Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): ____________

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): ____________
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: ____________

OR

2. Form I-94 Admission Number: ____________

OR

3. Foreign Passport Number: ____________

Country of Issuance: ____________

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | (b) Social security number

Address

City or town, state, and ZIP code

Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . ☐

TIP: If you have self-employment income, see page 2.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ ______

Multiply the number of other dependents by $500 . . . . . $ ______

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . | **3** | $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . | **4(a)** | $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . | **4(b)** | $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . | **4(c)** | $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

Employee's signature (This form is not valid unless you sign it.) | **Date**

Employers Only

Employer's name and address | First date of employment | Employer identification number (EIN)

STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT CHILD ABUSE

NOTE: RETAIN IN EMPLOYEE/LICENSEE FILE

NAME

POSITION | FACILITY NUMBER

California law REQUIRES certain persons to report known or suspected child abuse. As a licensee or an employee at a licensed facility or a child care institution, YOU are one of those persons - a "mandated reporter."

PERSONS WHO ARE REQUIRED TO REPORT ABUSE

Mandated reporters include a licensee, an administrator, or an employee of a licensed community care or child day care facility. [Penal Code ("PC") § 11165.7(a)(10)] Mandated reporters also include an employee of a child care institution, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities. [PC § 11165.7(a)(14)] No supervisor or administrator may impede or inhibit an individual's reporting duties or subject the mandated reporter to any sanction for making the report. [PC § 11166(h)]

WHEN REPORTING ABUSE IS REQUIRED

A mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has knowledge of or observes a person under the age of 18 years whom he or she knows or reasonably suspects has been the victim of child abuse or neglect must report the suspected incident. The reporter must contact a designated agency immediately or as soon as practically possible by telephone, and shall prepare and send a written report within 36 hours of receiving the information concerning the incident. [PC § 11166(a)]

ABUSE THAT MUST BE REPORTED

Physical injury inflicted by other than accidental means on a child. [PC § 11165.6]

Sexual abuse meaning sexual assault or sexual exploitation of a child. [PC § 11165.1]

Neglect meaning the negligent treatment, lack of treatment, or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. [PC § 11165.2]

Willful harming or injuring or endangering a child meaning a situation in which any person inflicts, or willfully causes or permits a child to suffer, unjustifiable physical pain or mental suffering, or causes or permits a child be placed in a situation in which the child or child's health is endangered. [PC § 11165.3]

Unlawful corporal punishment or injury willfully inflicted upon a child and resulting in a traumatic condition. [PC § 11165.4]

WHERE TO CALL IN AND SEND THE WRITTEN ABUSE REPORT

Reports of suspected child abuse or neglect must be made to any police department or sheriff's department (not including a school district police or security department), county probation department, if designated by the county to receive mandated reports, or the county welfare department. [PC § 11165.9] The written report must include the information described in Penal Code section 11167(a) and may be submitted on form SS 8572.

IMMUNITY AND CONFIDENTIALITY OF REPORTER AND OF ABUSE REPORTS

Persons legally mandated to report suspected child abuse have immunity from criminal or civil liability for reporting as required or authorized by law. [PC § 11172(a)] The identity of a mandated reporter is confidential and disclosed only among agencies receiving or investigating reports, and other designated agencies. [PC § 11167(d)(1)] Reports are confidential and may be disclosed only to specified persons and agencies. Any violation of confidentiality is a misdemeanor punishable by imprisonment, fine, or both. [PC § 11167.5(a)-(b)]

PENALTY FOR FAILURE TO REPORT ABUSE

A mandated reporter who fails to make a required report is guilty of a **misdemeanor** punishable by up to six months in jail, a fine of $1000, or both. [PC § 11166(b)]

COPY OF THE LAW

Prior to my employment in a licensed community care or child day care facility, or child care institution, my employer provided me with a copy of Penal Code sections 11165.7, 11166, and 11167. [PC § 11166.5(a)]

ACKNOWLEDGMENT OF RESPONSIBLITY

I, ____, have knowledge of my responsibility to report known or suspected child abuse in compliance with Penal Code section 11166. [PC § 11166.5(a)]

SIGNATURE	DATE

NOTICE

EMPLOYEE RIGHTS

Instructions:

This form is intended to meet the requirements of Health and Safety Code Sections 1596.881 and 1596.882 which require that employees be informed of their rights, at the time of employment, to filing complaints against their employer for violating any licensing law or regulation. The child care facility licensee is required to give the employee this form, to have the employee complete and detach the bottom of the form, and to maintain the signed acknowledgement of receipt of the form in the employee's file.

No employer shall discharge, demote, suspend or threaten to discharge, demote or suspend, or in any manner discriminate against any employee for taking any of the following actions:

1. Making an oral or written complaint against the employer to the California Department of Social Services or other agency having statutory responsibility for enforcement of the law or to the employer or representative of the employer for the violation of any licensing law or other laws (including but not limited to laws relating to child abuse, staff-child ratios, etc.).
2. Instituting or causing to be instituted any proceeding against the employer regarding the violation of any licensing law or other laws.
3. Is, or will be, a witness or testifier in a proceeding regarding the violation of any licensing law or other law.
4. Refusing to perform work that is in violation of a licensing law or regulation after notifying the employer of the violation.

