State of New Hampshire
Department of Health and Human Services
Bureau of Elderly and Adult Services (BEAS)

3655
4/11

BEAS STATE REGISTRY CONSENT FORM
(RSA 161-F:49*)

Employer Information

I hereby authorize the release of any adult abuse, neglect, and/or exploitation record that you may find concerning me to: (***This portion must be filled out in order to be processed.)***

Employer Name: _____

Mailing Address: _____

City/State/Zip: _____

Telephone: _____

Fax: _____

For Official Use Only

Employee Information

PLEASE PRINT IN CLEAR BLOCK LETTERS

(If content is illegible, it will be stamped "Unable to Process" and returned.)

Last Name: _____ First Name: _____ Middle Initial: ___

Mailing Address: _____ City/State/Zip: _____

Telephone: _____ Gender: ☐Female ☐Male

Also known by the following names (Maiden Name, etc.):

Last Name _____ First Name: _____ Middle Initial: ___

Last Name _____ First Name: _____ Middle Initial: ___

Date of Birth: Month ____ Day ___ Year ____ Social Security # : _____
(Required) (Optional)

Position: _____ Select one: ☐Applying ☐Current Position

☐employee ☐consultant ☐volunteer ☐vendor ☐other _____

I understand that the information disclosed and provided by BEAS, under this State Registry Consent Form, is intended for use by the above-named employer in conjunction with my employment/volunteering.

Employee Signature _____ Date _____

Witness Signature _____ Date _____
(REQUIRED)

Fax to: (603) 271-6875 or Email BEASStateRegistry@dhhs.state.nh.us

Or Mail to: BEAS State Registry, Concord District Office, 40 Terrill Park Drive, Concord, NH 03301-3857

***This record check pertains only to findings made on or after July 1, 2007 pursuant to RSA 161-F:49.**

State of New Hampshire - Department of Health and Human Services

STATE REGISTRY CONSENT FORM

(*RSA 161-F:49)

SMS Special Medical Services

Respite Provider Information

PLEASE PRINT IN CLEAR BLOCK LETTERS

(If content is illegible, it will be stamped "Unable to Process" and returned.)

Last Name: _____ First Name: _____ MI_____

Mailing Address: _____

City/State/Zip: _____

Gender: ☐ Female ☐ Male

Also known by the following names (maiden, alias, etc.)

Last Name: _____ First Name: _____ MI_____

Last Name: _____ First Name: _____ MI____

Date of Birth: Month _____ Day _____ Year_____

Social Security Number: ☐☐☐-☐☐-☐☐☐☐

Current Position: Respite Provider

Providers Signature: _____ Date: _____

Notary's Siganture: _____ Date: _____
(Affix Seal) (Comm. Expires)

I understand that the information disclosed and provided to DHHS/SMS under this request and release authorization is intended for use by the below named agency in conjunction with my enrollment as a respite provider.

Return to Agency Name: DHHS/ Special Medical Services, Sharon Kaiser

Mailing Address: 129 Pleasant St. Thayer Building, Concord, NH 03301

Phone: 271-4498 Fax: 271-4902

*This record check pertains only to findings made on or seven (7) years prior to signature date as listed above Pursuant to RSA 161-F:49