Plan de Preparación Familiar

Family Preparedness Plan

Revised 04/29/2026

Plan de Preparación Familiar/Family Preparedness Plan

MI HOGAR/MY HOME

Dirección de su Hogar/Your Home Address:_____

_____

Usted es dueño de su hogar?/Do you own your own home? Si/Yes No

Renta o Hipoteca/Rent or Mortgage

- Cuándo Paga/When You Pay :_____
- Cómo Paga/How You Pay: _____
- Dónde Paga/Where You Pay: _____

¿Quién tiene las llaves de casa de repuesto?/Who holds spare house keys?

_____

MI REGISTRO DE EMPLEO/MY EMPLOYMENT RECORDS

Lugar de trabajo #1/Workplace #1:_____
Dirección/Work Address: _____
Información de Contacto/Work Contact Information: _____

Lugar de trabajo #2/Workplace #2: _____
Dirección/Work Address: _____
Información de Contacto/Work Contact Information: _____

Lugar de trabajo #3/Workplace #3: _____
Dirección/Work Address: _____

Informaciónde Contacto/Work Contact Information:_____

MI REGISTRO FINANCIERO/MY FINANCIAL RECORDS

Banco #1/Bank #1:_____
de Cuenta/Account #: _____ Tipo de Cuenta/Account Type: _____
Usuario(s) Autorizado/Authorized User(s): _____

Banco #2/Bank #2: _____
de Cuenta/Account #: _____ Tipo de Cuenta/Account Type: _____
Usuario(s) Autorizado/Authorized User(s): _____

Banco #3/Bank #3: _____
de Cuenta/Account #: _____ Tipo de Cuenta/Account Type: _____
Usuario(s) Autorizado/Authorized User(s): _____

MIS FACTURAS/MY BILLS

Tipo Type	Compania Company	Cantidad Amount	Fecha de Pago Due Date	# de Cuenta Account #
Agua Water				
Electricidad Electric				
Gas				
Internet				
Televisión TV				
Teléfono Phone				
Tarjeta de crédito Credit Card				
Préstamo de coche Car Loan				
Seguro de auto Car Insurance				

CONTACTOS IMPORTANTES/IMPORTANT CONTACTS

PADRES O TUTORES/PARENTS OR GUARDIANS

Usted/You

- Nombre Completo/Full Name: _____
- Fecha de Nacimiento/Date of Birth: _____
- Teléfono Móvil/Cell Phone: _____
- Teléfono del Trabajo/Work Phone: _____
- Dirección del Trabajo/Work Address: _____
- Alergias/Allergies: _____
- Condiciones Medicas/Medical Conditions: _____
- Medicamentos/Medications: _____

Pareja o Esposo o Cónyuge/Partner or Spouse

- Nombre Completo/Full Name: _____
- Fecha de Nacimiento/Date of Birth: _____
- Teléfono Móvil/Cell Phone: _____
- Teléfono del Trabajo/Work Phone: _____
- Dirección del Trabajo/Work Address: _____
- Alergias/Allergies: _____
- Condiciones Medicas/Medical Conditions: _____
- Medicamentos/Medications: _____

NIÑOS O DEPENDIENTES/CHILDREN OR DEPENDENTS

Hij@ o Dependiente #1/Child or Dependent#1

- Nombre Completo/FullName: _____
- Fecha de Nacimiento/Date of Birth: _____
- Teléfono Móvil/Cell Phone: _____
- Escuela/School: _____
  - Dirección/Address: _____
  - Teléfono/Phone: _____
  - Nombre del Maestro o Maestra/Teacher's Name: _____
  - # de Salón/Classroom #: _____

- Programa Después de Escuela/Afterschool Program: _____
  - Teléfono/Phone: _____
- Otro Programa/Other Program: _____
  - Teléfono/Phone: _____
- Alergias/Allergies: _____
- Condiciones Medicas/Medical Conditions: _____
- Medicamentos/Medications: _____
- Doctor: _____
  - Teléfono/Phone: _____
  - Dirección/Address: _____

Seguro Medico/Health Insurance: _____

Hij@ o Dependiente #2/Child or Dependent#2

- Nombre Completo/Full Name: _____
- Fecha de Nacimiento/Date of Birth: _____
- Teléfono Móvil/Cell Phone: _____
- Escuela/School: _____
  - Dirección/Address: _____
  - Teléfono/Phone: _____
  - Nombre del Maestro o Maestra/Teacher's Name: _____
  - # de Salón/Classroom #: _____
- Programa Después de Escuela/Afterschool Program: _____
  - Teléfono/Phone: _____
- Otro Programa/Other Program: _____
  - Teléfono/Phone: _____
- Alergias/Allergies: _____
- Condiciones Medicas/Medical Conditions: _____
- Medicamentos/Medications: _____
- Doctor: _____
  - Teléfono/Phone: _____
  - Dirección/Address: _____
- Seguro Medico/Health Insurance: _____

Hij@ o Dependiente #3/Child or Dependent#3

- Nombre Completo/Full Name: _____
- Fecha de Nacimiento/Date of Birth: _____
- Teléfono Móvil/Cell Phone: _____
- Escuela/School: _____
  - Dirección/Address: _____
  - Teléfono/Phone: _____
  - Nombre del Maestro o Maestra/Teacher's Name: _____
  - # de Salón/Classroom #: _____
- Programa Después de Escuela/Afterschool Program: _____
  - Teléfono/Phone: _____
- Otro Programa/Other Program: _____
  - Teléfono/Phone: _____
- Alergias/Allergies: _____
- Condiciones Medicas/Medical Conditions: _____
- Medicamentos/Medications: _____
- Doctor: _____
  - Teléfono/Phone: _____
  - Dirección/Address: _____
- Seguro Medico/Health Insurance: _____

Hij@ o Dependiente #4/Child or Dependent#4

- Nombre Completo/Full Name: _____
- Fecha de Nacimiento/Date of Birth: _____
- Teléfono Móvil/Cell Phone: _____
- Escuela/School: _____
  - Dirección/Address: _____
  - Teléfono/Phone: _____
  - Nombre del Maestro o Maestra/Teacher's Name: _____
  - # de Salón/Classroom #: _____
- Programa Después de Escuela/Afterschool Program: _____
  - Teléfono/Phone: _____
- Otro Programa/Other Program: _____
  - Teléfono/Phone: _____
- Alergias/Allergies: _____
- Condiciones Medicas/Medical Conditions: _____
- Medicamentos/Medications: _____
- Doctor: _____
  - Teléfono/Phone: _____
  - Dirección/Address: _____
- Seguro Medico/Health Insurance: _____

Hij@ o Dependiente #5/Child or Dependent#5

- Nombre Completo/Full Name: _____
- Fecha de Nacimiento/Date of Birth: _____
- Teléfono Móvil/Cell Phone: _____
- Escuela/School: _____
  - Dirección/Address: _____
  - Teléfono/Phone: _____
  - Nombre del Maestro o Maestra/Teacher's Name: _____
  - # de Salón/Classroom #: _____
- Programa Después de Escuela/Afterschool Program: _____
  - Teléfono/Phone: _____
- Otro Programa/Other Program: _____
  - Teléfono/Phone: _____
- Alergias/Allergies: _____
- Condiciones Medicas/Medical Conditions: _____
- Medicamentos/Medications: _____
- Doctor: _____
  - Teléfono/Phone: _____
  - Dirección/Address: _____
- Seguro Medico/Health Insurance: _____

