DISTRICT ATTORNEY
WILLIAM J. FITZPATRICK

AUTHORIZATION FOR RELEASE OF INFORMATION AND TESTING – APPLICANT

To: Any Doctor, Physician, Psychologist, Dentist, Hospital, Nursing Home, and Medical Association;
The U.S. Armed Forces, Maritime Service, Veteran's Administration, Selective Service Administration;
Any Academic Dean, Registrar, Principal, Guidance Counselor or authorized person at any: School, College, University, Business School, Trade School, Elementary or High School;
Any Local, State, or Federal Law Enforcement Agency;
Any Past or Present Employer;
Any Credit Bureau or Retail Merchant's Association;
Any Bank or Financial Institution;
Any Insurance Company;
Any State, County, or Municipal Bureau of Vital Statistics Office;
Any Grievance Committee or Disciplinary Committee;
Other: _____

I, _____, have applied for employment with the County of Onondaga in the State of New York. I am aware that my entire background will be thoroughly investigated and hereby authorize and request the release of any and all information you have that concerns me, including academic transcripts and disciplinary matters, to any authorized representative of the Onondaga County District Attorney's Office. This authorization or reproduction thereof, shall remain in effect for the duration of my employment with the Onondaga County District Attorney's Office.

Name: (First)_____(Middle)_____(Last)_____

(Maiden)_____

Date of Birth: _____ Place of Birth: _____

SSN: _____

Driver's License (Client ID#)_____(State)_____

I also authorize to submit to testing which includes drug use screening to be administered by the Onondaga County District Attorney's Office.

Given under my hand this _____ day of _____, 20 ____.

_____ _____
Signature of Witness Signature

_____

_____
(Current Address)

PLEASE SEND REPLY TO:
Onondaga County District Attorney's Office
505 South State Street
Syracuse, New York 13202
315-435-2470