



Child Abuse History Record Request for Child Placement - Adam Walsh

NOTE: This form must be submitted by the agency identified at the bottom of this page. The applicant may **NOT SUBMIT THIS FORM DIRECTLY** to the Department of Children & Families. **Only one applicant per release.**

TO BE COMPLETED BY THE APPLICANT

Was the applicant a resident of the State of Florida within the past 5 years? YES NO

Name: _____
(Please *Print Clearly*) *Last* *First* *Middle*

Full SSN: _____ DOB: _____ Race: _____ Sex: _____ Prior Name(s), including Maiden: _____

Current **Non-Florida** Address: _____

Previous Address: _____ (Include city, state, and Zip Code)

_____ FL _____ Dates: _____

Previous Address: _____

_____ FL _____ Dates: _____

By signing this form, I, as an applicant for child placement and/or adoption, authorize a search for reports of abuse, neglect or abandonment investigated in which my name appears and there were "verified findings" of maltreatment of a child(ren) and I am listed as the "Caregiver Responsible". I understand I will be given the opportunity to discuss the findings of the report(s). I further understand that the child welfare search is only one part of the preliminary report to the court for adoption, one of the requirements reviewed by an agency with the authority to license or approve homes for the care of children. This consent is valid solely for the requesting agency/facility listed below on this form. (Chapter 39, F.S. Social Security Laws Section 471 [42 U.S.C. 671] (a)(20)(B)(i), Hague Convention on Private International Law, 1995)

Signature of Applicant

Date

TO BE COMPLETED BY REQUESTING AGENCY

Reason for Record Search:

- | | |
|---|---|
| <input type="checkbox"/> Adoption Applicant | <input type="checkbox"/> Relative/Non-relative Placement |
| <input type="checkbox"/> International Adoption Applicant | <input type="checkbox"/> Foster Care Licensing/Registration Applicant |
| <input type="checkbox"/> Household Member for Child Placement | <input type="checkbox"/> Other _____ |

Facility/Agency Name: ND DHHS, Criminal Background Check Unit

Address: 600 E. Blvd Ave, Dept 325 Bismarck ND 58505-0250
Mailing Address City State Zip Code

Representative/Contact Name: _____

Phone: 701-328-7575 Fax: 701-328-0358 Email: dhscfscbc@nd.gov

I understand it is a misdemeanor of the first degree for any agency to use or release abuse, neglect or abandonment information to others. The information is **CONFIDENTIAL** and may be used only for the purpose for which it was obtained.

Printed Name and Signature of Requesting Facility/Agency Representative

Date

Please return to DCF via email:
Attention: Adam Walsh Record Requests
email hqw.fs.adamwalsh.requests@myflfamilies.com