



The Commonwealth of Massachusetts
 Executive Office of Health and Human Services
 Department of Public Health



This form is not to be faxed. Please return form to organization.

**Criminal Offender Record Information (CORI)
 Acknowledgement Form**

To be used by organizations conducting CORI checks for employment or licensing purposes.

_____ is registered under the

 (Organization)
 provisions of M.G.L. c.6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective employees, subcontractors, volunteers, license applicants, or current licensees.

As a prospective or current employee, subcontractor, volunteer, license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to _____ to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing _____ with written notice of my intent to withdraw consent to a CORI check.

I also understand, that _____ may conduct subsequent CORI checks within one year of the date this Form was signed by me.

By signing below, I provide my consent to a CORI check and affirm that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

Signature of CORI Subject

Date

Volunteer Unit _____

Please note: CORIs cannot be accepted without photo ID Verification

Have your photo identification verified and this form signed indicating photo verification by your local program administrator or by a notary public before sending it in for processing. If you have selected the “State unaffiliated Volunteers” as your only organization please have your photo identification verified and CORI acknowledgement Form signed by a notary public.

Once photo ID is verified, mail from to:

Massachusetts Department of Public Health
 Office of Preparedness and Emergency Management
 250 Washington Street, 1st Floor
 Boston, MA 02108
 ATTN: MA Responds



The Commonwealth of Massachusetts
 Executive Office of Health and Human Services
 Department of Public Health



SUBJECT INFORMATION

Please complete this section using the information of the person whose CORI you are requesting.
 The fields marked with an asterisk (*) are required fields.

* First Name: _____ Middle Initial: _____

* Last Name: _____ Suffix (Jr., Sr., etc.): _____

Former Last Name 1: _____

Former Last Name 2: _____

Former Last Name 3: _____

Former Last Name 4: _____

* Date of Birth (MM/DD/YYYY): _____ Place of Birth: _____

* Last **SIX** digits of Social Security Number: _____ -- _____ No Social Security Number

Sex: _____ Height: _____ ft. _____ in. Eye Color: _____ Race: _____

Driver's License or ID Number: _____ State of Issue: _____

Father's Full Name: _____

Mother's Full Name: _____

Current Address

* Street Address: _____

Apt. # or Suite: _____ *City: _____ *State: _____ *Zip: _____

SUBJECT VERIFICATION

The above information was verified by reviewing the following form(s) of government-issued identification:

Verified by:

Print Name of Verifying Employee

Signature of Verifying Employee

Date



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health



Authentication of Signature

Please note that ALL fields in this section must be completed by the Notary Public.

On this _____ day of _____, 20____, before me, the undersigned Notary Public, personally appeared _____ (name of CORI requestor) and proved to me through satisfactory evidence of identification, which was _____ (Ex: Driver's license, passport, etc.), to be the person whose name is signed on the preceding or attached document, and acknowledged to me that (he)(she) signed it voluntarily for its stated purpose.

Signature of Notary Public (Notary stamp or seal is also required)

Date my Commission expires