

**NYS Department of Health  
ACKNOWLEDGEMENT AND CONSENT FORM FOR FINGERPRINTING AND DISCLOSURE OF CRIMINAL  
HISTORY RECORD INFORMATION**

**THIS FORM IS TO BE RETAINED BY THE AGENCY- DO NOT FORWARD TO THE DOH CHRC UNIT.**

[chrc@health.state.ny.us](mailto:chrc@health.state.ny.us)

**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	M.I.	
Date of Birth (mm/dd/yyyy)	Mother's Maiden Name	Alias: AKA	
Mailing Address (street)	City	State	Zip

**SECTION 2 - ATTESTATION**

- 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).
- I acknowledge and consent to having my fingerprints taken for the purpose of a criminal history record check by the DCJS and the FBI.
- 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 to be provided 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, as maintained by DCJS or the FBI, including convictions of a crime (felony or misdemeanor) or criminal charges which do not reflect a disposition. I have been advised that by law, DOH is authorized and may be required to provide the results of the criminal history record check through a criminal history record summary to the agency. 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 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.
- 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.
- 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.
- 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 have checked either "Have" and/or "Do", please provide a brief explanation. (Optional)
   
\_\_\_\_\_
- My current mailing or home address is indicated in Section 1 of this form.
- 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 redisclosure of any convictions or open charges on my criminal history record, received by DOH from DCJS, to the requesting agency. 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 (not applicable for Expedited Review submitted pursuant to CHRC Form 104).

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent or Legal Guardian \_\_\_\_\_ Date: \_\_\_\_\_  
(if subject individual is under 18 years of age)

**SECTION 3 – AGENCY AUTHORIZED PERSON INFORMATION**

Agency Name:	PFI/Operating License Number:
Print Name of Authorized Person:	Title:
Signature of Authorized Person:	Date:

New York State

# Criminal History Record Check

Employer Willow Point Rehabilitation And Nursing Center (NURSING HOME) (0064) ▼

## CHRC Submission Form

*First Name : _____	*Birth Country/Place : _____
Middle Initial : _____	*Sex : _____
*Last Name : _____	*Race : _____
*DOB : _____ (mm/dd/yyyy)	*Height : _____
Last 4 of SSN : _____	*Weight (Lbs) : _____
Maiden Name : _____	*Eyes : _____
Alias (AKA) : _____	*Hair : _____
*Address Type : <input type="radio"/> Physical <input type="radio"/> P.O.Box	*City : _____
*Street Number : _____	*State : _____
*Street Name : _____	*Zip Code : _____
Apartment : _____	Home Phone : _____
P.O.Box : _____	Cell Phone : _____

\* Fields marked with an asterisk (\*) are required.