STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

DATE: _____

CONFIRMATION OF REMOVAL FOR: _____

This is to confirm that the Department of Social Services, Caregiver Background Check Bureau, informed you that the person identified above must be removed from your facility/home. The individual must be removed because his/her criminal record exemption has been denied.

To confirm that the individual has been removed from your facility/home, you must sign below and return the entire notice, **within five (5) days** of the date of this notice to the address below. Retain a copy of the signed notice for your records.

Regional Office: _____

Address: _____

City/State/Zip Code: _____

Failure to immediately remove the individual and return this notice within five (5) days will may result in an assessment of civil penalties and/or a disciplinary action including suspension of your license. If you have any questions regarding this letter, you may contact your local regional office at _____.

I declare under penalty of perjury under the laws of the State of California that I have read and understand the information contained in this affidavit and that my responses are true and correct. I confirm that the individual named above has been removed from the facility/home.

DATE INDIVIDUAL WAS REMOVED: _____

NAME OF PERSON COMPLETING THIS FORM: _____

TITLE: _____

SIGNATURE: _____

C: _____