



**Authorized Person Designation  
Form  
For SCR Investigation Checks**

NYS Justice Center for the Protection of  
People with Special Needs  
Office of Incident Reporting and  
Investigations  
[subjectsearchs@justicecenter.ny.gov](mailto:subjectsearchs@justicecenter.ny.gov)

The purpose of this form is to designate an **Authorized Person** for your program who will be permitted to request, on behalf of your program, that the Justice Center make an inquiry of the Statewide Central Register of Child Abuse and Maltreatment (SCR). By signing this form, each signatory understands that all requests made by the **Authorized Person** for a check of the SCR by the Justice Center on any individual who is the subject of a report of abuse or neglect to the Vulnerable Persons Central Register (VPCR) will be made in conformance with the law.

**INSTRUCTIONS:**

1. Please complete all Parts of this form.
2. The **Authorized Person** must sign Part 1 and the **Director** must sign Part 2 this form where indicated, one form for each Authorized Person. The Director may be the Authorized Person.
3. Please return the completed form to the Justice Center. The form may be scanned and emailed to [subjectsearches@justicecenter.ny.gov](mailto:subjectsearches@justicecenter.ny.gov)

**Part 1. Authorized Person**

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

By submitting a request for a SCR check through the Justice Center on behalf of the above-named program, I understand the following:

1. I am a duly **Authorized Person** for the program and the Justice Center is authorized to request the a check of the SCR pursuant to Social Services Law §492(3)(c)(iv).
2. Each request for a check of the SCR has been made by a person authorized to make such request and shall identify by name the applicant who is the subject of a report of abuse or neglect to the VPCR.
3. The results of each check of the SCR will be used by the program solely for the purposes authorized by law.
6. Upon information and belief, the program, its agents, and employees are aware of and will abide by the confidentiality requirements of Social Services Law §496.

Signature of <b>Authorized Person</b> :	Date: / /
---	-----------

**Part 2. Provider Approval (DIRECTOR OF THE PROGRAM 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** to request a check of the SCR for the program named on this form.

Name:	Title:
-------	--------

Signature of <b>Director</b> :	Date: / /
--------------------------------	-----------