JANET T. MILLS
GOVERNOR

MICHAEL SAUSCHUCK
COMMISSIONER

STATE OF MAINE
Department of Public Safety
Maine State Police
Weapons and Professional Licensing
164 State House Station
Augusta, Maine
04333

COL. WILLIAM G. ROSS
CHIEF

LT. COL. BRIAN P. SCOTT
DEPUTY CHIEF

INVESTIGATIVE ASSISTANT LICENSE

Please complete ALL PAGES. Failure to fully complete application could result in delays. Return this entire package to address above with the following items:

- ☐ Application for Investigative Assistant, 1 pg.
  - Must be notarized.

- ☐ Certificates, 1 pg.
  - 3 Maine residents who you have known for at least 3 years.
  - Cannot be related by blood or marriage.

- ☐ Sponsor Information, 1 pg.
  - Must be a licensed PI through the state of Maine.

- ☐ Authority and Authorization to Release Information forms, 5 pgs total.
  - Form 577– Authorization DHHS, 3 pgs.
  - Form P-3E- Authority to release, 2 pgs.
  - Witness signature is anyone over the age of 18.
  - Return **ALL** forms to address above with application.

- ☐ Fee: Initial fee of $221 should be included with application.
  - Final payment of $400 due upon approval.
  - Checks made out to "Treasurer, State of Maine."

- ☐ Copy of High School Diploma or GED.

- ☐ Photo: color photograph of yourself taken within six months of the application date.

- ☐ Copy of birth certificate or resident alien card.

IMPORTANT: If you have lived in any state other than Maine in the past 5 years, you will need to obtain a state criminal history record from each state's criminal history record repository.

An approval letter and bond form will be forwarded after receipt and processing of your application which can take six to eight weeks.

SEND YOUR COMPLETED APPLICATION PACKET (8 PGS) TO THE MAINE STATE POLICE WEAPONS AND PROFESSIONAL LICENSING UNIT ADDRESS SHOWN ABOVE.

STATE OF MAINE

MAINE STATE POLICE- WEPONS AND PROFESSIONAL LICENSING

164 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0164

(207) 624-7210

Application for Investigative Assistant License

Application Fee: $221.00 ($200.00 plus $21.00 for Background Check) Upon Issuance of License $400.00

(Make Checks Payable to Treasurer, State of Maine)

Full Name (Last, First, Middle)(Please Print)			Date of Birth	Place of Birth
Complete Physical Address			SSN	Telephone #
City or Town	State	Zip Code	High School Graduate or High School Equivalency Yes ☐ No ☐	
Complete Mailing Address			Citizen or Resident Alien of the United States Yes ☐ No ☐	
City or Town	State	Zip Code	**FOR OFFICE USE ONLY**	
Eyes / Height	Weight		Case Number _____ Check Number _____ Check Amount _____	
E-mail Address:				

List Addresses for the Last 5 Years (If More Space is Needed use a Plain Sheet of Paper)

Address	Dates

Check Appropriate Box After Each Question

1. Are you currently under indictment or information for a crime for which the penalty is imprisonment for in excess of one year? Yes ☐ No ☐
2. Have you ever been convicted of a crime for which the possible penalty exceeded one year in prison? Yes ☐ No ☐
3. Are you a fugitive from justice? Yes ☐ No ☐
4. Are you an unlawful user of or addicted to marijuana or any other drug? Yes ☐ No ☐
5. Have you been adjudged mentally defective or been committed to a mental institution within the past 5 years? Yes ☐ No ☐
6. Are you an illegal alien? Yes ☐ No ☐
7. Do you presently derive plenary or special law enforcement powers from the State or Maine or any political subdivision thereof? Yes ☐ No ☐
8. Have you been dishonorably discharged from military service? Yes ☐ No ☐

By Affixing Your Signature Below as the Applicant You:

A. Certify that information provided by you in this application is true and correct;

B. Certify that you understand that an affirmative answer to any of the questions 1 through 8 is cause for refusal;

C. Certify that you understand that any false statement in this application may result in prosecution as provided in section 8114;

D. Give the Chief of the Maine State Police the authority to check the criminal records of any law enforcement agency;

E. Agree to submit to have your fingerprints taken by the issuing authority if it becomes necessary to resolve any question as to your identity and

F. Certify that you have received a copy of the booklet entitled *Laws Relating to Professional Investigators*, issued by the Bureau of Maine State Police.

