BACKGROUND PACKET

COMPLETE THIS PACKET IN ITS ENTIRETY

ONCE COMPLETED YOU MUST EITHER:

- UPLOAD IT INTO YOUR APPLICATION IN POLICEAPP,
- EMAIL IT TO JDUTILLY@JOHNSTONPD.COM or
- DROP IT OFF AT POLICE HEADQUARTERS TO CIV. JUSTINE DUTILLY

JOHNSTON POLICE DEPARTMENT

Chief of Police, Mark A. Vieira

INSTRUCTIONS TO THE APPLICANT

The information you provide in this personal history statement will be used in the investigation of your background to determine your suitability for the position of which you have applied. Please fill out the application completely and accurately.

Keep in mind that:

1. All statements are subject to verification.
2. **Deliberate inaccuracies or omissions will bar or remove you from further consideration for employment.**
3. **Failure to follow instructions or answer questions completely and accurately may bar or remove you from further consideration for employment.**
4. **All** time periods in your background **must** be accounted for.
5. You are responsible for updating this Personal History Statement in the event changes occur during the background investigation (e.g. change of address, arrests or legal actions, personal/family changes, telephone number changes, etc.). Notification of such changes must be submitted in writing to the Johnston Police Department to the attention of the Administrative Division.
6. If you have any questions regarding any section or part of this application, do not hesitate to contact this office at (401) 231-4210 for clarification. Our personnel will be glad to take time to explain any section or part of the application that you do not fully understand.

It is to your advantage to respond openly. Any negative factor in your background will be evaluated in terms of the circumstances and facts surrounding its occurrence and the degree of relevance to the position for which you have applied. During the investigation the investigator will inquire into the facts surrounding such an occurrence. Any evaluation will then be made of the relevance of these facts to the requirements of the job.

You may complete this packet electronically or if by hand, please **CLEARLY PRINT** your responses in **blue ink** **ONLY**. If a question does not apply to you, write "N/A" (not applicable) in the space provided for your answer. If you need more space to respond to a question, attach a separate sheet of paper and refer to the section heading or number. We strongly recommend that you preview this form before submitting.

JOHNSTON POLICE DEPARTMENT

Chief of Police, Mark A. Vieira

Personal

(If additional space is needed at any point in the application, attach typed/clearly written page(s) at the end of the packet, and be sure to reference the section and question being answered)

Name:			
	Last	First	Middle

Other Names you have used or have been known by: (including nicknames)	

Date of Birth:				Place of Birth:	
Social Security Number:				Blood Type:	

Phone/Contact

Cellular:		Home:		Work:	

E-mail Addresses:	
Social Media Account Names: Facebook, LinkedIn, Twitter, YouTube, Instagram, Google+, TikTok, WhatsApp, Pinterest, Snapchat, Tumblr, Flickr, etc.	

Description

Height	Weight		Eye color	Hair Color
		lbs.		

List any scars, marks and/or tattoos (and location if visible)	
Dominate Hand:	

Residence

Please list all residences since 16 years of age. Include all of those while in college and the Armed Forces. Begin with your most current residence. (Do NOT use PO BOXES)

Address of Residence	City, State, & Zip	Dates (mm/yy)	
		From	To

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Spouse/Dependents

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐

List information on your current spouse (include maiden name), all of your children, include step-children and adopted children. If engaged, list fiancé. If in a dating relationship, list partner.

Name	Address	Age	Relationship

If divorced or separated, list all previous spouses and dates of separation or divorce.

Current Name	Current Address	Phone Number	Date of Separation/Div. (mm/yy)

Provide the appropriate information pertaining to any individuals with whom you have resided with in the last three (3) years (excluding relatives listed above).

Name	Address of Residence	Phone #	Dates (mm/yy)

In the spaces below, list the requested information for your family members (even if deceased) to include mother, father, guardian, step-parents, parents-in-law, foster parents, brothers, sisters and step-siblings. Include their relationship to you and at least two (2) phone numbers.

Name/Relationship	Address	Phone	
		Home:	
		Cell:	
		Home:	
		Cell:	
		Home:	
		Cell:	
		Home:	
		Cell:	
		Home:	
		Cell:	
		Home:	
		Cell:	
		Home:	
		Cell:	
		Home:	
		Cell:	

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Education

Please indicate below all the schools you have attended beginning with high school.				
Name of School	Location of School (City and State)	Date Attended (mm/yy) From	To	Did you Graduate? Please list any Degree earned
If you do not possess a college degree, how many college semester credits have you successfully completed/earned?				credits

Have you ever been suspended or expelled from any high school or post-secondary school? (Post-Secondary schools include colleges and universities, graduate schools and business/vocational schools or any formal education beyond the high school level.)	Yes ☐ No ☐
If "Yes," please explain (include school, date and circumstances).	

List any organizations, clubs, fraternities, sororities, civic groups and/or social clubs of which you are now or have ever been a member of or associate with. Indicate any office or position held.

Military

Have you ever served in the Armed Forces, National Guard and/or Military Reserves?				Yes ☐ No ☐
If "Yes", please supply the following information:				
Branch of Service	Service Number	Dates of Service (mm/yy) From	To	Type of Discharge or Current Status
Are you currently participating in any military reserve or National Guard program?				Yes ☐ No ☐

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Military Continued

Did you receive any disciplinary actions while in the military? If "Yes," please explain.	Yes ☐ No ☐

List your rank, Military occupation, Specialty (MOS) and describe your duties:

List all duty stations, including Basic Training and other schools:

Military Installation	City/State/Country (if applicable)	Assignment

Please list those individuals in the military who know you well enough to provide accurate information about you.

Name	Address	Phone		Years known (mm/yy)	
				From	To
		Home:			
		Work:			
		Home:			
		Work:			
		Home:			
		Work:			
		Home:			
		Work:			
		Home:			
		Work:			
		Home:			
		Work:			
		Home:			
		Work:			

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Financial

Please fill in the financial statement below. Be complete and accurate.				
Current Gross Monthly Income		Current Monthly Expenditures		
Your current monthly salary:		Real Estate (mortgage) payment(s)/Rent (please specify):	Mortgage ☐ Rent ☐	
Spouses current monthly salary (if applicable):				
Other monthly income - describe:	(Enter info. below)	Other monthly payments - describe: (Estimated monthly cost of living including utilities, food, gas, home/car maintenance, entertainment, etc. and any other obligations)		(Enter info. below)
Total Monthly Income:		Total monthly expenditures:		

Savings Account(s)?	Yes ☐ No ☐	Real Estate indebtedness?	Yes ☐ No ☐
Checking Account(s)?	Yes ☐ No ☐	Long-term loans?	Yes ☐ No ☐
Real Estate?	Yes ☐ No ☐	Charge Accounts?	Yes ☐ No ☐
Stocks/Bonds?	Yes ☐ No ☐	Other Liabilities (list)?	Yes ☐ No ☐
Autos?	Yes ☐ No ☐		Yes ☐ No ☐ N/A ☐
Other Assets (list)?	Yes ☐ No ☐ N/A ☐		Yes ☐ No ☐ N/A ☐
	Yes ☐ No ☐ N/A ☐		Yes ☐ No ☐ N/A ☐
	Yes ☐ No ☐ N/A ☐		Yes ☐ No ☐ N/A ☐
	Yes ☐ No ☐ N/A ☐		Yes ☐ No ☐ N/A ☐
	Yes ☐ No ☐ N/A ☐		Yes ☐ No ☐ N/A ☐
	Yes ☐ No ☐ N/A ☐		Yes ☐ No ☐ N/A ☐
	Yes ☐ No ☐ N/A ☐		Yes ☐ No ☐ N/A ☐

Please supply more detailed information about your charge accounts, contracts, or other financial liabilities.	
Name of Firm	Address

Financial Continued

Have you ever filed for or declared bankruptcy or filed for the Wage Earner's Plan?	Yes ☐ No ☐
If "Yes," please give details (include when, where, why). Include a copy of all court related papers.	
Have any of your bills ever been turned over to a collection agency?	Yes ☐ No ☐
If "Yes," please give details (include when, firms involved, circumstances).	
Have you ever had purchased goods repossessed (taken back)?	Yes ☐ No ☐
If "Yes," please give details (include when, firms involved, circumstances).	
Have you ever had your wages garnished?	Yes ☐ No ☐
If "Yes," please give details (include when, where, and why).	

