The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Massachusetts Rehabilitation Commission
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CRIMINAL OFFENDER RECORD INFORMATION (CORI) ACKNOWLEDGEMENT FORM

The Massachusetts Rehabilitation Commission is registered under the provisions of M.G.L. c. 6 §172 to receive CORI for the purpose of screening current and otherwise qualified prospective employees, contract providers, volunteers, and interns.

As a prospective or current employee, contract provider, volunteer or intern, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to the Massachusetts Rehabilitation Commission 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 Massachusetts Rehabilitation Commission written notice of my intent to withdraw consent to a CORI check.

The Massachusetts Rehabilitation Commission may conduct subsequent CORI checks within one year of the date this Form was signed by me provided, however, that the Massachusetts Rehabilitation Commission must first provide me with written notice of this check.

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

_____ _____

Signature **Date**

CORI ACKNOWLEDGEMENT FORM (CONT.)

*Last Name *First Name Middle Name Suffix

Maiden Name (or other name(s) by which you have been known)

*Date of Birth Place of Birth

*Last Six Digits of Your Social Security Number: _____-_____

Sex:_____ Height: _____ft ___in. Eye Color: _____ Race:_____

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

Mother's Full Maiden Name Father's Full Name

Current and Former Addresses:

Street Number & Name City/Town State Zip code

Street Number & Name City/Town State Zip code

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

VERIFIED BY:_____
Name of Verifying Employee (Please Print)

_____
Signature of Verifying Employee

*Required

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