DCF		uthorization fo	or Re	lease o	of Informa	tion for	DCF C	PS Sea	rch		
DCF-3031 12/12 (Rev I,	ised)				da ha	rohy outborizo	the Departm	ent of Children	and Familias to r	aaarah	
', do hereby authorize the Department of Children and Families to research											
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 Other											
		Attention:									
By: Agency Name / Address/City / State / Zip Code			Brookfield Board of Education P.O. Box 5194								
		City: Broo	Brookfield			State: CT				Zip Code: 06804	
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:	Last,		First			Middle	Dat	e of Birth:			
A daha aa i	,						0	ial Casurity H			
Address:		P.O. Boxes)	Apartment No.			ocial Security #:					
· · ·						How Cur		w Long at rrent Address:	Yrs.	Mos.	
Provious A	City	ist All for the Last Eive V	are loo	State Zip Code ars (continue on reverse side of form if necessary)					Chack if rovo	rea cida ucad	
Street			ears (00)			City/Town		l	Check if reverse side used Dates		
(No		P.O. Boxes)			City/To			Zip Code	From (Month/Yr.)	To (Month/Yr.)	
									(#0101/11.)	(MOTICI/11.)	
Other Names I have Used – Including Maiden, Pr				Marriages(s)				Check if reverse	e side used	
Last					First				Middle		
Name of Spouses/Other Adults in the Home – Past and Present										e side used	
Last First				Middle		D.O.B.		Signature/Date			
					Month	Month/Day/Year		(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 how	o an active F	CE investigation at this	time? []Yes □ I	No						
	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 <u>COMPLETELY</u> AND PRINTED <u>CLEARLY</u> WILL BE RETURNED. <u>DO NOT LEAVE ANY BLANK SPACES</u>. <u>PLEASE SPECIFY WITH N/A IF NOT APPLICABLE</u>. ****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

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