Authorized Person Designation Sworn Statement Form

Justice Center Staff Exclusion List (SEL) Check

NYS Justice Center for the Protection of People with Special Needs
Criminal Background Check Unit
Fax: 518-549-0464
Email: cbc@JusticeCenter.ny.gov

The purpose of this form is to designate the Authorized Person who will be permitted to request, on behalf of the Provider Agency, a check of the Staff Exclusion List (SEL) pursuant to relevant statutory authority. By signing this form, each signatory attests 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 natural person operator ("subject individual") will be made in conformance with the law.

INSTRUCTIONS

1. Please complete all Parts of this form. Please fill out one form for each Authorized Person.
2. The Authorized Person must sign Part 1 and the Director of the Provider Agency must sign Part 2 and date this form where indicated.
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. Please maintain a copy of the form for your records.

Part 1. Authorized Person (Please Type or Print Clearly)

Last Name:	First Name:	M.I.:
Business Email Address (Note: group email boxes may only be tied to one person per facility)	Business Phone #	

I understand that my designation as an Authorized Person is granted for the sole purpose of performing responsibilities related to a request for a check of the SEL 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 a SEL check will only be used and disseminated for purposes authorized by law, and I agree to abide by the confidentiality requirements set forth in 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 PROVIDER AGENCY MUST APPROVE DESIGNATION 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 Provider as noted on this form.

Name (Please Print):	Title:
Signature:	Date:

Please proceed to Part 3 of the Authorized Person form on the next page

Part 3. Provider Information (Please Type or Print Clearly)

Name (Please avoid nicknames or abbreviations):

Street Address:	City	State:	Zip:

Provider Category and ID Number (If known, please fill out the ID Number in the appropriate Provider Category as shown in the tables below - leave all others blank)

Office of Mental Health (OMH)

Type	Sponsor	Agency	Facility	Program
ID#				

Office of People with Developmental Disabilities (OPWDD)

Type	Corporation	Agency	Program
ID#			

Office of Children and Family Services (OCFS)

Type	Program	Agency	Facility
ID#			

Department of Health (DOH)

Type	ACF	Camp	Facility
ID#			

Office of Alcoholism and Substance Abuse Services (OASAS)

Type	Provider
ID#	

State Education Department (SED)

Type	Provider
ID#	