The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Care Safety and Quality
Mobile Integrated Health Care Program
67 Forest Street, Marlborough MA 01752

Criminal Offender Record Information (CORI) Acknowledgement Form

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

The Department of Public Health, Mobile Integrated Health Care Program 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 The Department of Public Health, Mobile Integrated Health Care Program 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 The Department of Public Health, Mobile Integrated Health Care F with written notice of my intent to withdraw consent to a CORI check.

I also understand, that The Department of Public Health, Mobile Integrated Health Care Program 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*

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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*

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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*