Financial Continued

Have you ever been delinquent on income or other tax payments?	Yes ☐ No ☐
If "Yes", please give details (include when, where, and why)	

Have you ever been delinquent on child support payments?	Yes ☐ No ☐ N/A ☐
If "Yes," please give details (include when, where, and why).	

Legal

Have you ever been charged with a violation of law, arrested, or issued a defendants summons for any offense (excluding traffic citations)?	Yes ☐ No ☐
If "Yes", please give details (include when, where, and why)	

Date	Police Agency	Charge	Type	Disposition
			Felony ☐ Misdemeanor ☐	
Explanation:				

Date	Police Agency	Charge	Type	Disposition
			Felony ☐ Misdemeanor ☐	
Explanation:				

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Legal Continued

Date	Police Agency	Charge	Type	Disposition
			Felony ☐ Misdemeanor ☐	
Explanation:				

Date	Police Agency	Charge	Type	Disposition
			Felony ☐ Misdemeanor ☐	
Explanation:				

Have you ever committed an illegal act or done anything that would have been considered unlawful if caught?	Yes ☐ No ☐

Legal Continued

Have you ever been charged or convicted of a domestic assault type offense?	Yes ☐ No ☐
If "Yes," please give details (include when, where and why).	
Have you or your spouse ever been involved as a plaintiff or defendant in any civil court action?	Yes ☐ No ☐
If "Yes," please give details (include when, where, location of court and circumstances).	
Have you ever obtained a criminal warrant for any person?	Yes ☐ No ☐
If "Yes," please give details (include when, where, name and location of court, and circumstances). Note: Do **not** include cases if you are/were a law enforcement officer.	
Are you now or have you ever been a member of any organization, group of individuals, movement or association that:	
Advocates denying other individuals their equal civil rights or liberties?	Yes ☐ No ☐
Advocates the overthrow of our constitutional form of government by force or violence?	Yes ☐ No ☐
Has conducted or been involved in any illegal activity?	Yes ☐ No ☐
If "Yes" was given to any of the previous three (3) questions, please list the organization and details below.	

Motor Vehicle

Driver's License Number	Name under which license was granted	Exp. Date (dd/mm/yy)	State
Please list other states where you have been licensed to operate a motor vehicle and the name under which the license was issued	Name	Operators License #	State

Have you ever been refused a driver's license by any state?	Yes ☐ No ☐
If "Yes," please give details (include when, where, why):	

List any/all vehicle registration information that you own and/or operate:

Plate Type examples: PC-Passenger, CO-Commercial, CM-Combination, MC-Motorcycle

Plate #	Plate Type	State Registered	Plate #	Plate Type	State Registered	Plate #	Plate Type	State Registered

Rhode Island law requires that operators and owners of motor vehicles be covered by automobile liability insurance. Please list the current liability insurance information for your vehicle(s):

Make	Year (yyyy)	Insurance Company	Address	Policy Number	Exp. Date (mm/yy)

Have you ever been refused insurance for any reason other than failure to pay a premium?	Yes ☐ No ☐
If "Yes," please explain (include company name and address, date and reason).	

Have you ever been issued a traffic citation (excluding parking citations)?	Yes ☐ No ☐ N/A ☐
If "Yes," please list all traffic citations (exclude parking citations) you have received.	

Nature of violation	Location (City/State)	Date (mm/yy)	Disposition
			Guilty ☐ Not Guilty ☐ Driving School ☐
			Guilty ☐ Not Guilty ☐ Driving School ☐
			Guilty ☐ Not Guilty ☐ Driving School ☐
			Guilty ☐ Not Guilty ☐ Driving School ☐
			Guilty ☐ Not Guilty ☐ Driving School ☐
			Guilty ☐ Not Guilty ☐ Driving School ☐
			Guilty ☐ Not Guilty ☐ Driving School ☐

Motor Vehicle Continued

Have you ever been involved as a driver in a motor vehicle accident?	Yes ☐ No ☐
If "Yes," give details for each accident.	

Date (mm/yy)	Location (City/State)	Police Investigation	Police Department	Type
		Yes ☐ No ☐		Injury ☐ Non-injury ☐
		Yes ☐ No ☐		Injury ☐ Non-injury ☐
		Yes ☐ No ☐		Injury ☐ Non-injury ☐
		Yes ☐ No ☐		Injury ☐ Non-injury ☐
		Yes ☐ No ☐		Injury ☐ Non-injury ☐

Has your license ever been suspended or revoked by Rhode Island or any other state?	Yes ☐ No ☐
If "Yes," please give details (include when, where, and why).	

Have you ever been charged or convicted of a DUI related offense?	Yes ☐ No ☐
If "Yes," please give details (include when, where, and why).	

General Info.

Are you a citizen of the United States?	Yes ☐ No ☐
Are you legally eligible to work in the United States?	Yes ☐ No ☐
If you are successful in gaining an appointment to this Department, do you expect to engage in any other gainful occupation?	Yes ☐ No ☐
If "Yes," please explain.	

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General Info. Continued

Are you currently using any illegal drugs, inclusive of marijuana?	Yes ☐ No ☐
If "Yes," please explain.	
Have you ever used any illegal drugs, inclusive of marijuana?	Yes ☐ No ☐
If "Yes," please explain.	
Have you ever purchased, transported, and/or sold any illegal drugs, inclusive of marijuana?	Yes ☐ No ☐
If "Yes," please explain.	
Have you ever manufactured or stored any illegal drugs, inclusive of marijuana?	Yes ☐ No ☐
If "Yes," please explain.	

General Info. Continued

Have you ever applied for a permit to carry a concealed weapon?			Yes ☐ No ☐
If "Yes", please provide the following information:			
Permit Granted?	Type of Weapon	Date (mm/yy)	Law Enforcement Agency
Yes ☐ No ☐			
Purpose:			

Have you ever applied for employment with another law enforcement agency?			Yes ☐ No ☐
If "Yes", please provide the following information:			
Agency Name (City and State)	Position	Date (mm/yy)	Disposition/Status

Have you ever applied for employment with this department?		Yes ☐ No ☐
If "Yes", list below:		
Position	Date (mm/yy)	Disposition

Are you acquainted with any members of this Department?			Yes ☐ No ☐
If "Yes," please list.			

Have you ever participated in an internship program with a Law Enforcement Agency?			Yes ☐ No ☐
If "Yes", please fill in.			
College/University Affiliation	Law Enforcement Agency	Dates of participation (mm/yy)	
		To	From

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Employment

Beginning with your most current employment, please list in descending order all jobs (including part-time, temporary, and voluntary positions) you have held. (For the purposes of this employment history report, voluntary work should be included as employment). Please indicate the nature of the activity, i.e., full-time, part-time, or voluntary. If you have had intervening periods of military service or unemployment, please list those periods in sequence in the spaces provided.

Dates of Employment		Name and Address of Employer	Phone number	
From (mm/yy)	To (mm/yy)			
Full-time ☐ Part-time ☐ Voluntary ☐ Unemployed ☐ Military ☐		Title	Name/Phone number of Supervisor	
Duties/Responsibilities			Names of Co-Workers	
Your Name if Different:			Salary:	
N/A ☐			Starting:	Ending:
Termination Status				
Voluntary Resignation ☐ Resigned in lieu of being fired ☐ Fired ☐ Position Eliminated ☐				
Explain:				

Dates of Employment		Name and Address of Employer	Phone number	
From (mm/yy)	To (mm/yy)			
Full-time ☐ Part-time ☐ Voluntary ☐ Unemployed ☐ Military ☐		Title	Name/Phone number of Supervisor	
Duties/Responsibilities			Names of Co-Workers	
Your Name if Different:			Salary:	
N/A ☐			Starting:	Ending:
Termination Status				
Voluntary Resignation ☐ Resigned in lieu of being fired ☐ Fired ☐ Position Eliminated ☐				
Explain:				

Employment Continued

Dates of Employment		Name and Address of Employer	Phone number	
From (mm/yy)	To (mm/yy)			
Full-time ☐ Part-time ☐ Voluntary ☐ Unemployed ☐ Military ☐		Title	Name/Phone number of Supervisor	
Duties/Responsibilities			Names of Co-Workers	
Your Name if Different:			Salary:	
N/A ☐			Starting:	Ending:
Termination Status				
Voluntary Resignation ☐ Resigned in lieu of being fired ☐ Fired ☐ Position Eliminated ☐				
Explain:				