Pursuant to Health and Safety Code Section 1596.882, an employee alleging the violation by the employer of any action described above shall do the following:

1. Present the employer with a claim alleging violation of the employee's rights within 45 days after the discharge, demotion, suspension or threat thereof or for discriminating against the employee for taking such action.
2. File a claim with the Division of Labor Standards Enforcement no later than 90 days after the employer takes any of the above described actions against the employee.

Upon receipt of the employee's complaint, the Division of Labor Standards Enforcement shall do whatever investigation it deems appropriate to resolve the complaint. If it is determined that the employer has violated the employee's rights, the Division of Labor Standards Enforcement shall take action against the employer in any appropriate court. The court shall have jurisdiction of any action taken as well as to issue restraining orders and any other appropriate relief, including rehiring and reinstatements of the employee to his or her former position with backpay and benefits.

Within 30 days of receipt of a complaint from an employee as outlined above, the Division of Labor Standards Enforcement shall review the facts of the complaint and set either a hearing date or notify the employee and the employer of its decision. Where necessary, the Division of Labor Standards Enforcement shall begin the appropriate court action to enforce the decision.

Except for any grievance procedure or arbitration or hearing that is available to the employee pursuant to a collective bargaining agreement, Section 1596.882 is the exclusive means for presenting claims.

To file a claim with the Division of Labor Standards Enforcement, check the white pages of the local telephone directory under State Government Offices, California State of, Industrial relations Department, Labor Standards Enforcement-Working Conditions, for the local telephone number and address of the nearest office, or contact the headquarters office at P.O. Box 603, San Francisco, CA 94101, telephone (415) 703-4810.

(Detach Here)

- -

(This form is to be retained in the employee's file)

EMPLOYEE RIGHTS

This is to acknowledge that I ________________________________ have received a copy of
(PLEASE PRINT NAME OF EMPLOYEE)

"EMPLOYEE RIGHTS" from my employer ________________________________, who is the
(PLEASE PRINT NAME OF EMPLOYER)

licensee or authorized representative of ________________________________
(PLEASE PRINT NAME OF FACILITY)

____
(SIGNATURE OF EMPLOYEE)

____
(DATE)

REQUEST FOR LIVE SCAN SERVICE - COMMUNITY CARE LICENSING

Applicant Submission

1. ORI: **A0448**

2. Working Title: *(Check ✔ one)*
☐ Adult Resident other than Client ☐ Employee ☐ License, Certification, Applicant ☐ Volunteer ☐ Home Care Aide Registry Applicant

3. Authorized Applicant Type - Enter from list on Page 2, "DOJ Abbreviated CCLD Facility/Organization Type."

4. Agency Address Set Contributing Agency:

CA Dept of Social Services
Agency authorized to receive criminal history information

03502
Mail Code *(five-digit code assigned by DOJ)*

PO BOX 94244 **Mail Station 9-15-62**
Street No. Street or PO Box

N/A
Contact Name *(Mandatory for all school submissions)*

Sacramento, **CA** **94244-2430**
City State Zip Code

( ) **N/A**
Contact Telephone No.

5. Applicant Information:

Name of Applicant: *(Please print)*______ LAST ______ FIRST ______ MI

AKA's:______ LAST ______ FIRST

CDL No.______

DOB:______ SEX: ☐ Male ☐ Female

Misc. No. BIL - ______ AGENCY BILLING NUMBER *(IF APPLICABLE)*

HT:______ WT:______

Misc. No.:______ PERMANENT RESIDENT (I-551), OUT OF STATE DRIVER'S LICENSE OR I.D.

EYE Color:______ HAIR Color:______

Home Address: *(All applicants must complete)*

POB:______

______ STREET OR PO BOX

SOC:______
(See Privacy Statement on Page 4)

______ CITY, STATE AND ZIP CODE

6. Facility/Organization Number:______ Level of Service ☑ DOJ ☑ FBI

If resubmission for fingerprint quality (select R2), list Original ATI No.______

7. Employer: (*Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)*

Employer Name

Street No. Street or PO Box

Mail Code *(five digit code assigned by DOJ)*

City State Zip Code

Agency Telephone No. *(Optional)*

8.

Live Scan Transaction Completed By:______ Name of Operator Date______

Transmitting Agency LSID# ATI No. Amount Collected/Billed

GUIDELINES FOR COMMUNITY CARE LICENSING (CCLD) APPLICANTS WHO USE A LIVE SCAN SITE (CCLD or DOJ SITE) FOR FINGERPRINTING

Instructions for the LIC 9163

1. **Originating Response Indicator (ORI):** Preprinted
2. **Working Title:** Check the appropriate box
3. **Authorized Applicant Type:** Indicate the facility type where you will be working.

   Select your licensed facility type from the left column, and in the right column find its corresponding DOJ abbreviated facility type. **Enter the corresponding DOJ abbreviated facility type on this line.**

Note: In the following table you may be able to identify yourself with more than one facility type within each category. Please select only one facility type in any category using the facility that you are most associated with on a day-to-day basis.

