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

PROFESSIONAL INVESTIGATOR LICENSE RENEWAL

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 Professional Investigator, 2 pgs.
  - 2nd page must be notarized.

- ☐ 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: $521 should be included with application.
  - Checks made out to "Treasurer, State of Maine."

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

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

Once your application has been processed, 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 show proof of commercial general liability insurance.

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

SEND YOUR COMPLETED APPLICATION PACKET (7 PGS) TO THE MAINE STATE POLICE WEAPONS AND PROFESSIONAL LICENSING UNIT ADDRESS SHOWN ABOVE.

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 Name) (MI)

_____

(Birth, Alias or Other Name used)

Complete Physical Address: _____

City: _____ State: _____ Zip: _____

Complete Mailing Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____

Home Phone#: (_____)_____

Business Phone#: (_____)_____ Cell Phone#: (_____)_____

Eye Color: _____ Height: _____ Weight: _____

DOB: _____ Place of Birth: _____

SSN: _____ - ____ - _____

FOR OFFICAL USE ONLY
Case Number:
Check Number:
Check Amount:
Date Issued/Denied:

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.

The following statement is made pursuant to the Privacy Act of 1974, §7(b): Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 M.R.S. §175 as authorized by the Tax Reform Act of 1976 (42USC, §405(c)(2)(C)(i) and for child support enforcement purposes pursuant to 42 USC §666(a)(13)(A) and 19-A M.R.S. §§2104, 2201. Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes and/or to the Department of Human Services Division of Support Enforcement and Recovery for use in child support enforcement procedures. No further use will be made of your social security number. It will be treated as confidential tax information pursuant to 36 M.R.S. §191 and confidential support enforcement information pursuant to 19-A M.R.S. §2152.

List all addresses since previous license was issued. (If more space is needed, use 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 possible penalty is imprisonment for a period equal to or exceeding one year?	Yes ☐ No ☐
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?	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? 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. 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.	Yes ☐ No ☐
6. Are you an illegal alien?	Yes ☐ No ☐
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 ☐ 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 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 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)

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

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

Mailing Address: Weapons and Profession Licensing, 164 State House Station, Augusta, ME 04333-0164

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) Professional Investigator's 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 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.

(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.