Dates of Employment		Name and Address of Employer	Phone number	
From (mm/yy)	To (mm/yy)			
Full-time ☐ Part-time ☐ Voluntary ☐ Unemployed ☐ Military ☐		Title	Name/Phone number of Supervisor	
Duties/Responsibilities			Names of Co-Workers	
Your Name if Different:			Salary:	
N/A ☐			Starting:	Ending:
Termination Status				
Voluntary Resignation ☐ Resigned in lieu of being fired ☐ Fired ☐ Position Eliminated ☐				
Explain:				

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Employment Continued

Dates of Employment		Name and Address of Employer	Phone number	
From (mm/yy)	To (mm/yy)			
Full-time ☐ Part-time ☐ Voluntary ☐ Unemployed ☐ Military ☐		Title	Name/Phone number of Supervisor	
Duties/Responsibilities			Names of Co-Workers	
Your Name if Different:			Salary:	
N/A ☐			Starting:	Ending:
Termination Status				
Voluntary Resignation ☐ Resigned in lieu of being fired ☐ Fired ☐ Position Eliminated ☐				
Explain:				

Dates of Employment		Name and Address of Employer	Phone number	
From (mm/yy)	To (mm/yy)			
Full-time ☐ Part-time ☐ Voluntary ☐ Unemployed ☐ Military ☐		Title	Name/Phone number of Supervisor	
Duties/Responsibilities			Names of Co-Workers	
Your Name if Different:			Salary:	
N/A ☐			Starting:	Ending:
Termination Status				
Voluntary Resignation ☐ Resigned in lieu of being fired ☐ Fired ☐ Position Eliminated ☐				
Explain:				

Employment Continued

Dates of Employment		Name and Address of Employer	Phone number	
From (mm/yy)	To (mm/yy)			
Full-time ☐ Part-time ☐ Voluntary ☐ Unemployed ☐ Military ☐		Title	Name/Phone number of Supervisor	
Duties/Responsibilities			Names of Co-Workers	
Your Name if Different:			Salary:	
N/A ☐			Starting:	Ending:
Termination Status				
Voluntary Resignation ☐ Resigned in lieu of being fired ☐ Fired ☐ Position Eliminated ☐				
Explain:				

Dates of Employment		Name and Address of Employer	Phone number	
From (mm/yy)	To (mm/yy)			
Full-time ☐ Part-time ☐ Voluntary ☐ Unemployed ☐ Military ☐		Title	Name/Phone number of Supervisor	
Duties/Responsibilities			Names of Co-Workers	
Your Name if Different:			Salary:	
N/A ☐			Starting:	Ending:
Termination Status				
Voluntary Resignation ☐ Resigned in lieu of being fired ☐ Fired ☐ Position Eliminated ☐				
Explain:				

Employment Continued

Would any problems result if your present employer were contacted during the course of the background investigation?	Yes ☐ No ☐
If “Yes,” please explain why.	
When should contact be made?	
If you have had no prior employment, please explain.	N/A ☐
Have you ever been disciplined, suspended, or otherwise received punitive actions at a current or former place of employment?	Yes ☐ No ☐
If “Yes,” please explain why.	
Are you willing to work any type of shift associated with the position for which you have applied?	Yes ☐ No ☐
If “No,” please explain why.	
Have you ever been fired, asked to resign, or resigned because you believed you would be fired from a job?	Yes ☐ No ☐
If “Yes,” please give details (include when, where and circumstances).	

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References

Please provide 3 professional references **NOT** related to you

Reference 1

Name:		
	Last	First
Address:		
	Street Address	
	City	State	Zip Code
Phone Number:		
E-Mail Address:		

Reference 2

Name:		
	Last	First
Address:		
	Street Address	
	City	State	Zip Code
Phone Number:		
E-Mail Address:		

Reference 3

Name:		
	Last	First
Address:		
	Street Address	
	City	State	Zip Code
Phone Number:		
E-Mail Address:		

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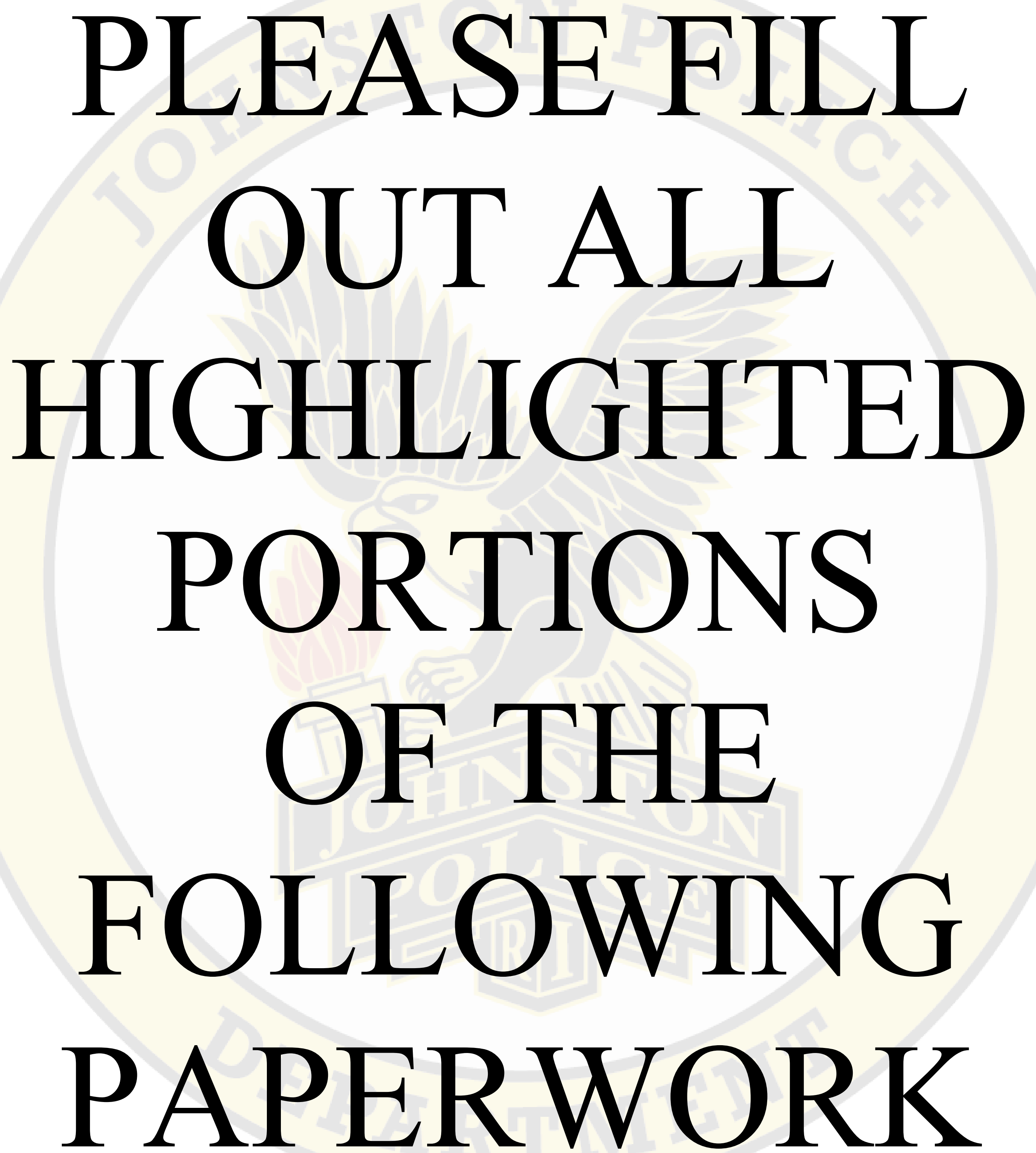
CONSENT TO RELEASE

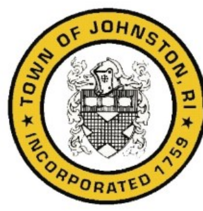
The statements made by me in my application for employment with the Town of Johnston are true and complete to the best of my knowledge. I understand that any willful misstatements or material omissions in the aforementioned applications will be sufficient cause to disqualify me from employment consideration with the Town of Johnston. If such misstatements or omissions are found after employment, it will be considered grounds for dismissal. I understand that the completed application, background investigation pre-screening packet and any materials submitted with it are the property of the Town of Johnston and will not be returned regardless if I am offered employment. I understand that any offer of employment is contingent upon my ability to produce documentation required by the Immigration and Naturalization Service documenting eligibility, if necessary, for employment.

