

**STATE OF MONTANA**  
Department of Public Health and Human Services  
Quality Assurance Division

**RELEASE OF INFORMATION (For Licensed Youth and Adult Care Providers)**  
**Criminal and Protective Service Background Checks**

PLEASE TYPE OR PRINT LEGIBLY

**Section A**

Facility Name:  Facility Location:

Actual or prospective dates of hire at facility:

Applicant's Name:      
First Middle Madien Last

Aliases/Other Names Used:

Applicants Current Address:

Phone #:  Date of Birth:  Sex:  M  F

Drivers License #:  Social Security #:

**Section B**

Please list below where you have resided in the past 5 years. Attach additional pages if necessary.

City	County	State	Dates of Residency (From:To)

**Section C**

I understand that any information obtained from these checks will be used by the Department to evaluate my employer's application or my own application as a licensed provider. I hereby authorize any law enforcement, protective services agency or the Montana Motor Vehicle Division to release any records they have regarding me to the State of Montana, Department of Public Health and Human Services (if applicable) to my employer as indicated in Section A of this form.

A copy of this form is as valid as teh original.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
To be signed in from of a Notary

To be completed by Notary Public:  
Taken, sworn and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_ A.D. 20\_\_\_\_

Notary Public for the State of Montana Residing at: \_\_\_\_\_ My Commission Expires: \_\_\_\_\_

RETURN TO: TRISH STROMAN, OFFICE MANAGER  
CHILD & FAMILY SERVICES  
P.O. BOX 8005  
HELENA, MT 59604-8005