



Office of the Secretary of State

Name-Based Criminal History Record Information Consent/Inquiry Form

I hereby authorize the Georgia Board of Nursing to conduct an inquiry for the purpose listed below and receive any Georgia and/or national criminal history record information as authorized by state and federal law.
Agency/Company

Full Name (print)			
Address			
Sex	Race	Date of Birth	Social Security Number

Please check **ONLY** one of the boxes listed below:

- This authorization is valid for _____ days from date of signature.
- I, _____, give consent to the above-named entity to perform periodic criminal history background checks for the duration of my employment.

Signature

Date

AREA BELOW IS FOR AGENCY USE ONLY

Date of Inquiry: _____ Time of Inquiry: _____ Operator's Initials: _____

Purpose Code Used: (check one)

NON-CRIMINAL JUSTICE PURPOSES	
<input type="checkbox"/>	E - Employment
<input type="checkbox"/>	M - Working with Mentally Disabled
<input type="checkbox"/>	N - Working with Elderly
<input type="checkbox"/>	W - Working with Children
<input type="checkbox"/>	P - Public Records (no consent required)
<input type="checkbox"/>	F - Probate Court / Weapons Carry License
PERSONAL REQUEST (INDIVIDUAL OR THEIR ATTORNEY)	
<input type="checkbox"/>	U - Personal Copy
CRIMINAL JUSTICE	
<input type="checkbox"/>	J - Civilian Criminal Justice Employment (State & III Info Received)
<input type="checkbox"/>	Z - Sworn Criminal Justice Employment (State & III Info Received)

The inquiry resulted in the following: (check all that apply)

<input type="checkbox"/>	No Criminal Record Available
<input type="checkbox"/>	Criminal Record (Attached/Released)
<input type="checkbox"/>	No NCIC/GCIC Warrant
<input type="checkbox"/>	Possible NCIC/GCIC Warrant (List Wanting Agency Below)

Wanting Agency Name: _____

Wanting Agency Telephone: _____

Agency Designee Signature and Title: _____ Date: _____