



Minnesota Department of Health Licensed Facilities
Data Collection Worksheet for Employee Background Check

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 use nicknames)

Middle Name: _____

Gender: Male Female
(Required information, please check one)

MN Drivers License Number: _____

Race*: _____ SSN*: _____ - _____ - _____

Phone*: (____) _____ - _____

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

Address: _____

City: _____ State: _____ Zip: _____

Aliases:
(All Name changes and dates are required)

Other First Names: _____

Other Last Names: _____

Signature

Date