I authorize the release of any and all education and credit related information that the Town of Johnston may request or any records pertaining to past or present employment, which may now exist or exist in the future.

______________________________	____________________
Signature	Date Signed



PLEASE FILL OUT ALL HIGHLIGHTED PORTIONS OF THE FOLLOWING PAPERWORK



JOHNSTON POLICE DEPARTMENT

Chief of Police, Mark A. Vieira

General Authorization for Release of Information

I, ____, do hereby authorize a review and full disclosure of all records, or any part thereof, concerning myself, by and to duly authorized agents of the Johnston Police Department and the Rhode Island Municipal Police Academy, whether the said records are of a public, private, or confidential nature.

The intent of this authorization is to give my consent for full and complete disclosure of Casino Gaming records; records of educational institutions; financial or credit institutions, including records of deposits, withdrawals and balances of checking and savings accounts, and loans, and also the records of commercial or retail credit agencies, including credit reports and ratings; medical and psychiatric treatment and consultation, including hospitals, clinics, private practitioners; the U.S. Veteran's Administration; the United States military; public utility companies; employment and pre-employment records, including background reports, efficiency ratings, complaints or grievances filed by or against me, and salary records; housing records; real and personal property tax statements and records; other financial statements and records wherever filed; records of complaint, arrest, trial and/or convictions for alleged or actual violations of law, including criminal and/or traffic records; records of complaints in any civil proceeding made in any case in which I presently have, or have had any interest.

I reiterate and emphasize that the intent of this authorization is to provide full and free access to the background and history of my personal life, for the specific purpose of pursuing a background investigation, which may provide pertinent data and/or information for the Johnston Police Department and the Rhode Island Municipal Police Academy to consider in determining my suitability for employment by that department.

It is my specific intent to provide access to personal information, however personal or confidential it may appear to be, and the sources of information specifically enumerated above is not intended to deny access to any records not specifically identified herein.
I understand that any information obtained by a personal history background investigation, which is developed directly or indirectly, in whole or in part pursuant to this release authorization will be considered in determining my suitability for employment by the Johnston Police Department and the Rhode Island Municipal Police Academy. I have had explained to me, and I fully understand that refusal to grant this authorization will not, of itself, constitute a basis for rejection of my application.

To the custodian of the records discussed herein, I hereby authorize you to release information to the bearer of this *Authorization for Release of Information*. I consider a copy of the *Authorization for Release of Information* to be as valid as the original even though a copy does not have my original signature.

I hereby release to the Johnston Police Department and the Rhode Island Municipal Police Academy and its agents and anyone who gives written or oral information about me to the Johnston Police Department from any claims of liability or damages which may occur as a result of the background investigation. This release of liability also extends to my heirs, executors, assigns and representatives.

Print Name: ____

Signature: ____

Address: ____
(Street Address) (City/Town) (State) (Zip Code)

Date of Birth: ______________________ Soc. Sec. Number: ______________________

Witness: ____

RHODE ISLAND DEPARTMENT OF PUBLIC SAFETY
Municipal Police Training Academy
Community College of Rhode Island — Flanagan Campus
1762 Louisquisset Pike, Lincoln, RI 02865-4585
Telephone: (401) 205-2500 — Fax: (401) 205-2501

Colonel Darnell S. Weaver
Superintendent, Rhode Island State Police
Director, Department of Public Safety

Lieutenant Christopher J. Zarrella
Executive Director
Municipal Police Training Academy

General Authorization for Release of Information

I, ____, do hereby authorize a review and full disclosure of all records, or any part thereof, concerning myself, by and to duly authorized agents of the ________Johnston________ Police Department and the Rhode Island Municipal Police Academy, whether the said records are of a public, private, or confidential nature.

The intent of this authorization is to give my consent for full and complete disclosure of Casino Gaming records; records of educational institutions; financial or credit institutions, including records of deposits, withdrawals and balances of checking and savings accounts, and loans, and also the records of commercial or retail credit agencies, including credit reports and ratings; medical and psychiatric treatment and consultation, including hospitals, clinics, private practitioners; the U.S. Veteran's Administration; the United States military; public utility companies; employment and pre-employment records, including background reports, efficiency ratings, complaints or grievances filed by or against me, and salary records; housing records; real and personal property tax statements and records; other financial statements and records wherever filed; records of complaint, arrest, trial and/or convictions for alleged or actual violations of law, including criminal and/or traffic records; records of complaints in any civil proceeding made in any case in which I presently have, or have had any interest.

I reiterate and emphasize that the intent of this authorization is to provide full and free access to the background and history of my personal life, for the specific purpose of pursuing a background investigation, which may provide pertinent data and/or information for the __________Johnston__________Police Department and the Rhode Island Municipal Police Academy to consider in determining my suitability for employment by that department.

It is my specific intent to provide access to personal information, however personal or confidential it may appear to be, and the sources of information specifically enumerated above is not intended to deny access to any records not specifically identified herein.

I understand that any information obtained by a personal history background investigation, which is developed directly or indirectly, in whole or in part pursuant to this release authorization will be considered in determining my suitability for employment by the ________Johnston________ Police Department and the Rhode Island Municipal Police Academy. I have had explained to me, and I fully understand that refusal to grant this authorization will not, of itself, constitute a basis for rejection of my application.

To the custodian of the records discussed herein, I hereby authorize you to release information to the bearer of this *Authorization for Release of Information.* I consider a copy of the *Authorization for Release of Information* to be as valid as the original even though a copy does not have my original signature.

I hereby release to the _______Johnston_______ Police Department and the Rhode Island Municipal Police Academy and its agents and anyone who gives written or oral information about me to the ______Johnston______ Police Department from any claims of liability or damages which may occur as a result of the background investigation. This release of liability also extends to my heirs, executors, assigns and representatives.

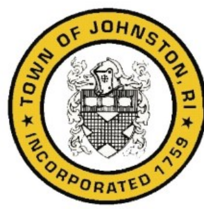
Print Name: ____

Signature: ____

Address: ____

Date of Birth: ________________________ Soc. Sec. Number: ________________________________

Witness: ____



JOHNSTON POLICE DEPARTMENT

Chief of Police, Mark A. Vieira

Mental Health
Authorization for Release of Information

I, ____, do hereby authorize a review and full disclosure of all records, or any part thereof, concerning myself, by and to duly authorized agents of the Johnston Police Department, whether the said records are of a public, private, or confidential nature.

The intent of this authorization is to give my consent for full and complete disclosure of the records from ____ (name of institution) regarding medical and psychiatric treatment and consultation, including records of hospitals, clinics and private practitioners operating within or in association with said ________________________________ (name of institution).

I reiterate and emphasize that the intent of this authorization is to provide full and free access to the background and history of my personal life, for the specific purpose of pursuing a background investigation, which may provide pertinent data and/or information for the Johnston Police Department to consider in determining my suitability for employment by that department.

It is my specific intent to provide access to personal information, however personal or confidential it may appear to be, and the sources of information specifically enumerated above is not intended to deny access to any records not specifically identified herein.

I understand that any information obtained by a personal history background investigation, which is developed directly or indirectly, in whole or in part, pursuant to this release authorization will be considered in determining my suitability for employment by the Johnston Police Department. I have had explained to me, and I fully understand, that refusal to grant this authorization will not, of itself, constitute a basis for rejection of my application.

To the custodian of the records discussed herein, I hereby authorize you to release information to the bearer of this *Authorization for Release of Information.* I consider a copy of the *Authorization for Release of Information* to be as valid as the original even though a copy does not have my original signature.

I hereby release to the Johnston Police Department and its agents and anyone who gives written or oral information about me to the Johnston Police Department from any claims of liability or damages which may occur as a result of the background investigation. This release of liability also extends to my heirs, executors, assigns and representatives.

Print Name: ____

Signature: ____

Address: ____
(Street Address) (City/Town) (State) (Zip Code)

Date of Birth: ____________________ Soc. Sec. Number: ____________________

Witness: ____

RHODE ISLAND DEPARTMENT OF PUBLIC SAFETY
Municipal Police Training Academy
Community College of Rhode Island — Flanagan Campus
1762 Louisquisset Pike, Lincoln, RI 02865-4585
Telephone: (401) 205-2500 — Fax: (401) 205-2501

Colonel Darnell S. Weaver
Superintendent, Rhode Island State Police
Director, Department of Public Safety

Lieutenant Christopher J. Zarrella
Executive Director
Municipal Police Training Academy

Mental Health

Authorization for Release of Information

I, ____, do hereby authorize a review and full disclosure of all records, or any part thereof, concerning myself, by and to duly authorized agents of the ___Johnston___ Police Department, whether the said records are of a public, private, or confidential nature.

