



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
04333-0164



COLONEL JOHN E. COTE
Chief

LT. COL. BRIAN P. SCOTT
Deputy Chief

To: Applicant for Contract Security Company License

Subject: Contract Security Company Application Procedure

Enclosed is an application for a Contract Security Company License, Laws Relating to Private Security Guards and three Authority to Release Information forms as follows:

- Form: P-3E - Authority to release information to the Commissioner of Public Safety or his designee for the purpose of evaluating information supplied on the application for a Contract Security Company license pursuant 32 M.R.S.A. § 9405-A (G) (1) (4).
- Form: Authorization to release information for the purpose of applying for licensure as a Contract Security Company pursuant to 32 M.R.S.A. § 9401-9418.
- Form: 577 – Client Authorization to Release Information specifically for Dorothea Dix Psychiatric Center or Riverview Psychiatric Center.

You must submit all of the completed forms listed above with the following:

1. Original Application fee of \$100.00 and State Bureau of Identification record check fee of \$21.00 for a total of \$121.00 payable to Treasurer, State of Maine. Upon approval, a balance of \$300 will be due.
2. A color photograph of yourself taken within six months of the date of your application.
3. Copy of your birth certificate.
4. Copy of military discharge, if applicable.

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

Please inform this office immediately anytime there is a change of address either physical and/or mailing.

OFFICES LOCATED AT: 45 COMMERCE DRIVE, SUITE 1

(207) 624-7210 (Voice)

(207) 624-4478 (TDD)

(207) 287-3424 (Fax)



STATE OF MAINE
DEPARTMENT OF PUBLIC SAFETY
MAINE STATE POLICE

Division of Weapons and Professional Licensing
164 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0164
(207) 624-7210

Application for Contract Security Company License

Application Fee - New: \$121.00 (\$100.00 plus \$21.00 for Background Check) Upon Issuance of License \$300.00

Application Fee - Renewal: \$221.00 (\$200.00 plus \$21.00 for Background Check)

(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 <input type="checkbox"/> No <input type="checkbox"/>	
Complete Mailing Address						Citizen or Resident Alien of the United States Yes <input type="checkbox"/> No <input type="checkbox"/>	
City or Town			State	Zip Code		FOR OFFICE USE ONLY Case Number _____ Check Number _____ Check Amount _____	
Eyes	Height		Weight				
Resident Alien Number		Federal ID Number					
E-Mail Address:				New	Renewal		

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

Address	Dates

Name of Company				Name of DBA			
Company's Physical Address				DBA Physical Address			
City or Town		State	Zip Code	City or Town		State	Zip Code
Company's Mailing Address				DBA Mailing Address			
City or Town		State	Zip Code	City or Town		State	Zip Code
Company's Telephone Number				DBA Telephone Number			

List of Previous Issuances of a Contract Security Company License by any Issuing Authority

List of Previous Refusals to Issue or Renew; Suspension or Revocations of any Contract Security Company License by any Issuing Authority

Check Appropriate Box After Each Question

- | | |
|--|--|
| 1. Are you less than 18 years of age? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Is there a formal charging instrument now pending against you in this or any other jurisdiction for a crime which is punishable by one year or more imprisonment or for any other crime alleged to have been committed by you with the use of a dangerous weapon, as defined in 17-A MRSA § 2(9), or of a firearm against another person? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. Is there a formal charging instrument now pending against you in this or any other jurisdiction for a juvenile offense which involves conduct which, if committed by an adult, would be punishable by one year or more imprisonment or for any juvenile offense alleged to have been committed by you with the use of a dangerous weapon, as defined in 17-A MRSA § 2(9), or of a firearm against another person? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4. Have you been convicted of a crime described in question 2 or adjudicated as having committed a juvenile offense as described in question 3? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 5. Are you a fugitive from justice? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 6. Are you a drug abuser [defined in 32 MSRA § 9403(3-E)] or drug addict [defined in 32 MSRA § 9403(3-C)] or drug dependent person [defined in 32 MSRA § 9403(3-D)]? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| NOTE: Definition of drug dependent person does not include a person who is able to function effectively as the result of taking prescription or other drugs, such as a diabetic who is able to function effectively as the result of taking insulin. | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 7. Do you have a mental disorder which causes you to be potentially dangerous to yourself or others? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 8. Have you been adjudicated to be an incapacitated person [defined in 18-A MRSA § 5-101(1)] pursuant to Title 18-A, Article V, Parts 3 and 4, and not had that designation removed by an order under Title 18-A, Section 5-307, Subsection (b)? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 9. Have you been dishonorably discharged from the military forces within the past 5 years? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 10. Are you an illegal alien? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 11. Is there a formal charging instrument now pending against you in this jurisdiction for any crime enumerated in section 9412? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 12. Is there a formal charging instrument now pending against you in this jurisdiction for a juvenile offense which involves conduct which if committed by an adult, would be a crime enumerated in section 9412? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 13. Have you within the past 5 years been convicted of a crime described in question 11 or adjudicated of having committed a juvenile offense described in question 12? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 14. Within the past 5 years have you been the subject of an investigation by any law enforcement agency regarding the alleged abuse by you of family or household members? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 15. Within the past 5 years have you been convicted of 3 or more crimes punishable by less than one year imprisonment? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 16. Within the past 5 years have you been adjudicated to have committed 3 or more juvenile offenses involving conduct which if committed by an adult, would be punishable by less than one year imprisonment? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 17. Within the past 5 years have you been adjudicated of 3 or more civil violation? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 18. Within the past 5 years has your license as a contract security company been suspended pursuant to section 9411-A? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 19. Within the past 5 years have you engaged in reckless or negligent conduct, as defined in 32 MSRA § 9403(8-A), which has been the subject of an investigation by a government entity? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Initials: _____

