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Disabled Persons Protection Commission Abuser Registry Consent Form

Pursuant to M.G.L. c. 19C, §15, before employing or contracting with a care provider, the Department of Developmental Services (DDS) or any employer who is licensed by, funded by, or contracts with DDS is required to complete a search of the Disabled Persons Protection Commission (DPPC) Abuser Registry. As a prospective or current care provider, I understand that DDS and employers may only search the Abuser Registry with my signed consent. I also understand that DDS or employers cannot hire, utilize the services of, or employ a person who appears on the Abuser Registry or a person who refuses to consent to a search of their name on the Abuser Registry.

I hereby acknowledge and grant permission to DDS or my prospective or current employer to perform a search of my name and other personally identifying information on the Abuser Registry to determine whether I am listed on the Abuser Registry. I understand that the search of the Abuser Registry will be based upon the information exactly as provided below, and as verified by DDS or my prospective or current employer. I further understand that I may be required to provide additional information to DDS or my prospective or current employer to verify a search. Should DDS or my prospective or current employer learn that my name appears on the Abuser Registry, they will inform me that I am listed on the Abuser Registry and provide me with contact information for the DPPC.

By signing below, I provide my consent to a DPPC Abuser Registry search and affirm that the information provided is true and accurate.

Employee Information

First Name:_____ Middle Name: _____

Last Name:_____

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

Last four digits of Social Security Number: _____

I attest that the information above is accurate and complete to the best of my knowledge.

_____ _____
(Employee's Signature) (Date)

DDS/Employer Verification (to be completed by Human Resources)

I attest that I reviewed the care provider's identifying documentation and confirmed the care provider's identity.

_____ _____
(Employer Name (print)) (Date)

_____ _____
(Employer Signature) (Job Title)