

CITY OF KASSON

401 Fifth Street SE
Kasson, MN 55944
(507)634-7071

Date: _____

The following individual has made application with this agency for volunteering.

Last Name of Applicant *(please print)*: _____

First Name *(please print)*: _____

Middle Name *(full) (please print)*: _____

Maiden, Alias or Former *(please print)*: _____

Date of Birth: _____ **Sex**: (M or F): _____
MO/Day/Year

Social Security Number *(optional)* : _____

I authorize the Minnesota Bureau of Criminal Apprehension to disclose all criminal history record information to the Kasson Police Department for the purpose of a volunteer position with this agency.

The expiration of this authorization shall be for a period no longer than one year from the date of my signature.

Signature of Applicant

Date