## ARKANSAS DEPARTMENT OF HUMAN SERVICES AUTHORIZATION FOR ADULT MALTREATMENT CENTRAL REGISTRY

## Print all information in ink Name Date of Birth Maiden and/or Any Names Formerly Used Social Security Number Current Address (Street, City, State, Zip) List all previous addresses for the past five years Dates (From/To) I authorize Department of Human Services/Adult Protective Services to release information from the Adult Maltreatment Central Registry in accordance with Arkansas Code [ACA 12-12-1717] to: Name Agency type: Volunteer (no charge) Non-Profit (no charge) State Agency (no charge) All Others (\$10.00 Fee) Mailing Address (Street or PO Box, City, State, Zip) I further certify that the information provided on this form is true and correct. Signature\_\_\_\_\_ Date \_\_\_\_\_ Notarization Required COUNTY OF STATE OF ARKANSAS Acknowledged before me this \_\_\_\_\_\_ day of \_\_\_\_\_\_, 20\_\_\_\_\_. (Notary Public) (My Commission Expires) The above listed applicant was\_\_\_\_\_/was not\_\_\_\_\_ found in the Adult Maltreatment Central Registry. Adult Protective Services – Slot W240 Adult Maltreatment Central Registry PO Box 1437

Little Rock, AR 72203

APS-0001 (05/09)