Aitkin County CARE, Inc.
P.O. Box 212
Aitkin, MN 56431
218-927-1383

Background Check Consent Form
Non-Profit Account
T189271383

Date: ____________________________

The following named individual has made application with this agency for ____.

Last Name of Applicant (please print): _______________________________________

First Name (please print): ____

Middle (full)(please print):
____

Maiden, Alias or Former (please print):
____

Date of Birth: ____________________ **Sex** (M or F): ______________
Month/Day/Year

Social Security Number (optional): ____________________________________

I authorize the Minnesota Bureau of Criminal Apprehension to disclose all criminal history record information to Aitkin County CARE, Inc. for the purpose of ____
with this agency.

The expiration of this authorization shall be one year from the date of my signature.

Signature of Applicant __________________________ **Date** _____________

Notary: