

Applicant - Complete personal information in Top Box and sign at bottom of form.

**IOWA HEALTH CARE FACILITY (135C) RECORD CHECK
Form C**

ACCOUNT NUMBER _____

TO: Iowa Division of Criminal Investigation **FROM:** _____
Bureau of Identification, 1st Floor _____
215 E 7th Street _____
Des Moines, IA 50319 _____
(515) 281-5138 (Voice-days) _____
(515) 281-4776 (Voice-nights) **Phone #** _____
(515) 242-6876 (Fax) **Fax #** _____

I am requesting an **IOWA CRIMINAL HISTORY** check on:

(Type or Print Legibly)

REQUEST

Last Name (mandatory)	First Name (mandatory)	Middle Name (recommended)
Maiden Name		
/ / Date of Birth (mandatory)	/ / Sex (mandatory)	- - - Social Security Number (recommended)
Signature of Requester (Friendship Home signature only)		

Applicant to sign at bottom of form)

(DCI Use Only)

RESULTS

As of _____, a Name and date of birth check revealed:

No CCH record found <input type="checkbox"/>	No record of founded Dependent Adult Abuse <input type="checkbox"/>
CCH record attached <input type="checkbox"/>	Potential DAAR "hit" send 2310 to DHS <input type="checkbox"/>

DCI initials _____

WAIVER

I hereby give permission for the above requesting official to conduct an Iowa criminal history record check with the Division of Criminal Investigation. Any information maintained by the DCI may be released as allowed by law.

_____ Signature (Applicant)	_____ Date
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