



# Authorization for Release of Information for DCF CPS Search



DCF-3031  
12/15 (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: Superintendent of Schools  
 Agency: Ashford Board of Education  
 Address: 440 Westford Rd.  
 City: Ashford State: CT Zip Code: 06278

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.

City State Zip Code

How Long at Current Address: \_\_\_\_\_ Yrs. Mos.

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.)	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: \_\_\_\_\_