

**Confederated Tribes of Siletz Indians  
Child Care Assistance Program  
Criminal History Check Release**

I authorize the Confederated Tribes of Siletz Indians to conduct an Oregon Criminal History Record Check. This authorization expires in six (6) months from the signature date below.

\_\_\_\_\_  
Signature of Provider (Adult 1) \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Provider (Adult 2) \_\_\_\_\_  
Date

Please complete the form by filling in the requested information below: **(Adult 1)**

Last Name	First Name	Middle Name
Street Address		City, State & Zipcode
Social Security Number		Birthdate

Please complete the form by filling in the requested information below: **(Adult 2)**

Last Name	First Name	Middle Name
Street Address		City, State & Zipcode
Social Security Number		Birthdate