If this is your applicable facility type ⇨ **Enter this abbreviated facility type on your application.**

CCLD Facility Type by Category	DOJ Abbreviated CCLD Facility Type
Home Care Aide	Home Care Aide
Home Care Organization	Home Care Organization
Adult Day Care Facility Adult Day Support Center Adult Residential Facility Social Rehabilitation Facility	Adult Day/Resident/Rehab
Child Care Center Infant Center Mildly Ill Center School Age Child Care Center	Day Care Center more/6 Child
Family Child Care Home	Family Day Care
Foster Family Agency Foster Family / Adoptions Agency Foster Family Agency Sub Office	Foster Family/Adopt Employment
Foster Family Agency - Certified Home Foster Family Home	Foster Family Home
Group Home (6 or less children)	Group Home 6/child less
Group Home (7 or more) Community Treatment Facility	Group Home more/6 child
Residential Care Facility for the Chronically Ill Residential Care Facilities for the Elderly	Residential Care Facility Elderly
Small Family Home Transitional Housing Placement Program	Residential Child Care 6/less

4. **Agency Address Set Contributing Agency:**

Agency authorized to receive criminal history information:
The following information is pre-printed:

Agency: CA Dept of Social Services **Mail Code:** 03502

Street No.: P.O. BOX 94244, M.S. 9-15-62 **Contact Name:** N/A

City, State, Zip: Sacramento, CA 94244-2430 **Contact Telephone No.:** N/A

5. **Applicant Information:** Print your full name (last, first, middle initial).

AKA's: Other names the applicant has used **CDL No:** CA Drivers License or CA ID

DOB: Date of Birth **SEX:** Male or Female **MISC No: BIL -** Enter the agency billing number, if applicable

HT: Height **WT:** Weight **MISC No.:** Enter any other identification numbers (PERMANENT RESIDENT, OUT OF STATE DRIVER'S LICENSE OR I.D.)

EYE Color: Color of eyes **HAIR Color:** Color of hair **Home Address:** Applicant's home address

POB: State or Country of Birth

SOC: Social Security Number (optional) (See Privacy Statement on Page 4)

6. **Facility Number:** Enter the facility number or assigned OCA number (Agency Identifying Number).

Level of Service: Preprinted
Note: If a Child Abuse Central Index (CACI) check is required, it will automatically be completed by DOJ and all applicable fees will be charged. There is no entry necessary on the applicant's part.

If resubmission for fingerprint quality, list Original Applicant Tracking Information (ATI) No.: If your fingerprints were rejected and this is a resubmission of your prints, enter the original ATI number provided on the reject notice to avoid paying an additional processing fee.

7. **Employer:** Enter the facility name and address for which you are being printed.

Employer Name:	Enter the facility/organization name.
Street No.:	Enter the facility/organization address.
Mail Code:	Enter the facility/organization mail code (if applicable).
City, State, Zip:	Enter the facility/organization city, state and zip.
Agency Telephone No.:	Enter the facility/organization phone number.

8. **Live Scan Transaction Completed By:** This section will be completed by the Live Scan operator.

Take two copies of this form with you the day you are fingerprinted. The Live Scan Operator will complete section 8. One copy will be retained by the Operator and the other you may retain for your records.

PRIVACY STATEMENT

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code section 1798 et seq.), notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person's SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

In order to be licensed, work at, or be present at, a licensed facility/organization, the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17 and 1596.871). The Department will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.). Under the California Public Records Act, the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

NOTE: IMPORTANT INFORMATION
The Department is required to tell people who ask, including the press, if someone in a licensed facility/organization has a criminal record exemption. The Department must also tell people who ask the name of a licensed facility/organization that has a licensee, employee, resident, or other person with a criminal record exemption.

If you have any questions about this form, please contact your local licensing regional office.

CRIMINAL BACKGROUND CLEARANCE TRANSFER REQUEST

Active criminal record clearances may be transferred from one state licensed facility/organization to another by a license applicant or licensee. **The transfer request must be submitted to the Department before the individual who is the subject of the transfer has client contact or the facility/organization will be in violation of the law and subject to a $100 civil penalty.**

The license applicant or licensee who is seeking the transfer must provide a LIC 508, and verify the individual's identity and include a copy of the person's driver's license, permanent resident card or a valid photo identification issued by the California Department of Motor Vehicles or by another state or the United States government if the person is not a California resident. Additionally, a Child Abuse Central Index (CACI) check must be submitted **if** the transfer is to a facility serving children and the individual has not previously submitted a CACI check or the date of the previous CACI inquiry was made prior to January 1, 1999. The CACI must be mailed directly to the Department of Justice with the applicable fee. *Note: This transfer request is for clearances only. Contact your licensing office for information about exemption transfers.*

This form may only be used to request a clearance transfer between state licensed facilities/organizations. To request a transfer between county and state licensed facilities, the requesting Licensing Agency must contact their county liaison.

