AUTHORIZATION FOR CHILD ABUSE AND NEGLECT BACKGROUND CHECK

ND DEPARTMENT OF HUMAN SERVICES
EARLY CHILDHOOD SERVICES
SFN 508 (11-2008)

Clear Fields

I. IDENTIFYING INFORMATION

Full Legal Name			Date of Birth
Address (Street & Apartment Number)	City	State	Zip Code
Mailing Address (If Different)	City	State	Zip Code
Facility Full Legal Name	Work Telephone Number	Home Telephone Number	

II. ASSURANCE

I CERTIFY THAT I HAVE NOT BEEN FOUND GUILTY OF A CRIME AGAINST CHILDREN OR BEEN CONVICTED OF A FELONY. IN THE EVENT THAT I AM FOUND GUILTY OF A CRIME AGAINST CHILDREN, BEEN CONVICTED OF A FELONY OR A CHILD ABUSE AND NEGLECT DECISION OF "SERVICE REQUIRED" HAS BEEN MADE, I WILL IMMEDIATELY NOTIFY MY EMPLOYER OR COUNTY SOCIAL SERVICE BOARD.

III. AUTHORIZATION FOR RELEASE OF INFORMATION (IN-STATE)

A. I give the North Dakota Department of Human Services and the County Social Service office permission to check for my name in child abuse or neglect files and the North Dakota Child Abuse and Neglect Information Index for a period not to exceed one year.

B. I further consent that any information found in the child abuse and neglect records can be shared with Early Childhood Services staff as well as the operator of the Early Childhood Facility.

IV. AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the state or county agency that maintains records concerning child abuse or neglect in the states listed below to release to the North Dakota Department of Human Services all information contained in those records related to the undersigned.

List States Where You Have Lived in the Past Ten Years	
Social Security Number	

V. FORMER ADDRESSES/NAMES

Please List Any Former Address(es) and County of Residence Where You Have Lived in the Past Ten Years
Please List Any Other Names You Have Gone by in the Past Ten Years

THIS IS A PUBLIC DOCUMENT AND MUST BE MADE AVAILALBE UPON REQUEST

VI. CERTIFICATION SIGNATURE

I Hereby Certify That The Above Information is True To The Best of My Knowledge:	Signature	Date

Provide a copy of the form to CSSB, HSC, and Provider.