BY AFFIXING YOUR SIGNATURE BELOW AS THE APPLICANT YOU:

- A. Certify that the statements you have made in this application, including Addendum A, and any documents you have made a part of this application, are true and correct.
- B. Certify that you understand that an affirmative answer to question 1, question 13, or any of the questions numbered 4 through 10 is cause for refusal.
- C. Certify that you understand that any false statements made in either this application, including Addendum A, or any documents you have made part of this application may result in criminal prosecution as provided in section 9412, subsection 1, paragraph D.
- D. Certify that you understand that at the request of the commissioner or his designee you are required and certify that you are willing to take whatever action is required of you by law to allow the commissioner or his designee to obtain from: hospitals and mental institutions either within or outside the State, limited to records of involuntary commitments; law enforcement agencies; and the military, information relevant to the following:
1. The ascertainment of whether the information supplied in the application or any documents made a part of the application is true and correct;
 2. The ascertainment of whether each of the additional requirements of section 9405 has been met and
 3. Section 9411-A.
- E. Certify that you understand that since a photograph is an integral part of the application process, you will submit a photograph of yourself taken within six months of the date of this application.
- F. Certify that you understand that if it becomes necessary to resolve any questions as to your identity, you will submit to having your fingerprints taken by the commissioner or his designee.
- G. Certify that you have received a copy of the pamphlet entitled "Laws Relating to Private Security Guards" dated May 2009, issued by the Bureau of Maine State Police.

Under penalties of perjury, I certify that the statements in this written application and any documents made a part thereof are, to the best of my knowledge and belief, true, correct and complete.

Signature

Date



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 <input checked="" type="checkbox"/> either, or both options
Disclose Information To...:	<input checked="" type="checkbox"/>
Obtain Information From ...:	<input type="checkbox"/>

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:

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

Purpose for Disclosing and/or Obtaining

- | | |
|---|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO Assistance to obtain government
benefits | <input type="checkbox"/> YES <input type="checkbox"/> NO Development of Service / Treatment /
Crisis Plans |
| <input type="checkbox"/> YES <input type="checkbox"/> NO At the request of the Individual | <input type="checkbox"/> YES <input type="checkbox"/> NO Eligibility determination entitlements,
insurance or employment |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Coordination with family / concerned
persons | <input type="checkbox"/> YES <input type="checkbox"/> NO Ongoing treatment / care management
plans |
| <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Other (specify) Contract Security Company License | |

Initials _____

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

_____ I DO _____ I DO NOTauthorize 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 NOTauthorize 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 NOTwish 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
CONTRACT SECURITY COMPANY PURSUANT TO 32 M.R.S.A. § 9401-9418
Please Print Legibly or Type

Name of Applicant _____ DOB _____

Alias and/or Prior Name(s): _____

Pursuant to 32 M.R.S.A § 9405, 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
Division of 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 contract security company. Information disclosed to the licensing authority pursuant to this release is confidential pursuant to 32 M.S.R.A. § 9418.

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, WEAPONS AND PROFESSIONAL LICENSING, 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)

01/12; 07/20

All previous versions of this form are obsolete.



Authority, pursuant to 32 M.R.S. §§ 9405(1-A)(G)(1) and 9405(4), to release information to the Commissioner or his/her designee for the purpose of evaluating information supplied on the application for a Contract Security Company 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 Commissioner of Public Safety 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 Commissioner of Public Safety 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 Commissioner of Public Safety 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 Commissioner of Public Safety 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 Commissioner of Public Safety 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	

All information obtained pursuant to this release is confidential by virtue of 32 M.R.S. § 9418 and may not be made available for public inspection or copying by the Commissioner or his/her designee unless the confidentiality is waived by this applicant by written notice to the Commissioner.