

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
QUALITY ASSURANCE DIVISION

RELEASE OF INFORMATION (For Licensed Youth and Adult Care Providers)
Criminal and Protective Service Background Checks and Release of Driving Record

Please Type Or Print Legibly

Section A

Facility Name _____ Facility Location _____

Actual or prospective date of hire at facility _____

Applicant's Name _____
 First Middle Maiden Last

Aliases/Other Names Used _____

Applicants Current Address _____

Phone # _____ Date of Birth _____ Sex { } M { } F

Drivers License# _____ Social Security# _____

Section B

Please list below where you have resided in the past 5 years. Attach additional pages if necessary

CITY	COUNTY	STATE	DATES (FROM – TO)

Section C

I understand that any information obtained from these checks will be used by the Department to evaluate my employer's application or my own application as a licensed provider. I hereby authorize any law enforcement, protective services agency or the Montana Motor Vehicle Division to release any records they have regarding me to the State of Montana, Department of Public Health and Human Services and (if applicable) to my employer or perspective employer as indicated in Section A of this form.

A copy of this form is as valid as the original.

Signed: _____ Date: _____

To be signed in front of a Notary

To be completed by Notary Public:

Taken, sworn and subscribed before me this _____ day of _____ A.D.20 _____

Notary Public for the State of Montana Residing at: _____

My Commission Expires _____

RETURN TO: DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
QUALITY ASSURANCE DIVISION-LICENSURE BUREAU
2401 COLONIAL DR 2ND FLOOR
PO 202953
HELENA MT 59620-2953