NEW YORK STATE OF OPPORTUNITY.

Justice Center for the Protection of People with Special Needs

Authorized Person Designation/Notarized Sworn Statement Form Justice Center Criminal Background Check (CBC) Unit

Fax: 518-549-0464
Email: cbc@JusticeCenter.ny.gov

REQUIRED

Provider Name: _____

Agency Code: _____

Address: _____

City: _____ ,NY Zip

Telephone Number: _____

Fax: _____

State Oversight Agency: ☐ **OMH** ☐ **OPWDD** ☐ **OCFS**
(Please check all that apply)

INSTRUCTIONS:

1. Please complete all Parts of this form, including top right corner and check the State agency for which you are a provider.
2. The Authorized Person must sign Part 1 in the presence of a Notary Public. The Director of the Provider Agency must sign Part 2 and date this form where indicated.
3. Please submit one form for each Authorized Person.
4. Please return the completed form to the Justice Center.

Part 1. Authorized Person (Please Print)

Last Name:	First Name:	M. I.:
Business Email Address:	Business Phone #	
	Title:	
Business Address (Street):		
City:	State:	Zip:

I understand that my access to the Justice Center CBC system is granted for the sole purpose of performing responsibilities related to the request, receipt and review of criminal history summaries pursuant to relevant statutory authority. I agree that such requests will be made solely to carry out those specific responsibilities. I further understand that the results of the criminal history summaries will only be used and disseminated for purposes authorized by law, and I agree to abide by the confidentiality requirements set forth in Executive Law §845-b, Labor Law §203-d and Article 6-A of the Public Officers Law.

By submitting a request for a CBC through the Justice Center's CBC system on behalf of the above-named Provider Agency, I hereby attest to the following:

1. I am a duly Authorized Person for the Provider Agency. As such, I am authorized to request, receive, and review criminal history information for this Provider Agency in accordance with the relevant statutory provisions.
2. Each request for a CBC will be made by a person authorized to make such a request and each request entry will identify the subject individual by his or her name, and will identify the subject individual as either a prospective operator, employee, volunteer or consultant of the Provider Agency who will have regular and substantial unsupervised or unrestricted physical contact with the Provider Agency's clients. For each request entry, the specific duties of the subject individual which permit the Provider Agency to request a CBC will be identified.
3. Each subject individual will be informed that the Provider Agency is authorized to request a CBC.
4. Each subject individual will be informed of the right to obtain, review and, if necessary, seek correction of his/her criminal history information under regulations established by the NYS Division of Criminal Justice Services and the Federal Bureau of Investigation. The signed, informed consent of each subject individual will be obtained prior to requesting a check by the CBC Unit and maintained by the Provider Agency.
5. The results of each check of the CBC will be used by the Provider Agency solely for the purposes authorized by law.
6. Upon information and belief, the Provider Agency, its agents, and employees are aware of and will abide by the confidentiality requirements of Executive Law §845-b, Labor Law §203-d and Article 6-A of the Public Officers Law.

Signature of Authorized Person	Date:

Acknowledgment to be completed by a Notary Public:
State of _____ County of _____

On this _____ day of _____, 20____, before me personally appeared

_____

To me known and known to me to be the same person described in and who executed the foregoing instrument, and __he duly acknowledged to me that __he executed same.

_____
Notary Public
(Please sign, affix stamp and include expiration date.)

Part 2. Director Signature (DIRECTOR OF THE PROVIDER AGENCY MUST APPROVE DESIGNATION OF AUTHORIZED PERSON BY SIGNING BELOW)

I hereby designate the person identified in Part 1 of this form to serve as the Authorized Person for the Provider Agency noted on this form. I also request access and appropriate permission for this person to use the Justice Center CBC system in support of this responsibility.

Name (Please Print)	Title:
Signature:	Date:

Clear Form Print Form