PLEASE TYPE OR PRINT LEGIBLY | DATE:

PLEASE TRANSFER THE CRIMINAL RECORD CLEARANCE FOR THE FOLLOWING INDIVIDUAL:

LAST NAME	FIRST NAME	MIDDLE INITIAL
CA DRIVER'S LICENSE OR ID #/PERMANENT RESIDENT ID# (i-551):		DOB:
LICENSING INFORMATION SYSTEM ID#:		SSN: (OPTIONAL)

FROM THE FOLLOWING FACILITY/ORGANIZATIONS:

NAME OF FACILITY/ORGANIZATION:		FACILITY/ORGANIZATION NUMBER:
STREET ADDRESS:		
CITY	STATE	ZIP CODE:

TO THE FOLLOWING FACILITY/ORGANIZATION: ☐ **PLEASE ALSO KEEP THIS INDIVIDUAL ASSOCIATED WITH ABOVE FACILITY/ORGANIZATION.**

NAME OF FACILITY/ORGANIZATION:

FACILITY/ORGANIZATION NUMBER: | DATE OF EMPLOYMENT:

STREET ADDRESS:

CITY | STATE | ZIP CODE:

Transferee Association Type

- ☐ Facility Administrator
- ☐ Corporation Board Member
- ☐ Employee
- ☐ Certified Home
- ☐ Licensee/Applicant
- ☐ Non-client Adult Resident
- ☐ Partnership Member
- ☐ Spouse of Licensee
- ☐ Affiliated Home Care Aide

I certify I have verified the above individual's identity and have enclosed a copy of the individual's photo I.D and LIC 508.

Signature

Title *(licensee, administrator, director)*

FOR DISTRICT OFFICE USE ONLY

DATE OF TRANSFER ENTRY:	INITIAL OF PERSON ENTERING TRANSFER:

FILE IN NEWLY ASSOCIATED FACILITY/ORGANIZATION FILE

PRIVACY STATEMENT

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In order to be licensed, work at, or be present at, a licensed facility/organization, the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17, 1596.871 and 1796.19). The Department will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.). Under the California Public Records Act, the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

NOTE: IMPORTANT INFORMATION
The Department is required to tell people who ask, including the press, if someone in a licensed facility/organization has a criminal record exemption. The Department must also tell people who ask the name of a licensed facility/organization that has a licensee, employee, resident, or other person with a criminal record exemption.

If you have any questions about this form, please contact your local licensing regional office.

FACILITIES STAFF WORK SCHEDULE

INSTRUCTIONS: This form is to be completed by the licensing evaluator and reviewed by the licensing supervisor.

The purpose of this form is to review staff coverage in large Residential Facilities for 24-hours per day covering a (3) three-week period to ensure sufficient staff coverage. CAREFULLY review split shifts, weekend coverage and irregular days off to ensure sufficient staff coverage.

FACILITY NAME	FACILITY NUMBER	FACILITY TYPE	FACILITY CAPACITY
CLIENT/RESIDENT CENSUS	LICENSING EVALUATOR		DATE

For The Month(s) ______________ **20** ______

SERVICE AREA AND WORK TITLE	Enter Dates of Week							Enter Dates of Week							Enter Dates of Week						
	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
1. Care and Supervision (e.g., Aides) Employee Name(s)	Enter Work Hours							Enter Work Hours							Enter Work Hours						
2. Food Services (e.g. includes cook, dishwasher) Employee Name(s)																					

FACILITY NAME/NUMBER

FACILITY STAFF WORK SCHEDULE (Continued)

For The Month(s) ______ 20 ____	Enter Dates of Week							Enter Dates of Week							Enter Dates of Week						
SERVICE AREA AND WORK TITLE	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
3. **Housekeeping (e.g. Maid)** Employee Name(s)	Enter Work Hours							Enter Work Hours							Enter Work Hours						
4. **Administrative/Clerical Staff** Employee Name(s)																					
5. **Transportation/Maintenance** Employee Name(s)																					
6. **Other** (specify other service areas below) Employee Name(s)																					

CRIMINAL RECORD STATEMENT

State law requires that persons associated with licensed facilities or Home Care Aide Registry applicants be fingerprinted and disclose any conviction. A conviction is any plea of guilty or nolo contendere (no contest) or a verdict of guilty. The fingerprints will be used to obtain a copy of any criminal history you may have.

Have you ever been convicted of a crime in California ? .... ☐ **YES** ☐ **NO**

You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.

Have you ever been convicted of a crime from another state, federal court, military or jurisdiction outside of U.S.? .... ☐ **YES** ☐ **NO**

Criminal convictions from another State or Federal court are considered the same as criminal convictions in California.

If you answer YES, give details on the back of this page indicating the nature and circumstances of each crime and the date and the location in which each crime occurred.

You must disclose convictions, including reckless and drunk driving convictions even if:

1. It happened a long time ago;
2. It was only a misdemeanor;
3. You didn't have to go to court (your attorney went for you);
4. You had no jail time or the sentence was only a fine or probation;
5. You received a certificate of rehabilitation;
6. The conviction was later dismissed, set aside or the sentence was suspended.

NOTE: IF THE CRIMINAL BACKGROUND CHECK REVEALS ANY CONVICTION(S) THAT YOU DID NOT DISCLOSE ON THIS FORM, YOUR FAILURE TO DISCLOSE THE CONVICTION(S) WILL RESULT IN AN EXEMPTION DENIAL, LICENSE APPLICATION DENIAL, LICENSE REVOCATION, OR EXCLUSION FROM A LICENSED FACILITY/ORGANIZATION.

