PROVIDE FINGERPRINT CLEARANCE CARD NUMBER (if known)				PROVIDE ORIGINAL APPLICATION NUMBER (if known)			
NAME (Last)		(First)			(Middle)		
DATE OF BIRTH	SOCIAL SECURITY NUMBER			TELEPHONE NUMBER (□ Check if new)			
MAILING ADDRESS ☐ Check if new							
STREET / P.O. BOX						APARTMENT/LOT NUMBER	
CITY				STA	TE	ZIP CODE	
REASON FOR RE	PLACEMENT:						
☐ Card was lost, stolen or damaged							
☐ Original care	d never receive	ed					
☐ Name has le copy of legal docu						ith new name and a nt with request.)	
FORMER NAME ON C	ARD (Last)	(First)			(Middle)		

You can either:

 Mail this form, any required documentation, and a \$5.00 money order, cashier's check or check drawn on a business account made payable to DPS (DPS does not accept cash or personal checks) to the Applicant Clearance Card Team (ACCT)

The ACCT mailing address is: (by mail, please allow approximately 15 business days for DPS to complete your request.)
Arizona Department of Public Safety
Applicant Clearance Card Team
P.O. Box 18390
Phoenix, AZ 85005

Bring this form, any required documentation, and payment of \$5.00 in the form of money order, cashier's check, credit card or check drawn on a business account made payable to DPS (DPS does not accept cash or personal checks) to the DPS Public Service Center located at 2222 West Encanto Boulevard, Phoenix, Arizona 85009

If you have any questions, please call the Applicant Clearance Card Team at (602) 223-2279.

DPS 802-03027 Rev. 3-2019 On-line Replacement Form