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

**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.

MA Department of Public Health/OEMS 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 MA Department of Public Health/OEMS 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 MA Department of Public Health/OEMS with written notice of my intent to withdraw consent to a CORI check.

I also understand, that MA Department of Public Health/OEMS 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: _____

**Reason for CORI**

❑ Initial Certification ❑ Recertification ❑ATI (Name:_____)❑ MIH Application ❑ Other: _____

**SUBJECT VERIFICATION (Only if signed by DPH Staff)**

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.<br>**Evidence of identification must be government issued photo ID** |

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*