

# 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. 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 BEN CAM CBS CEN CHS COA DAL FRA FRS FYT GRA GRN HOU**  
(Camp Hill)  
**HUN LAU MAH MER MUN PIT PNG QBC RET ROC SMI SMR TRA WAM CCC**

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

**Category: (Check one)**

- VENDOR (Construction, Food delivery, Service, Repairs, IT, etc) \_\_\_\_\_ COMMONWEALTH EMPLOYEE Employee # \_\_\_\_\_
- CONTRACT SERVICE PROVIDER \_\_\_\_\_ OFFICIAL VISITOR (PA Prison Society)
- (Medical, Mental Health, Therapeutic or Contract Chaplaincy) \_\_\_\_\_ OFFICIAL VISITOR (Govt)
- VOLUNTEER PROGRAM \_\_\_\_\_ ORGANIZATION
- PUBLIC VISITOR (Ministry) \_\_\_\_\_ INTERN/EXTERN
- PUBLIC VISITOR (Government ) \_\_\_\_\_ REENTRY SERVICES
- PUBLIC VISITOR (Criminal Justice Agency) \_\_\_\_\_ AGENCY TEMP SERVICES
- PUBLIC VISITOR (Entertainment, Activities, Sports, Guest Speaker) \_\_\_\_\_ 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: \_\_\_\_\_, City \_\_\_\_\_, State \_\_\_\_\_ Zip Code \_\_\_\_\_

Prior Address: \_\_\_\_\_, City \_\_\_\_\_, State \_\_\_\_\_ Zip Code \_\_\_\_\_

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. I also agree to abide by all Department rules and assume all risks which may result from the normal operation of a Department facility.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**SECTION "B" (REQUESTING DOC STAFF MEMBER)**

Requesting Staff Member: \_\_\_\_\_ Emp #: \_\_\_\_\_ Date of Request \_\_\_\_\_

Describe Specific Event or Access: \_\_\_\_\_ Specific Period of Access Required \_\_\_\_\_

Security Office approving staff member signature \_\_\_\_\_ Emp # \_\_\_\_\_ Facility \_\_\_\_\_ Date \_\_\_\_\_