Authorization for Release of Confidential Information Contained within the Arkansas Child Maltreatment Central Registry

I hereby request that the Arkansas Child Maltreatment Central Registry release any information their files may Contain indicating the undersigned applicant as an offender of true report of child maltreatment. This information should be addressed to:

UNITED CEREBRAL PALSY OF ARKANSAS – 9720 NORTH RODNEY PARHAM ROAD
LITTLE ROCK, AR 72227
Contact: Evelyn Cox (501) 224-6067

I understand that the name of any confidential informants, or other information which does not pertain to the applicant as alleged perpetrator, will not be released.

_____ Applicant's Name

_____ Maiden Name/Aliases

_____ Race Age/DOB

Current Address:

_____

_____ From _____ to present

Past Addresses:

_____

_____ From _____ to present

_____

_____ From _____ to present

_____

_____ From _____ to present

_____ Social Security Number

_____ Full Name & DOB Children

_____ Full Name & DOB Children

_____ Full Name & DOB Children

_____ Full Name & DOB Children

_____ Full Name & DOB Children

_____ Full Name & DOB Children

_____

_____ From _____ to present

_____ Applicant's Signature

_____ Date

County of Pulaski State of Arkansas

Acknowledged before me this _____ day of _____, 20____.

My Commission Expires: _____

_____ Notary Public