Arizona Department of Health Services
BUREAU OF CHILD CARE LICENSING
Fingerprint Clearance Card Tracking Form

Facility Name/Provider	CDC/SGH #	Page ___ of ___

Applicant * Staff Members ** Residents (SGH) Provider (SGH)	Hire Date Mo/Yr	Fingerprint Registration ***						Dept. of Child Safety	Staff member responsible Initials / Date
		Clearance Card Application Date	Clearance Card #	Card Verified with DPS (Phone or Website)		Clearance Card Exp. Date	DHS Criminal History Affidavit Date Completed	Central Registry Direct Service Position Affidavit Date Completed	
				Date	Method				
					P ☐ W ☐				
					P ☐ W ☐				
					P ☐ W ☐				
					P ☐ W ☐				
					P ☐ W ☐				
					P ☐ W ☐				
					P ☐ W ☐				
					P ☐ W ☐				
					P ☐ W ☐				
					P ☐ W ☐				
					P ☐ W ☐				
					P ☐ W ☐				
					P ☐ W ☐				
					P ☐ W ☐				
					P ☐ W ☐				
					P ☐ W ☐				
					P ☐ W ☐				
					P ☐ W ☐				
					P ☐ W ☐				

This form is optional. Please maintain for your records. Copies of required documents shall be maintained in each individual's on-site file.

* License/Certificate Applicant
** List all staff members at the facility
*** Anyone 18 yrs or older must be fingerprinted and registered