MINNESOTA DEPARTMENT OF HEALTH LICENSED FACILITIES DATA COLLECTION WORKSHEET FOR EMPLOYEE/STUDENT BACKGROUND CHECK (OTA PROGRAM)

PLEASE PRINT

OPTIONAL: Items marked with an asterisk (*) are optional. All other information is required.

Last Name: _____
(Your legal name is required)

First Name: _____
(Your legal name is required – do not list nicknames)

Middle Name: _____

Gender: Male or Female (Required information, please circle one)

MN Drivers License Number: _____

Race* _____ **SSN*** _____

Phone*: ( )_____ **Date of Birth** _____/_____/_____
Month, day, and year are required mm/dd/yyyy)

Address: _____

State: _____**City:** _____ **Zip:**_____

Aliases:
(All Name changes and dates are required)

Other First Names: _____**Date** _____

Other First Names: _____**Date** _____

Other Last Names: _____**Date** _____

Other Last Names: _____**Date** _____

Out of State Address in past 5 years:
(All addresses and dates are required)

Address: _____**Dates**_____

State: _____**City:** _____ **Zip**:_____

Address: _____**Dates**_____

State: _____**City**: _____ **Zip**:_____

_____

Signature **Date**