



The Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Department of Public Health



**This form is not to be faxed. Please return form to organization.**

**Criminal Offender Record Information (CORI)  
Acknowledgement Form**

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

\_\_\_\_\_ is registered under the  
(Organization)  
provisions of M.G.L. c.6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective employees, subcontractors, volunteers, license applicants, or current licensees.

As a prospective or current employee, subcontractor, volunteer, 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 \_\_\_\_\_ 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 \_\_\_\_\_ with written notice of my intent to withdraw consent to a CORI check.

I also understand, that \_\_\_\_\_ 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*

Volunteer Unit Metro East Medical Reserve Corps

**Please note: CORIs cannot be accepted without photo ID Verification**

Have your photo identification verified and this form signed indicating photo verification by your local program administrator or by a notary public before sending it in for processing. If you have selected the “State unaffiliated Volunteers” as your only organization please have your photo identification verified and CORI acknowledgement Form signed by a notary public.  
Once photo ID is verified, mail form to:

Massachusetts Department of Public Health  
Office of Preparedness and Emergency Management  
**67 Forest Street Suite 100**  
Marlboro, MA 01752



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**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 Last Name 1: \_\_\_\_\_

Former Last Name 2: \_\_\_\_\_

Former Last Name 3: \_\_\_\_\_

Former Last Name 4: \_\_\_\_\_

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

\* Last **SIX** digits of Social Security Number: \_\_\_\_\_ -- \_\_\_\_\_  No Social Security Number

Sex: \_\_\_\_\_ 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**

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

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Verified by:**

\_\_\_\_\_  
*Print Name of Verifying Employee*

\_\_\_\_\_  
*Signature of Verifying Employee*

\_\_\_\_\_  
*Date*



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**Authentication of Signature**

Please note that ALL fields in this section must be completed by the Notary Public.

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me, the undersigned Notary Public, personally appeared \_\_\_\_\_ (name of CORI requestor) and proved to me through satisfactory evidence of identification, which was \_\_\_\_\_ (Ex: Driver's license, passport, etc.), to be the person whose name is signed on the preceding or attached document, and acknowledged to me that (he)(she) signed it voluntarily for its stated purpose.

\_\_\_\_\_  
*Signature of Notary Public (Notary stamp or seal is also required)*

\_\_\_\_\_  
*Date my Commission expires*