About the Disclosure and Authorization Form

A new form (as of June 30, 2011) has to be used for newly hired workers. The facilities must use this form rather than a form that they have created because this form allows the IDPH to be the requestor of the fingerprint background check. The facility initiates the fingerprint background check but the Department is the requestor. For the fingerprint background checks to be ongoing, a government entity has to be the requestor, in this case the Illinois Department of Public Health (IDPH). The Illinois State Police (ISP) cannot retain the fingerprints from background checks requested by private entities. Since IDPH is the requestor ISP can retain the fingerprint and can send a notification to the original requestor (IDPH) if these fingerprints are associated with a later conviction.

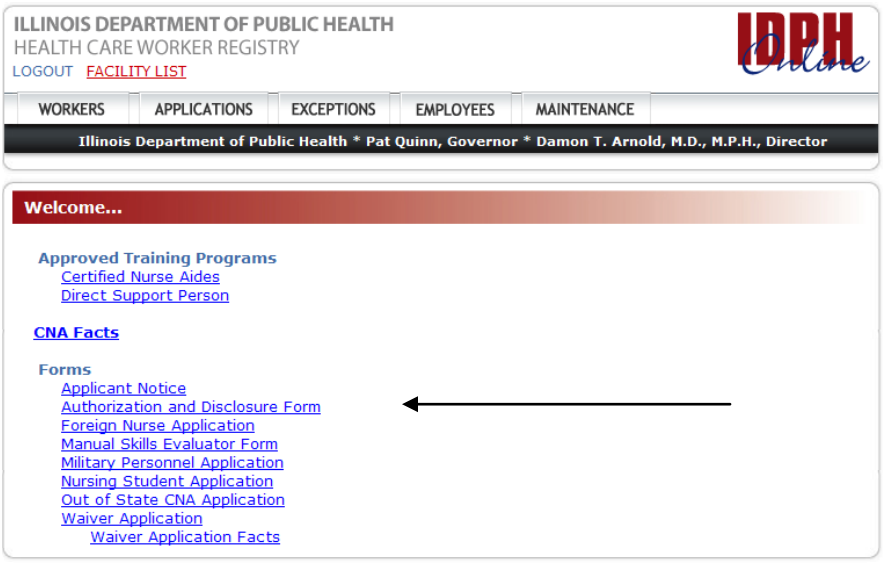
By facilities entering the employment information, our computer system knows for which facility the individual is working and will send an email notification to that facility. If the convictions are disqualifying, the facility will be required to terminate the individual. This is why you do not need to initiate a fingerprint background check through the registry if the individual already has a FEE_APP background check, as it is ongoing. Additionally, this is why a UCIA name or UCIA fingerprint background check is no longer allowed.

This form also authorizes the facility to have access to a specific individual's personal information and the rap sheet from ISP: "I authorize the Department to provide any health care facility, training program. or staffing agency, to which I have provided this authorization and disclosure form, a copy of my ISP CHRI and a determination of eligibility of the FBI CHRI."

This form has an acknowledgement that the information received because of this authorization is used "solely to determine my suitability for training or testing in a health care training program, employment, continued employment, or to work as a volunteer." It also has an acknowledgement that "I understand that the information requested below regarding gender, race, height, eye color, hair color, weight, place of birth and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my Social Security number is required by law."

