

OK-SCREEN BILLING ACCOUNT APPLICATION

(To submit the form, you may electronically sign and submit using the button provided, or via facsimile to 405-271-3611)

COMPANY INFORMATION

Business Name: _____

Billing Address: _____

Business Phone #: _____ Business Fax #: _____

Contact Person for this Account: _____ Phone #: _____

Contact Email Address: _____

I request emailed invoices []: Email address for invoices: _____

Federal Tax Identification Number*: _____

Social Security Number (Sole Proprietorship or Partnership)*: _____

*EITHER a Federal Tax Identification Number OR Social Security Number **must be** provided.

FACILITIES AUTHORIZED TO SCREEN ON THIS ACCOUNT (attach separate sheet if more facilities are authorized)

OK-SCREEN account holders for the facilities below will be authorized to request an *Authorization to Fingerprint* or to enroll an applicant, previously determined eligible for hire, as a facility employee subject to electronic criminal history monitoring. Pursuant to 63 O.S. § 1-1947(J)(1), the company or individual authorizing this billing account shall pay a fee of Nineteen Dollars (\$19.00) to the Department for each applicant submitted for fingerprinting or criminal history monitoring or both fingerprinting and criminal history monitoring.

Name: _____ License/FEI #: _____

Name: _____ License/FEI #: _____

I, the undersigned, have the authority to conduct business for the business/agency/provider listed above. I confirm that all the information on this application is true and correct. I understand this is an agreement to pay the processing fees associated with access to the OK-SCREEN web portal and employment eligibility determinations obtained through the OK-SCREEN portal pursuant to the Long Term Care Security Act, Title 63, Oklahoma Statutes, Section 1-1944 *et. seq.*, including fees incurred by duplicate transmissions or other errors on the part of the above business/agency/provider or its representatives(s). Failure to remit payment in a timely manner may result in deactivation of the OK-SCREEN account, loss of access to fingerprint authorizations, employment eligibility determinations, and the OSDH utilizing all information provided on this billing account application for collection purposes. I agree to the terms of this agreement and understand it will remain in effect until written cancellation is provided by either party with 30 days notice.

I Agree

PRINTED NAME: _____ TITLE: _____

DATE: _____ SIGNATURE: _____

Oklahoma National Background Check Program
1000 NE 10th Street
Oklahoma City, OK 73117
Phone: 405.271.3598 Toll-Free: 855.584.3550
Fax: 405.271.3611
okscreen@health.ok.gov
<http://onbc.health.ok.gov>

FOR OSDH-OKSCREEN USE

Input by: _____ Acct #: _____

Processed Date: _____