I declare under penalty of perjury under the laws of the State of California that I have read and understand the information contained in this affidavit and that my responses and any accompanying attachments are true and correct.

FACILITY/ORGANIZATION NAME		FACILITY/ORGANIZATION NUMBER	
YOUR NAME *(PRINT CLEARLY)*	YOUR ADDRESS	CITY	ZIP
SOCIAL SECURITY NUMBER *(SEE PRIVACY STATEMENT ON REVERSE SIDE)*	DATE OF BIRTH	DMV LICENSE NUMBER	
SIGNATURE		DATE	

I. Instructions to Respondents:

If you have been convicted of a crime in California, another state or in federal court, provide the following information:

(You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.)

What was the offense? ____________________

In which state and city did you commit the offense? ____________________

When did this occur? ____________________

Tell us what happened. (Use additional sheets of paper if needed) ____________________

I certify under penalty of perjury that the above information is true and correct to the best of my knowledge.

Signature ____________________ ***Date*** ____________________

II. Instructions to Licensees:

If the person discloses a criminal conviction, review the person's statement and discuss it with your Licensing Program Analyst (LPA). Maintain this form in your facility/organization personnel file and send a copy to your LPA.

PRIVACY STATEMENT

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code section 1798 et seq.), notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person's SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

In order to be licensed, work at, or be present at, a licensed facility/organization, the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17, 1596.871, and 1796.19). The Department will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.). Under the California Public Records Act, the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

NOTE: IMPORTANT INFORMATION
The Department is required to tell people who ask, including the press, if someone in a licensed facility/organization has a criminal record exemption. The Department must also tell people who ask, the name of a licensed facility/organization that has a licensee, employee, resident, or other person with a criminal record exemption.

If you have any questions about this form, please contact your local licensing regional office.

EVALUATION OF DIRECTOR QUALIFICATIONS

The courses listed below have been reviewed and verified by the Department of Social Services, Community Care Licensing Division, as meeting the requirements for child care center directors in the California Code of Regulations, Title 22, Division 12.
The original of this form, along with copies of transcripts or other relevant documentation, must be kept in the facility file at the District Office. A copy of this form, along with copies of the backup documentation, must be kept in the personnel records of the licensed facility. This form is transferable to other centers and will be accepted by all District Offices.

I. PERSONAL INFORMATION

	COMPONENTS	FACILITY NUMBER
DIRECTOR:	☐ Preschool	
FACILITY:	☐ Infant	
ADDRESS:	☐ School-Age	
	☐ Mildly Ill Child	

II. EDUCATION/EXPERIENCE

☐ Children's Center Supervisory Permit (Copy attached.)

☐ BA in Child Dev. or ECE and one year of experience (Copy of degree or transcripts attached.)

☐ AA in Child Dev. or ECE and two years of experience (Copy of degree or transcripts attached.)

☐ Coursework only and four years of experience (Copy of transcripts attached.)

III. QUALIFYING POSTSECONDARY COURSES

COURSEWORK IN CD/ECE	COURSE #	UNITS (S/Q)	COLLEGE/UNIVERSITY
CHILD/HUMAN GROWTH AND DEV.			
CHILD, FAMILY AND COMMUNITY			
PROGRAM/CURRICULUM			
ADMINISTRATION/STAFF RELATIONS			
OTHER: INFANT, SCHOOL-AGE, ETC.			
TOTAL:			
ADDITIONAL UNITS REQUIRED:			

IV. QUALIFYING EXPERIENCE

FROM	TO	HOURS PER DAY	POSITION(S)	EMPLOYER(S)/ADDRESS(ES)	TOTAL: MO/DAY/YR

V. OTHER APPLICABLE EDUCATION/COURSES (based on statutory/regulatory changes) (Backup documentation attached.)

COURSE TITLE	DATE COMPLETED	VERIFIED BY
CPR		
First Aid		
Others		

Was an exception granted? ☐ No ☐ Yes (Copy of exception attached.)

Based on the completion of the requirements identified above, this employee is approved as a:

☐ Fully qualified preschool director ______________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

☐ Fully qualified infant director ______________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

☐ Fully qualified school-age director ______________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

☐ Fully qualified mildly ill child director ______________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

DISTRICT OFFICE COPY (ORIGINAL)

Directions for Completing Evaluation of Director Qualifications

The LPA should fill out this form using the following instructions.

Type or print clearly using black ink. Retain the original form in the facility file at the District Office. Retain one copy in the director's personnel file at the licensed center and return a copy to the director. Attach (to each evaluation) copies of the forms and documents identified below.

I. PERSONAL INFORMATION:

Name: Enter the name of the person applying for an evaluation of qualifications. Include first, middle, and last names.

Facility: Enter complete name, address, and number of facility where the evaluated individual is currently employed.

Components of Program: Check appropriate box(es).

II. EDUCATION/EXPERIENCE:

Check appropriate box and attach appropriate documentation.

