Passaic County Sheriff's Office
CONTACT VISITOR BACKGROUND CHECK FORM

Eligible Adult Visitors: Please print all answers to all questions clearly and concisely. If a question does not pertain to you, write "N/A" in the appropriate space. If you need more space to answer a question, write "See other side" at the bottom of this form and continue writing on the back. Any special needs and mobility equipment shall be listed below. **You must complete this form and submit it to the Bureau of Criminal Identification at least seven (7) calendar days prior to the inmate's approved visitation date. It may be completed in-person during business hours or be sent by mail or facsimile.**

Address: Passaic County Sheriff's Office, Bureau of Criminal Identification, 11 Marshall St. Paterson, NJ 07501
Fax: 973-881-4607

Inmate's Name: _____ Inmate #: _____ Date of Visit: _____

Your Full Name: _____ Relationship to Inmate: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security #: _____ Primary Phone #: _____

Driver's License # and State: _____ Email: _____

Have you ever been convicted of a crime? ☐ Yes ☐ No (if yes, provide the date and an explanation below)

_____

Is there any legal action or Domestic Violence Restraining Order (Temporary or Permanent) between you and the inmate you request to visit: ☐ Yes ☐ No

I, _____, hereby authorize any representative of the County of Passaic, holding this release, to conduct a background check on me for clearance into the Passaic County Jail. I hereby authorize the release of said information whether such records are public, private or confidential. I consent to full and complete information disclosure. I also understand that I may have certain rights under the Federal Privacy Act of 1974 (Title 5 of the United States Code Section 552(a)) with regard to the access and disclosure of records. I hereby waive those rights with the understanding that the information furnished will only be used by the County of Passaic to conduct a background check for the purpose of my inmate contact visit.

I further certify that I may be charged with making a false or misleading statement (N.J.S.A. 2C:28-3).

The contact information I provided above will be used to notify me of approval or denial of the visit.

Signature of Applicant: _____ Date: _____

VISITOR MOBILITY AIDS/SPECIAL NEEDS

Please list all mobility aids (cane, walker, etc.) or special needs you may have during your requested visit.

_____

BCI USE ONLY:

Cleared by the following: County: ☐ Yes ☐ No State: ☐ Yes ☐ No Federal: ☐ Yes ☐ No

Review Completed by: _____

BCI Supervisor Signature: _____