CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

REQUEST FOR RELEASE OF INFORMATION

TO: Director
Illinois State Police

I, _____, do hereby authorize the Illinois State Police to release information relative to the existence or nonexistence of any criminal record which it might have concerning me to any Department of the State of Illinois solely to determine my suitability for employment or continued employment with the State of Illinois. I further authorize any agency which maintains records relating to me to provide same on request to the Illinois State Police for the purpose of this investigation.

I certify that the Illinois State Police, and its officers or employees who furnish this information concerning me, and any agency and its officers and employees which provides these records to the Illinois State Police, shall not be held accountable for giving this information. I do hereby release and save harmless the Illinois State Police, its officers and employees, and any other agency and its officers and employees which provides records concerning me for the purpose of this investigation, from any and all liability which may be incurred as a result of releasing such information.

A photocopy of this release form will be valid as an original thereof, even though the said photocopy does not contain an original writing of my signature.

I have read and understand the contents of this Request for Release of Information.

_____
Witness

_____
Signature (include maiden name)

_____
Address

_____
City, State Zip Code

_____
Date of Birth

_____
Social Security Number

_____
Drivers License Number

COMPLETE AND SIGN BOTH SIDES OF THIS FORM

APPLICANT BACKGROUND INFORMATION

Please complete the following question:

Have you ever been convicted of a criminal offense other than a minor traffic violation?

Yes ☐ No ☐

If your answer to the foregoing question is "yes," please provide a detailed statement for each such occurrence.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____
Signature

_____
Date

COMPLETE AND SIGN BOTH SIDES OF THIS FORM

State of Illinois
Department of Human Services

VOLUNTEER/INTERN APPLICATION

Facility/Office: John J. Madden Mental Health Center

Volunteer assignments are based upon operating needs of the facility/office.
Thank you for your application expressing a desire to serve as a volunteer/intern. Your application will be reviewed and approved by the Volunteer Coordinator and will be subject to a background check.

Name: _____ Birthdate: _____

Street Address: _____

City, State, Zip Code: _____

Area Code & Telephone Number:

Home: _____

Work: _____

Fax: _____

E-Mail: _____

Are you completing an internship, Practicum or service learning? Yes ☐ No ☐ If no, skip to the next section.

Name of your internship/service learning coordinator: _____

Name of school affiliation: _____

BS/BA ☐ Master's ☐ PhD ☐ Major:

Education/Special Training/Employment Experience: (Medical School Attending and Year of Graduation)

Volunteer Experience:

Hobbies, Skills, and Special Interest:

How did you hear about our volunteer program?

Medical School Requirement

List area(s) of interest for volunteering or any specific projects:

State of Illinois
Department of Human Services

VOLUNTEER/INTERN APPLICATION

Do you require special accommodations? If so, please indicate:

Time available for volunteer services:

	MON	TUE	WED	THURS	FRI	~~SAT~~	~~SUN~~
FROM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM
TO	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM	☐ AM ☐ PM

References (other than family):

NAME	ADDRESS (INCLUDE CITY/STATE/ZIP CODE)	TELEPHONE NUMBER (INCLUDE AREA CODE)
Amy Andel	2160 S. First Ave., Maywood, IL 60153	708-216-2109
Dr. David Schilling	2160 S First Ave., Maywood, IL 60153	708-216-2068

Emergency Contact:	Relationship:	Area Code & Phone Number:

I understand that all information about people served is strictly confidential and I will not violate this confidentially while at the facility/office or in the community. Cameras, photos, or recording devices are not allowed without administrative approval and written release.

I understand that the services described herein will be provided on a voluntary basis and no agreement has been made, in writing or otherwise, to compensate me for these services.

I understand that I may be represented and indemnified as a volunteer/intern only as determined by the Office of the Attorney General pursuant to the State Employee Indemnification Act (5 ILCS 350/0.01 et seq.). I also agree to hold the Department harmless for any injuries which might be incurred while acting within the scope of my volunteer/intern relationship.

I hereby certify that I do not have and shall not acquire a contract for personal services with any entity which will satisfy that contract in whole or in part with state funds unless an exception to this requirement has been granted.

Signature of Applicant	Date
Printed Name and Signature of Parent or Guardian (if applicant is under 18)	Date
Printed Name and Signature of Volunteer Coordinator	Date

CFS 689
Rev 7/2012

State of Illinois
Department of Children and Family Services

AUTHORIZATION FOR BACKGROUND CHECK

Facility/Office

Child Abuse and Neglect Tracking System (CANTS)

For Programs NOT Licensed by DCFS

NOTE: Do not use this form if you are an applicant for licensure or an employee/volunteer of a licensed child care facility. Please contact your licensing representative.

Name: _____
Last First Middle

Date of Birth: ☐ -- ☐ -- ☐ Gender: ☐ Male ☐ Female Race: _____

Current Address: _____
Street/Apt #

_____
City State Zip Code

If you currently reside in Illinois, please list all previous addresses for the past five years.
OR
If you currently reside out-of-state, please provide ALL Illinois addresses in which you did reside while living in Illinois.

(Street/Apt#/City/County/State/Zip Code)	Dates From/To

List maiden name and/or all other names by which you have been known: (last, first, middle)

I hereby authorize the Illinois Department of Children and Family Services to conduct a search of the Child Abuse and Neglect Tracking system (CANTS) to determine whether I have been a perpetrator of an indicated incident of child abuse and/or neglect or involved in a pending investigation. I further consent to the release of this information to the agency listed below.

_____ _____
Signed Date

Submit by mail OR fax OR email.
Mail to: Department of Children and Family Services
406 E. Monroe – Station #30
Springfield, IL 62701
FAX to: 217-782-3991
Scan/Email to: CFS689Background@illinois.gov

Please type, use bold letters or label:

708-338-7057 (Submitting Agency Fax Number)
Lorrie.Smietanski@illinois.gov (Submitting Email Address)

John J. Madden MHC (Agency Name)
Lorrie Smietanski (Contact Person)
1200 S. 1st Ave. (Address)
Hines, IL. 60141 (City/State/Zip)

Print Form