ARKANSAS DEPARTMENT OF HUMAN SERVICES DIVISION OF CHILD CARE & EARLY CHILDHOOD EDUCATION

Authorization for release of confidential information:

ARKANSAS CHILD MALTREATMENT CENTRAL REGISTRY

Note to users of thi	s form:			mation! Illegible forms w may be copied and shared	ill not be processed! Fill out d.
RETURN THE ORI	GINAL COMPLETED F	ORM TO: YOU	JR CHILD C	ARE LICENSING SPE	CIALIST
FACILITY REQUESTING CHECK AND REPORT			NAME OF LICENSING SPECIALIST REQUESTING THE CHECK		
MAILING ADDRESS				TITLE	COUNTY
CITY	STATE	ZIP	TELEPHONE NUMBER		
TO BE COMPLETE	RECTOR & TELEPHONE ED BY THE PERSON TO	BE CHECKED		DATE OF REC	QUEST
NAME OF PERSON	TO BE CHECKED:(La	AST NAME)		(FIRST NAME)	(MIDDLE NAME)
				ALIASES:	
DOB: (/ / / DATE YEAR	2	SSN:		
RACE: SEX: (MALE/FEMALE) TELEPHONE NUMBER: (
COMPLETE ADDRE	STREET	CITY		STATE	ZIP
PLACE OF EMPLOY	YEMENT:				
FULL NAME/AGE OF OWN CHILDREN DO			B SOCIAL SECURITY NUMBER		
Prosecuting Attorney' resided in my home of	e Arkansas Child Maltreatn s report, concerning the un f the undersigned. I also un or my children, will not be	dersigned and any nderstand that the	y birth/legal cl name of any c	nildren ages 10 through 17	7 who are now or have other information which
STATE OF ARKANS	ne on this				
My Commission Expi DCC 316 R (2/04)	Notary Public res:	1		_	