OHIO HEALTH CONSORTIUM, INC.

1032 Buckeye Ave. Newark, Ohio 43055
(740)344-4622 (888)368-3926 Fax (740)344-4623

Granville Parent Co-Operative Preschool

SELF PAY - Method of Payment: ☐ **Visa** ☐ **MasterCard** ☐ **American Express** ☐ **Check** ☐ **Cash**

Amount $_____.___

Attn: This form **must** be completed prior to arrival.

Name_____SSN_____Date_____

Please check the box of the background check needed.

☒ **BCI** Reason for BCI background check :__5104.013 = _Daycare_____

NOTE: This "reason" field must be completed. Please indicate the appropriate Ohio Revised Code section number or reason. For any questions call Civilian Identification Office (BCI) at 877-224-0043.

☒ **FBI** Reason for FBI code for background check: CCDBGA = Child Care and Development Block Grant Act

NOTE: The "reason" field must include the section number or reason for the type of background check. The FBI background check can only be processed for working with children, working with the elderly, and certain types of licensing. If you are not certain about the reason, please contact the FBI at 540-868-1535.

Mail To: **Granville Parent Co-Operative Preschool**
P.O Box 292
Granville, Ohio 43023
Attn: Joan Derryberry

Have you lived in Ohio for more than 5 years? _Y / N

Direct Copy to (circle only one):	Ohio Dept. of Education	Ohio Board of Nursing
Oho Dept. of Public Safety	Ohio Dept. of Liquor Control	Respiratory Care Board
BMV Dealer License	BMV Deputy Registrar	(Child Care Ctr-Type A-ODJFS)
Ohio State Racing Commission	Ohio Dept. of Insurance	Lottery Commission
Dietetic Board	OPOTA	Ohio Construction Board
Ohio Pharmacy Board	Social Work Board	None

I certify that the personal identifiers provided on this form are accurate and I voluntarily and knowingly authorize the Ohio Bureau of Criminal Investigation and/or the Federal Bureau of Investigation to conduct criminal records check for the information relating to me. I also voluntarily and knowingly authorize BCI to disseminate criminal conviction and juvenile delinquency adjudication records to __ (those indicated above) ___. I voluntarily and knowingly release and discharge the Ohio Health Consortium, Inc., Ohio Attorney General's Office, BCI the FBI and their employees and officers from all claims and liability related to this authorized criminal record review and dissemination.

Attention: To be signed at Ohio Health Consortium, Inc.

_____ _____
Applicant's Name (please print) OHC Staff Name (please print)

_____ _____
Applicant's Signature (date) OHC Staff Signature (date)

Phone _____

Rev. September 29, 2020