III. QUALIFYING POSTSECONDARY COURSES:

Courses: Enter course number, number of units (specify semester or quarter units), and the college where credits were earned. Indicate each course completed. Enter the total units for all courses completed. Enter any additional units required.

IV. QUALIFYING EXPERIENCE:

Employment: Enter the dates of employment; include month/day/year, as well as hours per day. List position(s) held, employer(s)/address(es), and the total number of months, days, and/or years employed.

V. OTHER APPLICABLE EDUCATION/COURSES:

Complete if other additional education/course requirements are applicable based on new statutory/regulatory changes. If not applicable, indicate N/A. Verification of course completion must be attached to this form. Indicate course title and date of completion, and initial.

Exceptions: Check appropriate box. Attach exception if required.

Check the appropriate box(es), and date and sign for every area for which it has been determined that the director is qualified under Title 22 licensing requirements.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING

EVALUATION OF DIRECTOR QUALIFICATIONS

The courses listed below have been reviewed and verified by the Department of Social Services, Community Care Licensing Division, as meeting the requirements for child care center directors in the California Code of Regulations, Title 22, Division 12.
The original of this form, along with copies of transcripts or other relevant documentation, must be kept in the facility file at the District Office.
A copy of this form, along with copies of the backup documentation, must be kept in the personnel records of the licensed facility. This form is transferable to other centers and will be accepted by all District Offices.

I. PERSONAL INFORMATION

DIRECTOR:	COMPONENTS	FACILITY NUMBER
	☐ Preschool	
FACILITY:	☐ Infant	
ADDRESS:	☐ School-Age	
	☐ Mildly Ill Child	

II. EDUCATION/EXPERIENCE

☐ Children's Center Supervisory Permit (Copy attached.)

☐ BA in Child Dev. or ECE and one year of experience (Copy of degree or transcripts attached.)

☐ AA in Child Dev. or ECE and two years of experience (Copy of degree or transcripts attached.)

☐ Coursework only and four years of experience (Copy of transcripts attached.)

III. QUALIFYING POSTSECONDARY COURSES

COURSEWORK IN CD/ECE	COURSE #	UNITS (S/Q)	COLLEGE/UNIVERSITY
CHILD/HUMAN GROWTH AND DEV.			
CHILD, FAMILY AND COMMUNITY			
PROGRAM/CURRICULUM			
ADMINISTRATION/STAFF RELATIONS			
OTHER: INFANT, SCHOOL-AGE, ETC.			
TOTAL:			
ADDITIONAL UNITS REQUIRED:			

IV. QUALIFYING EXPERIENCE

FROM	TO	HOURS PER DAY	POSITION(S)	EMPLOYER(S)/ADDRESS(ES)	TOTAL: MO/DAY/YR

V. OTHER APPLICABLE EDUCATION/COURSES (based on statutory/regulatory changes) (Backup documentation attached.)

COURSE TITLE	DATE COMPLETED	VERIFIED BY
CPR		
First Aid		
Others		

Was an exception granted? ☐ No ☐ Yes (Copy of exception attached.)

Based on the completion of the requirements identified above, this employee is approved as a:

☐ Fully qualified preschool director ______________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

☐ Fully qualified infant director ______________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

☐ Fully qualified school-age director ______________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

☐ Fully qualified mildly ill child director ______________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

DIRECTOR COPY

EVALUATION OF DIRECTOR QUALIFICATIONS

The courses listed below have been reviewed and verified by the Department of Social Services, Community Care Licensing Division, as meeting the requirements for child care center directors in the California Code of Regulations, Title 22, Division 12.
The original of this form, along with copies of transcripts or other relevant documentation, must be kept in the facility file at the District Office.
A copy of this form, along with copies of the backup documentation, must be kept in the personnel records of the licensed facility. This form is transferable to other centers and will be accepted by all District Offices.

I. PERSONAL INFORMATION

	COMPONENTS	FACILITY NUMBER
DIRECTOR:	☐ Preschool	
FACILITY:	☐ Infant	
ADDRESS:	☐ School-Age	
	☐ Mildly Ill Child	

II. EDUCATION/EXPERIENCE

☐ Children's Center Supervisory Permit (Copy attached.)

☐ BA in Child Dev. or ECE and one year of experience (Copy of degree or transcripts attached.)

☐ AA in Child Dev. or ECE and two years of experience (Copy of degree or transcripts attached.)

☐ Coursework only and four years of experience (Copy of transcripts attached.)

III. QUALIFYING POSTSECONDARY COURSES

COURSEWORK IN CD/ECE	COURSE #	UNITS (S/Q)	COLLEGE/UNIVERSITY
CHILD/HUMAN GROWTH AND DEV.			
CHILD, FAMILY AND COMMUNITY			
PROGRAM/CURRICULUM			
ADMINISTRATION/STAFF RELATIONS			
OTHER: INFANT, SCHOOL-AGE, ETC.			
TOTAL:			
ADDITIONAL UNITS REQUIRED:			

IV. QUALIFYING EXPERIENCE

FROM	TO	HOURS PER DAY	POSITION(S)	EMPLOYER(S)/ADDRESS(ES)	TOTAL: MO/DAY/YR

V. OTHER APPLICABLE EDUCATION/COURSES (based on statutory/regulatory changes) (Backup documentation attached.)

COURSE TITLE	DATE COMPLETED	VERIFIED BY
CPR		
First Aid		
Others		

Was an exception granted? ☐ No ☐ Yes (Copy of exception attached.)

