

NHSS – Regulation and Licensure
Credentialing Division – Child Care Licensure
PO Box 94986
Lincoln, NE 68509-4986
Fax: 402-471-7763

RELEASE OF INFORMATION FORM

Nebraska Child Care Regulations require:

“Candidates being considered for employment as a director, teacher, assistant teacher, and all support staff must be checked against the Nebraska Central Registry of Abuse and Neglect and the Nebraska Adult Protective Services Central Registry BEFORE being hired”.

Before being accepted as an... **Employee** ___ **Volunteer** ___ at the following licensed Child Care Center/Preschool...

If Employee: Date of vacancy _____ *Date of Candidate's Interview* _____

If Volunteer: Planned start date _____

Facility Name: _____ Family Service Association of Lincoln _____

Address: _____ 501 S. 7th Street _____, City/State/Zip: _____ Lincoln, NE 68508 _____

Area Code/Phone Number: _____ (402) 441-7949 _____, Fax Number: _____ (402) 441-6466 _____

The Department needs your permission to check the Nebraska Child Abuse/Neglect Central Registry and the Nebraska Adult Protective Services Central Registry to confirm your name does not appear.

I authorize Nebraska Health and Human Services System to release information from the Child Abuse/Neglect Central Registry **AND** the Nebraska Adult Protective Services Central Registry pertaining to me to the above named facility. The Department may state if my name appears or does not appear on the registries.

Print Name (First, Middle, Last, Suffix (Jr./Sr./II/III))

Social Security Number

Signature

Date of Signature

Other Names (Married/Alias/Nicknames. If none, write NONE)

Date of Birth

Addresses: (last 20 years – begin with current address, include Street, City, State AND date you lived at each address. Date to include month and year moved TO and AWAY from each address)

Names of Children: (Full Name: If none, write NONE)

For office use only

ONE SOURCE

THE BACKGROUND CHECK COMPANY

P.O. Box 24148 Omaha, NE 68124
(P) 800.608.3645 • (P) 402.933.9999 • (F) 402.333.3280

APPLICANT RELEASE AUTHORIZATION

In connection with my application for employment, I understand that an investigative consumer report may be requested that will include information as to my character, work habits, performance and experience, along with reason for termination and employment. I understand that as directed by company policy and consistent with the job described, you may be requesting information from public and private sources about my: worker's compensation injuries, driving record, court record, education, credentials and references.

Medical and worker's compensation information will only be requested with the Federal Americans with Disabilities Act (ADA) and/or any other applicable state laws. According to the Fair Credit Reporting Act, I am entitled to know if employment is denied because of information obtained by my perspective employer from a consumer-reporting agency. If so, I will be notified and given the name and address of the agency or the source, which provided the information. I acknowledge that facsimile (FAX), photographic copy or email shall be as valid as the original.

I hereby authorize, without reservation, any law enforcement agency, institution, information service bureau, school, employer, reference or insurance company contacted by One Source, The Background Check Company or its agent, to furnish the information described above. I understand that in the event a negative hiring decision is made based upon the results of my background check, a report will be furnished to me upon my request.

The following information is required by law enforcement agencies and other entities for positive identification purposes when checking public records. It is confidential and will not be used for any other purposes. I hereby release the employer and agents and all persons, agencies, and entities providing information or reports about me from any and all liability arising out of the request for or release of any of the above mentioned information or reports.

PERSONAL INFORMATION (PLEASE PRINT)

(Please Print) LAST NAME: FIRST NAME: MIDDLE INITIAL (REQUIRED)

OTHER LEGAL NAMES YOU HAVE USED, INCLUDING MAIDEN NAME(S):

HOME ADDRESS: CITY: STATE: ZIP CODE

SOCIAL SECURITY NUMBER DATE OF BIRTH (REQUIRED)

DRIVERS LICENSE # STATE OF ISSUE NAME AS IT APPEARS ON LICENSE

OTHER ADDRESSES IF LESS THAN 7 YEARS AT HOME ADDRESS: (USE BACK OF SHEET FOR ADDITIONAL ADDRESSES)

ADDRESS: CITY: STATE: ZIP CODE:

ADDRESS: CITY: STATE: ZIP CODE;

I CERTIFY THAT THE INFORMATION ON THIS APPLICATION IS TRUE

SIGNATURE OF APPLICANT: NAME OF APPLICANT (PLEASE PRINT): DATE:

RELEASE OF INFORMATION
PLEASE FILL OUT COMPLETELY AND LEGIBLY

I understand that as a condition of my employment, my name will be checked against the Nebraska Department of Health and Human Services Adult/Child Protective Services Central Registries. A check of these registries is necessary to ensure that I meet provider standards. One copy of this form will be sent to the Adult Registry and one will be sent to the Child Protective Service Registry, as they are two separate areas.

The purpose of this check will be to determine if my name is being maintained on either registry as a result of previous abuse/neglect allegations which have been investigated and have not been determined to be unfounded.

To the best of my knowledge, I do not have a conviction or prior history of adult or child abuse/neglect or maltreatment. Neither have I been convicted of a crime involving moral turpitude.

I hereby authorize the Nebraska Department of Health and Human Services to release information contained on the Adult or Child Protective Services Central Registry including the information that a record has been found to:

Family Service Association
(Agency/Facility)

501 South 7th Street, Lincoln, NE 68508-2920 FAX No. (402) 441-6466
(Complete Agency Address and Fax Number)

(Signature of Applicant/Employee)

(Date Signed)

(Printed or Typed Name of Applicant/Employee)

(Social Security Number)

Other Names Used in Past Twenty (20) Years
(Please Print or Type)
(Use back of sheet if necessary)

Other Addresses in Past Twenty (20) Years
(Please Print or Type)
(Use back of sheet if necessary)

Names of Children Who Have Lived With You
(Please Print or Type)
(Use back of sheet if necessary)

(Applicant's Date of Birth)

(Home Address of Applicant/City/Zip-**DO NOT** use a PO #)

(Witness Signature)

(Date Witnessed)

This release becomes void ninety (90) days after signature by Applicant/Employee