CONTACTOS DE EMERGENCIA/EMERGENCY CONTACTS

Contacto de emergencia #1/Emergency Contact #1

- Relación/Relationship: _____
- Nombre Completo/Full Name: _____
- Teléfono Móvil/Cell Phone: _____
- Dirección de Domicilio/Home Address: _____

_____

¿Podrían potencialmente cuidar de sus hijos?/Could this person potentially care for your children? _____
¿Cuándo puede hablar con ellos sobre esto?/When can you talk to them about this? _____
¿Cuándo habló con ellos y qué dijeron?/When did you talk to them and what did they say? _____

_____

Contacto de emergencia #2/Emergency Contact #2

- Relación/Relationship: _____
- Nombre Completo/Full Name: _____
- Teléfono Móvil/Cell Phone: _____
- Dirección de Domicilio/Home Address: _____
- _____

¿Podrían potencialmente cuidar de sus hijos?/Could this person potentially care for your children? _____
¿Cuándo puede hablar con ellos sobre esto?/When can you talk to them about this? _____
¿Cuándo habló con ellos y qué dijeron?/When did you talk to them and what did they say? _____

_____

Contacto de emergencia #3/Emergency Contact #3

- Relación/Relationship: _____
- Nombre Completo/Full Name: _____
- Teléfono Móvil/Cell Phone: _____
- Dirección de Domicilio/Home Address: _____

_____

¿Podrían potencialmente cuidar de sus hijos?/Could this person potentially care for your children? _____
¿Cuándo puede hablar con ellos sobre esto?/When can you talk to them about this? _____
¿Cuándo habló con ellos y qué dijeron?/When did you talk to them and what did they say? _____

_____

Actualizaciones de Contactos de Emergencia/Emergency Contact Updates

¿Cuándo actualicé por última vez los contactos de emergencia de mis hijos?
When did I last update my children's emergency contacts?

- Escuela o Programa/School or Program: _____
- Fecha de Actualización/Date Updated: _____
- Escuela o Programa/School or Program: _____
- Fecha de Actualización/Date Updated: _____
- Escuela o Programa/School or Program: _____
- Fecha de Actualización/Date Updated: _____
- Escuela o Programa/School or Program: _____
- Fecha de Actualización/Date Updated: _____

CONTACTOS VARIOS/MISCELLANEOUS CONTACTS

Doctor

- Nombre/Name: _____
- Teléfono/Phone: _____
- Dirección/Address: _____
- Compañía del seguro de salud/Health Insurance Company: _____
- Número de póliza/Policy #: _____

Pediatra/Pediatrician

- Nombre/Name: _____
- Teléfono/Phone: _____
- Dirección/Address: _____
- Compañía del seguro de salud/Health Insurance Company: _____
- Número de póliza/Policy #: _____

Dentista/Dentist

- Nombre/Name: _____
- Teléfono/Phone: _____
- Dirección/Address: _____
- Compañía de seguros dentales/Dental Insurance Company: _____
- Número de póliza/Policy #: _____

Consulado/Consulate

- Nombre/Name: _____
- Teléfono/Phone: _____
- Dirección/Address: _____

Abogado o Proveedor de Servicios Legales/Attorney or Legal Services Provider

- Nombre/Name: _____
- Teléfono/Phone: _____
- Dirección/Address: _____
- Correo Electrónico/Email: _____

Iglesia/Church/Temple/Mosque/Place of Worship

- Nombre/Name: _____
- Teléfono/Phone: _____
- Dirección/Address: _____

INFORMACIÒN DEL AUTO/CAR INFORMATION

Coche #1/Car #1

- Marca y Modelo de Vehículo/Car Make & Model: _____
- # de las Placas/License Plate #: _____

Coche #2/Car #2

- Marca y Modelo de Vehículo/Car Make & Model: _____
- # de las Placas/License Plate #: _____

MASCOTAS/ PETS

Mascota #1/ Pet #1

- **Nombre/Name**_____
- **Descripción de la mascota/Pet description:**
  - Raza/Breed_____
  - Genero/Sex_____
  - Color_____
  - Peso/Weight_____
- Foto reciente de la mascota/Recent photograph of pet
- ¿Está esterilizado/castrado? /Spayed/neutered? SI/YES NO
- **Historial veterinario/Veterinary Records:**
  - Certificado de vacunación contra la rabia/Rabies Certificate
  - Vacunas/Vaccinations
  - Recetas médicas/Prescriptions for medications
  - Alergias/Allergies
  - Resultados más recientes de las pruebas de filariasis cardíaca (perros)/Most recent heartworm test results (dogs)
  - Resultados más recientes de las pruebas de FeLV/FIV (gatos)/Most recent FeLV/FIV test results (cats)
- **Información sobre la registración/Registration information** (por ejemplo: certificado de propiedad, licencia del animal o documentos de adopción/ex: proof of ownership/animal license or adoption records)
- Información sobre el microchip/**Microchip Information** (por ejemplo: número de microchip, nombre y número de la empresa del microchip/ex: microchip number, name and number of the microchip company)
- Fechas de administración de los medicamentos preventivos contra pulgas, garrapatas y gusanos del corazón/**Flea/tick/and heartworm preventative medication administration dates:**
- _____

  Instrucciones de alimentación/ Feeding Instructions:

  _____

  _____

- **Veterinario/Vet**
  - Nombre/Name_____
  - Teléfono/Phone_____
  - Dirección/Address_____
  - Compañía de seguros médicos/ Health Insurance Company _____
  - # de póliza/Policy #_____

CAREGIVER'S AUTHORIZATION AFFIDAVIT

Use of this affidavit is authorized by Part 1.5 (commencing with Section 6550) of Division 11 of the California Family Code.

Instructions: Completion of items 1–4 and the signing of the affidavit is sufficient to authorize enrollment of a minor in school and authorize school-related medical care. Completion of items 5 through 8 is additionally required to authorize any other medical care. **Only complete items 5 through 8 if you are related to the child.** Type or print clearly.

The minor named below lives in my (the caregiver's) home and I am 18 years of age or older.

1. **Name of minor:** _____
2. **Minor's birth date:** _____
3. **My name (adult giving authorization):** _____
4. **My home address:** _____
5. [ ] I am a relative of the child (see back of this form for definition of "relative").
6. **Check one or both (for example, if one parent was advised and the other cannot be located):**
   [ ] I have advised the parent(s) or other person(s) having legal custody of the minor of my intent to authorize medical care, and have received no objection.
   [ ] I am unable to contact the parent(s) or other person(s) having legal custody of the minor at this time, to notify them of my intended authorization.
7. **My date of birth:** _____
8. **My California driver's license or identification card number or government-issued consular card number:** _____

WARNING TO CAREGIVER: DO NOT SIGN THIS FORM IF ANY OF THE STATEMENTS ABOVE ARE INCORRECT, OR YOU WILL BE COMMITTING A CRIME PUNISHABLE BY FINE, IMPRISONMENT, OR BOTH.