Based on the completion of the requirements identified above, this employee is approved as a:

☐ Fully qualified preschool director ______________________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

☐ Fully qualified infant director ______________________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

☐ Fully qualified school-age director ______________________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

☐ Fully qualified mildly ill child director ______________________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

FACILITY COPY

EVALUATION OF TEACHER QUALIFICATIONS

The courses listed below have been reviewed and verified by the Department of Social Services, Community Care Licensing Division, as meeting the requirements for child care center teachers in the California Code of Regulations, Title 22, Division 12.

The original of this form, along with copies of transcripts or other relevant documentation, must be kept in the teacher's personnel file at the licensed center. This form is transferable to other centers and will be accepted by all District Offices.

I. PERSONAL INFORMATION	COMPONENTS	FACILITY NUMBER
TEACHER:	☐ Preschool	
FACILITY:	☐ Infant	
ADDRESS:	☐ School-Age	
	☐ Mildly Ill Child	

II. EDUCATION/EXPERIENCE

☐ Children's Center Permit (Copy attached.)

☐ Regional Occupational Program Certificate (Copy attached.)

☐ Child Development Associate Credential (Copy attached.)

☐ Coursework only and six months of experience (Copy of transcripts attached.)

III. QUALIFYING POSTSECONDARY COURSES

COURSEWORK IN CD/ECE	COURSE #	UNITS (S/Q)	COLLEGE/UNIVERSITY
CHILD/HUMAN GROWTH AND DEV.			
CHILD, FAMILY AND COMMUNITY			
PROGRAM/CURRICULUM			
OTHER: INFANT, SCHOOL-AGE, ETC.			
TOTAL:			
ADDITIONAL UNITS REQUIRED:			

IV. QUALIFYING EXPERIENCE

FROM	TO	HOURS PER DAY	POSITION(S)	EMPLOYER(S)/ADDRESS(ES)	TOTAL: MO/DAY/YR

V. OTHER APPLICABLE EDUCATION/COURSES (based on statutory/regulatory changes) (Backup documentation attached.)

COURSE TITLE	DATE COMPLETED	VERIFIED BY
CPR		
First Aid		
Others		

Was an exception granted? ☐ No ☐ Yes (Copy of exception attached.)

Based on the completion of the requirements identified above, this employee is approved as a :

☐ Fully qualified preschool teacher ______________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

☐ Fully qualified infant teacher ______________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

☐ Fully qualified school-age teacher ______________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

☐ Fully qualified mildly ill child teacher ______________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

CHILD CARE CENTER COPY (ORIGINAL)

Directions for Completing Evaluation of Teacher Qualifications

The LPA should fill out this form using the following instructions.

Type or print clearly using black ink. Return the original form to the director of the licensed center. Retain one copy in the teacher's personnel file at the licensed center. Retain one copy in the teacher's file at the licensed center and return a copy to the teacher. Attach (to each evaluation) copies of the forms and documents identified below.

I. PERSONAL INFORMATION:

Name: Enter the name of the person applying for an evaluation of qualifications. Include first, middle, and last names.

Facility: Enter complete name, address, and number of facility where the evaluated individual is currently employed.

Components of Program: Check appropriate box(es).

II. EDUCATION/EXPERIENCE:

Check appropriate box and attach appropriate documentation.

III. QUALIFYING POSTSECONDARY COURSES:

Courses: Enter course number, number of units (specify semester or quarter units), and the college where credits were earned. Indicate each course completed. Enter the total units for all courses completed. Enter any additional units required.

IV. QUALIFYING EXPERIENCE:

Employment: Enter the dates of employment; include month/day/year, as well as hours per day. List position(s) held, employer(s)/address(es), and the total number of months, days, and/or years employed.

V. OTHER APPLICABLE EDUCATION/COURSES:

Complete if other additional education/course requirements are applicable based on new statutory/regulatory changes. If not applicable, indicate N/A. Verification of course completion must be attached to this form. Indicate course title and date of completion, and initial.

Exceptions: Check appropriate box. Attach exception if required.

Check the appropriate box(es), and date and sign for every area for which it has been determined that the teacher is qualified under Title 22 licensing regulations.

EVALUATION OF TEACHER QUALIFICATIONS

The courses listed below have been reviewed and verified by the Department of Social Services, Community Care Licensing Division, as meeting the requirements for child care center teachers in the California Code of Regulations, Title 22, Division 12.

The original of this form, along with copies of transcripts or other relevant documentation, must be kept in the teacher's personnel file at the licensed center. This form is transferable to other centers and will be accepted by all District Offices.

I. PERSONAL INFORMATION

I. PERSONAL INFORMATION	COMPONENTS	FACILITY NUMBER
TEACHER:	☐ Preschool	
FACILITY:	☐ Infant	
ADDRESS:	☐ School-Age	
	☐ Mildly Ill Child	

II. EDUCATION/EXPERIENCE

☐ Children's Center Permit (Copy attached.)

