HEALTH CARE AUTHORITY

Division of Health Improvement

CAREGIVERS CRIMINAL HISTORY SCREENING PROGRAM

AFFIDAVIT – NO KNOWN CRIMINAL HISTORY

Applicant Affidavit Information

1. Applicant's Last Name:	2. Applicant's First Name	3. Applicant's Middle Name:
4. Applicant's Social Security Number	5. Applicant's Date of Birth	6. Applicant's Date of Employment
7. List all other names by which the Applicant has been also known as (aka):		
8. Length of Time as a Resident of New Mexico:		
IF Applicant has resided in the State of New Mexico for less than ten (10) years, then a ten (10) year work history is **required**. (Attach to document)		
9. Medical or Physical condition that prevents the Applicant from supplying readable fingerprints: (Required by 7.1.9.8.D.6 NMAC)		
I hereby certify that I **DO NOT** have any **FELONY** convictions and all information provided is truthful and correct.		
_____ Signature of Applicant		_____/_____/_____ Date of Signature

Care Provider Information

10. Care Provider Agency Name:		
11. Care Provider Address:		
12. Care Provider City:	13. Care Provider State:	14. Care Provider Zip Code:
15. Care Provider Phone:	16. Care Provider Fax:	17. Care Provider Email:
18. Authorized Representative Submitting Affidavit: (Last, First, MI)		
19. Explanation of Statement describing the good faith effort to provide readable fingerprints: (Required by 7.1.9.8.D.6.b NMAC)		

Notary Public

Subscribed and Sworn before me:
On This _____ Day of _____, _____
My Commission Expires: _____/_____/_____

FOR CCHSP USE ONLY		
Date of FBI Name Check Requested	Date FBI Name Check Received	Result of FBI Name Check
		C / H