NEW YORK STATE OF OPPORTUNITY.

Justice Center for the Protection of People with Special Needs

Staff Exclusion List (SEL) Check

Authorized Person Designation Form
For OCFS Day Care Center and School Age Child Care Programs

Criminal Background Check Unit
Fax: 518-549-0464
Email: cbc@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, a check of the Staff Exclusion List (SEL). By signing this form, each signatory understands that all requests made by the **Authorized Person** for a check of the SEL by the Justice Center on each prospective employee, volunteer, consultant or resident in the home 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.
3. Please return the completed form to the Justice Center. The form may be scanned and emailed, or faxed to the Justice Center's CBC Unit at the contact information above.

Part 1. Authorized Person

Last Name:	First Name:	M.I.:
Business Name: Business Email Address:	Business Phone #	
Business Address (Street):		
City:	State:	Zip:
OCFS DCC or SACC License/Facility id #	<-- Required	

By submitting a request for a SEL 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 am authorized to request a check of the SEL pursuant to Social Services Law §495(2).
2. Each request for a check of the SEL has been made by a person authorized to make such request and shall identify by name the applicant who will have regular and substantial physical contact with the children served by the program.
3. Each applicant will be informed that the program is authorized to request a check of the SEL and that the results of SEL check may result in a determination that the subject individual should not be hired or retained.
4. Each subject individual will be informed that he or she may, pursuant to Social Services Law §494, challenge the determination that resulted in placement on the SEL.
5. The results of each check of the SEL 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, Labor Law §203-d and Article 6-A of the Public Officers Law.

Signature of ***Authorized Person:***	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 SEL for the program named on this form.

Name:	Title:
Signature of ***Director:***	Date:

Clear Form Print Form