The Commonwealth of Massachusetts

Executive Office of Health and Human Services

Department of Public Health

250 Washington Street, Boston, MA 02108-4619



**Criminal Offender Record Information (CORI) Acknowledgement Form**

To be used by organizations conducting CORI checks for employment or licensing purposes.

The Bureau of Health Professions Licensure is registered under the provisions of M.G.L. c.6, §172 to receive CORI for the purpose of screening current and otherwise qualified license applicants and current licensees.

As a license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to the Bureau of Health Professions Licensure to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing the Bureau of Health Professions Licensure with written notice of my intent to withdraw consent to a CORI check.

I also understand that the Bureau of Health Professions Licensure may conduct subsequent CORI checks within one year of the date this Form was signed by me.

By signing below, I provide my consent to a CORI check and affirm that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

*Signature of CORI Subject Date*

* First Name: Middle Initial:

Please complete this section using the information of the person whose CORI you are requesting.

The fields marked with an asterisk (\*) are required fields.

**SUBJECT INFORMATION**

* Last Name: Suffix (Jr., Sr., etc.):

Former Last Name 1:

Former Last Name 2:

Former Last Name 3:

Former Last Name 4:

* Date of Birth (MM/DD/YYYY): Place of Birth:
* Last **SIX** digits of Social Security Number: ‐‐

Sex: Height: ft. in. Eye Color: Race:

Driver’s License or ID Number: State of Issue:

Father’s Full Name:

Mother’s Full Name:

**Current Address**

* Street Address:

Apt. # or Suite:

\*City:

\*State:

\*Zip:

**SUBJECT VERIFICATION (Complete only if signed by BHPL staff)**

\*The above information was verified by reviewing the following form(s) of government‐issued identification:

Verified by:

*Print Name of Verifying BHPL Employee*

*Signature of Verifying BHPL Employee Date*

Please note that ALL fields in this section must be completed by the Notary Public. Evidence of identification must be government issued photo ID.

**Authentication of Signature**

On this \_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , 20\_\_\_, before me, the undersigned notary public, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of applicant) personally appeared, proved to me through satisfactory evidence of identification, which were \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (Ex: Driver’s license, passport, etc.) to be the person who signed the preceding document in my presence and who swore or affirmed to me that the contents of the document are truthful and accurate to the best of (his) (her) knowledge and belief.

Seal of Notary Public

Notary Public Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Commission Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_