The intent of this authorization is to give my consent for full and complete disclosure of the records from ____ (name of institution) regarding medical and psychiatric treatment and consultation, including records of hospitals, clinics and private practitioners operating within or in association with said ________________________________ (name of institution).

I reiterate and emphasize that the intent of this authorization is to provide full and free access to the background and history of my personal life, for the specific purpose of pursuing a background investigation, which may provide pertinent data and/or information for the ___Johnston___ Police Department to consider in determining my suitability for employment by that department.

It is my specific intent to provide access to personal information, however personal or confidential it may appear to be, and the sources of information specifically enumerated above is not intended to deny access to any records not specifically identified herein.

I understand that any information obtained by a personal history background investigation, which is developed directly or indirectly, in whole or in part, pursuant to this release authorization will be considered in determining my suitability for employment by the ___Johnston___ Police Department. I have had explained to me, and I fully understand, that refusal to grant this authorization will not, of itself, constitute a basis for rejection of my application.

To the custodian of the records discussed herein, I hereby authorize you to release information to the bearer of this *Authorization for Release of Information.* I consider a copy of the *Authorization for Release of Information* to be as valid as the original even though a copy does not have my original signature.

I hereby release to the ___Johnston___ Police Department and its agents and anyone who gives written or oral information about me to the ___Johnston___ Police Department from any claims of liability or damages which may occur as a result of the background investigation. This release of liability also extends to my heirs, executors, assigns and representatives.

Print Name: ____

Signature: ____

Address: ____

Date of Birth: ______________________ Soc. Sec. Number: _____________________

Witness: ____

10136

10136 (1-2022)

Care New England

AUTHORIZATION TO RELEASE HEALTH INFORMATION

FOR INPATIENTS: AFFIX PATIENT LABEL **OR** WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: ______________________________

DOB OR MR #: ______________________________

1. Patient name: ______________________________ ("Patient") Date of Birth: ______________ Telephone: ______________

   Address: ______________________________ Med. Rec. #: ______________
   Street City State Zip

2. The undersigned hereby authorizes the following CNE Provider ______________________________
   (Insert Hospital/Facility/Physician name) (the **"Provider"**)

   Address: ______________________________
   Street City State Zip

   Telephone: ______________________ Fax: ______________________

   ☐ to release/disclose (including verbal) to the individual and/or entity named in Section 3 **("Recipient")**
   AND/OR
   ☐ to request/receive (including verbal) from the individual and/or entity named in Section 3 **("Disclosing Party")**
   the protected health information **("Health Information")** specified in Section 4

3. Recipient or Disclosing Party: ______________________________ (Insert Individual/Entity Name)

   Telephone: ______________________ Fax Number (if Health Information is to be faxed): ______________________

   Address: ______________________________
   Street City State Zip

4. Please check one or more types of Health Information to be released/requested:

______ Allergies	______ Laboratory Results	______ Operative Report
______ Immunization Records	______ X-Ray/Imaging Results	______ Psychiatric Exam
______ Emergency Dept. Records**	______ History & Physical	______ Psychological Tests
______ Registration Record	______ Progress Notes	______ Treatment Plan(s)
______ Discharge Summary	______ Consultation Reports	______ Entire Record

   OTHER (Please specify): ______________________________
   *****An authorization for Emergency Department Records may include any of the above listed Health Information records.***

5. Time frame for which the Health Information authorized in Section 4 above should be released/requested:
   For the period from ____________ (insert start date) through ____________ (insert end date);
   OR ALL DATES OF TREATMENT ______________ (Please initial)

6. The undersigned acknowledges, agrees, and understands that unless specifically limited below, any Health Information released may include mental health treatment information, alcohol and substance abuse treatment information, STDs and/or HIV/AIDS-related information.
   DO NOT RELEASE THE FOLLOWING HEALTH INFORMATION (Please specify): ______________________________

   ____

7. This authorization is being requested by the undersigned for the following purpose(s) (initial all that apply)
   ______ Medical Care ______ Legal ______ Insurance ______ Personal
   Other (Please describe): ______________________________

8. The undersigned acknowledges and understands each of the following:
   - authorizing the release of the Patient's Health Information is voluntary;
   - refusal to sign this authorization does not affect the Patient's treatment, payment of claims, health plan enrollment or eligibility for benefits;
   - this authorization may be revoked at any time upon written request to the Provider's privacy officer or health information department except to the extent that release of Patient's Health Information has already occurred in reliance on this authorization;
   - unless previously revoked, this authorization will automatically expire TWELVE (12) months from the date of signature below unless a shorter timeframe specified here ______________________________ (enter date authorization will expire);
   - ***any information released to the Recipient may be re-disclosed and may no longer be protected by federal or state privacy and or confidentiality laws.***

THE UNDERSIGNED (1) HAS READ AND UNDERSTANDS THIS AUTHORIZATION; (2) HAS HAD ANY QUESTIONS WITH RESPECT TO THIS AUTHORIZATION EXPLAINED TO HIS/HER SATISFACTION; (3) IS AUTHORIZED TO SIGN THIS AUTHORIZATION INDIVIDUALLY AS THE PATIENT OR AS THE PATIENT'S LEGAL REPRESENTATIVE; AND (4) HEREBY EXPRESSLY AND VOLUNTARILY AUTHORIZES THE RELEASE/ REQUEST OF THE PATIENT'S HEALTH INFORMATION AS SPECIFIED ABOVE.

______________________________ ______________________________
Signature of Patient or Legal Representative of Patient Date/Time

______________________________ ______________________________
PRINT name of Patient or Legal Representative of Patient Relationship to Patient or Authority to Act for Patient

TPC Internal Use Only: Process Hold

THIS AUTHORIZATION SHALL BE INVALID UNLESS ALL APPLICABLE SECTIONS ARE COMPLETE

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILTIES AND HOSPITALS

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

1. I, ____
(Print first name, last name & date of birth of the Individual for whom information is being requested)

2. I hereby authorize the following information to be released: (check all that apply)

- ☑ Physician Orders
- ☑ Progress Notes
- ☑ Discharge Summary
- ☑ History and Physical
- ☑ Treatment Plan
- ☑ Social Service Records
- ☑ Laboratory Reports
- ☑ Consultation Reports
- ☑ Continuity of Care Forms
- ☑ Inter-Agency Referral(s)
- ☑ School/Edu. Records
- ☑ Psychology Records
- ☑ Therapy Reports
- ☑ Financial Records
- ☑ Billing Requests/Reports
- ☑ Vocational Records

☑ Other (please be specific) ____

3. I hereby authorize the following information not to be released*: (check all that apply)

- ☑ Substance Abuse/dependency/diagnosis/treatment/referral (42 CFR)
- ☑ Mental Health/diagnosis/treatment/referral
- ☑ HIV Test results /AIDS related information/(ARC) diagnosis and/or treatment
- ☑ Diagnoses and/or treatment relating to other communicable diseases

* This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

4. My information is to be obtained from:

ELEANOR SLATER HOSPITAL
(Name of Organization)
P.O. BOX 8269 ______________
(Address)
CRANSTON RI,02920
(City/State/Zip)
Alyssa Carlson (401) 462-3639
(Contact Name and Telephone Number)

5. My information is to be released to:

Johnston Police Department
(Name of Organization)
1651 Atwood Avenue
(Address)
Johnston, RI 02919
(City/State/Zip)
Justine Dutilly (401) 757-3182 or (401) 231-4210
(Contact Name and Telephone Number)
E-Mail: jdutilly@johnstonpd.com

Method of Communication:
☐ Verbal ☑ Printed Materials

6. This authorization is for information applicable to the time period specified below:

From:______________________________ To:______________________________

7. Pre-Employment Background
(Indicate the specific purpose or need for this release of information)

8. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the federal privacy regulations. BHDDH may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of an authorization. I understand that I have the right to revoke this authorization in writing at anytime, and that the revocation will be effective except to the extent that the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) has already taken action in reliance on my authorization. I understand that if this authorization has not been revoked, it will expire in 90 days from the date of my signature. **My instructions to revoke my authorization should be directed to:**

