



CITY OF FALL RIVER, MASSACHUSETTS

Dear Applicant:

Thank you for your interest in serving as a Constable in the City of Fall River.

Constables are appointed for three (3) years by the Mayor and can be removed by the Mayor in accordance with Massachusetts General Laws, Chapter 41, Section 91.

Processing of your application will take approximately two weeks.

Failure to answer questions truthfully will result in immediate disapproval of the application and incomplete documents or information as requested will cause a processing delay.

Appointments must be renewed 2 weeks prior to the expiration date.

At any given time during the application process, please feel free to call the following municipal offices with questions or concerns:

Mayor's Office, 508-324-2600

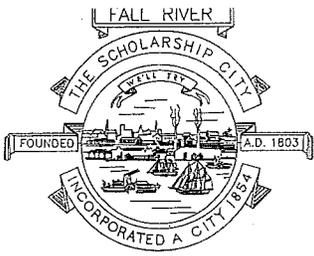
Fall River Police Department/Office of Professional Standards, 508-324-2810

Office of the Corporation Counsel, 508-324-2650

Thank you.

For timely processing of your application, please follow these instructions:

1. Complete the application and attach two 2"x 2" passport style photos. A street address must be provided. P.O. Boxes are NOT accepted.
2. Corrigan Mental Health is charging a fee of \$5.00 to process their form. You must obtain both the Corrigan and SStar information before bringing in your completed application to the Police Department Major Crimes Division, located at 685 Pleasant Street. You will be contacted after the background investigation is completed and the form is signed by the Chief of Police.
3. Obtain a letter from an attorney stating that he/she will utilize your services as a Constable to serve civil process.
4. Acquire at least a \$3,000.00 bond by completing the Constable Bond form, available in the Office of the Corporation Counsel located on the sixth floor of Government Center or in the Forms section of the website.
5. Drop off all completed forms at the Fall River Police Department, Office of Professional Standards, located at 685 Pleasant Street. You will be contacted after the background investigation is completed and the application is signed by the Chief of Police.
6. Leave the signed documents with the Mayor's Office for the Mayor's signature and the Constable Certificate of Appointment. You will be contacted when the documents are ready.
7. File the original copy of the Constable Bond with the Office of the Corporation Counsel.
8. Submit all forms to the Clerk's Office, located on the second floor of Government Center, where suitable credentials will be issued. A \$180 fee is applicable.



CITY OF FALL RIVER, MASSACHUSETTS

Renewal

Application for Appointment as Constable

Fall River, MA _____

To: His Honor, the Mayor,
Fall River, MA

Name: _____

Address: _____

Home Telephone: _____ Cell Phone: _____ E-mail: _____

Occupation: _____

License and Vehicle registration: _____

of the City of Fall River, hereby request an appointment as a Constable for the City of Fall River, for the year ending the first Monday in February _____, in accordance with General Laws, Chapter 41, Sections 91 and 91B.

My reasons for desiring such appointment are as follows: _____

Date of Birth: _____ Place of birth: _____ Are you a U.S. citizen? _____

Have you ever been convicted of any offense in any court? _____ If so, state when the nature of the offense, and the disposition of the case: _____

Signature of Applicant

We, citizens of the City of Fall River, hereby state that the above named applicant is to our knowledge and belief of good moral character.

Signature

Address

Occupation

_____	_____	_____
_____	_____	_____
_____	_____	_____

Attorney at Law

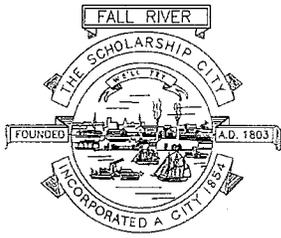
The Fall River Police Department approves/ disapproves the granting of said application.

Fall River Police Department.

Chief

I appoint _____ to the position of Constable.
I certify that in my opinion he is a person specially fitted by education, training, or experience to perform the duties of said office, and I make the appointment solely in the interest of the City.

Mayor



CITY OF FALL RIVER, MASSACHUSETTS

TELETYPE FORMAT FOR BOARD OF PROBATION REQUEST

FROM PD FALL RIVER

TO BOARD OF PROBATION:

DATE _____

REQUEST RECORD CHECK ON APPLICANT FOR POSITION OF CONSTABLE

NAME _____ DATE OF BIRTH _____

ADDRESS _____

FATHER _____ MOTHER _____ MAIDEN
NAME _____

SOCIAL SECURITY NUMBER _____

AUTH CHIEF OF POLICE _____ OPER _____



AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client's Name: _____ Date of Birth: _____

Previous Name: _____ Soc. Security#: _____

I request and authorize Stanley Street Treatment & Resources, Inc.
386 Stanley Street, Fall River, MA 02720

Release to/or request healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code _____

This request and authorization applies to:

- Admission Note
- Discharge Summary
- Psychosocial Assessment
- Substance Abuse Evaluation
- Progress in Treatment
- Attendance
- Compliance with Treatment Plan
- Back to work/school Letter
- Excuse from work/school Letter
- Verification of Treatment (letter)
- Other (specify)
- academic evaluation
- DCF service plan
- police report
- arrest record/legal history
- psychological evaluation
- IEP/504 Plan

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse patient records, 42CFR, Part2, and the Health Insurance Portability and Accountability Act of 1996(HIPPA), 45CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(Specification of the date, event or condition upon with this consent expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

Yes No I have been provided a copy of this form.

Signature of Client

Date Signed

Authorized Signature: (if not patient)

Date signed

Relationship: _____
Describe authority to sign on behalf of patient _____

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information
Two-Way

Name: _____ Other Name(s): _____
Address: _____ Phone: _____
Social Security #: _____ Date of Birth: _____

I authorize the Department of Mental Health (DMH) to receive and release information from or to the person, agency or facility named below, either verbally or in writing, as indicated in this authorization.

Name: _____ Attention: _____ Phone: _____
Street: _____ City/Town: _____ State: _____
Zip: _____

DMH Contact Information:

Name: _____ Phone: _____
Address: _____

The person filling out this form must provide details as to date(s) of requested information. Please note that a request for release of psychotherapy notes cannot be combined with any other type of request. Specify information to be released e.g., Entire Record, Admission(s) Documentation, Discharge Summary(ies), Transfer Summary(ies), Evaluations, Assessments and Tests, Consultation(s) including names of consultant(s), Treatment Plan(s), ISP(s) & IAP(s), Physical Exam & Lab Reports, Progress Note(s):

Purpose for the authorization:

- The subject of the information or Personal Representative initiated the authorization (specific purpose not required)
or
- Coordinate care Facilitate billing
 Referral Obtain insurance, financial or other benefits
 Other purpose (please specify)

A copy of this authorization shall be considered as valid as the original.