WARNING TO LOCAL EDUCATIONAL AGENCIES AND HEALTH CARE SERVICE PROVIDERS: A SEAL OR SIGNATURE FROM A COURT IS NOT REQUIRED. THIS FORM IS NOT REQUIRED TO BE NOTARIZED.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: _____ **Signed:** _____

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NOTICES

1. *THIS DECLARATION DOES NOT AFFECT THE RIGHTS OF THE MINOR'S PARENTS OR LEGAL GUARDIAN REGARDING THE CARE, CUSTODY, AND CONTROL OF THE MINOR, AND DOES NOT MEAN THAT THE CAREGIVER HAS LEGAL CUSTODY OF THE MINOR.*

2. *A PERSON WHO RELIES ON THIS AFFIDAVIT HAS NO OBLIGATION TO MAKE ANY FURTHER INQUIRY OR INVESTIGATION.*

ADDITIONAL INFORMATION:

TO CAREGIVERS:

1. *"RELATIVE," FOR PURPOSES OF ITEM 5, MEANS AN ADULT WHO IS RELATED TO THE CHILD BY BLOOD, ADOPTION, OR AFFINITY WITHIN THE FIFTH DEGREE OF KINSHIP, INCLUDING STEPPARENTS, STEPSIBLINGS, AND ALL RELATIVES WHOSE STATUS IS PRECEDED BY THE WORDS "GREAT," "GREAT-GREAT," OR "GRAND," OR THE SPOUSE OF ANY OF THESE PERSONS EVEN IF THE MARRIAGE WAS TERMINATED BY DEATH OR DISSOLUTION.*

2. *THE LAW MAY REQUIRE YOU, IF YOU ARE NOT A RELATIVE OR A CURRENTLY LICENSED, CERTIFIED, OR APPROVED FOSTER PARENT, TO OBTAIN RESOURCE FAMILY APPROVAL PURSUANT TO SECTION 1517 OF THE HEALTH AND SAFETY CODE OR SECTION 16519.5 OF THE WELFARE AND INSTITUTIONS CODE IN ORDER TO CARE FOR A MINOR. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR LOCAL DEPARTMENT OF SOCIAL SERVICES.*

3. *IF THE MINOR STOPS LIVING WITH YOU, THE AFFIDAVIT IS NO LONGER VALID. YOU ARE REQUIRED TO NOTIFY ANY SCHOOL, HEALTH CARE PROVIDER, OR HEALTH CARE SERVICE PLAN TO WHICH YOU HAVE GIVEN THIS AFFIDAVIT THAT THE MINOR IS NO LONGER LIVING WITH YOU AND THAT, AS A RESULT, THE AFFIDAVIT IS NO LONGER VALID.*

4. *IF YOU DO NOT HAVE THE INFORMATION REQUESTED IN ITEM 8 (CALIFORNIA DRIVER'S LICENSE OR I.D., OR GOVERNMENT-ISSUED CONSULAR CARD), PROVIDE ANOTHER FORM OF IDENTIFICATION SUCH AS YOUR SOCIAL SECURITY NUMBER OR MEDI-CAL NUMBER.*

TO SCHOOL OFFICIALS:

1. *SECTION 48204 OF THE EDUCATION CODE PROVIDES THAT THIS AFFIDAVIT CONSTITUTES A SUFFICIENT BASIS FOR A DETERMINATION OF RESIDENCY OF THE MINOR, WITHOUT THE REQUIREMENT OF A GUARDIANSHIP OR OTHER CUSTODY ORDER, UNLESS THE SCHOOL DISTRICT DETERMINES FROM ACTUAL FACTS THAT THE MINOR IS NOT LIVING WITH THE CAREGIVER.*

2. *THE SCHOOL DISTRICT MAY REQUIRE ADDITIONAL REASONABLE EVIDENCE THAT THE CAREGIVER LIVES AT THE ADDRESS PROVIDED IN ITEM 4.*

3. *A SEAL OR SIGNATURE OF THE COURT IS NOT REQUIRED. THIS FORM IS NOT REQUIRED TO BE NOTARIZED.*

TO HEALTH CARE PROVIDERS AND HEALTH CARE SERVICE PLANS:

1. *WHEN SIGNED BY A RELATIVE, THIS AFFIDAVIT SHALL CONFER THE SAME RIGHTS TO AUTHORIZE MEDICAL CARE*

continued...

AND DENTAL CARE FOR THE MINOR THAT ARE GIVEN TO GUARDIANS UNDER SECTION 2353 OF THE PROBATE CODE. THE MEDICAL CARE AUTHORIZED BY A RELATIVE CAREGIVER MAY INCLUDE MENTAL HEALTH TREATMENT SUBJECT TO THE LIMITATIONS OF SECTION 2356 OF THE PROBATE CODE.

2. *A HEALTH CARE SERVICE PROVIDER WHO ACTS IN GOOD FAITH RELIANCE UPON A CAREGIVER'S AUTHORIZATION AFFIDAVIT TO PROVIDE MEDICAL OR DENTAL CARE, WITHOUT ACTUAL KNOWLEDGE OF FACTS CONTRARY TO THOSE STATED ON THE AFFIDAVIT, IS NOT SUBJECT TO CRIMINAL LIABILITY OR TO CIVIL LIABILITY TO ANY PERSON, AND IS NOT SUBJECT TO PROFESSIONAL DISCIPLINARY ACTION, FOR THAT RELIANCE IF THE APPLICABLE PORTIONS OF THE FORM ARE COMPLETED. A SEAL OR SIGNATURE OF THE COURT IS NOT REQUIRED. THIS FORM IS NOT REQUIRED TO BE NOTARIZED.*

3. *THIS AFFIDAVIT DOES NOT CONFER DEPENDENCY FOR HEALTH CARE COVERAGE PURPOSES*

DECLARACIÓN JURADA DE AUTORIZACIÓN DEL CUIDADOR

CAREGIVER'S AUTHORIZATION AFFIDAVIT

El uso de esta declaración jurada está autorizado por la Parte 1.5 (que comienza con la Sección 6550) de la División 11 del Código de Familia de California.

Instrucciones: Completar los puntos 1 a 4 y firmar la declaración jurada es suficiente para autorizar la inscripción de un niño(a) en la escuela y para el cuidado médico relacionado con la escuela. Completar los puntos 5 a 8 también es necesario para autorizar cualquier otra atención médica. **Complete los puntos 5 a 8 solo si es pariente del niño(a).** Escriba con letra legible.

El niño(a) indicado a continuación vive en mi casa (la del cuidador) y yo tengo 18 años de edad o más.

1. **Nombre del niño/a:** _____
2. **Fecha de nacimiento del niño/a:** _____
3. **Mi nombre (adulto que otorga la autorización):** _____
4. **Mi domicilio:** _____
5. [ ] Soy pariente del niño(a) (consulte el reverso de este formulario para ver la definición de "pariente").
6. **Marque una o ambas (por ejemplo, si se informó a uno de los padres y no se puede localizar al otro):**
   [ ] He informado a los padres u otras personas que tengan la custodia legal del niño(a) sobre mi intención de autorizar atención médica y no he recibido ninguna objeción.
   [ ] No puedo comunicarme con los padres u otras personas que tengan la custodia legal del niño(a) en este momento para notificarles sobre mi intención de autorizar.
7. **Mi fecha de nacimiento:** _____
8. **Mi número de licencia de conducir de California, documento de identidad de California, o número de tarjeta consular emitida por el gobierno:** _____

ADVERTENCIA PARA EL CUIDADOR: NO FIRME ESTE FORMULARIO SI ALGUNA DE LAS DECLARACIONES ANTERIORES ES INCORRECTA O ESTARÁ COMETIENDO UN DELITO PUNIBLE CON MULTA, PRISIÓN, O AMBAS.

ADVERTENCIA PARA LAS AGENCIAS EDUCATIVAS LOCALES Y LOS PROVEEDORES DE SERVICIOS DE SALUD: ESTE FORMULARIO NO REQUIERE SELLO NI FIRMA DE UN TRIBUNAL. ESTE FORMULARIO NO REQUIERE SER NOTARIZADO.

Declaro bajo pena de perjurio bajo las leyes del Estado de California que lo anterior es verdadero y correcto.

Fecha: _____ **Firma:** _____

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AVISOS

1. *ESTA DECLARACIÓN NO AFECTA LOS DERECHOS DE LOS PADRES O DEL TUTOR LEGAL DEL NIÑO(A) RESPECTO AL CUIDADO, CUSTODIA, Y CONTROL DEL NIÑO(A), Y NO SIGNIFICA QUE EL CUIDADOR TENGA LA CUSTODIA LEGAL DEL NIÑO(A).*

2. *LA PERSONA QUE CONFÍE EN ESTA DECLARACIÓN JURADA NO TENDRÁ OBLIGACIÓN DE REALIZAR NINGUNA OTRA INVESTIGACIÓN O AVERIGUACIÓN.*

INFORMACIÓN ADICIONAL:

A LOS CUIDADORES:

1. *"PARIENTE", PARA LOS EFECTOS DEL PUNTO 5, SIGNIFICA UN ADULTO QUE ESTÁ RELACIONADO CON EL NIÑO(A) POR SANGRE, ADOPCIÓN, O AFINIDAD DENTRO DEL QUINTO GRADO DE PARENTESCO, INCLUYENDO PADRASTROS, HERMANASTROS, Y TODOS LOS PARIENTES CUYA RELACIÓN ESTÉ PRECEDIDA POR LAS PALABRAS "BIS", "TÁTARA", O EL CÓNYUGE DE CUALQUIERA DE ESTAS PERSONAS, INCLUSO SI EL MATRIMONIO SE TERMINÓ POR MUERTE O DISOLUCIÓN.*

2. *LA LEY PODRÍA EXIGIRLE A USTED, SI NO ES FAMILIAR, O ACTUALMENTE UN PADRE ADOPTIVO CON LICENCIA, CERTIFICADO, O APROBADO, QUE OBTENGA LA APROBACIÓN DE RECURSOS FAMILIARES DE CONFORME CON EL ARTÍCULO 1517 DEL CÓDIGO DE SALUD Y SEGURIDAD O EL ARTÍCULO 16519.5 DEL CÓDIGO DE BIENESTAR E INSTITUCIONES, PARA CUIDAR A UN NIÑO(A). SI TIENE ALGUNA PREGUNTA, COMUNÍQUESE CON SU DEPARTAMENTO LOCAL DE SERVICIOS SOCIALES.*

3. *SI EL NIÑO(A) DEJA DE VIVIR CON USTED, LA DECLARACIÓN JURADA PIERDE SU VALIDEZ. USTED DEBE NOTIFICAR A CUALQUIER ESCUELA, PROVEEDOR DE SALUD, O PLAN DE SERVICIOS DE SALUD AL QUE HAYA ENTREGADO ESTA DECLARACIÓN JURADA QUE EL NIÑO(A) YA NO VIVE CON USTED Y QUE, EN CONSECUENCIA, LA DECLARACIÓN JURADA YA NO TIENE VALIDEZ.*

4. *SI USTED NO TIENE LA INFORMACIÓN SOLICITADA EN EL PUNTO 8 (LICENCIA DE CONDUCIR DE CALIFORNIA, DOCUMENTO DE IDENTIDAD DE CALIFORNIA, O TARJETA CONSULAR EMITIDA POR EL GOBIERNO), PROPORCIONE OTRA FORMA DE IDENTIFICACIÓN, COMO SU NÚMERO DE SEGURO SOCIAL O NÚMERO DE MEDI-CAL.*

A LOS FUNCIONARIOS DE LA ESCUELA:

1. *EL ARTÍCULO 48204 DEL CÓDIGO DE EDUCACIÓN ESTABLECE QUE ESTA DECLARACIÓN JURADA CONSTITUYE UNA BASE SUFICIENTE PARA DETERMINAR LA RESIDENCIA DEL NIÑO(A), SIN EL REQUISITO DE UNA TUTELA U OTRA ORDEN DE CUSTODIA, A MENOS QUE EL DISTRITO ESCOLAR DETERMINE A PARTIR DE HECHOS REALES QUE EL NIÑO(A) NO VIVE CON EL CUIDADOR.*

2. *EL DISTRITO ESCOLAR PUEDE REQUERIR PRUEBA RAZONABLE ADICIONAL DE QUE EL CUIDADOR VIVE EN LA DIRECCIÓN PROPORCIONADA EN EL PUNTO 4.*

3. *NO SE REQUIERE SELLO NI FIRMA DE UN TRIBUNAL. ESTE FORMULARIO NO NECESITA SER NOTARIZADO.*

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A LOS PROVEEDORES DE ATENCIÓN MÉDICA Y A LOS PLANES DE SERVICIOS DE ATENCIÓN MÉDICA:

1. *AL SER FIRMADA POR UN FAMILIAR, ESTA DECLARACIÓN JURADA CONFERIRÁ LOS MISMOS DERECHOS PARA AUTORIZAR LA ATENCIÓN MÉDICA Y DENTAL DEL NIÑO(A) QUE AQUELLOS DERECHOS QUE SE OTORGAN A LOS TUTORES SEGÚN EL ARTÍCULO 2353 DEL CÓDIGO DE SUCESIONES. LA ATENCIÓN MÉDICA AUTORIZADA POR UN FAMILIAR CUIDADOR PUEDE INCLUIR TRATAMIENTO DE SALUD MENTAL, SUJETO A LAS LIMITACIONES DEL ARTÍCULO 2356 DEL CÓDIGO DE SUCESIONES.*

2. *UN PROVEEDOR DE SERVICIOS DE SALUD QUE ACTÚE DE BUENA FE BASÁNDOSE EN LA DECLARACIÓN JURADA DE AUTORIZACIÓN DE UN CUIDADOR PARA BRINDAR ATENCIÓN MÉDICA O DENTAL, SIN TENER CONOCIMIENTO REAL DE HECHOS CONTRARIOS A LOS DECLARADOS EN LA DECLARACIÓN JURADA, NO ESTARÁ SUJETO A RESPONSABILIDAD PENAL NI CIVIL ANTE NINGUNA PERSONA, NI A MEDIDAS DISCIPLINARIAS PROFESIONALES POR BASARSE EN DICHA DECLARACIÓN, SIEMPRE QUE SE COMPLETEN LAS SECCIONES CORRESPONDIENTES DEL FORMULARIO. NO SE REQUIERE SELLO NI FIRMA DE UN TRIBUNAL. ESTE FORMULARIO NO REQUIERE SER NOTARIZADO.*

3. *ESTA DECLARACIÓN JURADA NO CONFIERE DEPENDENCIA PARA FINES DE COBERTURA DE ATENCIÓN MÉDICA.*

FILE OF IMPORTANT DOCUMENTS

ep a file of these documents or a copy of these documents in a safe place. your children, family members, and emergency caregivers where to find this file in an emergency.

[ ] PASSPORTS

[ ] BIRTH CERTIFICATES

[ ] MARRIAGE LICENSE (IF APPLICABLE)

[ ] CAREGIVER'S AUTHORIZATION AFFIDAVIT

[ ] ANY RESTRAINING ORDERS YOU MAY HAVE AGAINST ANYONE (IF APPLICABLE)

[ ] A-NUMBER AND ANY IMMIGRATION DOCUMENTS (WORK PERMIT, GREEN CARD, VISA, ETC.)

[ ] DOCUMENTS DEMONSTRATING YOUR RESIDENCE IN THE UNITED STATES AND AMOUNT OF TIME YOU HAVE BEEN PHYSICALLY PRESENT IN THE UNITED STATES

[ ] DRIVER'S LICENSE AND/OR OTHER IDENTIFICATION CARDS

[ ] SOCIAL SECURITY CARD OR ITIN NUMBER

[ ] REGISTRY OF BIRTH (FOR U.S. BORN CHILDREN REGISTERED IN PARENT'S HOME COUNTRY) (IF APPLICABLE)

[ ] IMPORTANT CHILDREN'S INFORMATION

[ ] EMERGENCY NUMBERS AND IMPORTANT CONTACT INFORMATION

[ ] CHILDREN(S)' MEDICAL INFORMATION, INCLUDING HEALTH INSURANCE, MEDICATION LIST, AND DOCTOR'S CONTACT INFORMATION

[ ] ANY OTHER DOCUMENTS YOU WOULD WANT TO BE ABLE TO FIND QUICKLY

ARCHIVO DE DOCUMENTOS IMPORTANTES

Guarde un archivo de estos documentos o una copia de estos documentos en un lugar seguro. Dígale a sus hijos, familiares y cuidadores de emergencia dónde encontrar este archivo en caso de emergencia.

[ ] PASAPORTES

[ ] ACTAS DE NACIMIENTO

[ ] LICENCIA DE MATRIMONIO (SI APLICA)

[ ] LA DECLARACIÓN JURADA DE AUTORIZACIÓN DEL CUIDADOR (CAREGIVER'S AUTHORIZATION AFFIDAVIT), SI ESTA EN CALIFORNIA

[ ] CUALQUIER ORDEN DE RESTRICCIÓN QUE PUEDA TENER CONTRA CUALQUIER PERSONA (SI CORRESPONDE)

[ ] NÚMERO A (A NUMBER) Y CUALQUIER DOCUMENTO DE INMIGRACIÓN (PERMISO DE TRABAJO, TARJETA VERDE, VISA, ETC.)

[ ] DOCUMENTOS QUE DEMUESTREN SU RESIDENCIA EN LOS ESTADOS UNIDOS Y LA CANTIDAD DE TIEMPO QUE HA ESTADO FÍSICAMENTE PRESENTE EN LOS ESTADOS UNIDOS

[ ] LICENCIA DE CONDUCIR Y/U OTRAS TARJETAS DE IDENTIFICACIÓN

[ ] TARJETA DE SEGURO SOCIAL O NÚMERO ITIN

[ ] REGISTRO DE NACIMIENTO (PARA NIÑOS NACIDOS EN EE. UU. REGISTRADOS EN EL PAÍS DE ORIGEN DE LOS PADRES) (SI CORRESPONDE)

[ ] INFORMACIÓN IMPORTANTE DE SU NIÑOS

[ ] NÚMEROS DE EMERGENCIA E INFORMACIÓN DE CONTACTO IMPORTANTE

[ ] CINFORMACIÓN MÉDICA DE LOS NIÑOS, INCLUIDO EL SEGURO MÉDICO, LA LISTA DE MEDICAMENTOS Y LA INFORMACIÓN DE CONTACTO DEL MÉDICO

[ ] CUALQUIER OTRO DOCUMENTO QUE DESEE PODER ENCONTRAR RÁPIDAMENTE

LAST SUNDAY OF THE MONTH

SWAP MEET JUSTICE!

MONTHLY CITIZENSHIP & SOCIAL JUSTICE FAIR

ÚLTIMO DOMINGO DE CADA MES

¡JUSTICIA TIANGUERA!

FERIA MENSUAL DE CIUDADANÍA Y JUSTICIA SOCIAL

OXNARD COLLEGE SWAP MEET

9AM - 3PM

DATES/FECHAS: 1/25, 2/22, 3/29, 4/26, 5/31, 6/28, 7/26, 8/30, 9/27...

Citizenship Fair */Feria De Ciudadanía*

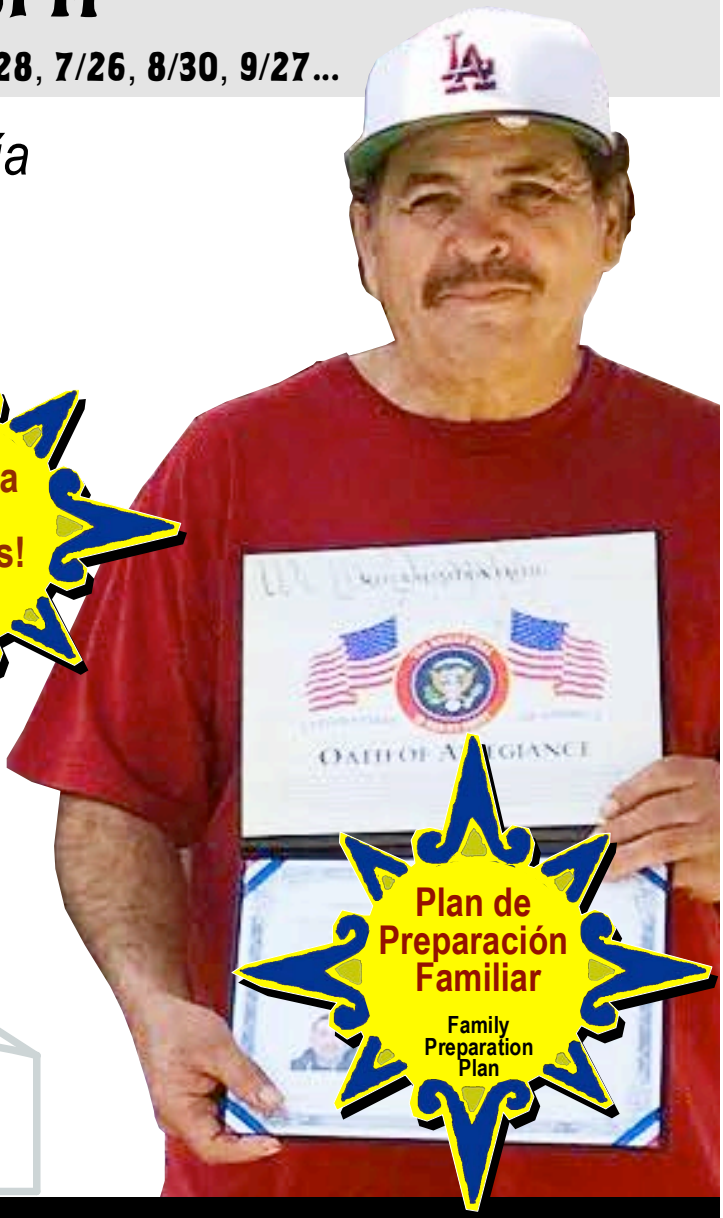
Expungement/ *Borrar record penal*

Consulado de México

Community advocacy/
Abogacía comunitaria

Resources/*Recursos:*

- **Legal**/ *Legal y Medicare*
- **Family**/*Familia*
- **Farmworkers**/*Trabajador agrícola*
- **Mobile library**/*Biblioteca móvil*
- **Renew Medi-Cal**/ *Renovar Medi-Cal*
- **Health care**/ *Cuidado a la salud*
- **Clinics**/*Clínicas*
- **Financial** /*Recursos financieros*



CyberCopy GRAPHIC & PRINT SOLUTIONS | COUNTY of VENTURA | WEINGART FOUNDATION | Gold Coast Health Plan A Public Entity | McCune FOUNDATION

OXNARD COLLEGE FOUNDATION | Elegant Event Rental Inc.

SWAPMEETJUSTICE.ORG More info/Para más información: (805) 616-2715

4000 S. Rose Ave., Oxnard - Near the gym/Ubicado frente al gimnasio

Specific services subject to cancellation/ Servicios específicos sujetos a cancelación.
Event subject to cancellation due to weather/El evento puede cancelar debido al clima

Ventura County Public Defender
Fresh Start Unit

WE OFFER

EXPUNGEMENTS
An expungement is when the court orders a conviction be set aside, a plea of not guilty be entered, and the complaint be dismissed.

SEALINGS
If you have suffered an arrest that did not result in a conviction you may petition the court to have your arrest and related records sealed.

RETURN OF PROPERTY
If the arresting agency confiscated your personal item when arrested, our office can request an order from the judge requesting the property be released to you.

SEX OFFENDER REGISTRATION RELIEF
Petition the Court to terminate sex offender registration based on the tier level.

EARLY TERMINATION OF PROBATION
If you have not violated probation, paid all fines/fees, and have completed more than 1/2 of your term, we can petition to terminate early.

CERTIFICATE OF REHABILITATION
Restores some rights of citizenship which were forfeited as a result of a conviction.

APPLY FOR OUR SERVICES ONLINE

CONTACT US NOW

805-654-2201

PDFreshStart@ventura.org

800 S. Victoria Ave.
Room 207
Ventura, CA 93009

https://vcpublicdefender.org/

COUNTY of VENTURA
Public Defender

Defensor Público del Condado de Ventura Programa de Nuevo Comienzo

SE OFRECE

ELIMINACIÓN DE ANTECEDENTES PENALES
Una eliminación de antecedentes es cuando el Tribunal ordena anular una condena, usted se declara no culpable, y la acusación formal se despide.

SELLAR EL ARRESTO
Si fue arrestado, pero el fiscal nunca presentó cargos penales, usted puede peticionar que la corte selle el arresto y cualquier expediente relacionado al arresto .

DEVOLUCIÓN DE PROPIEDAD
Si acaso le confiscaron algún articulo personal por parte de la agencia de arresto, nuestra oficina puede pedir una orden judicial para la devolución de su propiedad.

ALIVIO DEL REGISTRO DE DELINCUENTE SEXUAL
Solicitar al Tribunal que cancéle el registro de delincuente sexual segun el nivel.

TERMINACIÓN ANTICIPADA DE LA LIBERTAD CONDICIONAL
Si no tuvo un incumplimiento de libertad condicional, pagó sus multas/recargos, y completó más de la mitád de su mandato, podémos pedir terminación anticipade la libertad condicional.

CERTIFICADO DE REHABILITACIÓN
Se restaura ciertos derechos de su cuidadanía que perdió como resultado de su condena.

SOLICITE NUESTROS SERVICIOS EN LÍNEA

CONTÁCTENOS HOY

805-654-2201

PDFreshStart@ventura.org

800 S. Victoria Ave.
Room 207
Ventura, CA 93009

https://vcpublicdefender.org/

COUNTY of VENTURA
Public Defender

Immigration Warriors

La asociación profesional de abogados y representantes acreditados a través de la Costa Central (condados de Ventura, Santa Barbara, y San Luis Obispo)

Condado de Ventura

Mixteco/Indígena Community Organizing Project (MICOP)
135 Magnolia Avenue
Oxnard, CA 93030
Servicios de inmigración: (805) 940-5541
Email: liza.diniakos@mixteco.org
Tienen abogados de defensa a la deportación

El Concilio
301 S. C St.
Oxnard, CA 93030
(805) 486-9777

MARIPOSA
143 Figueroa Street
Ventura, CA 93001
(805) 641-9300
info@mariposaadvocacy.org

Fundación de la Unión Campesina (UFW Foundation)
920 S. A St.
Oxnard, CA 93030
(805) 246-3864

Condado de San Luis Obispo

Immigrant Hope Arroyo Grande
995 E Grand Ave
Arroyo Grande, CA 93420
(805) 221-4319
immigranthopeag.org

Catholic Charities – Diocese of Monterey
San Luis Obispo, CA
(805) 541-9110

Mixteco/Indígena Community Organizing Project (MICOP)
1502 15th Street, Suite B
Paso Robles, CA 93446
Servicios de inmigración: (805) 940-5541
liza.diniakos@mixteco.org
Tienen abogados de defensa a la deportación

Condado de Santa Barbara

Mixteco/Indígena Community Organizing Project (MICOP)
110 S. Lincoln St. Suite #201
Santa Maria, CA 93458
Servicios de inmigración: (805) 940-5541
liza.diniakos@mixteco.org
Tienen abogados de defensa a la deportación

Centro de Defensa Legal de Inmigrantes de Santa Barbara (SBILDC)
Santa Barbara:
1136 E. Montecito St.
Santa Barbara, 93103
805-886-9136
julissa@sbimmigrantdefense.org
Tienen abogados de defensa a la deportación

Centro de Defensa Legal de Inmigrantes de Santa Barbara (SBILDC)
Santa Maria:
120 E. Jones St., Ste. 117
Santa Maria, 93454
(805) 886-9136
Tienen abogados de defensa a la deportación

Immigrant Hope – Santa Barbara
935 San Andres St.
Santa Barbara, CA 93101
(805) 516-5422
info.santabarbara@immigranthope.org

IMPORTA
(805) 604-5060
info@importasb.org

Fundación de Asistencia Legal del Condado de Santa Bárbara (SBLAF)
Lompoc:
102 E. Ocean Avenue Lompoc, CA 93436
(805) 736-6582

Fundación de Asistencia Legal del Condado de Santa Bárbara (SBLAF)
Santa Barbara:
301 E Canon Perdido Street
Santa Barbara, CA 93101
(805) 963-6754

Immigration Warriors

La asociación profesional de abogados y representantes acreditados a través de la Costa Central (condados de Ventura, Santa Barbara, y San Luis Obispo)

Condado de Santa Barbara

Fundación de Asistencia Legal del Condado de Santa Bárbara (SBLAF)
Santa Maria:
201 S. Miller Street, Ste. 201
Santa Maria, CA 93454
(805) 922-9909

TODO EL ESTADO DE CALIFORNIA

Servicios Legales de Inmigración la Universidad de California
University of California, Santa Barbara
Santa Barbara, CA
(530) 574-6329
Amber.ucimm@law.ucdavis.edu

Part 4. Client's Consent to Representation and Signature (continued)

Options Regarding Receipt of USCIS Notices and Documents

USCIS will send notices to both a represented party (the client) and his, her, or its attorney or accredited representative either through mail or electronic delivery. USCIS will send all secure identity documents and Travel Documents to the client's U.S. mailing address.

If you want to have notices and/or secure identity documents sent to your attorney or accredited representative of record rather than to you, please select **all applicable** items below. You may change these elections through written notice to USCIS.

1.a. ☐ I request that USCIS send original notices on an application or petition to the business address of my attorney or accredited representative as listed in this form.

1.b. ☐ I request that USCIS send any secure identity document (Permanent Resident Card, Employment Authorization Document, or Travel Document) that I receive to the U.S. business address of my attorney or accredited representative (or to a designated military or diplomatic address in a foreign country (if permitted)).

NOTE: If your notice contains Form I-94, Arrival-Departure Record, USCIS will send the notice to the U.S. business address of your attorney or accredited representative. If you would rather have your Form I-94 sent directly to you, select **Item Number 1.c.**

1.c. ☐ I request that USCIS send my notice containing Form I-94 to me at my U.S. mailing address.

Signature of Client or Authorized Signatory for an Entity

2.a. Signature of Client or Authorized Signatory for an Entity

➡ _____ Firme aquí

2.b. Date of Signature (mm/dd/yyyy) _____

Part 5. Signature of Attorney or Accredited Representative

I have read and understand the regulations and conditions contained in 8 CFR 103.2 and 292 governing appearances and representation before DHS. I declare under penalty of perjury under the laws of the United States that the information I have provided on this form is true and correct.

1. a. Signature of Attorney or Accredited Representative

_____

1.b. Date of Signature (mm/dd/yyyy) _____

2.a. Signature of Law Student or Law Graduate

_____

2.b. Date of Signature (mm/dd/yyyy) _____

Part D. Your Signature

I certify, under penalty of perjury under the laws of the United States of America, that this application and the evidence submitted with it are all true and correct. Title 18, United States Code, Section 1546(a), provides in part: Whoever knowingly makes under oath, or as permitted under penalty of perjury under Section 1746 of Title 28, United States Code, knowingly subscribes as true, any false statement with respect to a material fact in any application, affidavit, or other document required by the immigration laws or regulations prescribed thereunder, or knowingly presents any such application, affidavit, or other document containing any such false statement or which fails to contain any reasonable basis in law or fact - shall be fined in accordance with this title or imprisoned for up to 25 years. I certify that I am physically present in the United States or seeking admission at a Port of Entry when I execute this application. I authorize the release of any information from my immigration record that U.S. Citizenship and Immigration Services (USCIS) needs to determine eligibility for the benefit I am seeking.

WARNING: **Applicants who are in the United States unlawfully are subject to removal if their asylum or withholding claims are not granted by an asylum officer or an immigration judge. Any information provided in completing this application may be used as a basis for the institution of, or as evidence in, removal proceedings even if the application is later withdrawn. Applicants determined to have knowingly made a frivolous application for asylum will be permanently ineligible for any benefits under the Immigration and Nationality Act. You may not avoid a frivolous finding simply because someone advised you to provide false information in your asylum application. If filing with USCIS, unexcused failure to appear for an appointment to provide biometrics (such as fingerprints) and your biographical information within the time allowed may result in an asylum officer dismissing your asylum application or referring it to an immigration judge. Failure without good cause to provide DHS with biometrics or other biographical information while in removal proceedings may result in your application being found abandoned by the immigration judge. See sections 208(d)(5)(A) and 208(d)(6) of the INA and 8 CFR sections 208.10, 1208.10, 208.20, 1003.47(d) and 1208.20.**

Print your complete name.	Write your name in your native alphabet.

Did your spouse, parent, or child(ren) assist you in completing this application? ☐ No ☐ Yes *(If "Yes," list the name and relationship.)*

(Name)	*(Relationship)*	*(Name)*	*(Relationship)*

Did someone other than your spouse, parent, or child(ren) prepare this application? ☐ No ☐ Yes *(If "Yes,"complete Part E.)*

Asylum applicants may be represented by counsel. Have you been provided with a list of persons who may be available to assist you, at little or no cost, with your asylum claim? ☐ No ☐ Yes

Firma aquí ➡ Signature of Applicant *(The person in Part. A.I.)*

[_____] _____

Sign your name so it all appears within the brackets — Date (mm/dd/yyyy)

Part E. Declaration of Person Preparing Form, if Other Than Applicant, Spouse, Parent, or Child

I declare that I have prepared this application at the request of the person named in Part D, that the responses provided are based on all information of which I have knowledge, or which was provided to me by the applicant, and that the completed application was read to the applicant in his or her native language or a language he or she understands for verification before he or she signed the application in my presence. I am aware that the knowing placement of false information on the Form I-589 may also subject me to civil penalties under 8 U.S.C. 1324c and/or criminal penalties under 18 U.S.C. 1546(a).

Signature of Preparer	Print Complete Name of Preparer		
Daytime Telephone Number ( )	Address of Preparer: Street Number and Name		
Apt. Number	City	State	Zip Code

To be completed by an attorney or accredited representative (if any)**.**	☐ **Select this box if Form G-28 is attached.**	**Attorney State Bar Number** (if applicable)	**Attorney or Accredited Representative USCIS Online Account Number** (if any)

DEPARTMENT OF HOMELAND SECURITY
U.S. Immigration and Customs Enforcement

OMB No. 1653-0021
Expires: 10/31/2027

APPLICATION FOR A STAY OF DEPORTATION OR REMOVAL

Action Block - For ICE Use Only	Fee/Date Stamp
☐ **GRANTED** ☐ One Year ☐ Six Months ☐ Three Months ☐ Other: _____ ☐ **DENIED** ☐ Denial letter attached. ☐ **REJECTED** ☐ Incorrect Fee ☐ Application was not submitted in person ☐ Other: _____ ☐ Additional information attached. Date: _____ Decision made by: _____ *(Printed Name/Title)* Deciding Official Signature *(Sign in ink):* _____ Office: _____	

A-File Number:	Date:	If you are currently detained by ICE, provide the name of the detention facility:		
Last Name:	First Name:	Middle Name:		
Address (*Number and Street*):		Country of Citizenship:	Passport No:	Expiration Date:
Apartment Number:		Length of stay requested: ☐ One year ☐ Six months ☐ Three months ☐ Other:		
Town/City:	State:	Zip Code:	Arrested by police or other law enforcement agency (other than for immigration reasons) ☐ Yes - Documents attached ☐ No	
Telephone Number:	Cell Telephone Number:			

REASON(S) FOR REQUESTING A STAY OF DEPORTATION OR REMOVAL:

EVIDENCE SUBMITTED (attached):

☐ Medical ☐ Brief ☐ Other *(specify)*:

I certify under penalty of perjury that the information provided and contained herein is true and correct to the best of my knowledge and belief:

Firma aquí

(Printed Name) *(Signature) (Sign in ink)*

INFORMATION IF FORM PREPARED BY OTHER THAN APPLICANT:

I declare under penalty of law that this document was prepared by me at the request of the applicant and is based on all information of which I have knowledge. I understand that providing false information on behalf of the applicant could result in criminal prosecution and, upon conviction, a fine or imprisonment or both.

(Printed Name) *(Signature) (Sign in ink)*

(Telephone Number) *(Street Address)* *(City)* *(State)* *(Zip Code)*

Part 3. Certification of Request and Consent to Release, Amend, or Correct Records

Requestor Consent to Pay Potential Fees

USCIS will contact you with instructions if any fees are required. **Please do not send any payment at the time of your request.**

In accordance with Department of Homeland Security Regulations, your request constitutes an agreement to pay any fees that may be chargeable up to **$25.00**. We may charge fees for searching for records at the respective clerical, professional, and/or managerial rates of **$4.00**/**$7.00**/**$10.25** per quarter hour, and for duplication of copies at the rate of **$.10** per copy. We do not charge for the first 100 copies and two hours of search time, and the remaining combined charges for search and duplication must exceed **$14.00** before we will charge you any fees. Search and processing fees are not applicable for Privacy Act requests.

If the total anticipated fees are more than **$250**, or you have failed to pay fees in the past, USCIS may request an advance deposit. USCIS will not process any Form G-639 until you pay all fees from prior requests.

☐ I, the requestor, consent to pay all costs incurred for search, duplication, and review of documents up to **$25**.

Declaration that the Request is True and Complete

If you are the subject of record and requesting records about yourself or requesting a correction or amendment of your records, you must verify your identity by providing the information requested in **Part 2.** You **MUST** also sign your request below and have your signature notarized **OR** submitted under penalty of perjury**.**

Sign and date the request. A stamped or typewritten name in place of a signature is not acceptable.

I certify, swear, or affirm, under penalty of perjury under the laws of the United States of America, that the information in this request is complete, true, and correct.

1. Signature of Requestor | Date of Signature (mm/dd/yyyy)

Firma aquí

Part 4. Third-Party Requestor

1. Third-Party Requestor Identifying Information

Family Name (Last Name) | Given Name (First Name) | Middle Name (if applicable)

2. Third-Party Requestor Mailing Address and Contact Information

In Care Of Name (if any)

Street Number and Name | Apt. Ste. Flr. ☐ ☐ ☐ | Number

City or Town | State | ZIP Code *(USPS ZIP CodeLookup)*

Province | Postal Code | Country

Telephone Number | Email Address

U.S Department of Justice

Certification of Identity

FORM APPROVED OMB NO. 1103-0016
EXPIRES 04/30/27

Privacy Act Statement. In accordance with 28 CFR Section 16.41(d) personal data sufficient to identify the individuals submitting requests by mail under the Privacy Act of 1974, 5 U.S.C. Section 552a, is required. The primary purpose for the collection of the information on this form is to ensure that the records of individuals who are the subject of U.S. Department of Justice systems of records are not wrongfully disclosed by the Department. The authority by which information is collected on this form is 5 U.S.C. § 552 and 5 U.S.C. § 552a(a), as well as 28 CFR Section 16.41(d). Any information you provide may also be disclosed pursuant to a "routine use" under the Privacy Act of 1974, 5 U.S.C. § 552a, listed in a DOJ System of Records Notice, which may include: JUSTICE/DOJ-004 Freedom of Information Act, Privacy Act, and Mandatory Declassification Review Records (CMS) for the Department of Justice, available at https://www.justice.gov/opcl/doj-systems-records#DOJ. Your disclosure of information to the Department of Justice on this form is voluntary. If you do not complete all or some information fields in this form, however, the Department of Justice may not be able to effectively respond to your request. False information on this form may subject the requester to criminal penalties under 18 U.S.C. § 1001 and/or 5 U.S.C. § 552a(i)(3).

Public reporting burden for this collection of information is estimated to average 0.50 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Suggestions for reducing this burden may be submitted to the Office of Information and Regulatory Affairs, Office of Management and Budget, Public Use Reports Project (1103-0016), Washington, DC 20503.

Full Name of Requester [1] _____

Citizenship Status [2] _____ Social Security Number [3] _____

Current Address _____

Date of Birth _____ Place of Birth _____

OPTIONAL: Authorization to Release Information to Another Person

This form is also to be completed by a requester who is authorizing information relating to himself or herself to be released to another person.

Further, pursuant to 5 U.S.C. Section 552a(b), I authorize the U.S. Department of Justice to release any and all information relating to me to:

_____

Print or Type Name

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct, and that I am the person named above, and I understand that any falsification of this statement is punishable under the provisions of 18 U.S.C. Section 1001 by a fine of not more than $10,000 or by imprisonment of not more than five years or both, and that requesting or obtaining any record(s) under false pretenses is punishable under the provisions of 5 U.S.C. 552a(i)(3) by a fine of not more than $5,000.

Firma aquí

Signature [4] _____ **Date** _____

[1] Name of individual who is the subject of the record(s) sought.

[2] Individual submitting a request under the Privacy Act of 1974 must be either "a citizen of the United States or an alien lawfully admitted for permanent residence," pursuant to 5 U.S.C. Section 552a(a)(2). Requests will be processed as Freedom of Information Act requests pursuant to 5 U.S.C. Section 552, rather than Privacy Act requests, for individuals who are not United States citizens or aliens lawfully admitted for permanent residence.

[3] Providing your social security number is voluntary. You are asked to provide your social security number only to facilitate the identification of records relating to you. Without your social security number, the Department may be unable to locate any or all records pertaining to you.

[4] Signature of individual who is the subject of the record sought.