



Identification Bureau Individual Record Check Form

Full Name: First Middle Last Name Maiden/Other

Date of Birth: (Month/Day/Year) State of Birth: Race: Sex:

Social Security #: Driver's License #: State

Mailing Address: Street City State ZIP

Daytime Phone #: ( )

I GIVE MY CONSENT FOR THE ARKANSAS STATE POLICE TO CONDUCT A CRIMINAL RECORD SEARCH ON MYSELF AND RELEASE ANY RESULTS TO THE FOLLOWING PERSON OR ENTITY:

Name: ARKANSAS INSURANCE DEPARTMENT (First/MI/Last Name) or Full Name of Agency

Mailing Address: 1200 West Third Street Little Rock AR 72201-1904 Street City State ZIP

Signature: (First/MI/Last Name) Date: (Month/Day/Year)

(NO REQUEST WILL BE PROCESSED WITHOUT A NOTARIZED SIGNATURE)

STATE OF §

COUNTY OF

Subscribed and sworn before me, a Notary Public, in and for the county and state aforesaid, this the day of , 20 .

Notary Public

82001 Civil Record Check