Department of Behavioral Health and Developmental Services

# REQUEST FOR CRIMINAL RECORDS INVESTIGATIONS FOR EMPLOYEES AFFILIATED WITH DBHDS' LICENSED PROVIDERS

**To be completed by the Provider only.**

## APPLICANT DATA
**(Please print or type)**

| 1. (a) Last Name | (b) First Name | (c) Middle Name |
|---|---|---|
| Rosine | Kwedi | |

**(d) All other names currently or previously used (Maiden, Former Married, Religious, etc.)**

| 2. Social Security Number | 3. Date of Birth (month, day & year) | 4. Gender | 5. Race* |
|---|---|---|---|
| | | | |

| 6. Height (ft & in) | 7. Weight (lbs) | 8. Eye Color* | 9. Hair Color* | 10. Place of Birth (State or Country) |
|---|---|---|---|---|
| | | | | |

| 11. Application Date for Employment | 12. Hire Date/Transfer Date |
|---|---|
| | |

**13. Applicant Status (check one)**

☐ Owner ■ New Hire ☐ Transfer ☐ Foster Parent/Residency

**14. Applicant hired only for compensated employment at**

☐ Adult Substance Abuse Treatment Facility (ASATF)
☐ Adult Mental Health Treatment Facility (AMHTF)

***Use Race, Eye and Hair Color codes on Attachment 7 ~ Enter same on fingerprint card**

## PROVIDER DATA
**(Please print or type)**

**1. Licensed Provider Name and Address**

Imperial Care, LLC
6564 Loisdale Ct. Suite 600-D
Springfield, VA 22150

| 2. Provider Number (3 or 4 digit) | 2231 |
|---|---|
| 3. Date of Request | 4. Contact Person |
| | |
| 5. Phone Number | 6. Email Address |
| 703-944-0162 | |

**Original – DBHDS' BIU**

**Copy – Licensed Provider**