

APPENDIX A

[Template]

Direct Care Worker Testing Records Search Authorization Form

Current/Prospective Employee

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Date of Birth (MM/DD): \_\_\_\_/\_\_\_\_ SSN (Last Four Digits): \_\_\_\_\_ Sex (M/F): \_\_\_\_\_

*I give permission to a representative of the following organization to access and retrieve my Direct Care Worker testing records from the AHCCCS online database. I understand that the organization's purpose in accessing the records is to ensure that employees meet the testing standards required by AHCCCS.*

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Organizational Representative

Organization Name: \_\_\_\_\_  
Name of Organizational Representative: \_\_\_\_\_  
Title: \_\_\_\_\_ Phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_

*My sole purpose in accessing the record is to ensure that employees meet the testing standards required by AHCCCS. Failure to maintain the security of and/or access testing records for any other purposes for which it is intended, will result in the termination of my access to the online testing records database. I also understand that I will have to agree to a similar attestation statement at the point in time I search, access and retrieve the testing records for the aforementioned current/prospective employee. A hard copy of this consent will be on record.*

Date: \_\_\_\_\_ Signature: \_\_\_\_\_