



Dear Employee,

The state of Idaho, Department of Health and Welfare, requires the employee to complete the attached Child Protection Registry background screening, for purposes of making employment decisions to any organization working directly with children.

- Please PRINT or TYPE, no cursive handwriting
- Use only BLUE or BLACK ink
- PRINT your Last and First Name (No initials) in the space provided
- List your DOB & Sex in the spaces provided
- List any Maiden/Former/Alias names and your SSN in the spaces provided

Enter the following information under “RETURN RESULTS TO”

- Name – **Prince William County Schools Attn: HR, Compliance Specialist**
- Street/PO Box – **14715 Bristow Road**
- City/State/Zip – **Manassas, VA 20112**
- Telephone Number – **(703)791-8958/8382**
- Email - compliance@pwcs.edu
- Fax – **(703)791-8848**
- Check box – **Other** (please specify: **School Employment/Code of Virginia 22.1-296.4.**)
- Read the release of information statement
- **Signature and Notarization will be completed during your appointment**

Bring this form, along with all completed documents, to your Employment Processing appointment with PWCS. You will sign and date this form at your appointment. This form will be submitted to the Idaho Department of Health and Welfare on your behalf.

If you have any questions on this matter, please contact us directly at (703)791-8958/8382.

Sincerely,

Compliance Specialist
Human Resources Department

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION FROM THE IDAHO CHILD ABUSE AND NEGLECT CENTRAL REGISTRY

INSTRUCTIONS

- This form **must** be completed in its entirety.
- It **must** be signed by the person that is being checked, or, by their parent/guardian if the subject of the search is under the age of eighteen (18).
- The signature **must** be notarized.
- Include a check, money order, or appropriate invoice in the amount of \$20.00 payable to: “Idaho Department of Health and Welfare” or “IDHW”. DO NOT SEND CASH.
- Requests **must** be mailed to:

IDHW – Background Check Unit
ATTN: CWIS
P.O. Box 83720
Boise, Idaho 83720

PERSON BEING CHECKED (PRINT CLEARLY OR TYPE):
IF THE FORM IS ILLEGIBLE OR INCOMPLETE, IT WILL BE REJECTED AND RETURNED

LAST NAME:

FIRST NAME:

MAIDEN/FORMER NAME(S)/ALIASES:

DATE OF BIRTH:

SOCIAL SECURITY NUMBER:

AGENCY INFORMATION:

IF THIS REQUEST IS FOR A CITY DAYCARE LICENSE, LIST THE CITY NAME AS THE LICENSING AGENCY IN THE SECTION BELOW

LICENSING AGENCY/EMPLOYER NAME:

RETURN RESULTS TO:

IF AN EMAIL ADDRESS IS PROVIDED, THAT WILL BE THE DEFAULT RETURN PROCESS

NAME:

STREET/PO BOX:

EMAIL:

CITY/STATE/ZIP:

FAX NUMBER:

REASON FOR REQUEST:

SELECT THE REASON TO SEARCH THE IDAHO CHILD PROTECTION REGISTRY. IF THE REASON FOR THE REQUEST IS NOT LISTED, SELECT “OTHER” AND SPECIFY THE LAW/ORDINANCE REQUIRING THE CHECK TO BE COMPLETED.

Foster Care/Adoption/ICPC (Adam Walsh Act 42 USC 16961 Section 152)

Child Care Employment (CCDBG)

Guardian ad Litem/Court Appointed Special Advocate

Other (must specify law/ordinance):



AUTHORIZATION AND CONSENT TO RELEASE INFORMATION FROM THE IDAHO CHILD ABUSE AND NEGLECT CENTRAL REGISTRY

IMPORTANT:

THIS REQUEST CANNOT BE PROCESSED WITHOUT THE NOTARIZED SIGNATURE OF THE PERSON BEING CHECKED

I authorize and direct the Idaho Department of Health and Welfare Background Check Unit to release the results of this search of the Child Abuse and Neglect Central Registry to the agency above.

I understand that the results and information about me contained in the Child Abuse and Neglect Central Registry may prove to be unfavorable to me and that a history of substantiated child abuse or neglect will effect my ability to work with children or vulnerable adults. I further understand that this information may later be disclosed by the individual/organization listed above. I do hereby fully, finally and forever discharge, release, acquit, and hold harmless the Idaho Department of Health and Welfare, its officers, agents, employees, and staff from any and all claims, liens, demands, liability, suits, judgments, or actions of whatever kind, whether known or unknown, which I may have at any time associated with the release of information I have requested using this form. If it appears to me that the information in the Child Abuse and Neglect Central Registry has not been updated or appears inaccurate, I will notify the Idaho Department of Health and Welfare immediately. This authorization and consent shall be binding upon my heirs, representatives, executors, administrators, assigns, and successors and no promise, inducement or agreement not herein expressed has been made to me. The terms of this authorization and consent are contractual in nature and are not mere recitals. This is a continuing authorization and consent which shall remain effective until revoked by me in writing.

THE UNDERSIGNED HAVE READ THE FOREGOING AND FULLY UNDERSTAND IT.

PRINT NAME:

SIGN (PARENT/GUARDIAN IF UNDER 18):

STATE OF _____

COUNTY OF _____

SUBSCRIBED AND SWORN (OR AFFIRMED) BEFORE ME THIS _____ DAY OF _____, 20____.

NOTARY PUBLIC SIGNATURE _____

MY COMMISSION EXPIRES ON _____

SEAL

RESULTS:

TO BE COMPLETED BY IDHW STAFF ONLY

THE ABOVE NAMED INDIVIDUAL IS NOT LISTED ON THE IDAHO CHILD ABUSE AND NEGLECT CENTRAL REGISTRY.

THE ABOVE NAMED INDIVIDUAL IS LISTED ON THE IDAHO CHILD ABUSE AND NEGLECT CENTRAL REGISTRY.

UNABLE TO PROCESS DUE TO:

INCOMPLETE FORM

PAYMENT NOT INCLUDED

ILLEGIBLE - UNABLE TO READ INFORMATION ON FORM

OTHER:

COMPLETED BY: (IDHW STAFF ONLY)

SIGNATURE:

DATE: