



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 two (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

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

1. Complete the application and attach two (2) 2"x2" passport style photos.
2. A street address must be provided. P.O. Boxes are NOT accepted.
3. 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 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.
4. Obtain a letter from an attorney stating that he/she will utilize your services as a Constable to serve civil process.
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. Acquire at least a \$5,000.00 bond by completing the Constable Bond form.
7. 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.
8. Submit the Constable Certificate from the Mayor's office along with one (1) of the photos to the Clerk's Office, located on the second floor of the Government Center, where suitable credentials will be issued. A \$180 fee is applicable.



City of Fall River, Massachusetts

Application for Appointment as Constable

To His Honor the Mayor, Fall River, Ma

Type of application: ___ New ___ Renewal

Name: _____

Address: _____

Home Telephone: _____ Cell Phone: _____ Email: _____

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: ___ Yes ___ No

Have you ever been convicted of any offense in any court? ___ Yes ___ No

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 of said application. Application: Approved Not Approved

Fall River Police 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



Commonwealth of Massachusetts
 Department of Mental Health
Authorization for Release of Information
Two Way

1. Patient/Applicant Information	
Name: _____	Other Names: _____
Street: _____	APT.#: _____
City/Town: _____	State: _____ Zip Code: _____
Social Security #: _____	Date of Birth: _____
Phone : _____	

2. Authorization to Release: I authorize the Department of Mental Health (DMH) to receive and release information, including confidential communications, from or to the Person, Agency or Facility named below, either verbally or in writing.	
Person, Agency or Facility (e.g., name and address of hospital, outpatient provider, residential program, other) Name: _____ Attention: _____ Street: _____ City/Town: _____ State/Zip Code: _____ Phone: _____ Fax: _____	DMH Contact Information: Name: _____ Street: _____ City/Town: _____ State/Zip Code: _____ Phone: _____ Fax: _____ Email: _____

3. Check to indicate the information you want shared: (check all that apply)		
<input type="checkbox"/> Mental Health Diagnosis and Treatment provided by a Psychiatrist; Psychologist; Mental Health Clinical Nurse Specialist; Licensed Social Worker Counseling; all other Licensed Mental Health Providers.		
<input type="checkbox"/> Entire Mental Health Record, <i>excluding Psychotherapy Notes which require a separate authorization</i>		
<input type="checkbox"/> Entire Record (Medical and Mental Health)	<input type="checkbox"/> ISPs & IAPs	<input type="checkbox"/> Treatment Plans
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Neuropsych Testing	<input type="checkbox"/> Transfer Summary
<input type="checkbox"/> Admission Documentation	<input type="checkbox"/> Physical Exam	<input type="checkbox"/> Lab Reports
<input type="checkbox"/> Other (please specify) / additional information: _____ _____		

4. Dates of the information you want shared: (Specify dates)
Dates of Requested Information: From: _____ To: _____



Authorization To Release Confidential Information

Client Name: _____ Date of Birth: _____

Previous Name: _____ Social 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: _____ Zipcode: _____

This request and authorization applies to:

- Academic Evaluation Admission Note Arrest record/legal history
- Attendance Back to Work/School Letter Compliance with Treatment Plan
- DCF Service Plan Discharge Summary Excuse from Work/School Letter
- IEP/504 Plan Police Report Progress in Treatment
- Psychosocial Assessment Psychological Evaluation Substance Abuse Evaluation
- Verification of Treatment Letter Other (specify)

I understand that my alcohol and/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).

Authorized Signature (if not patient)

Date

Relationship: _____

Describe authority to sign on behalf of patient: _____



City of Fall River, Massachusetts

From: Fall River Police

To: Board of Probation

Date: _____

Request Record Check on Application for position of Constable

Name: _____

Date of Birth: _____

Address: _____

Father: _____

Mother: _____

Maiden Name: _____

Social Security #: _____

Chief of Police

OPER

**** Teletype Format For Board of Probation Request ****