

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. WILLIAM S. HARWOOD Deputy Chief

To: Applicant for Renewal of Professional Investigator License

Subject: Professional Investigator Renewal Application Procedure

Enclosed is a renewal application for a Professional Investigator License and three Authority to Release Information forms.

- Form: P-3 Professional Investigator Authority to release information to the Chief for the purpose of evaluating information supplied on the application for an Investigative Assistant license pursuant 32 M.R.S.A. § 8105.
- Form: Authorization to release information for the purpose of applying for a Professional Investigator license pursuant 32 M.R.S.A. § 8105.
- 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. Application fee of \$500.00 and State Bureau of Identification record check fee of \$21.00 for a total of \$521.00 payable to Treasurer, State of Maine.

Once the processing of your application materials has been completed, which takes approximately six to eight weeks, you will receive an approval letter requesting a '4 YEAR' continuation certificate from your insurance company. If you have changed your insurance company, please notify us and a new bond form will be provided. You must also submit proof of commercial general liability insurance. You may submit a current photograph with your continuation certificate or call to schedule an appointment to have a photograph taken for your ID card.

If you require further assistance, please contact this office at 624-7210.

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.

STATE OF MAINE

MAINE STATE POLICE -WEAPONS AND PROFESSIONAL LICENSING



164 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0164 (207) 624-7216

Application for Professional Investigator License Renewal Application

Application Fee: \$521.00 (\$500.00 plus \$21.00 for Background Check) (Make Checks Payable to Treasurer, State of Maine)

Name:(Last Name)	(First Nar	ne)	(MI)	FOR OFFICAL USE ONLY Case Number:
(Birth, Alias or Other Name	used)			Check Number:
•	•			Check Pulmber.
Complete Physical Address:	State:			Check Amount:
Complete Mailing Address:	State:			Date Issued/Denied:
E-mail Address:				
				
Home Phone#: ()				
Business Phone#: ()		Cell Pl	none#: ()
Eye Color: H	eight: V	Veight:		
DOB: Pla	ce of Birth:			
SSN:				
NOTE: This application and 402(3), and, with the except numbers; mental health adjumade pursuant to the Freedom	ion of portions identifie udications; college tran	d as confidentic	al by statute (e	e.g., social security
The following statement is made pursuant social security number is solely for tax adr §405(c)(2)(C)(i) and for child support enfowill be disclosed to the State Tax Assessor Revised Statutes and/or to the Department No further use will be made of your social support enforcement information pursuant	ministration purposes pursuant to 3 prement purposes pursuant to 42 U or an authorized agent for use in conf Human Services Division of Su security number. It will be treated	5 M.R.S. §175 as authors (SC §666(a)(13)(A) and etermining filing oblig pport Enforcement and	orized by the Tax Ref d 19-A M.R.S. §§210 ations and tax liabilit Recovery for use in	form Act of 1976 (42USC, 04, 2201. Your social security number ty pursuant to Title 36 of the Maine child support enforcement procedures.
List all addresses since previ	ious license was issued	(If more space	e is needed, us	se plain sheet of paper)
Addre	ess			Dates
			L	

Page 1 of 2

Initials of applicant: _____

Date Modified: 10/13/15; 08/10/20

PI – Renewal

Check appropriate box after each question: 1. Are you currently under indictment or information for a crime for which the possible penalty is Yes \(\sum \) No \(\subseteq \) imprisonment for a period equal to or exceeding one year? 2. Have you ever been convicted of a crime for which the possible penalty was imprisonment for a period equal to or exceeding one year? 3. Are you a fugitive from justice? Yes No No Yes \(\sum \) No \(\sum \) 4. Are you an unlawful user of or addicted to marijuana or any other drug? 5. Have you been adjudged mentally defective or been committed to a mental institution within the past 5 For the purposes of this question, "Adjudged mentally defective" or "committed to a mental institution" means: a. Having been involuntarily admitted to a psychiatric hospital as defined in 34-B M.R.S §3863. Yes No b. Having been involuntarily committed to a psychiatric hospital as defined in 34-B M.R.S § 3864. c. Having been found to be not guilty by reason of insanity. d. Having been found incompetent to stand trial. e. Having been adjudicated in probate court as an "Incapacitated person" as defined in 18-A M.R.S. §5. 6. Are you an illegal alien? Yes \(\sum \) No \(\sum \) 7. Are you currently a Law Enforcement Officer in the State of Maine? Yes No 8. Have you been dishonorably discharged from military service? Yes \(\sum \) No \(\sum \) 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 a false statement or material omission in this application and the documents submitted in support of this application may result in prosecution as pursuant to 32 M.R.S. § 8114; 17-A M.R.S. §§§ 453, 702 or 703; or denial of licensure; 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 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 Signature of Applicant , 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)

