

CRIMINAL BACKGROUND CLEARANCE TRANSFER REQUEST

Active criminal record clearances may be transferred from one state licensed facility to another by a license applicant or licensee. Clearances cannot be transferred from a state licensed facility to a county licensed facility, or from county to state. **The transfer request must be submitted to the Department before the individual who is the subject of the transfer has client contact or the facility will be in violation of the law and subject to a \$100 civil penalty.**

The license applicant or licensee who is seeking the transfer must verify the individual's identity and include a copy of the person's driver's license or a valid photo identification issued by the California Department of Motor Vehicles or by another state or the United States government if the person is not a California resident. Additionally, a Child Abuse Central Index (CACI) check must be submitted **if** the transfer is to a facility serving children and the individual has not previously submitted a CACI check or the date of the previous CACI inquiry was made prior to January 1, 1999. The CACI must be mailed directly to the Department of Justice with the applicable fee. *Note: This transfer request is for clearances only. Contact your licensing office for information about exemption transfers.*

PLEASE TYPE OR PRINT LEGIBLY	DATE:
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PLEASE TRANSFER THE CRIMINAL RECORD CLEARANCE FOR THE FOLLOWING INDIVIDUAL:

LAST NAME	FIRST NAME	MIDDLE INITIAL
CA DRIVER'S LICENSE #/OR ID #:		DOB:
LICENSING INFORMATION SYSTEM ID#:		SSN: (OPTIONAL)

FROM THE FOLLOWING FACILITY:

NAME OF FACILITY:	FACILITY NUMBER:
STREET ADDRESS:	
CITY	STATE
ZIP CODE:	

TO THE FOLLOWING FACILITY: ☐ PLEASE ALSO KEEP THIS INDIVIDUAL ASSOCIATED WITH ABOVE FACILITY.

NAME OF FACILITY:		<u>Transferee Association Type</u> <input type="checkbox"/> Facility Administrator <input type="checkbox"/> Corporation Board Member <input type="checkbox"/> Employee <input type="checkbox"/> Certified Home <input type="checkbox"/> Licensee/Applicant <input type="checkbox"/> Non-client Adult Resident <input type="checkbox"/> Partnership Member <input type="checkbox"/> Spouse of Licensee
FACILITY NUMBER:	DATE OF EMPLOYMENT:	
STREET ADDRESS:		
CITY	STATE	
ZIP CODE:		Title (<i>licensee, administrator, director</i>)
<i>I certify I have verified the above individual's identity and have enclosed a copy of the individual's photo I.D.</i> Signature		

FOR DISTRICT OFFICE USE ONLY

DATE OF TRANSFER ENTRY:	INITIAL OF PERSON ENTERING TRANSFER:
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