AUTHORIZATION TO TRANSFER BACKGROUND CHECK RESULTS - EARLY CHILDHOOD (THERAPY PROVIDER)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CRIMINAL BACKGROUND CHECK UNIT
SFN 356 (1-2025)

Clear Fields

EMPLOYMENT IN EARLY CHILDHOOD SERVICES

Pursuant 42 U.S. Code § 985f(d)(4)(C), if an individual who has been fingerprinted for one early childhood services program moves to another early childhood services program, the original fingerprint results may be used if the individual has not been separated from childcare employment for more than 180 days.

THIS FORM MUST BE TYPED. HANDWRITTEN AND/OR INCOMPLETE FORMS WILL BE REJECTED.

IDENTIFYING INFORMATION

Full Legal Name (First Name, Middle Name, Last Name)	Date of Birth
Full Legal Name at Time of Most Recent Background Check	Email Address

☐ **By checking this box, I agree that my electronic initials are the legal equivalent of my manual/handwritten initials. I agree that the electronic initials appearing on this document have the same validity and enforceability as handwritten initials.**

_____ (Initials) For the purposes of therapy services in an early childhood services program, I give the North Dakota Department of Health and Human Services permission to share the results of my criminal background check from my previous employer to my current employer as indicated below.

_____ (Initials) I understand that if it is determined that it has been more than 180 days (6 months) since I have provided therapy service with an early childhood services program, I must complete a new fingerprint-based criminal background check.

_____ (Initials) I understand that if at any time during the past 180 days I resided outside of North Dakota, I may be required to complete a new fingerprint-based background check.

_____ (Initials) I understand that prior to the transfer of my background check results a review of ND Child Abuse/Neglect Index, ND Public Courts, and MN Court Records will be completed. If new convictions or CPS involvement is found, I may be required to complete a new background check prior to continuing employment in a licensed childcare program.

When were you fingerprinted as a therapy service provider for the purposes of entering a licensed childcare program? (Month/Year)	
Name of Child Care Program or Licensed Provider	Date of Separation

ADDITIONAL PROVIDERS

Name of Early Childhood Services Program	Date of Hire
Name of Early Childhood Services Program	Date of Hire
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I certify that all information I have provided on this form is true and correct to the best of my knowledge. I further certify that if I am found guilty of a crime or named as a subject of a Services Required child abuse/neglect decision, I will immediately notify my employer or county social service agency.

☐ By checking this box and typing my name below, I am signing this document electronically. I agree that my electronic signature is the legal equivalent of my manual/handwritten signature. I agree that the electronic signature appearing on this document has the same validity and enforceability as a handwritten signature.

Signature	Date

Submit completed forms to: Department of Health and Human Services
Criminal Background Check Unit
600 East Boulevard Avenue, Dept. 325
Bismarck, ND 58505-0250

OR Fax: 701-328-0358 or Email: dhscfscbc@nd.gov