To: Mississippi Department of Human Services
Division of Family & Children Services
Child Abuse Central Registry
P.O. Box 352
Jackson, MS 39205

From: Tara Dearman / Director of Human Resources
Southern Healthcare Agency, Inc
1088 Flynt Drive
Jackson, MS 39232
601-933-0037

(Printed) Applicant Full Name (list maiden name & list any aliases)

_____

Social Security Number: _____ Date of Birth: _____
(Requesting agency should verify by attaching a copy of the applicant's Driver's License and Social Security Card)

Physical Address: _____

By signing this form, I give the above named agency permission to request an MDHS Child Abuse/Neglect Central Registry background check. I understand that this information will be used only for employment purposes and will not be re-disseminated to other persons or used for other purposes.

_____ _____
Applicant Signature Date

I have witnessed the applicant's signature and the information is true and attested by my viewing of the applicant's Social Security Card and Driver's License. I understand that this information must be kept confidential with my agency.

Signature of Witness: _____ Date: _____
(Witness must be a representative of the requesting agency)

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This section to be completed by MDHS Office

_____No Identifying information was found in the Central Registry

_____The following information was found in the Central Registry

_____

_____

_____ _____
Signature of MDHS Representative Date

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