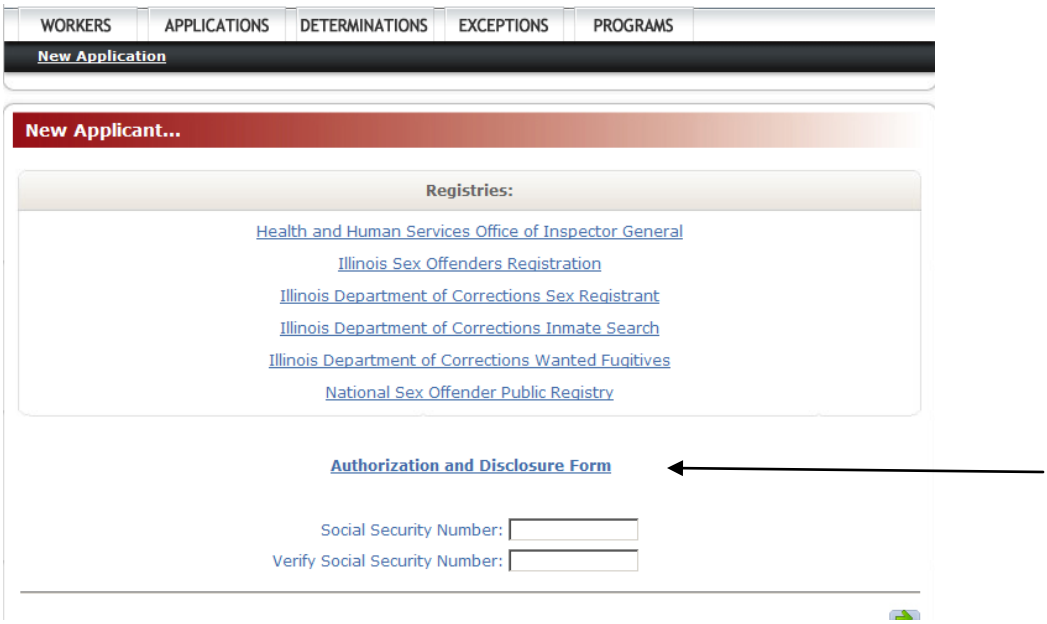
HOW TO PRINT

From the Welcome page:

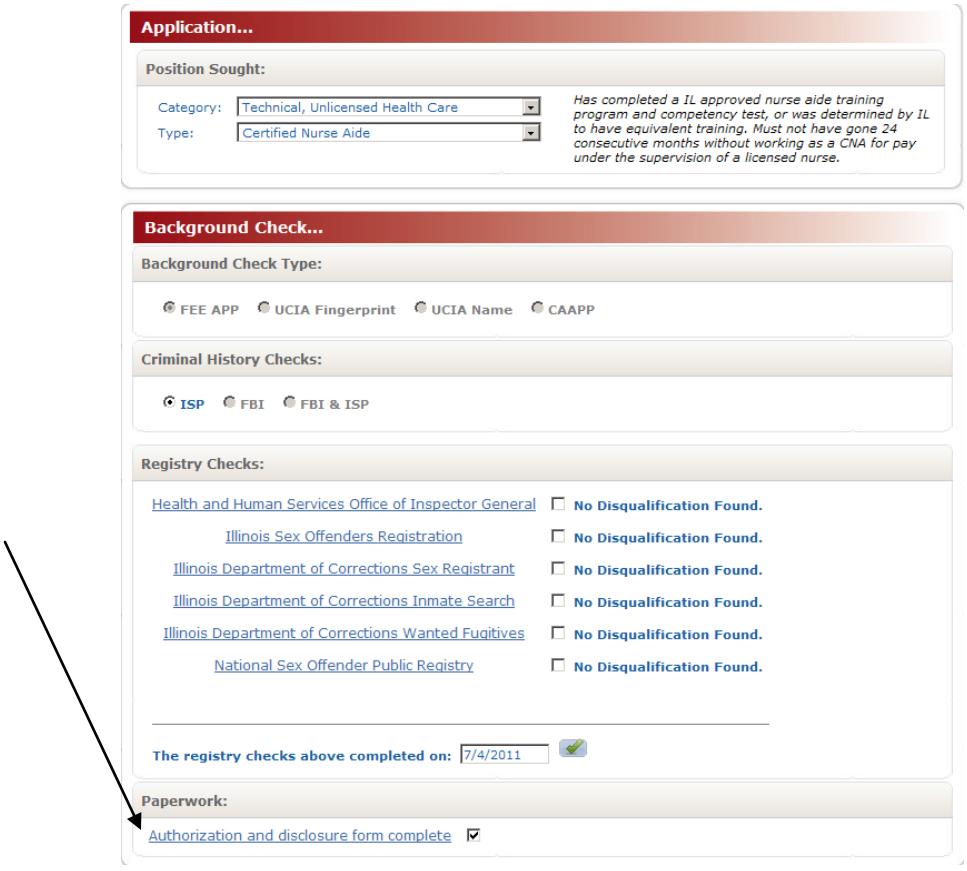


From the New Application page:

Click on the "Applications" tab then click on "New Application."



