Processed: _X_ Anna _____ Murphysboro _____ Pinckneyville

AUTHORIZATION FOR RELEASE OF CRIMINAL HISTORY RECORD CHECK

Alexander, Jackson, Perry, Pulaski, Union Regional Office of Education

Jackson County Courthouse ~ Murphysboro, IL 62966
PHONE: 618/687-7290 FAX: 618/687-7296

TO BE COMPLETED BY APPLICANT/EMPLOYEE

Please PRINT legibly.

Please read carefully before signing.

I, _____, SS# _____ hereby authorize the Regional Office of Education to submit a Fingerprint Conviction Inquiry to the Illinois State Police and the Federal Bureau of Investigation. The inquiry is for the purpose of employment or volunteer services in the Alexander, Jackson, Perry, Pulaski, Union Region.

I do hereby fully waive, release, and discharge the Regional Office of Education and the Counties of Alexander, Jackson, Perry, Pulaski, Union Illinois, their officers, agents, servants, and employees from any and all claims from damages which I may have or which may accrue to me or arise out of the results of any aspect of the criminal background investigation or my participation in a criminal conviction investigation.

I further agree to indemnify and hold harmless and defend the Regional Office of Education #30, and the Counties of Alexander, Jackson, Perry, Pulaski, Union Illinois, their officers, agents, servants, and employees from any and all claims resulting from damages sustained by me or rising out of, connected with, or in any way associated with, any of the activities of the criminal background investigation and review. I also understand and consent that a copy of the inquiry and report be sent to my Regional Office of Education and any prospective school district that may want to employ me or utilize my services.

I have fully read and understand this waiver and release. The information below is accurate.

_____ _____

Date Signature

Last Name _____ First Name _____ MI _____

Social Security # _____ Date of Birth _____/_____/_____
Month Day Year

Drivers License # _____ Current Address _____

City _____ State _____ Zip Code _____ Phone _____

Sex _____ Race _____ (Note: Select white for Hispanic)
Race selection options (Asian; American Indian/Alaskan; Black; White; Unknown)

Height _____ Weight _____ Hair Color _____ Eye Color _____

Place of Birth: State _____ or Country _____

For Substitutes only: email address: _____ include on email List Serv: Yes No

Counties for Sub List (please check all that apply):
Alexander_____Jackson_____Perry_____Pulaski_____Union_____

APPLICANT SIGNATURE: _____ DATE: _____

VERIFY Account Code: _____ VERIFY Reference # _____ Applicant Job Category _____

TO BE COMPLETED BY LIVE SCAN TECHNICIAN

Date: _____ Time: _____ ISP TCN tracking #: **LS10375L4959**_____

Proof of Identification:
Drivers License _____ Passport _____
State ID _____ Other _____
Technician Name _____

District: _____
ORI Type: _____
CC Number: **1633**

Update – 7/24/18

Privacy Act Statement

Authority: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

Principal Purpose: Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

Routine Uses: During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

Applicant Consent

By signing below, I acknowledge and hereby authorize the release of any criminal history record information that may exist regarding me from any agency, organization, institution, or entity having such information on file. I am aware and understand that my fingerprints may be retained and will be used to check the criminal history record information files of the Illinois State Police and/or the Federal Bureau of Investigation, to include but not limited to civil, criminal and latent fingerprint databases. I also understand that if my photo was taken, my photo may be shared only for employment or licensing purposes. I further understand that I have the right to challenge any information disseminated from these criminal justice agencies regarding me that may be inaccurate or incomplete pursuant to Title 28 Code of Federal Regulation 16.34 and Chapter 20 ILCS 2630/7 of the Criminal Identification Act.

Applicant Name (printed):	
Applicant Name (signature):	Date:

THIS SIGNED FORM MUST BE RETAINED BY THE AGENCY FOR AT LEAST TWO YEARS.

Illinois Department of
DCFS
Children & Family Services

ACKNOWLEDGEMENT OF MANDATED REPORTER STATUS

I, _____, understand that when I am employed as a
(Employee Name)

_____, I will become a mandated reporter under the
(Type of Employment)
Abused and Neglected Child Reporting Act [325 ILCS 5/4]. This means that I am required to report or cause a report to be made to the child abuse Hotline number at 1-800-25-ABUSE (1-800-252-2873) whenever I have reasonable cause to believe that a child known to me in my professional or official capacity may be abused or neglected. I understand that there is no charge when calling the Hotline number and that the Hotline operates 24-hours per day, 7 days per week, 365 days per year.

I further understand that the privileged quality of communication between me and my patient or client is not grounds for failure to report suspected child abuse or neglect, I know that if I willfully fail to report suspected child abuse or neglect, I may be found guilty of a Class A misdemeanor. This does not apply to physicians who will be referred to the Illinois State Medical Disciplinary Board for action.

I also understand that if I am subject to licensing under but not limited to the following acts: the Illinois Nursing Act of 1987, the Medical Practice Act of 1987, the Illinois Dental Practice Act, the School Code, the Acupuncture Practice Act, the Illinois Optometric Practice Act of 1987, the Illinois Physical Therapy Act, the Physician Assistants Practice Act of 1987, the Podiatric Medical Practice Act of 1987, the Clinical Psychologist Licensing Act, the Clinical Social Work and Social Work Practice Act, the Illinois Athletic Trainers Practice Act, the Dietetic and Nutrition Services Practice Act, the Marriage and Family Therapy Act, the Naprapathic Practice Act, the Respiratory Care Practice Act, the Professional Counselor and Clinical Professional Counselor Licensing Act, the Illinois Speech-Language Pathology and Audiology Practice Act, I may be subject to license suspension or revocation if I willfully fail to report suspected child abuse or neglect.

I affirm that I have read this statement and have knowledge and understanding of the reporting requirements, which apply to me under the Abused and Neglected Child Reporting Act.

_____
Signature of Applicant/Employee

_____
Date

CANTS 22
Rev. 8/2013

Office of the Director
406 E. Monroe Street • Springfield, Illinois 62701
www.DCFS.illinois.gov