State of Maine

_____, ss. Signature of Applicant _____

On this _____ day of _____, 20 _____ personally appeared the above-named applicant and made oath that the statements and answers contained in this application, whether in writing or print, are true.

Before me,

_____

(Notary Seal)

CERTIFICATES

Certification required by each of three reputable citizens of the State **of Maine.**

I

I, _____, being at least eighteen years of age, a citizen of the State of Maine and a resident of _____, have personally known the applicant for at least three years and I do state on honor as follows:

(1) I have known said applicant since _____
(2) I have read the application of said applicant and believe each of the statements made therein to be true.
(3) Said applicant to my knowledge is of good moral character, is honest, and is not related to be by blood or marriage.

(Signature) _____

Mailing Address) _____ (Zip Code) _____

(Occupation) _____

(Date of Birth) _____ (Telephone #) _____

II

I, _____, being at least eighteen years of age, a citizen of the State of Maine and a resident of _____, have personally known the applicant for at least three years and I do state on honor as follows:

(4) I have known said applicant since _____
(5) I have read the application of said applicant and believe each of the statements made therein to be true.
(6) Said applicant to my knowledge is of good moral character, is honest, and is not related to be by blood or marriage.

(Signature) _____

Mailing Address) _____ (Zip Code) _____

(Occupation) _____

(Date of Birth) _____ (Telephone #) _____

III

I, _____, being at least eighteen years of age, a citizen of the State of Maine and a resident of _____, have personally known the applicant for at least three years and I do state on honor as follows:

(7) I have known said applicant since _____
(8) I have read the application of said applicant and believe each of the statements made therein to be true.
(9) Said applicant to my knowledge is of good moral character, is honest, and is not related to be by blood or marriage.

(Signature) _____

Mailing Address) _____ (Zip Code) _____

(Occupation) _____

(Date of Birth) _____ (Telephone #) _____

Initials: _____

NOTE: This application and any supporting documentation are public records pursuant to 1 M.R.S. § 402(3), and, with the exception of portions identified as confidential by statute (e.g., social security numbers; mental health adjudications; college transcripts), may be disseminated in response to a request made pursuant to the Freedom of Access Act.

Date Modified: 10/14/15; 08/27/20

INVESTIGATIVE ASSISTANT
SPONSOR INFORMATION
Please Print Legibly or Type

Applicant Name: _____ DOB: _____

Sponsor Name: _____

Sponsor Company Name: _____

Sponsor Company Phone Number: _____

Employer (while performing IA work):

What is the nature of the employment relationship between you and the sponsoring Professional Investigator?

(Note: A sponsoring Professional Investigator may not be employed by the Investigative Assistant in a business related to private investigation.)

If you are not employed by the sponsoring Professional Investigator, please describe the manner in which the sponsoring Professional Investigator will oversee and document your activities, keep a record of the required 1200 training hours, including hours worked on specific activities performed by you, and provide any other training and instruction on specific topics, as required by 32 MRS 8110-B.

_____ _____
IA Applicant Signature Date

_____ _____
Sponsor Signature Date

_____ _____
Witness Signature Date

12/14 by JAG
All previous versions of this form are obsolete.

STATE OF MAINE - Department of Health and Human Services (DHHS)

Client Authorization to Release Information Specifically for:
Dorothea Dix Psychiatric Center or Riverview Psychiatric Center
Please Print Legibly or Type

Client's Name _____ DOB _____ SSN _____

I hereby authorize ☒ Dorothea Dix Psychiatric Center, PO Box 926, 656 Bangor Street, Bangor, ME 04402

☒ Riverview Psychiatric Center, 250 Arsenal Street, 11 State House Station, Augusta, ME 04332

To:	Client may check ☒ either, or both options
Disclose Information To…:	☒
Obtain Information From …:	☐

This Person or Organization: Maine State Police

Address: Division of Weapons and Professional Licensing, 164 State House Station, Augusta, ME 04330

Fax #: 207-287-3424 _____ Phone number to verify receipt of information: 207-624-7216

Relationship to Client: _____

(Include fax number and phone number ONLY if fax is being used to transmit information)

Information to Be Disclosed and/or Obtained

☒ Check YES or NO for each of the following:

☐ YES	☐ NO	Alcohol and/or Drug Treatment – (Authorization is required to share ANY information about alcohol/drug treatment, whether spoken or written)	☐ YES	☐ NO	Locus Report
			☐ YES	☐ NO	Medical and/or Physical History
☐ YES	☐ NO	Any reference to or information about alcohol or other drugs	☐ YES	☐ NO	Outpatient Treatment
☐ YES	☐ NO	Assessments / Consultations	☐ YES	☐ NO	Physical Therapy (PT and/or Occupational Therapy (OT)
☐ YES	☐ NO	Treatment Plan / Crisis Plans / Emergency Services	☐ YES	☐ NO	Physician Orders, including Medical Index
☒ YES	☐ NO	Discharge Summaries	☐ YES	☐ NO	Progress Notes
☐ YES	☐ NO	Face Sheet	☐ YES	☐ NO	Psychiatric History, Evaluations, DSM
☐ YES	☐ NO	Gould Assessment(s)	☐ YES	☐ NO	Psychological and/or Psychosocial History, Reports, Evaluations
☐ YES	☐ NO	Legal / Financial	☐ YES	☐ NO	Social History (Recent and/or Developmental
☐ YES	☐ NO	Other _____			

Purpose for Disclosing and/or Obtaining

☐ YES	☐ NO	Assistance to obtain government benefits	☐ YES	☐ NO	Development of Service / Treatment / Crisis Plans
☐ YES	☐ NO	At the request of the Individual	☐ YES	☐ NO	Eligibility determination entitlements, insurance or employment
☐ YES	☐ NO	Coordination with family / concerned persons	☐ YES	☐ NO	Ongoing treatment / care management plans
☒ YES	☐ NO	Other (specify) Contract Security Company License			

Initials _____

Please *INITIAL* and *CIRCLE* Your Response to EACH of the following statements:

_____ I DO _____ I DO NOT …..authorize disclosure of information that refers to treatment or diagnosis of alcohol or drug abuse. I understand that it cannot be re-disclosed without my specific consent.

_____ I DO _____ I DO NOT …..authorize disclosure of information that refers to treatment or diagnosis of HIV or AIDS. I understand that some individuals about whom such disclosures have been made have encountered discrimination from others in the areas of employment, housing, insurance, or social / family relations.

_____ I DO _____ I DO NOT …..wish to review, prior to its release, any information I have authorized for release.

I understand that the information indicated is protected by law and cannot be released without my written permission, unless otherwise specifically permitted by law. I understand that I have the right to review information and material released. I understand I have the right to revoke this authorization in writing at any time. I understand that I do not need to sign this form to receive services and that I may receive a copy of this authorization if I wish. The benefits, risks, and consequences of releasing or not releasing this information have been explained to me.

_____ _____
Client Signature or Mark Date

_____ _____
Witness Signature Date

_____ _____
Guardian/Parent/Legal Representative Signature (specify role) Date

This authorization is effective until _____ (date not to exceed one [1] year)

Revocation of this Authorization:

_____ _____ _____
Signature or Mark of Person revoking Authorization Relationship Date

_____ _____ _____
Witness Signature (if Mark/Stamp above) Witness Printed Name Date

Additional Information for Persons/Organizations Receiving either Substance Abuse or Mental Health Information

For Persons/Organizations Receiving Substance Abuse Information:
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

For Persons/Organizations Receiving Mental Health Information:
This information has been disclosed to you from records protected by State confidentiality laws (34-B M.R.S.A. §1207); Rights of Recipients of Mental Health Services. This information remains confidential and should not be disclosed any further, except as expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.

AUTHORIZATION TO RELEASE INFORMATION
FOR THE PURPOSE OF APPLYING FOR LICENSURE AS A
PROFESSIONAL INVESTIGATOR OR INVESTIGATIVE ASSISTANT
PURSUANT TO 32 M.R.S.A. § 8101-8121

Please Print Legibly or Type

Name of Applicant _____ DOB _____

Alias and/or Prior Name(s): _____

Pursuant to 32 M.R.S.A § 8105, I authorize the Riverview Psychiatric Center and the Dorothea Dix Psychiatric Center to disclose any record of whether I have been involuntarily committed to the Riverview Psychiatric Center or the Dorothea Dix Psychiatric Center to the designee of the Commissioner of the Department of Public Safety.

