



Big Brothers Big Sisters of Flathead County

Volunteer Board Member Release and Authorization Form

I hereby authorize Big Brothers Big Sisters of Flathead County or other authorized representatives of the company bearing this release, or copy thereof, to obtain any information in our files pertaining to my employment, credit, criminal, driving record, Child and Family Services, educational records including, but not limited to, information concerning academic achievement, attendance, disciplinary actions, character, work habits, performance, experience and reasons for termination of past employment.

I hereby direct you to release such information upon request of Big Brothers Big Sisters or other authorized representatives.

I hereby fully release and discharge Big Brothers Big Sisters of Flathead County or other authorized representatives, their respective affiliates, employees, agents, attorneys and any individual organization, entity, agency or other source providing information to Big Brothers Big Sisters of Flathead County from all claims and damages arising out of or relating to any investigations of my background.

I acknowledge that a telephonic facsimile or photographic copy shall be valid as the original. This release is valid for most federal, state and county agencies.

Print Full Name _____

Other Names Used (Maiden, divorced, alias, etc.) Please indicate date on which name was changed. _____

Signature _____ Date _____

Witness _____ Date _____

Current Address _____

City _____ County _____ State _____ Zip _____ Dates _____

Home Phone _____ Cell Phone _____ Home E-mail Address _____

Driver License # _____ Issuing State _____ Years Held _____

Social Security # _____ Sex _____ Date of Birth _____

Please list all cities/counties in which you have lived for the last 10 years or since the age of 18 (use a separate sheet if necessary).

City _____ County _____ State _____ Zip _____

Dates _____ Driver License # _____ Issuing State _____

City _____ County _____ State _____ Zip _____

Dates _____ Driver License # _____ Issuing State _____

DO NOT WRITE BELOW THIS LINE – FOR OFFICIAL USE ONLY.

Please forward any information regarding the potential volunteer whose signature appears above.

Big Brothers Big Sisters of Flathead County _____ Date of Request _____

POLICE DEPARTMENT REPLY

DATE _____ NO RECORD FOUND _____ RECORD ATTACHED _____ SIGNATURE _____



**DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES**

STATE OF MONTANA

**- RELEASE OF INFORMATION -
For Registered and Licensed Child Care Providers
Criminal / Protective Service / Motor Vehicle
Background Checks**

PERSONAL INFORMATION

Section A – Current Information

Phone # _____

Legal Name: _____
(First) (Middle) (Maiden) (Last)

Aliases/Other Names Used: _____

Residential Address: _____
(Street) (City) (State) (Zip)

Mailing Address: _____
(Street) (City) (State) (Zip)

Sex: Male Female Date of Birth: _____ Social Security # _____

Section B – Past Residences

Within the last five (5) years, have you...

1. ...lived in another state? Yes No

2. ...lived on or do you now live in an area designated as an Indian reservation? Yes No

If you answered yes to the any of the above questions:

- Please state where you have lived since turning 18 in the table below.
- You will need to obtain an out of state background check or a tribal background check at your cost.

City	County	Reservation	State	Dates of Residency (From – To)

Section C – Prior Caregiver Approvals

Have you been...
 ...registered / licensed to care for children before? Yes No
 ...approved, in any capacity, to provide care in a child care facility? Yes No

IF YES: Please give the Director / Facility Name and the Dates at the facility.

(Director / Facility Name) (Dates)

(Director / Facility Name) (Dates)

PLEASE COMPLETE BOTH SIDES OF THIS FORM

FACILITY INFORMATION

Section D – Employment Status

The facility that I am working / living at is:

Provider #: _____

Director Name / Facility Name: _____

Facility Mailing Address : _____

My ROLE with this facility is (please check all that apply):

Center Use Only:

- | | |
|--|--|
| <input type="checkbox"/> Director | <input type="checkbox"/> Substitute Provider |
| <input type="checkbox"/> Primary Caregiver | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Aide | <input type="checkbox"/> Non-Provider Staff |

Family and Group Only:

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Director | <input type="checkbox"/> Spouse |
| <input type="checkbox"/> Caregiver | <input type="checkbox"/> Adult Child |
| <input type="checkbox"/> Non-Provider Staff | <input type="checkbox"/> Other Adult |
| <input type="checkbox"/> Substitute Provider | <input type="checkbox"/> Volunteer |

My START DATE at this facility is: _____

Section E – Authorization Statement and Signature

I, _____ (applicant name), am aware that _____ (provider or its authorized representative), has requested confidential information from the Montana Department of Public Health and Human Services, in accordance with 41-3-205(3)(o), MCA as part of a review of my personal background in connection with my status as a current or prospective employee of or volunteer for that entity.

I am aware that CFSD, DMV, and DOJ records may contain information that could adversely affect my employment or volunteer status and/or approval as outlined in ARM 37.95.161 and ARM 37.95.176. These records will relate to criminal history records, motor vehicle records as well as any report(s) of child abuse or neglect in Montana that indicates a risk to children. Records that indicate a risk to children are those that show a substantiation of child abuse/neglect on the person; and/or a history that shows that a child in the care of the person was adjudicated by a court as a youth in need of care, and/or a history that shows that the person has had their caregiver rights to a child terminated. As a household member, I understand that I am also subject to the above requirements.

I am also aware that although the entities or individuals requesting and receiving confidential CFSD information are bound by law or agreement with DPHHS to protect or preserve its confidential nature, DPHHS has no ability or authority to ensure that confidentiality is maintained after this information is released by DPHHS.

In full acknowledgement of the above information and notice, I authorize CFSD to provide the requested confidential information to the provider or its authorized representative identified above, and **I hereby also release CFSD from any claims or causes of action which may subsequently arise from release of this confidential information.**

NOTE: Any deletions or oversights may result in the denial of your application.

Signed: _____ Date: _____

(To be signed in front of a notary)

TO BE COMPLETED BY A NOTARY PUBLIC:

Taken, sworn, and subscribed before me this _____ day of _____ A.D. _____

Notary Public for the State of Montana

Residing at: _____

My commission expires: _____