NEW YORK STATE DEPARTMENT OF HEALTH

Criminal History Record Check

NEW YORK STATE | Department of Health

DOH CHRC form 102: Acknowledgement and Consent for Fingerprinting and Disclosure of Criminal History Record Information
The purpose of this form is to obtain consent from the subject individual for fingerprints and criminal history record information pursuant to Article 28-E of the Public Health Law and Section 845-b of the Executive Law.

SECTION 1 – SUBJECT INDIVIDUAL INFORMATION

Last Name	First Name	Middle Initial	Maiden Name

Date of Birth (mm/dd/yyyy)	Alias/AKA	Mother's Maiden Name

Mailing Address (street)	City	State	ZIP Code

SECTION 2 – ATTESTATION

1.	I have applied to an agency to provide direct care or supervision to residents or patients. I understand that as part of the application process, the Public Health Law (PHL) Article 28-E requires that the New York State Department of Health perform a criminal history check on me with the New York State Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI).
2.	I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.
3.	I have been advised that DOH is authorized by law to receive the results of the criminal history record check from DCJS and the FBI for the purpose of developing a criminal history record summary. In accordance with applicable laws, DOH will furnish appropriate summary information to the agency to which I applied for a position to provide direct care or supervision to residents or patients. I have been advised that the criminal history record summary will indicate whether I have a criminal history, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. The criminal history record summary prepared by DOH and sent to the agency will contain the results of the criminal history record check performed by DCJS. I have been advised that the information shall be confidential pursuant to applicable federal and state laws, rules and regulations and shall only be disclosed to persons authorized by law. I have been informed that upon receiving notification from DCJS that there is a subsequent pending criminal action or proceeding or conviction, the DOH shall promptly notify an authorized person(s) of a provider of the additional allegation or new conviction.
4.	I hereby consent to DOH sharing with any DCJS agency to which I applied for a position to provide direct care or supervision, any criminal history record check information provided to DOH by the FBI, including the specific crime(s) for which I was convicted or charged, the date of the arrest for such charge, and/or date of conviction, and the jurisdiction in which the arrest or conviction took place.
5.	I have been informed of the procedures and my rights to obtain, review and seek correction of my criminal history information pursuant to regulations and procedures established by the DCJS and the FBI. If I believe an error has been made by DCJS for any New York State conviction/charge or the FBI for a non-New York State conviction/charge, I understand that I should notify DCJS and/or the FBI to report and request correction of this error to the addresses below.
	NYS Division of Criminal Justice Services Criminal History Bureau Record Review Unit-5th Floor 4 Tower Place, Albany, NY 12203 (518) 485-7675 — Federal Bureau of Investigation Criminal Justice Information Services (CJIS) Division 1000 Custer Hollow Road, Clarksburg, WV 26306 (304) 625-5590
6.	I understand that I have the right to withdraw my application for employment, without prejudice, any time before employment is offered or declined, regardless of whether an agency, DOH or I have reviewed my criminal history information.
7.	I certify to the best of my knowledge and belief that I (check as appropriate): ◯ Have ◯ Have not been convicted of a crime in New York State or any other jurisdiction ◯ Do ◯ Do not have a final finding of patient or resident abuse If you checked either "Have" and/or "Do", please provide a brief explanation. (Optional)
8.	My current mailing or home address is indicated in Section 1 of this form.
9.	I have read this form and hereby consent to the request by the agency to use my fingerprints to obtain my criminal history record, if any, from the DCJS and the FBI. I hereby consent to the re-disclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency in accordance with applicable laws. I declare and affirm that the information I have provided on this consent form is true, complete and accurate and that the fingerprints to be submitted are my own.

Applicant Signature: _____ Date: __/__/____

Name and Signature of Parent or Legal Guardian: (if subject individual is under 18 years of age) _____ Date: __/__/____

SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION

Agency Name: Bushwick Stuyvesant Heights Home Health Care Attendants

Operating License Number (PFI): 0565L001

Print Name of Authorized Person: _____

Title: Exec. Asst/HR Monitor

Signature of Authorized Person: _____

Date: __/__/____

This form is to be retained by the agency. Do not forward to the DOH CHRC