

STATE OF MARYLAND  
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES  
CRIMINAL JUSTICE INFORMATION SYSTEMS-CENTRAL REPOSITORY  
REGISTRATION FOR AUTHORIZATION FOR RECORD CHECKS

Date: \_\_\_\_\_

- This is a NEW registration.
- This is a CHANGE to a current registration.

List Authorization Number if known: \_\_\_\_\_  
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I. COMPANY OR AGENCY NAME: \_\_\_\_\_  
(Must be listed as employer on application & fingerprint card submitted for check)

CONTACT PERSON: \_\_\_\_\_  
(Person who will be handling the criminal history record information from CJIS)

CONTACT PERSON'S TITLE: \_\_\_\_\_

CONTACT PERSON'S TELEPHONE NUMBER: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY, STATE AND ZIP CODE: \_\_\_\_\_

E-mail address \_\_\_\_\_

Fax Number: \_\_\_\_\_  
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II. REASON FOR REQUEST:

- \_\_\_ ADULT DEPENDENT CARE (For Maryland Adult Dependent Program Only)
- \_\_\_ ATTORNEY/CLIENT
- \_\_\_ CHILD CARE (Licensed Agencies working with Children in Maryland Only)
- \_\_\_ CRIMINAL JUSTICE (For Criminal Justice Agencies ONLY)
- \_\_\_ GOVERNMENT EMPLOYMENT - Federal \_\_\_ State \_\_\_ Local \_\_\_
- \_\_\_ GOVERNMENT LICENSING/CERTIFICATION

Business License Number : \_\_\_\_\_ ( REQUIRED)

IF AUTHORIZED BY STATUE, ENTER STATUTORY CITATION: \_\_\_\_\_  
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IV. I CERTIFY THAT UNDER THE SPIRIT AND INTENT OF THE LAWS OF MARYLAND, I UNDERSTAND THAT DATA RETURNED TO ME CAN ONLY BE USED AS REQUESTED AND THAT I AM NOT AUTHORIZED FOR FURTHER DISSEMINATION.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
TITLE

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MAIL OR FAX COMPLETED FORM TO: CJIS AUTHORIZATION ADMINISTRATOR  
POST OFFICE BOX 32708  
PIKESVILLE, MARYLAND 21282-2708  
FAX# 410-653-6320