South Central Community Action Program
1500 W. 15th Street Bloomington, IN 47404
812-339-3447

Consent for Release of Information for Criminal History & Child Protective Service
State Central Registry Checks

Full Name: _____
First Middle Last Previous

Address: _____
Street City State Zip County

Date of birth: ___/____/_____ Race/Ethnicity _____ Social Security #: _____-_____-_____

Previous Address(es) for past 10 years:

Address: _____
Street City State Zip County

Address: _____
Street City State Zip County

Address: _____
Street City State Zip County

List names of dependent, independent & deceased child(ren): _____

_____

Applicant expressly agrees to waive any privileges of confidentiality to permit any and all information to be released to South Central Community Action Program, Inc.(SCCAP) and Child Protective Services. Applicant expressly agrees and understands that any or all information obtained through this signed consent form may be used at the discretion of SCCAP and Child Protective Services in determining the applicant's suitability for working with children as a Legally Licensed Exempt Provider.

Signature: _____ Date: _____

Witness: _____ Date: _____

For Administrative Use Only:

Type of check: _____Criminal History _____Child Protective Services

_____ Legally Licensed Exempt Provider _____Circles™ Initiative

Please Check the Appropriate Findings Below:

_____: Our Agency has no information/record(s) concerning the above named individual.

_____: Our Agency has the following information/record(s) concerning the above named individual: (Submit documentation or summarize areas you believe should be considered in evaluating the suitability of this individual working for a youth service agency.) Please use the back of the form or contact: _____

Signature: _____Date: _____

Agency: _____