680 2nd St SE Suite 200
Cedar Rapids, IA 52401

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I understand that, prior to my employment, it will be necessary for The Arc of East Central Iowa to investigate my driving record. I hereby give consent for The Arc of East Central Iowa to contact the Linn County Clerk of Court office and for that office to release to The Arc of East Central Iowa any information they have regarding my record.

Dated this ________________ day of ____________________________, 20________

Full Name ____

Name(s) previously known by ____

Signature ____

Date of Birth ____

Social Security Number ____

Address ____

Street City State Zip

Record checked by: ______________________________ Date: __________________

☐ None

Date of ticket	Violation	Closed	Open	Dismissed
____________	______________________________	☐	☐	☐
____________	______________________________	☐	☐	☐
____________	______________________________	☐	☐	☐
____________	______________________________	☐	☐	☐
____________	______________________________	☐	☐	☐

Authorization For Release Of Confidential Information

I understand that, prior to my employment, it will be required by The Arc of East Central Iowa to verify that I am not on the Office of Inspector General (OIG) exclusion from participation list as well as the Excluded Parties List System (EPLS). These lists name individuals who have been excluded from participating in Federal Health Care Programs. Further, I understand, that if my name is on the exclusion list(s), The Arc of east Central Iowa cannot offer me employment.

Please list current name:____

If applicable, please list any maiden name that you may have had:

____

____

If applicable, please list any married name(s) that you may have had:

____

____

____

If applicable, please list any alias name(s) that you may have had:

____

____

____

If applicable, please list any former name(s) that you may have had:

____

____

____

I hereby give consent to The Arc of East Central Iowa to verify the above listed names.

____________________________________ ____________________

Name Date

IOWA HEALTH CARE FACILITY (135C) RECORD CHECK

ACCOUNT NUMBER: 8073

To: Iowa Division of Criminal Investigation
Bureau of Identification
Wallace State Office Building
Des Moines, Iowa 50319
(515) 281-5138 (voice– days)
(515) 281-4776 (voice– nights)
(515) 242-6876 (fax)

From: The Arc of East Central Iowa
680 2nd Street SE Suite 200
Cedar Rapids, IA 52401
Phone: (319) 365-0487
Fax: (319) 365-9938

I am requesting an Iowa **Criminal History Check, Sex Offender, Child and Dependent Adult Abuse check** on:

(Type/Print Legibly):

REQUEST

Last Name (mandatory)	First Name (mandatory)	Middle Name (recommended)
Date of Birth (mandatory)	Sex (mandatory)	Social Security Number (mandatory)

Signature of Requestor

There is a separate form "C" required for each last name submitted

(DCI Use Only)

RESULTS

As of ______________________________, a Name and date of birth check revealed:
(Date)

CCH record attached ☐ No CCH record found ☐

DCI Initials __________________

WAIVER

I hereby give permission for the above requesting official to conduct an Iowa criminal history check with the Division of Criminal Investigation.

Signature	Date

Form No. 595-1490 (03/05)

IOWA HEALTH CARE FACILITY (135C) RECORD CHECK

ACCOUNT NUMBER: 8073

To: Iowa Division of Criminal Investigation
Bureau of Identification
Wallace State Office Building
Des Moines, Iowa 50319
(515) 281-5138 (voice– days)
(515) 281-4776 (voice– nights)
(515) 242-6876 (fax)

From: The Arc of East Central Iowa
680 2nd Street SE Suite 200
Cedar Rapids, IA 52401
Phone: (319) 365-0487
Fax: (319) 365-9938

I am requesting an Iowa **Criminal History Check, Sex Offender, Child and Dependent Adult Abuse check** on:

(Type/Print Legibly):

REQUEST

Last Name (mandatory)	First Name (mandatory)	Middle Name (recommended)

Date of Birth (mandatory)	Sex (mandatory)	Social Security Number (mandatory)

____
Signature of Requestor

There is a separate form "C" required for each last name submitted

(DCI Use Only)

RESULTS

As of ______________________________, a Name and date of birth check revealed:
(Date)

CCH record attached ☐ No CCH record found ☐

DCI Initials __________________

WAIVER

I hereby give permission for the above requesting official to conduct an Iowa criminal history check with the Division of Criminal Investigation.

Signature	Date

Form No. 595-1490 (03/05)

IOWA HEALTH CARE FACILITY (135C) RECORD CHECK

ACCOUNT NUMBER: 8073

To: Iowa Division of Criminal Investigation
Bureau of Identification
Wallace State Office Building
Des Moines, Iowa 50319
(515) 281-5138 (voice– days)
(515) 281-4776 (voice– nights)
(515) 242-6876 (fax)

From: The Arc of East Central Iowa
680 2nd Street SE Suite 200
Cedar Rapids, IA 52401
Phone: (319) 365-0487
Fax: (319) 365-9938

I am requesting an Iowa **Criminal History Check, Sex Offender, Child and Dependent Adult Abuse check** on:

(Type/Print Legibly):

REQUEST

Last Name (mandatory)	First Name (mandatory)	Middle Name (recommended)
Date of Birth (mandatory)	Sex (mandatory)	Social Security Number (mandatory)

Signature of Requestor

There is a separate form "C" required for each last name submitted

(DCI Use Only)

RESULTS

As of ____________________ (Date), a Name and date of birth check revealed:

CCH record attached ☐ No CCH record found ☐

DCI Initials ____________

WAIVER

I hereby give permission for the above requesting official to conduct an Iowa criminal history check with the Division of Criminal Investigation.

Signature	Date

Form No. 595-1490 (03/05)