From the Background Check Initiation page:



State of Illinois
Illinois Department of Public Health

Health Care Worker Background Check

Authorization and Disclosure for Criminal History Records Information (CHRI) Check

I hereby authorize the Illinois Department of Public Health (the Department), the Department's designee, educational entities that train and/or test health care workers, staffing agencies, my current or potential employer, or a health care facility where I want to volunteer to initiate/request a CHRI check on me. I further authorize the Illinois State Police (ISP) and/or the Federal Bureau of Investigation (FBI) to release information relative to the existence or nonexistence of any criminal record, which it might have concerning me, to any initiator/requestor solely to determine my suitability for training or testing in a health care training program, employment, continued employment, or to work as a volunteer. I further authorize any entity that maintains criminal records relating to me, including but not limited to a local unit of government in any State, to release those records to the ISP, FBI, or the Department. I authorize the Department to provide any health care facility, training program. or staffing agency, to which I have provided this authorization and disclosure form, a copy of my ISP CHRI and a determination of eligibility of the FBI CHRI. I certify that the ISP, FBI, any entity that maintains criminal records, the Department, and any of their employees or officers who furnish this information shall be held harmless from all liability, which may be incurred as a result of releasing such information. I further acknowledge that a educational entity or health care employer shall not be liable for the failure to hire or retain me as an applicant, student, employee, or volunteer if I have been convicted of committing or attempting to commit one or more of the offenses stated in the Health Care Worker Background Check Act (225 ILCS 46/25)

I understand that any false statements or deliberate omissions on this document may be grounds for disqualification from employment, training, or volunteering, if discovered after employment, training, or volunteering begins, and can result in discipline up to and including my termination of employment, being a volunteer, or a student.

I understand that the information requested below regarding gender, race, height, eye color, hair color, weight, place of birth and date of birth is for the sole purpose of identification and the accurate gathering of the criminal history record information, and that it will not be used to discriminate against me in violation of the law. I understand that the provision of my Social Security number is required by law. A facsimile or photographic copy of this authorization will be as valid as the original.

First Name _____ Full Middle Name _____ Last Name _____

Mailing Address _____ City: _____ State: _____ Zip Code _____

Other Names Used _____ Telephone _____ - _____ - _____

States Where You Have Lived? _____ Place of Birth (State or Country if not US): _____ Hair Color _____ Weight _____

☐ Male ☐ Female Date of Birth _____ Height _____ Eye Color _____ Social Security Number _____ - _____ - _____

Race
- **A** Chinese, Japanese, Filipino, Korean, Polynesian, Indian, Indonesian, Asian Indian, Samoan, or any other Pacific Islander.
- **B** Black or African American (Not Hispanic or Latino)
- **H** Hispanic or Latino (Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin)
- **I** American Indian, Eskimo, or Alaskan native, or a person having origins in any of the 48 contiguous states of the United States or Alaska who maintains cultural identification through tribal affiliation or community recognition.
- **U** Of undeterminable race. Of Untold mixture.
- **W** Caucasian (not Hispanic or Latino)

Have you ever had an administrative finding of Abuse, Neglect or Theft? ☐ Yes ☐ No If "Yes," give full details and state. Continue on back if more space is needed.

Have you ever been convicted of a criminal offense other than a minor traffic violation (do not include convictions that have been expunged, sealed or adjudicated delinquent)? ☐ Yes ☐ No If "Yes," give full details of each offense and the state in which convicted. Continue on back if more space is needed.

I certify that the above is true and correct and give my consent for my name to appear on Department's Health Care Worker Registry with the results of my criminal history records check.

_____ _____
(Signature) (Date)

As the parent or guardian of the above named individual, who is younger than the age of 17, I give my consent for this named individual to have a criminal history records check.

_____ _____
(Signature of Parent or Guardian when applicable) (Date)

Health Care Worker Registry, 525 W. Jefferson St., Springfield, IL 62761 Phone: 217-785-5133