

AGENCY LICENSE# \_\_\_\_\_

**ARKANSAS DEPARTMENT OF HUMAN SERVICES  
DIVISION OF CHILD CARE & EARLY CHILDHOOD EDUCATION  
PLACEMENT AND RESIDENTIAL LICENSING UNIT**  
Authorization for release of confidential information:  
**ARKANSAS CHILD MALTREATMENT CENTRAL REGISTRY**

**THIS FORM WILL NOT BE PROCESSED UNTIL ALL INFORMATION IS COMPLETED.**

Mail completed form and \$10.00 check or money order made out to DHS to: Child Maltreatment Registry, Slot S 566, P.O. Box 1437, Little Rock, AR 72203. This fee may be waived for non-profits who provide proof of 501(c)(3) status. Allow 7 – 10 business days for processing.

This information should be addressed to:

Name/Title (print)	Agency Requesting the Report	
Address (physical)	Telephone #	Fax #
Address (provide mailing, if different than physical)	Date of Request	

**Name of Applicant:** \_\_\_\_\_

**Maiden Name/Other Names Used:** \_\_\_\_\_

**Race:** \_\_\_\_\_ **Sex:** \_\_\_\_\_ **Age/DOB:** \_\_\_\_\_ / \_\_\_\_\_ **SSN:** \_\_\_\_\_

Children (related or non-related) now residing or who have resided in the home at any time and all biological children, even if they have not resided in the home:

Full Name: _____	Full Name: _____
DOB/Age: _____ / _____	DOB/Age: _____ / _____
Relationship: _____	Relationship: _____
SS# (if known): _____	SS# (if known): _____
Full Name: _____	Full Name: _____
DOB/Age: _____ / _____	DOB/Age: _____ / _____
Relationship: _____	Relationship: _____
SS# (if known): _____	SS# (if known): _____

Present Address: (since \_\_\_\_\_, \_\_\_\_\_ ) \_\_\_\_\_  
\_\_\_\_\_

