

Application for an Adult Abuse Registry Check by Employers and Others

Application pursuant to Section 41(4) of *The Adult Abuse Registry Act* for access to the Adult Abuse Registry

Part 2 Information and Results

SECTION A – Access by EMPLOYERS AND OTHERS (to be completed by the Employer/Other)

A-1 Applicant's Mailing Label. Please print all information clearly.

Administrative Assistant - HR
Southern Health – Santé Sud
180 Centenaire Drive
Southport MB R0H 1N1

Contact Person	Telephone Number	Organization
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A-2 Purpose of Registry Check: (Please check at least one of the following)

To assess the Subject of this check:

- Whose work, whether paid or unpaid, involves or may involve the care of a specified adult, or the provision of support services or other assistance to a specified adult as defined under *The Adult Abuse Registry Act*.
- Whose work, whether paid or unpaid, permits or may permit access to a specified adult as defined under *The Adult Abuse Registry Act*.

A-3 Position: Paid Staff Volunteer Student Trainee Letter of Approval (Foster) Applicant Other

Briefly describe position: _____

A-4 Applicant Authorization: ACCESS CODE: A119-14

Signature of Applicant staff who verified Subject's identification	Applicant's Signature (Executive Director or Supervisor)
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NOTE: There is a **non-refundable** fee of \$20.00 per application. Please refer to Part 3 for fee payment details.

SECTION B – SUBJECT'S INFORMATION (to be completed by the person being checked) (PLEASE PRINT CLEARLY)

B-1 Name: _____

Surname	Given Name	Middle Name
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Previous and Other Names:

a) Maiden Name: _____ b) Legal Name Change: _____

c) Also Known As: _____ d) Other Names Known by: _____

B-2 Birth Date: Month _____ Day _____ Year _____ **B-3** Male Female

B-4 Current Address: _____ City: _____

Postal Code: _____ Telephone: (_____) _____

B-5 Previous addresses for a minimum of 5 years: _____

B-6 IDENTIFICATION: I have chosen and presented **two (2)** pieces of identification that have been verified by the Applicant in A-4:

SIN No. _____ MHSC No. (6 digit) _____

Band and Status No. _____ Driver's Licence: _____

Passport or Birth Certificate No. _____ Other (please identify) _____

B-7 I hereby authorize the Registrar of the Adult Abuse Registry to search the Adult Abuse Registry to determine if my name is listed on the Registry. I hereby give my consent for the release of this information in writing to the applicant in A1 for purposes identified in A-2 and Part 1.

Date: _____ SUBJECT'S SIGNATURE: _____

SECTION C – ADULT ABUSE REGISTRY RESULTS (to be completed by the Registrar of the Adult Abuse Registry) Office Use Only

This is to certify that as of the date indicated in this section, the subject:

IS NOT listed on the Adult Abuse Registry DATE: _____

IS LISTED on the Adult Abuse Registry _____

Registrar, Adult Abuse Registry or Designate

Note: The name of a young offender (under 18) may not appear on the Adult Abuse Registry due to the non-disclosure provisions of *The Young Offenders Act* or *The Youth Criminal Justice Act*. The Applicant shall not use or disclose the personal (health) information provided by the Subject except for the purpose(s) stated in Part 1 and Part 2.



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Part 1 Consent to Collection & Disclosure of Information and Results

I understand that the Applicant is obtaining my personal information (including, if necessary for identification purposes, my Manitoba Health Personal Health Identification Number) described in Part 2 B to disclose this information to the Registrar of the Adult Abuse Registry so that the Registrar can conduct an Adult Abuse Registry check on me. I understand that the Registrar will also use this information to update the Adult Abuse Registry. I understand that my personal information is being collected under the authority of paragraphs 36(1)(a) and (b) and subsection 37(1) of *The Freedom of Information and Protection of Privacy Act* and subsection 41(4) of *The Adult Abuse Registry Act* and that my personal health information, **if any**, is being collected under the authority of subsections 13(1) and 14(1) of *The Personal Health Information Act*.

I understand that the results of the Adult Abuse Registry check will disclose whether my name is listed on the Registry and that the Registrar will disclose these results to the Applicant.

I understand that the disclosure of the results of the check to the Applicant is authorized under subsection 41(4) of *The Adult Abuse Registry Act* and is the minimum amount of information necessary to accomplish the purpose(s) specified in Part 2 A-2.

I understand that the Applicant requires the results of the Adult Abuse Registry check for the purpose(s) specified in Part 2 A-2. This information will be available to employees or agents of the Applicant only on a need to know basis.

I understand that the Applicant will use the information only for the above purpose(s) unless use for another purpose is authorized or required by law.

I understand that the Applicant will not further disclose the results of the Adult Abuse Registry check without my written consent unless authorized or required to do so by law.

I understand that the Registrar will release no other information without my written consent unless the Registrar is authorized or required to do so by law.

I understand that I may revoke this consent to the collection and disclosure of information and results by written statement at any time prior to the information being released under this consent.

I acknowledge that a photocopy of this signed consent is sufficient to allow for the disclosure of the information requested.

Consent below is limited to this application only and becomes effective on the date signed. This consent expires six months from the effective date.

I hereby consent to the collection of information in Part 2 B by the Applicant, its disclosure to the Registrar and the disclosure of the results of the check, described in Part 2 C, by the Registrar to the Applicant.

DATE: _____ SUBJECT'S SIGNATURE: _____

Please note that you have a right to examine and receive a copy of any personal health information about you maintained by the Adult Abuse Registrar and to authorize another person to examine and receive a copy of this information. For any questions you may have about this collection or disclosure of your personal information, or to examine or receive a copy of your personal health information, you may contact:

**The Adult Abuse Registrar
Adult Abuse Registry Unit
2nd Floor-777 Portage Avenue, Winnipeg, MB R3G 0N3
(204) 945-6967**



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Part 3 Fee Payment

Applicant's Name **Southern Health – Santé Sud**

Subject's Name _____

Payment Exemption

There may be no fee depending on the purpose of the check. Please refer to Section 16(2) of the Adult Abuse Registry Regulation.

All fee exemptions are subject to an audit by the Adult Abuse Registry Unit.

Exempted – no fee attached

Payment Method (Please check ✓ one box only and print all information clearly)

VISA Card Number _____ Expiry Date _____
 Name as it Appears on Card _____
 Amount: _____ (Canadian funds)
 Authorization: _____
 Signature of Cardholder

MASTERCARD Card Number _____ Expiry Date _____
 Name as it Appears on Card _____
 Amount: _____ (Canadian funds)
 Authorization: _____
 Signature of Cardholder

CHEQUE *made payable to the Minister of Finance*

Note: Post-dated cheques will not be accepted. **There is a \$20.00 NSF charge for all returned cheques.**

MONEY ORDER *made payable to the Minister of Finance*

CASH (**Note:** It is recommended that you **do not** send cash through the mail.)

Receipts will only be issued if requested at the time the Application is submitted.

Check ✓ if receipt is required.

All three parts of this Application must be forwarded to the Adult Abuse Registry for a check to be completed.

FOR ADULT ABUSE REGISTRY OFFICE USE ONLY	
Application Received	Date
<input type="checkbox"/> IN-HOUSE	_____
<input type="checkbox"/> MAIL	_____
<input type="checkbox"/> COURIER	_____
<input type="checkbox"/> FAX	_____
<input type="checkbox"/> Multiple Applications # _____	