CSO-1058A (5-19)

ARIZONA DEPARTMENT OF CHILD SAFETY
Child Safety Central Registry, Site Code C010-19
P.O. Box 6030 • Phoenix, AZ 85005-6030
EMAIL: DCSCentralRegistry@azdcs.gov

PROSPECTIVE CAREGIVER CENTRAL REGISTRY CHECK

For use for adoptive and foster families, prospective caregivers, and Adam Walsh checks

Department of Child Safety (DCS) records are confidential and can be released only to those individuals permitted by state (A.R.S. § 8-807) and federal law. This form is to be completed for all household members and requested information will be used to check the Child Safety Central Registry for any history of prior reports. Please return completed form to the EMAIL address listed above.

ADOPTIVE PARENT'S NAME ***(Last, First, Middle)***	DATE OF BIRTH	SOC. SEC. NO.
OTHER NAMES USED *(Include maiden and/or prior married names)*		
ADOPTIVE PARENT'S ADDRESS *(No., Street, City, State, ZIP)*		
ADOPTIVE PARENT'S'S NAME ***(Last, First, Middle)***	DATE OF BIRTH	SOC. SEC. NO.
OTHER NAMES USED *(Include maiden and/or prior married names)*		
ADOPTIVE PARENT'S ADDRESS *(No., Street, City, State, ZIP)*		
OTHER ADULT HOUSEHOLD MEMBER'S NAME ***(Last, First, Middle)***	DATE OF BIRTH	SOC. SEC. NO.
OTHER NAMES USED *(Include maiden and/or prior married names)*		
OTHER ADULT HOUSEHOLD MEMBER'S ADDITIONAL ADDRESS *(No., Street, City, State, ZIP)*		
OTHER ADULT HOUSEHOLD MEMBER'S NAME ***(Last, First, Middle)***	DATE OF BIRTH	SOC. SEC. NO.
OTHER NAMES USED *(Include maiden and/or prior married names)*		
OTHER ADULT HOUSEHOLD MEMBER'S ADDITIONAL ADDRESS *(No., Street, City, State, ZIP)*		
OTHER ADULT HOUSEHOLD MEMBER'S NAME ***(Last, First, Middle)***	DATE OF BIRTH	SOC. SEC. NO.
OTHER NAMES USED *(Include maiden and/or prior married names)*		
OTHER ADULT HOUSEHOLD MEMBER'S ADDITIONAL ADDRESS *(No., Street, City, State, ZIP)*		

Children's Names *(Include birth, adopted and any other minor children living in household). Adult children living in the household must be listed as an Other Adult above.*

CHILD'S NAME *(Last, First, Middle)*	DATE OF BIRTH
CHILD'S NAME *(Last, First, Middle)*	DATE OF BIRTH
CHILD'S NAME *(Last, First, Middle)*	DATE OF BIRTH
CHILD'S NAME *(Last, First, Middle)*	DATE OF BIRTH
CHILD'S NAME *(Last, First, Middle)*	DATE OF BIRTH
CHILD'S NAME *(Last, First, Middle)*	DATE OF BIRTH

I certify that all information provided is true and accurate to the best of my knowledge.

ADOPTING PARENT'S SIGNATURE	DATE
ADOPTING PARENT'S SIGNATURE	DATE
OTHER ADULT HOUSEHOLD MEMBER'S SIGNATURE	DATE
OTHER ADULT HOUSEHOLD MEMBER'S SIGNATURE	DATE
OTHER ADULT HOUSEHOLD MEMBER'S SIGNATURE	DATE

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NAME OF AGENCY REQUESTING CENTRAL REGISTRY RECORDS CLEARANCE		AREA CODE AND PHONE NO.
NDDHHS, Criminal Background Check Unit		701-328-7575
NAME OF REQUESTOR	EMAIL ADDRESS dhscfscbc@nd.gov	
REQUESTOR'S SIGNATURE		DATE

NAME AND ADDRESS OF **AGENCY** TO RECEIVE INFORMATION FROM CENTRAL REGISTRY ***(THIS BLOCK MUST BE COMPLETED)***	**TO BE COMPLETED BY DCS PERSONNEL**	
NDDHHS, Criminal Background Check Unit 600 E. Blvd Ave, Dept 325 Bismarck ND 58505-0250	Central Registry information checked: _____ ☐ There are no substantiated reports. ☐ _____Report(s) attached. RID: _____	
	SIGNATURE OF PERSON CHECKING CENTRAL REGISTRY	DATE

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Free language assistance for Department services is available upon request. • Disponible en español en la oficina local.