The Commonwealth of Massachusetts

Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

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Guide to the Criminal Offender Record Information (CORI) Acknowledgement Form

Please review the following important instructions to successfully complete your CORI Acknowledgement Form.

1. You **must** sign the CORI Acknowledgement Form in the presence of a Notary Public or Bureau of Health Professions Licensure (BHPL) employee to verify your identity using a form of government-issued identification.
    a. If a Notary Public is authenticating your signature, they must complete all fields on the "Authentication of Signature" section of this form.
    b. If a BHPL employee is verifying your identification, they must complete all fields on the "Subject Verification" section of this form. You may call your Board to arrange an in-person appointment to complete this form.
    c. Only ONE of these sections needs to be completed.

2. All fields in the "Subject Information" section of this form with an asterisk (*) **must** be completed.

3. If you have listed additional names on your licensure application, you **must** list those names on the CORI Acknowledgement Form as Former Names.

4. Use caution when entering your date of birth and Social Security Number on your licensure application and this form. If a discrepancy is identified, you will be required to correct the application and/or CORI Acknowledgement Form. Only the **LAST SIX DIGITS** of your Social Security Number should be listed on this form.

5. **Once you complete the CORI Acknowledgement Form, you must upload it to your licensure application in the online application portal. You do not need to include this instruction cover page.**

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Criminal Offender Record Information (CORI) Acknowledgement Form

To be used by organizations conducting CORI checks for employment or licensing purposes.

The Bureau of Health Professions Licensure is registered under the provisions of M.G.L. c.6, §172 to receive CORI for the purpose of screening current and otherwise qualified license applicants and current licensees.

As a license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to the Bureau of Health Professions Licensure to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing the Bureau of Health Professions Licensure with written notice of my intent to withdraw consent to a CORI check.

I also understand that the Bureau of Health Professions Licensure may conduct subsequent CORI checks within one year of the date this Form was signed by me.

By signing below, I provide my consent to a CORI check and affirm that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

_____ _____

Signature of CORI Subject *Date*

_____ _____

Board Name **License Type**

SUBJECT INFORMATION

Please complete this section using the information of the person whose CORI you are requesting.
The fields marked with an asterisk (*) are required fields.

* First Name: _____ Middle Initial: _____

* Last Name: _____ Suffix (Jr., Sr., etc.): _____

Former First Name 1: _____

Former Last Name 1: _____

Former Last Name 2: _____

Former Last Name 3: _____

* Date of Birth (MM/DD/YYYY): _____ Place of Birth: _____

* Last **SIX** digits of Social Security Number: _____ -- _____

Height: _____ ft. _____ in. Eye Color: _____ Race: _____

Driver's License or ID Number: _____ State of Issue: _____

Father's Full Name: _____

Mother's Full Name: _____

Current Address

* Street Address: _____

Apt. # or Suite: _____ *City: _____ *State: _____ *Zip: _____

SUBJECT VERIFICATION (Complete only if signed by BHPL staff)

*The above information was verified by reviewing the following form(s) of government-issued identification:

_____

_____

_____

Verified by:

_____

Print Name of Verifying BHPL Employee

_____ _____

Signature of Verifying BHPL Employee *Date*

Authentication of Signature
Please note that ALL fields in this section must be completed by the Notary Public. Evidence of identification must be government issued photo ID.

On this ____ day of _____ , 20___, before me, the undersigned notary public, _____ (name of applicant) personally appeared, proved to me through satisfactory evidence of identification, which were _____, (Ex: Driver's license, passport, etc.) to be the person who signed the preceding document in my presence and who swore or affirmed to me that the contents of the document are truthful and accurate to the best of (his) (her) knowledge and belief.

Seal of Notary Public

Notary Public Signature _____

State of _____

County of _____

Commission Expires: _____