

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:
CLS	<input type="checkbox"/> Volunteer (no charge) <input checked="" type="checkbox"/> Non-Profit (no charge) <input type="checkbox"/> State Agency (no charge)
Mailing Address (Street or PO Box, City, State, Zip)	<input type="checkbox"/> All Others (\$10.00 Fee)
105 E. Roosevelt Rd. Little Rock, AR 72206	

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