Authorization for Release of Information for DCF CPS Search

DCF-3031
12/12 (Revised)

I, _____ do hereby authorize the Department of Children and Families to research
(Type Applicant Name)

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 *(check one):* ☐ **Employment** ☐ **Day Care** ☐ **Volunteer** ☐ **Intern** ☐ **Mentor** ☐ **Other**

By: Agency Name / Address/City / State / Zip Code

Attention: Joseph Macary
Agency: Vernon Public Schools
Address: 30 Park Street
City: Vernon **State:** CT **Zip Code:** 06066

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 Dept. of Children and Families in their search.

PLEASE TYPE OR PRINT LEGIBLY / LEAVE NO BLANK SPACES

Name: _____ Date of Birth: _____
Last, First Middle

Address: _____ Social Security #: _____
Street (No P.O. Boxes) Apartment No.

How Long at Current Address: _____ Yrs. _____ Mos.
City State Zip Code

Previous Address(es)/List All for the Last Five Years *(continue on reverse side of form if necessary)* ☐ **Check if reverse side used**

Street (No P.O. Boxes)	Apt. #	City/Town	State	Zip Code	Dates From (Month/Yr.)	Dates To (Month/Yr.)

Other Names I have Used – *Including Maiden, Previous Marriages(s)* ☐ **Check if reverse side used**

Last	First	Middle

Name of Spouses/Other Adults in the Home – *Past and Present* ☐ **Check if reverse side used**

Last	First	Middle	D.O.B. Month/Day/Year	Signature/Date (If Still in the Home)

Names of ALL Child(ren) – *Biological, Stepchildren Including Adult Children In or Out of the Home* ☐ **Check if reverse side used**

Last	First	Middle	Gender	D.O.B. (Month/Day/Year)

Do you have an active DCF investigation at this time? ☐ **Yes** ☐ **No**
Do you have an active appeal of a DCF investigation at this time? ☐ **Yes** ☐ **No**

Date: _____ **Applicant Signature:** _____

THIS AUTHORIZATION WILL EXPIRE 180 DAYS AFTER THE DATE OF THE SIGNATURE. FORMS NOT FILLED OUT *COMPLETELY* AND PRINTED *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

DCF-CT Careline CPS-BGC USE ONLY DO NOT WRITE BELOW THIS LINE

DATE: _____ Central Registry: YES ___ NO ___ Processor's Initials: _____