ARKANSAS DEPARTMENT OF HUMAN SERVICES
AUTHORIZATION FOR ADULT MALTREATMENT CENTRAL REGISTRY

Print all information in ink

Name	Date of Birth
Maiden and/or Any Names Formerly Used	Social Security Number
Current Address (Street, City, State, Zip)	

List all previous addresses for the past five years	Dates (From/To)

I authorize Department of Human Services/Adult Protective Services to release information from the Adult Maltreatment Central Registry in accordance with Arkansas Code [ACA 12-12-1717] to:

Name

The University of Arkansas Service Learning Initiative Staff & Committee and The University of Arkansas Center for Community Engagement

Mailing Address (Street or PO Box,City, State, Zip)

1 University of Arkansas
A643 Arkansas Union
Fayetteville, Arkansas 72701

Agency type:

- ■ Volunteer (no charge)
- ☐ Non-Profit (no charge)
- ☐ State Agency (no charge)
- ☐ All Others ($10.00 Fee)

I further certify that the information provided on this form is true and correct.

Signature_____ Date _____

Notarization Required

COUNTY OF _____
STATE OF ARKANSAS

Acknowledged before me this _____ day of _____, 20_____.

_____ _____
(Notary Public) (My Commission Expires)

The above listed applicant was_____/was not_____ found in the Adult Maltreatment Central Registry.

Adult Protective Services – Slot W240
Adult Maltreatment Central Registry
PO Box 1437
Little Rock, AR 72203

APS-0001 (05/09)