____
(Name and address of BHDDH Records person responsible for this request)

9. Signature of individual: ______________________________ Date: ______________

10. Signature of authorized representative ______________________________ Relationship: ______________

Print Name: ______________________________ Date: ______________

For Office Use Only: Information Released: Y N Date of release: ______________________________
Staff Person Releasing Information: ______________________________

(Form 1) 703.5 Rev:10/11

FULLER HOSPITAL

LEADING THE WAY IN BEHAVIORAL HEALTH

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Birth Date: ______________

Maiden/Prior Names: ______________________________ Current Phone #: ______________

Current Address: ______________________________ Last 4 of SS#: ______________

To be released to or requested from:

☐ Self (address above)

☐ ______________ (____)__________ ______________________

Agency/Organization — Telephone Number — Street Address

______________ (____)__________ ______________________

Name / Attention to — Fax Number — City — State — Zip Code

Via (only when released to): ☐ Mail ☐ Fax ☐ Pick-up ☐ Email: ______________________

☐ Verbal Exchange of Information ONLY

I am requesting disclosure of my protected health information for the following purpose:

☐ Continuing Care ☐ Disability Determination ☐ Child Custody ☐ Personal Use

☐ Academic ☐ Legal Investigation ☐ Billing/Insurance ☐ Other: ______________

Dates of Service Requested: ______________________________________

☐ **I authorize the release of the following information <u>including</u> all records that include any substance use disorder and/or substance use disorder treatment records, or**

☐**I authorize the release of the following information <u>excluding</u> all records that include any substance use disorder and/or substance use disorder treatment records,**

Only the information and records indicated below (check all that apply and /or specific if "Other is checked):

☐ Continuity/Transition of Care Packet

☐ Psychiatric Evaluation

☐ History and Physical

☐ Discharge Summary

☐ Progress Notes

☐ Physician Orders

☐ Lab/Diagnostic Reports

☐ HIV Test Results and AIDS Treatment Records

☐ Other: ______________________

This authorization will expire on ____/____/20____. (If not indicated, authorization will expire <u>one year</u> from signature date)

This form must be completed in full before signing:

______________________ ______________________ ______________

Patient's signature (required for ages 18 and older) — Parent/Legal Guardian signature (if applicable) — Relationship to Patient

______________________ ______________

Witness signature/Credentials — Date Signed

This authorization is intended to allow Fuller Hospital to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request. ______________________ ______________

Revocation Signature — Date/Time

McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Mail or Fax Release Form To:
Release of Information
121 Inner Belt Road, Room 240
Somerville, MA 02143-4453
Fax: 617-726-3661
For questions, contact: 617-726-2361
For copies of radiology images or films, contact (617) 855-3385 / Fax (617) 855-3757

Authorization for Release of Protected or Privileged Health Information

Please print all information clearly in order to process your request in a timely manner.

A. Patient information

Patient Name: ______________________ Date of Birth: ______________________

Medical Record #: ______________

Address: Street: ______________________ Apt. #: ______

City: ______________________ State: ____________ Zip Code: __________

Preferred Phone #: ______________

B. Permission to share: I give my permission to share my protected health information.

Records from:

Name of Site Location: ______________________

Practice Name: ______________________

____

Provider Name: ______________________

Purpose: (check the appropriate box)☐ Medical Care
☐ Insurance*
☐ Legal*
☐ Personal
☐ School
☐ Other* (please specify) pre-employment background
**Copying fees may apply*

Send records to (Enter where you would like Mass General Brigham to send your information to):
☐ Check here if the records are to be mailed to the patient at the above address (section A), otherwise complete the information below:

Name: ______________________

Address: ______________________

____

Telephone Number: ______________________

Send by:
☐ Mass General Brigham Patient Gateway (if available)
☐ Secure Email
Email Address: ______________________
☐ Fax (provide fax number): ______________________
☐ Paper Copy via Mail

C. Information to be released (please check all that apply, and MUST specify dates):

☐ Date(s) of Medical Record Abstract (e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary) ______________________
☐ Date(s) of Clinic Visit Notes ______________________
☐ Date(s) of Discharge Summary ______________________
☐ Date(s) of Lab Reports ______________________
☐ Date(s) of Operative Reports ______________________
☐ Date(s) of Pathology Reports ______________________
☐ Date(s) of Radiation Reports ______________________
☐ Date(s) of Radiology Reports ______________________
☐ Date(s) of Photographs ______________________
☐ Date(s) of Billing Records ______________________
☐ Other (please specify below and include dates)

McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Mail or Fax Release Form To:
Release of Information
121 Inner Belt Road, Room 240
Somerville, MA 02143-4453
Fax: 617-726-3661
For questions, contact: 617-726-2361
For copies of radiology images or films, contact (617) 855-3385 / Fax (617) 855-3757

Authorization for Release of Protected or Privileged Health Information

D. Please check YES to indicate if you give permission to release the following information if present in your record:

☐ Yes HIV test results (Patient authorization required for each release request.)
Specify dates ____________________

☐ Yes Genetic Screening test results
Specify type of test ____________________

☐ Yes Substance Use Disorder Treatment Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.) This consent may be revoked upon oral or written request.

☐ Yes Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) (I understand that my permission may not be required to release my mental health records for payment purposes)

☐ Yes Confidential Communications with a Licensed Social Worker

☐ Yes Details of Domestic Violence/ Intimate Partner Abuse Counseling

☐ Yes Details of Sexual Assault Counseling

E. I understand and agree that:

- Mass General Brigham cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Mass General Brigham may or may not protect this information once it has been released to the recipient
- This authorization is voluntary
- My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form
- I may cancel this authorization at any time by submitting a written request to the Department or Office where I originally submitted it, except:
  - if Mass General Brigham has already processed the request (for example, once information is released, it will not be retrieved)
  - if I signed this authorization as a condition of obtaining insurance. Other laws may provide the insurer with a right to contest a claim under the policy or the policy itself
- This authorization will automatically expire 6 months from the date signed unless otherwise specified:__________
- I understand that if Mass General Brigham maintains any of my records from outside providers, these will not be released unless I specifically ask for them under "Other" in section C. Please include entity name, provider, and specific dates if known.
- My questions about this authorization form have been answered

Patient's Signature: ____________________ **Date:** __________

Print Name: ____________________

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: ____________________ **Date:**__________

Print Name: ____________________ **Relationship of representative to patient:** __________

For Internal Use Only: Information Released/Reviewed By: ____________________Date: __________

Picked up by: ____________________ Pick-up Identification: ☐ License ☐ State ID ☐ Passport ☐ Other Photo ID __________

Roger Williams MEDICAL CENTER

CharterCARE HEALTH PARTNERS

St. Joseph Health Services of Rhode Island

HEALTH INFORMATION SERVICES
AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED INFORMATION

☑ **REQUEST COPIES OF MEDICAL RECORD** ______ **REVIEW MEDICAL RECORD**

I do hereby authorize the following CharterCARE Health Partners affiliates entities (to include without limitation)

- ☐ Roger Williams Medical Center
- ☐ Roger Williams Medical Associates
- ☐ Elmhurst Extended Care Facility
- ☐ Elmhurst Health Associates
- ☐ St. Joseph Health Services
- ☐ Our Lady of Fatima Ancillary Services
- ☐ Southern New England Rehabilitation Center
- ☑ All

to release my protected health information, including copies of my medical record of care to the following person(s) or persons at the location/facility listed below for the purpose(s) as indicated:

Patient Name: ______________________________ **DOB**: ____________
(Last) (First) (M.I.)

