CONSENT AND DISCLAIMER FORM

(TO BE MAILED BY THE EMPLOYER TO:
The Department of Attorney General
Attn: Deputy Director, Medicaid Fraud &Patient Abuse Unit
150 South Main Street, Providence, RI 02903)

NAME OF JUVENILE APPLICANT: _____

PLEASE PRINT NAME CLEARLY

ALIAS: _____ DATE OF BIRTH: _____/ _____/ _____

ADDRESS: _____

NAME AND ADDRESS OF EMPLOYING AGENCY: _____
_____
_____

Signature of Employer/Supervisor: _____

I, _____, am the parent/guardian/or attorney of record of the above-named juvenile, who seeks employment with _____.
I hereby authorize and direct The Department of Attorney General to review any file in reference to the above-named juvenile for record of an offense, which, if committed by an adult, would constitute disqualifying information pursuant to R.I.G.L. §23-17-37. If no such record is found, The Department of Attorney General will return this form to the above-mentioned Employing Agency indicating same.

I hereby waive and release any and all manners of action, causes of action, and demands of every kind, nature and description, arising from this request, whatsoever against the State of Rhode Island and the employees of The Department of Attorney General in both law and equity which I may now have or in the future may have.

_____
Signature of Parent/Guardian/Attorney

Notary
(TO BE COMPLETED & NOTARIZED PRIOR TO SUBMISSION)

Subscribed and sworn to before me at _____, County of _____, State of _____ this _____ day of _____, 20 ____.

_____
NOTARY PUBLIC
My Commission Expires: ___/ ___/ ___.

_____
Signature of Juvenile Applicant

Notary
(TO BE COMPLETED & NOTARIZED PRIOR TO SUBMISSION)

Subscribed and sworn to before me at _____, County of _____, State of _____ this _____ day of _____, 20 ____.

_____
NOTARY PUBLIC
My Commission Expires: ___/ ___/ ___.

_ _

_____ **NO RECORD OF AN OFFENSE WHICH IF COMMITTED BY AN ADULT WOULD CONSTITUTE DISQUALIFYING INFORMATION PURSUANT TO R.I.G.L. §23-17-37.**

Date: ___/ ___/ ____ _____
Department of Attorney General