**ARKANSAS DEPARTMENT OF HUMAN SERVICES**

# **REQUEST FOR ADULT MALTREATMENT REGISTRY INFORMATION**

Print all information in ink.

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Date of Birth | |  |
|  |  | | |
| Maiden Name and/or Any Names Formerly Used | Social Security Number | | |
|  |  | | |
| Email Address | | | |
| Current Address (Street, City, State, Zip) | | | |
| List all previous addresses for the past five years. (Attach additional pages, if needed.) | | Dates (From/To) | |
|  | |  | |
|  | |  | |
|  | |  | |

I authorize Department of Human Services/Adult Protective Services to release information from the Adult Maltreatment Central Registry in accordance with Ark. Code Ann. § 12-12-1717 to the following:

|  |  |  |
| --- | --- | --- |
| Agency Name/Contact Person |  | Agency type: |
|  |  | Volunteer (no charge) |
|  |  | Non-Profit (no charge) |
|  |  | State Agency (no charge) |
| Mailing Address (Street or PO Box, City, State, Zip) |  | All Others ($10.00 Fee) |
|  |  |  |
|  |  |  |
|  |  |  |

I further certify that the information provided on this form is true and correct.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COUNTY OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STATE OF ARKANSAS

Acknowledged before me this \_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_.

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [SEAL]

Notary Public My Commission Expires