Patient Address: ______________________________
____
____

Patient Telephone (for contact): ( ) __________________ work /home / cell

Email address: ______________________________

Recipient

Johnston Police Department
Name
Attn: Justine Dutilly Administrative Div. Clerk
1651 Atwood Ave
Address
Johnston, RI 02919
City, State, Zip Code
Phone: (401) 757-3182 Fax: (401) 233-3314 E-Mail: jdutilly@johnstonpd.com

Purpose (*check the appropriate box*)

- ☐ Medical Care
- ☐ Legal Matter
- ☐ Insurance
- ☐ Personal
- ☑ Other (please specify) *

* pre-employment background

Concerning my treatment for the period of: any/all

PROTECTED HEALTH INFORMATION TO BE RELEASED ***(Please check the appropriate box(s) and provide dates):***

- ☐ Discharge Summary (dates) _______________
- ☐ Operative Reports (dates) _______________
- ☐ Outpatient Test Results (dates) ____________
- ☐ X-Rays/Scan Reports (dates) ______________
  - ☐ Reports ☐ Films
- ☐ Pathology Reports (dates) _______________
- ☐ Emergency Room (dates) ________________
- ☐ Lab Reports (dates) ______________________
- ☐ Other *(please specify)* ___________________
- ☐ Billing _________________________________

☑ Medical Record Abstract (*e.g. Discharge Summary, Consultations, History & Physical, Operative, Pathology, and Test Reports*)

ROI

Authorization for Release of
Specifically Protected Information

I request the release of the specific categories of information that I have _INITIALED_ below:

_____ HIV test results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)
SPECIFY DATE(S): any/all

_____Records pertaining to Sexually-Transmitted Diseases

_____ Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)

_____ Other(s): Please List ____

Confidential Details of:

_____ Psychotherapy (from a Psychiatrist, Psychologist, or Psychiatric Clinical Nurse Specialist)
(cannot be authorized in conjunction with non psychotherapy authorization)

_____ Other professional services of a licensed psychologist

_____ Social Work Counseling/Therapy

_____ Domestic Violence Victims' Counseling

_____ Sexual Assault Counseling

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Management.
- Authorization may be withdrawn except for the following:
  *To the extent that action has been taken in reliance on this statement
  *If the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.
- I may refuse to sign this authorization.
- If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and no longer protected by this rule.
- I understand that even if I do not withdraw this consent that this statement shall expire in:
  (please check one):_____3 months ______6 months_____12 months _____Other
  (if no time is indicated authorization will expire in one year)

I have carefully read and understand the above, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: ____________________________ Date:____________ Relationship, if not patient____________

Print Name: ______________________________Witness:__________________________Date:__________

____
Basis of Authority to act on behalf of the patient

TO BE COMPLETED BY OFFICE STAFF/FACILITY RELEASING INFORMATION:

Date___/___/____ ID Verified: Y / N # Pages (if) Given to Patient__________ Initials: ___________

Type of Delivery: Email _____ Mail _____ Other________________________________

ROI

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT AND PAPER WORK REDUCTION ACT INFORMATION: The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless is displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out this form. The execution of this form does not authorize the release of information other than that specifically described below.

The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if information needed to locate records for release is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition the provision of treatment, payment, enrollment in the VA Health Care Program, or eligibility for benefits on the signing of an authorization, except for research-related treatment where an authorization for the use or disclosure of individually-identifiable health information for such research is required. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10A7 "Patient Medical Record - VA", 08VA05 "Employee Medical File System Records (Title 38)-VA" and in accordance with the Notice of Privacy Practices. VA may also use this information to identify Veterans and person claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

LAST NAME- FIRST NAME- MIDDLE NAME

DATE OF BIRTH *(mm/dd/yyyy)*

PATIENT'S MAILING ADDRESS (*including City, State and Zip Code*)

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL, OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Johnston Police Department ~ Administrative Division ~ Attn. Justine Dutilly
1651 Atwood Ave, Johnston, RI 02919
Phone: (401) 231-4210 | Direct Line: (401) 757-3182 | Fax: (401) 233-3314 | E-Mail: jdutilly@johnstonpd.com

PURPOSE(S) OR NEED: Information is to be used by the requestor for:

- [ ] TREATMENT
- [ ] BENEFITS
- [ ] LEGAL
- [x] EMPLOYMENT
- [ ] OTHER *(Please specify)* ______

INFORMATION REQUESTED: Check applicable box(es) and state the extent or nature of information to be provided:

- [x] HEALTH SUMMARY *(Prior 2 Years)*
- [x] INPATIENT DISCHARGE SUMMARY *(Dates)*: ______
- [x] PROGRESS NOTES:
  - [ ] SPECIFIC CLINICS *(Name & Date Range)*: ______
  - [ ] SPECIFIC PROVIDERS *(Name & Date Range)*: ______
  - [ ] DATE RANGE: ______
- [x] OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: ______
- [x] LAB RESULTS:
  - [ ] SPECIFIC TESTS *(Name & Date)*: ______
  - [ ] DATE RANGE: ______
- [x] RADIOLOGY REPORTS *(Name & Date)*: ______
- [x] LIST OF ACTIVE MEDICATIONS: ______
- [x] FLU VACCINATION *(Dose, Lot Number, Date & Location)*: ______
- [x] OTHER *(Describe)*: ______

LAST NAME- FIRST NAME- MIDDLE NAME	DATE OF BIRTH *(mm/dd/yyyy)*

SENSITIVE DIAGNOSES: REVIEW AND, IF APPROPRIATE, COMPLETE WHEN RELEASE IS FOR ANY PURPOSE <u>OTHER THAN TREATMENT</u>.

I request and authorize Department of Veterans Affairs to release the information pertaining to the condition(s) below for the non-treatment purpose(s) listed in this authorization.

☑ DRUG ABUSE ☑ ALCOHOLISM OR ALCOHOL ABUSE ☑ SICKLE CELL ANEMIA

☑ HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

I understand that information on these sensitive diagnoses may be released for treatment purposes without me checking the above boxes, and will be released even if the boxes are unchecked <u>unless</u> I indicate by checking the box below that I do not want this information released for this specific disclosure.

☐ **I do not want sensitive diagnoses released for treatment purposes under this specific authorization. I realize this does not impact other future requests unrelated to this authorization.**

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION: Without my express revocation, the authorization will automatically expire *(select one of the following)*:

☐ AFTER ONE-TIME DISCLOSURE, IF ALL NEEDS ARE SATISFIED

☐ ON *(mm/dd/yyyy)* ________________ *(enter a future date other than date signed by patient)*

☑ UNDER THE FOLLOWING CONDITION(S): one year

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE *(if applicable) (Sign in ink)*	DATE *(mm/dd/yyyy)*
PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED *(mm/dd/yyyy)*	RELEASED BY:

Form **4506-T** (June 2023)
Department of the Treasury
Internal Revenue Service

Request for Transcript of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506-T, visit *www.irs.gov/form4506t*.**

OMB No. 1545-1872

Tip: Get faster service: Online at www.irs.gov, **Get Your Tax Record** (Get Transcript) or by calling **1-800-908-9946** for specialized assistance. We have teams available to assist. **Note:** Taxpayers may register to use Get Transcript to view, print, or download the following transcript types: **Tax Return Transcript** (shows most line items including Adjusted Gross Income (AGI) from your original Form 1040-series tax return as filed, along with any forms and schedules), **Tax Account Transcript** (shows basic data such as return type, marital status, AGI, taxable income and all payment types), **Record of Account Transcript** (combines the tax return and tax account transcripts into one complete transcript), **Wage and Income Transcript** (shows data from information returns we receive such as Forms W-2, 1099, 1098 and Form 5498), and **Verification of Non-filing Letter** (provides proof that the IRS has no record of a filed Form 1040-series tax return for the year you request).

1a Name shown on tax return. If a joint return, enter the name shown first.

1b **First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)**

2a If a joint return, enter spouse's name shown on tax return.

2b **Second social security number or individual taxpayer identification number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 Customer file number (if applicable) (see instructions)

Note: Effective July 2019, the IRS will mail tax transcript requests only to your address of record. See **What's New** under **Future Developments** on Page 2 for additional information.

6 **Transcript requested.** Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. ▶ ____________

a **Return Transcript,** which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days . . . . ☑

b **Account Transcript,** which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days . ☑

c **Record of Account,** which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days . . . . ☑

7 **Verification of Nonfiling,** which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days . . ☑

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2016, filed in 2017, will likely not be available from the IRS until 2018. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days . ☑

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 **Year or period requested.** Enter the end date of the tax year or period requested in mm/dd/yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12/31/2018 for a calendar year 2018 Form 1040 transcript.

| / / | / / | / / | / / |

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 120 days of the signature date.

☑ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T.** See instructions.

Phone number of taxpayer on line 1a or 2a

Sign Here

▶ **Signature** (see instructions) Date

▶ **Title** (if line 1a above is a corporation, partnership, estate, or trust)

▶ **Spouse's signature** Date

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506-T and its instructions, go to *www.irs.gov/form4506t.* Information about any recent developments affecting Form 4506-T (such as legislation enacted after we released it) will be posted on that page.