Department of Public Safety
Maine State Police
Weapons and Professional Licensing
164 State House Station
Augusta, ME 04333-0164

Fax#: (207) 287-3424
Telephone #: (207) 624-7210

I understand that the information requested is protected by law and cannot be released without my written permission, unless otherwise specifically permitted by law. I understand that I have the right to review information and material prior to its release. I understand I have the right to revoke this authorization in writing at any time by contacting the licensing authority identified above. I understand that my refusal to sign this release will cause my application for licensure as a contract security company to be rejected. I understand that if the licensing authority receives an affirmative response to its inquiry, I may be asked to authorize the release of additional information to determine my eligibility for licensure as a Private Investigator or Investigative Assistant.

NOTE: This application is a public record pursuant to 1 M.R.S. § 402(3), and, with the exception of portions identified as confidential by statute (e.g., social security numbers; mental health adjudications), may be disseminated publicly.

This authorization is effective for ninety (90) days following my dated signature.

_____ _____
Applicant Signature Date

_____ _____
Witness Signature Date

****

APPLICANT: RETURN THIS FORM TO THE MAINE STATE POLICE, SPECIAL INVESTIGATIONS UNIT, WITH YOUR LICENSE APPLICATION. RETAIN A COPY FOR YOUR RECORDS.

****

MAINE STATE POLICE: Send completed form (or a copy) by regular mail with a stamped, self-addressed envelope; OR by fax; OR by e-mail (scan this waiver if using e-mail) to:

Riverview Psychiatric Center, PO Box 724, Augusta ME 04333-0724, Attention Medical Records (fax: 207-287-7127)
and
Dorothea Dix Psychiatric Center, PO Box 926, Bangor ME 04401, Attention Medical Records (fax 207-941-4029)

08/15 ; 08/20
All previous versions of this form are obsolete.

Authority, pursuant to 32 M.R.S. § 8105, to release information to the Chief of the Maine State Police or his/her designee for the purpose of evaluating information supplied on the application for a Investigative Assistant License.

To all law enforcement agencies and courts, either within or outside the State of Maine:

I hereby authorize and direct you to release to the Chief of the Maine State Police or his/her designee bearing this release, a copy thereof, within six months of the date appearing below, any information in your possession or control concerning me pertaining to the following:

1. conviction data;
2. any criminal matter in which a formal charging instrument is now pending;
3. adjudication data within the past 5 years relating to any civil violation;
4. fugitive from justice status;
5. incidents of abuse of family or household members within the past 5 years;
6. unlawful use of, or addiction to, marijuana or any other drug;
7. reckless or negligent conduct within the past 5 years.

To all military forces, both State and Federal:

I hereby authorize and direct you to release to the Chief of the Maine State Police or his/her designee bearing this release, or a copy thereof, within 6 months of the date appearing below, any information in your possession or control concerning me pertaining to a dishonorable discharge from the military forces.

To the Justice Department, Immigration and Naturalization Service:

I hereby authorize and direct you to release to the Chief of the Maine State Police or his/her designee bearing this release, or a copy thereof, within 6 months of the date appearing below, any information in your possession or control concerning me pertaining to being an illegal alien.

To all hospitals and mental institutions wither within or outside the State of Maine:

I hereby authorize and direct you to release to the Chief of the Maine State Police or his/her designee bearing this release, or a copy thereof, within 6 months of the date appearing below any information, if contained within your records, pertaining to being adjudged to be mentally defective or committed to a mental institution within the past 5 years.

(Check appropriate box below)

I *wish* to review this material prior to its release: ☐

I *do not wish* to review this material prior to its release: ☐

To all above addressed governmental entities:

I hereby authorize and direct you to release to the Chief of the Maine State Police or his/her designee bearing this release, or a copy thereof, within 6 months of the date appearing below any information to your possession or control concerning me pertaining to the following:

1. my full name;
2. my full current address and addresses for the prior 5 years;
3. the date and place of my birth any my physical description;
4. my signature

Should there be any questions as to the validity of this release, you may contact me at the address and/or telephone number listed below.

Full Name (Last, First, Middle)(Please Print)	Date of birth	
Complete Physical Address	Telephone #	
City or Town	State	Zip Code
Complete Mailing Address		
City or Town	State	Zip Code
Signature of Applicant	Date	
Signature of Witness	Date	

NOTE: This application is a public record pursuant to 1 M.R.S. § 402(3), and, with the exception of portions identified as confidential by statute (e.g., social security numbers; mental health adjudications), may be disseminated publicly.