NYS Justice Center for the Protection of People with Special Needs
Criminal Background Check Unit
161 Delaware Avenue
Delmar, NY 12054, Fax: 518-549-0464
Email: cbc@JusticeCenter.ny.gov

Authorized Person Designation/Notarized Sworn Statement Form

Justice Center Staff Exclusion List (SEL) Check

Provider Agency Name:
Agency Code:
Address:

City , NY Zip
Telephone Number:
Fax:
State Oversight Agency: DOH SED OCFS (circle one)

The purpose of this form is to designate the Authorized Person for your agency 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, including the top right corner and circling the State agency for which you are a provider.
2. The Authorized Person must sign Parts 1 and 3, and the Director of the Provider Agency must sign Part 2 and date this form where indicated, one form for each AUthorizrd Person.
3. The Authorized Person must sign Part 3 in the presence of a Notary Public.
4. Please return the completed form to the Justice Center. The form may be mailed, scanned and emailed, or faxed to the Justice Center's CBC Unit at the contact information above. If the original form is not mailed to the Justice Center, it must be maintained by the Provider Agency.

Part 1. Authorized Person (Please Print)

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

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 OF AUTHORIZED PERSON BY SIGNING BELOW)

I hereby designate the person identified in Part 1 of this form to serve as the Authorized Person for the Provider as noted on this form. I also request access and appropriate permission for this person to request a check of the SEL in support of this responsibility.

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

Part 3. Authorized Person Signature and Notary Acknowledgement

By submitting a request for a SEL check through the Justice Center on behalf of the above-named Provider Agency, I hereby attest to the following:

1. I am a duly Authorized Person for the Provider Agency. As such, I 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 of a subject individual has been made in the Justice Center VPCR by a person authorized to make such request. Each such request entry shall identify the subject individual by his or her name, and will identify the subject individual as either a prospective operator, employee, volunteer or consultant of the Provider Agency who will have regular and substantial physical contact with the Provider Agency's clients.
3. Each subject individual will be informed that the Provider Agency is authorized to request a check of the SEL and that if the SEL check results in a determination that the subject individual should not be hired or retained, a criminal background check will NOT be performed.
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 Provider Agency solely for the purposes authorized by law.
6. Upon information and belief, the Provider Agency, 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.

Authorized Person Signature:		Date :

Acknowledgment to be completed by a Notary Public

State of _____

County of _____

On this _____ day of _____, 20____, before me personally appeared _____

To me known and known to me to be the same person described in and who executed the foregoing instrument, and __he duly acknowledged to me that __he executed same.

_____
Notary Public (Please sign, affix stamp and include expiration date.)