The filing location for the Form 4506-T has changed. **Please see Chart for individual transcripts or Chart for all other transcripts** for the correct mailing location.

What's New. As part of its ongoing efforts to protect taxpayer data, the Internal Revenue Service announced that in July 2019, it will stop all third-party mailings of requested transcripts. After this date masked Tax Transcripts will only be mailed to the taxpayer's address of record.

If a third-party is unable to accept a Tax Transcript mailed to the taxpayer, they may either contract with an existing IVES participant or become an IVES participant themselves. For additional information about the IVES program, go to *www.irs.gov* and search IVES.

General Instructions

Caution: Do not sign this form unless all applicable lines have been completed.

Purpose of form. Use Form 4506-T to request tax return information. Taxpayers using a tax year beginning in one calendar year and ending in the following year (fiscal tax year) must file Form 4506-T to request a return transcript.

Note: If you are unsure of which type of transcript you need, request the Record of Account, as it provides the most detailed information.

Customer File Number. The transcripts provided by the IRS have been modified to protect taxpayers' privacy. Transcripts only display partial personal information, such as the last four digits of the taxpayer's Social Security Number. Full financial and tax information, such as wages and taxable income, are shown on the transcript.

An optional Customer File Number field is available to use when requesting a transcript. This number will print on the transcript. See Line 5 instructions for specific requirements. The customer file number is an optional field and not required.

Tip. Use Form 4506, Request for Copy of Tax Return, to request copies of tax returns.

Automated transcript request. You can quickly request transcripts by using our automated self-help service tools. Please visit us at IRS.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-908-9946.

Where to file. Mail or fax Form 4506-T to the address below for the state you lived in, or the state your business was in, when that return was filed. There are two address charts: one for individual transcripts (Form 1040 series and Form W-2) and one for all other transcripts.

If you are requesting more than one transcript or other product and the chart shows two different addresses, send your request to the address based on the address of your most recent return.

Line 1b. Enter your employer identification number (EIN) if your request relates to a business return. Otherwise, enter the first social security number (SSN) or your individual taxpayer identification number (ITIN) shown on the return. For example, if you are requesting Form 1040 that includes Schedule C (Form 1040), enter your SSN.

Line 3. Enter your current address. If you use a P.O. box, include it on this line.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note: If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address. For a business address, file Form 8822-B, Change of Address or Responsible Party — Business.

Line 5. Enter up to 10 numeric characters to create a unique customer file number that will appear on the transcript. The customer file number **should not** contain an SSN. Completion of this line is not required.

Note. If you use an SSN, name or combination of both, we will not input the information and the customer file number will reflect a generic entry of "9999999999" on the transcript.

Line 6. Enter only one tax form number per request.

Signature and date. Form 4506-T must be signed and dated by the taxpayer listed on line 1a or 2a. The IRS must receive Form 4506-T within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines are completed before signing.

You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed and returned to you if the box is unchecked.

Individuals. Transcripts of jointly filed tax returns may be furnished to either spouse. Only one signature is required. Sign Form 4506-T exactly as your name appeared on the original return. If you changed your name, also sign your current name.

Corporations. Generally, Form 4506-T can be signed by: (1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506-T but must provide documentation to support the requester's right to receive the information.

Partnerships. Generally, Form 4506-T can be signed by any person who was a member of the partnership during any part of the tax period requested on line 9.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Note: If you are Heir at law, Next of kin, or Beneficiary you must be able to establish a material interest in the estate or trust.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Signature by a representative. A representative can sign Form 4506-T for a taxpayer only if the taxpayer has specifically delegated this authority to the representative on Form 2848, line 5. The representative must attach Form 2848 showing the delegation to Form 4506-T.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested tax information under the Internal Revenue Code. We need this information to properly identify the tax information and respond to your request. You are not required to request any transcript; if you do request a transcript, sections 6103 and 6109 and their regulations require you to provide this information, including your SSN or EIN. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506-T will vary depending on individual circumstances. The estimated average time is: **Learning about the law or the form,** 10 min.; **Preparing the form,** 12 min.; and **Copying, assembling, and sending the form to the IRS,** 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506-T simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526

Washington, DC 20224

Do not send the form to this address. Instead, see *Where to file* on this page.

Chart for individual transcripts (Form 1040 series and Form W-2 and Form 1099)

If you filed an individual return and lived in:	Mail or fax to:
Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, or A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team Stop 6716 AUSC Austin, TX 73301 855-587-9604
Delaware, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, New York, Vermont, Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999 855-821-0094
Alaska, Arizona, California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kansas, Maryland, Michigan, Montana, Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Washington, West Virginia, Wyoming	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409 855-298-1145

Chart for all other transcripts

If you lived in or your business was in:	Mail or fax to:
Alabama, Alaska, Arizona, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, a foreign country, American Samoa, Puerto Rico, Guam, the Commonwealth of the Northern Mariana Islands, the U.S. Virgin Islands, A.P.O. or F.P.O. address	Internal Revenue Service RAIVS Team P.O. Box 9941 Mail Stop 6734 Ogden, UT 84409 855-298-1145
Connecticut, Delaware, District of Columbia, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin	Internal Revenue Service RAIVS Team Stop 6705 S-2 Kansas City, MO 64999 855-821-0094

Form **8821**

(Rev. January 2021)

Department of the Treasury
Internal Revenue Service

Tax Information Authorization

▶ Go to *www.irs.gov/Form8821* for instructions and the latest information.
▶ Don't sign this form unless all applicable lines have been completed.
▶ Don't use Form 8821 to request copies of your tax returns or to authorize someone to represent you. See instructions.

OMB No. 1545-1165

For IRS Use Only
Received by:
Name ____________
Telephone ____________
Function ____________
Date

1 Taxpayer information. Taxpayer must sign and date this form on line 6.

Taxpayer name and address

Taxpayer identification number(s)

Daytime telephone number | Plan number (if applicable)

2 Designee(s). If you wish to name more than two designees, attach a list to this form. **Check here if a list of additional designees is attached** ▶ ☐

Name and address
Johnston Police Department
Attn: Justine Dutilly ~ Administrative Division
1651 Atwood Ave., Johnston, RI 02919
E-Mail: jdutilly@johnston pd.com

Check if to be sent copies of notices and communications ☐

CAF No. ____________
PTIN ____________
Telephone No. (401) 757-3182 or (401) 231-4210
Fax No. (401) 233-3314
Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

Name and address

Check if to be sent copies of notices and communications ☐

CAF No. ____________
PTIN ____________
Telephone No. ____________
Fax No. ____________
Check if new: Address ☐ Telephone No. ☐ Fax No. ☐

3 Tax information. Each designee is authorized to inspect and/or receive confidential tax information for the type of tax, forms, periods, and specific matters you list below. See the line 3 instructions.

☑ By checking here, I authorize access to my IRS records via an Intermediate Service Provider.

(a) Type of Tax Information (Income, Employment, Payroll, Excise, Estate, Gift, Civil Penalty, Sec. 4980H Payments, etc.)	(b) Tax Form Number (1040, 941, 720, etc.)	(c) Year(s) or Period(s)	(d) Specific Tax Matters
Tax Return	1040	2021, 2020 & 2019	Pre-Employment Background

4 Specific use not recorded on the Centralized Authorization File (CAF). If the tax information authorization is for a specific use not recorded on CAF, check this box. See the instructions. If you check this box, skip line 5 . . . . . . ▶ ☑

5 Retention/revocation of prior tax information authorizations. If the line 4 box is checked, skip this line. If the line 4 box isn't checked, the IRS will automatically revoke all prior tax information authorizations on file unless you check the line 5 box and **attach a copy** of the tax information authorization(s) that you want to retain . . . . ▶ ☐

To revoke a prior tax information authorization(s) without submitting a new authorization, see the line 5 instructions.

6 Taxpayer signature. If signed by a corporate officer, partner, guardian, partnership representative (or designated individual, if applicable), executor, receiver, administrator, trustee, or individual other than the taxpayer, I certify that I have the legal authority to execute this form with respect to the tax matters and tax periods shown on line 3 above.

▶ IF NOT COMPLETED, SIGNED, AND DATED, THIS TAX INFORMATION AUTHORIZATION WILL BE RETURNED.

▶ DON'T SIGN THIS FORM IF IT IS BLANK OR INCOMPLETE.

Signature | Date

Print Name | Title (if applicable)