

**Northeast Iowa Community College
Background Check Release Authorization**

Identification (Please type or print clearly):

Name: Last	First	Full Middle Name
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Alias, maiden, previous married name (Please list <u>every</u> previous name)	Phone #
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Address:	Street	City	State	County
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Date of Birth	Social Security Number	Sex (M/F)
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Do you have a record of founded child or dependent adult abuse in Iowa or any other state? No Yes

Have you ever been charged of a crime or convicted of a crime in Iowa or any other state? No Yes

If yes, please explain the nature of the incident and date of occurrence: _____

Authorization and Release

The undersigned acknowledges:

1. I have executed this document in conjunction with admission into a health program at Northeast Iowa Community College. (Hereinafter referred to as "NICC".)
2. I hereby authorize NICC access to any criminal history and abuse records produced by federal, state, or local law agencies pertaining to me. I understand that NICC contracts with a third party vendor for nationwide criminal background checks. NICC accesses abuse registry information via Iowa's single contact repository (SING) and the Iowa Department of Human Services' Central Abuse Registry.
3. I agree to release NICC and any other person, company or other entity from any and all causes of action that otherwise might arise from supplying clinical agencies with information they may request pursuant to this release.
4. I understand that any false answers or statements, or misrepresentations by omission made by me on this form or any related document, will be sufficient cause for rejection of my application or for my immediate discharge should such falsifications or misrepresentation be discovered after my nursing program begins.
5. I understand and agree that if I am rejected for participation in a clinical experience by an affiliating agency or if I refuse to submit to the registry checks that are required by an affiliating agency, I will be unable to complete my program of study in the health program to which I am enrolled in.
6. I understand that during my educational program with NICC, it is my responsibility to report any criminal, child abuse, and adult abuse charges pending against my record along with convictions. I further authorize NICC to conduct background checks on my record at any time during my education program, as needed.

Applicant Signature: _____ Date: _____



Iowa Department of Human Services

Authorization for Release of Child and Dependent Adult Abuse Information

This form must be used to authorize release of child or dependent adult abuse information when the person requesting the information does not have independent access to it under Iowa law. Complete a separate form for each person for whom information is requested and email to dhsabuseregistry@dhs.state.ia.us, or fax to (515) 564-4112, or mail to the Iowa Department of Human Services, Central Abuse Registry, P.O. Box 4826, Des Moines, IA 50305.

Please specify which abuse registry you are requesting by checking the appropriate box below:

☐ Child Abuse Registry ☐ Dependent Adult Abuse Registry ☒ Both

Please specify your preferred **method of response** by checking a box and completing the information in Section 1.

☐ Address ☐ Fax ☒ Email

Section 1: To be completed by the person or agency requesting the information.

Requester: Last		First		Agency Name Viewpoint Screening		Telephone Number (888) 974-8111		
Address 201 N Front St Ste 709						Fax Number (888) 516-2444		
City Wilmington				State NC	Zip Code 28401	Email results@viewpointscreening.com		
List the name and address of the person whose information is being requested:								
Name (last, first, middle)					Birth Date		Social Security Number	
Address			City		County		State	Zip Code
List maiden name, previous married names, and any alias:								
What is the purpose of your request for child or dependent adult abuse information? Background check prior to educational field experience								
I have read and understand the legal provisions for handling child and dependent adult abuse information which is printed on the second page of this form.								
Signature of Requestor						Date		

Section 2: To be completed by the person authorizing the Department of Human Services to release their child or dependent adult abuse information.

I understand that my signature authorizes the requester to receive information to verify whether I am named on the Child Abuse or Dependent Adult Abuse Registry as having abused a child (Iowa Code section 235A.15) or dependent adult (Iowa Code section 235B.6). To the best of my knowledge, the information contained in Section 1 of this form is correct.

Signature of Person Authorizing	Date
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Section 3: To be completed by the Central Abuse Registry or designee.

- ☐ The person whose information is being requested is listed on the Child Abuse Registry as having abused a child.
- ☐ The person whose information is being requested is not listed on the Child Abuse Registry as having abused a child.
- ☐ The person whose information is being requested is listed on the Dependent Adult Abuse Registry as having abused a dependent adult.
- ☐ The person whose information is being requested is not listed on the Dependent Adult Abuse Registry as having abused a dependent adult.
- ☐ This request for information is denied because the form is incomplete.

Signature of Registry Staff or Designee	Date
Comments	