></p> |
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The purpose of this form is to enable Agencies to request criminal history record checks for subject individuals pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

For purposes of this form, the term **"Agency"** means residential health care facility, certified home health agency, licensed home care services agency or long term home health care programs that are authorized by law to request a check of criminal history record information. **"Agency representative"** shall mean a sole proprietor for a sole proprietorship, any authorized partner of a partnership, any authorized director or officer of a corporation and any authorized member or manager of a limited liability corporation (LLC). **"Authorized Person"** is the individual that is allowed to request, on behalf of the Agency, fingerprints and criminal history record checks. **"Subject individual"** is an "employee" as defined by Public Health Law Section 2899(3).

**Type or print all information – USE CAPITAL LETTERS.
Inaccurate, incomplete or illegible information will delay processing.**

INSTRUCTIONS:

1. Please complete all fields on this form.
2. This form must be signed by an authorized representative of the agency.
3. This form and DOH CHRC 101 (Authorized Person Designation Form) must be forwarded to the DOH CHRC Unit at the address indicated above **BEFORE** submitting subject individual CHRC requests.

SECTION 1 - AGENCY IDENTIFICATION

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| Agency Name | Agency PFI number or LHCSA Operating License number | |
| Work Address (Street) | | |
| City | State | Zip |
| Telephone Number | Fax Number | |
| Name of Agency Representative | Title | |

I understand my Agency's role in the Criminal History Record Check (CHRC) Program which is granted for the sole purpose of performing responsibilities related to the request, review and receipt of criminal history record checks pursuant to provisions of Article 28-E of the Public Health Law and Section 845-b of the Executive Law. I agree to use this application solely in support of that responsibility. I further understand that the results of the criminal history record checks will only be used and disseminated for purposes authorized by law, and I will abide by the confidentiality requirements set forth in law.

Signature of Agency Representative: _____
(refer to definition of Agency representative shown above)

Date: _____

DOH USE ONLY

ENTERED: _____
Date By