I understand that making a false statement that I do not believe to be true on this application or knowingly creating or attempting to create a false impression by omitting information necessary to prevent this application from being misleading constitutes a criminal offense, and may be prosecuted as, among other offenses, unsworn falsification pursuant to 17-A M.R.S. §453 (Class D)

Mail to: Department of Public Safety
Maine State Police
Weapons and Professional Licensing
164 State House Station
Augusta, ME 04333

PI – Renewal Page 2 of 2 Initials of applicant: _____

Date Modified: 10/13/15; 08/10/20



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	y check 🛚	either, or both options			
	Disclose Information To:						
	Obtain Information From:						
This Person	n or Organization: Maine State Police						
Mailing Ac	ddress: Weapons and Profession Licensin	ng, 164 Stat	e House S	tation, Augusta, ME 04333-0164			
Fax #: 207	-287-3424	Phone num	ber to veri	fy receipt of information: 207-624-7216			
Relationsh	ip to Client:						
	(Include fax number and phone number ON						
	Information to Be	Disclosed	and/or C	Obtained			
Check YES or	NO for each of the following:						
☐ YES ☐ NO	Alcohol and/or Drug Treatment – (Authorization is required to share ANY	YES	□ NO	Locus Report			
	information about alcohol/drug treatment, whether spoken or written)	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			<u>.</u>			
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							
				Initials			

Please INITIAL and CIRCLE Your Response to EACH	i 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 I DO NOTauthorize of HIV or AIDS. I understand that some individuals abordiscrimination from others in the areas of employment, he	out whom such disclosures ha					
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 written permission, unless otherwise specifically preview information and material released. I understrain at any time. I understand that I do not not not receive a copy of this authorization if I wish. The releasing this information have been explained to	permitted by law. I under erstand I have the right to leed to sign this form to re benefits, risks, and cons	estand that I have the right to revoke this authorization in eceive services and that I may				
Client Signature or Mark		Date				
Witness Signature		Date				
Guardian/Parent/Legal Representative Signature (specify	Date					
This authorization is effective until	te 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 Psych disclose any record of whether I have been involuntarily commit Dix Psychiatric Center to the designee of the Commissioner of the	ted to the Riverview Psychiatric Center or the Dorothea
Department of Pub	lic Safety
Maine State P	
Weapons and Profession 164 State House	
Augusta, ME 043	
Fax#: (207) 287	
Telephone #: (207)	624-7210
I understand that the information requested is protected by law unless otherwise specifically permitted by law. I understand that to its release. I understand I have the right to revoke this authoria authority identified above. I understand that my refusal to sign contract security company to be rejected. I understand that if the inquiry, I may be asked to authorize the release of additional in Private Investigator or Investigative Assistant. NOTE: This application is a public record pursuant to 1 M.R.S. § 4	I have the right to review information and material prior zation in writing at any time by contacting the licensing this release will cause my application for licensure as a licensing authority receives an affirmative response to its formation to determine my eligibility for licensure as a
confidential by statute (e.g., social security numbers; mental health	
This authorization is effective for ninety (90) days following my days	ated signature.
Applicant Signature	Date
Witness Signature	Date
*******************	****************
APPLICANT: RETURN THIS FORM TO THE MAINE STA WITH YOUR LICENSE APPLICATION. RET	
******************	****************
MAINE STATE POLICE: Send completed form (or a copy) by reg by fax; OR by e-mail (scan this waiver if using e-mail) to:	gular mail with a stamped, self-addressed envelope; OR

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 Professional Investigator 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.

e box below)						
ase:						
I <u>do not wish</u> to review this material prior to its release:						
	Taine State Police or his/her the date appearing below any the following:					
prior 5 years;						
al description;						
is release, you ma	ay contact me at the address					
Date of birth						
Telephone #						
State	Zip Code					
State	Zip Code					
Date						
Date						
	ase: its release: its release: ine Chief of the Main 6 months of the graph pertaining to prior 5 years; all description; its release, you main pate of birth telephone # State State Date of Date of Date of Date of Date of Date of 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.