

I, _____ do hereby authorize the Department of Children and Families to research <i>Applicant Name</i>						
its records to determine whether or not I am on the central registry of persons responsible for child abuse and neglect I understand that this information may be used to determine my suitability solely for <i>(check one)</i> :						
<input checked="" type="checkbox"/> Employment <input type="checkbox"/> Day Care <input type="checkbox"/> Volunteer <input type="checkbox"/> Intern <input type="checkbox"/> Mentor <input type="checkbox"/> Other:						
Name of Agency: NH Child Care Licensing Unit				Attention: Mychelle Brown		
Address: (No. and Street): 129 Pleasant Street		Apartment #	City: Concord		State: NH	Zip: 03301
I release the Department of Children and Families from any liability for any damages I may incur which may result from the release / use of this information. I submit my following information to assist the Department. of Children and Families in their search.						
Last Name		First Name:		Middle:	DOB:	SS:
Address: (No. and Street):		Apartment #:	City:	State:	Zip:	Years at current address?: Years Months
Previous Address(es)/List All for the Last Five Years <i>(continue on reverse side of form if necessary)</i>						<input type="checkbox"/> Check if reverse side used
Address: (No. and Street):		Apartment #:	City:	State:	Zip:	Dates From: (Month/Year) Dates To: (Month/Year)
Other Names I have Used – <i>Including Maiden, Previous Marriages(s) (continue on reverse side of form if necessary)</i>						<input type="checkbox"/> Check if reverse side used
Last Name		First Name:		Middle:	DOB:	SS:
Name of Spouses/Other Adults in the Home – <i>Past and Present (continue on reverse side of form if necessary)</i>						<input type="checkbox"/> Check if reverse side used
Last Name		First Name:		Middle:	DOB:	Signature (if still in Home) Date:
Names of ALL Child(ren) – <i>Biological, Stepchildren Including Adult Children In or Out of the Home</i>						<input type="checkbox"/> Check if reverse side used
Last Name		First Name:		Middle:	DOB:	Gender:
Do you have an active DCF investigation at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have an active appeal of a DCF investigation at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Applicant Signature:					Date:	
THIS AUTHORIZATION WILL EXPIRE 180 DAYS AFTER THE DATE OF THE SIGNATURE. FORMS NOT FILLED OUT COMPLETELY AND / OR CLEARLY WILL BE RETURNED. DO NOT LEAVE ANY BLANK SPACES. PLEASE SPECIFY WITH N/A IF NOT APPLICABLE. ****DCF Conducts a Search of the CT Registry ONLY*** The Accuracy of this Search is Limited to the Information Provided by the Applicant to DCF						
Mail to: DCF Careline Background Searches – 505 Hudson Street – 5th Floor – Hartford, CT 06106 or FAX: 860-560-7071 <i>DCF-CT Careline CPS-BGC USE ONLY - DO NOT WRITE BELOW THIS LINE</i>						
Date:		Central Registry?: <input type="checkbox"/> Yes <input type="checkbox"/> No			Processors Initials:	