☐ Regional Occupational Program Certificate (Copy attached.)

☐ Child Development Associate Credential (Copy attached.)

☐ Coursework only and six months of experience (Copy of transcripts attached.)

III. QUALIFYING POSTSECONDARY COURSES

COURSEWORK IN CD/ECE	COURSE #	UNITS (S/Q)	COLLEGE/UNIVERSITY
CHILD/HUMAN GROWTH AND DEV.			
CHILD, FAMILY AND COMMUNITY			
PROGRAM/CURRICULUM			
OTHER: INFANT, SCHOOL-AGE, ETC.			
TOTAL:			
ADDITIONAL UNITS REQUIRED:			

IV. QUALIFYING EXPERIENCE

FROM	TO	HOURS PER DAY	POSITION(S)	EMPLOYER(S)/ADDRESS(ES)	TOTAL: MO/DAY/YR

V. OTHER APPLICABLE EDUCATION/COURSES (based on statutory/regulatory changes) (Backup documentation attached.)

COURSE TITLE	DATE COMPLETED	VERIFIED BY
CPR		
First Aid		
Others		

Was an exception granted? ☐ No ☐ Yes (Copy of exception attached.)

Based on the completion of the requirements identified above, this employee is approved as a :

☐ Fully qualified preschool teacher ______________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

☐ Fully qualified infant teacher ______________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

☐ Fully qualified school-age teacher ______________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

☐ Fully qualified mildly ill child teacher ______________________
LPA'S SIGNATURE/PRINTED NAME AND DISTRICT OFFICE DATE

TEACHER COPY

PERSONNEL RECORD

(Form to be completed by employee)

DATE

NAME OF FACILITY

FACILITY ADDRESS

FACILITY FILE NUMBER

1. PERSONAL

NAME (LAST FIRST MIDDLE)

TELEPHONE ( )

ADDRESS

ARE YOU 18 YEARS OF AGE OR OLDER? ☐ YES ☐ NO IF NO, PLEASE STATE YOUR AGE ____

SOCIAL SECURITY NUMBER: (VOLUNTARY FOR ID ONLY) - -

DATE OF LAST PHYSICAL EXAMINATION

DATE OF LAST TB TEST

HAVE YOU EVER BEEN EMPLOYED UNDER A DIFFERENT NAME? ☐ YES ☐ NO IF YES, PLEASE LIST ALL NAMES USED.

DO YOU POSSESS A VALID CALIFORNIA DRIVER'S LICENSE? ☐ YES ☐ NO

CDL NUMBER

HAS YOUR DRIVER'S LICENSE EVER BEEN SUSPENDED OR REVOKED? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN ON BACK OF FORM.

NEAREST LIVING RELATIVE — NAME:

TELEPHONE NUMBER

RELATIONSHIP

ADDRESS

2. POSITION

TITLE

SALARY

HOURS

DATE OF EMPLOYMENT

NAME OF SUPERVISOR

3. PREVIOUS EMPLOYMENT *(List most recent experience first. If additional space is needed, please attach a separate page.)*

NAME AND ADDRESS OF EMPLOYER	TELEPHONE NUMBER	JOB TITLE AND TYPE OF WORK	REASON FOR LEAVING	DATES FROM	DATES TO

4. EDUCATION

CIRCLE HIGHEST YEAR COMPLETED

☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12

DIPLOMA

CURRENTLY ENROLLED IN HIGH SCHOOL COMPLETION COURSE?

☐ NO ☐ YES IF YES, GIVE EXPECTED COMPLETION DATE____

EMPLOYMENT — RELATED EDUCATION COURSES

COURSE TITLE	NAME OF SCHOOL OR ORGANIZATION AND ADDRESS	NUMBER UNITS COMPLETED	DATE COMPLETED	CURRENTLY ENROLLED

4. EDUCATION (Continued)

NAME UNIVERSITY, COLLEGE OR BUSINESS SCHOOL AND ADDRESS	MAJOR SUBJECT	NO. OF YEARS COMPLETED	NO. OF UNITS COMPLETED	DIPLOMA DEGREE OR CERTIFICATE	DATE COMPLETED

5. REFERENCES

List names of three persons who can give information about your background, character, abilities, etc.

NAME	ADDRESS	TELEPHONE NUMBER	RELATIONSHIP TO YOU (FRIEND, EMPLOYER, ETC.)

6. PROFESSIONAL AND TECHNICAL QUALIFICATIONS

A. List Licenses or Certificates of Competence held:

B. Names of Professional Associations of which you are a member:

NOTES:

I hereby certify under penalty of perjury that the above statements are true and correct. I give my permission for any necessary verification.

SIGNATURE OF EMPLOYEE	DATE

HEALTH SCREENING REPORT - FACILITY PERSONNEL

All personnel, including applicant, licensee or employed staff of Residential Care Facilities for the Elderly, Community Care or Child Care Facilities must demonstrate that their health condition allows them to perform the type of work required. This health appraisal is to be completed by or under the direction of a physician.

A health screening, by or under the direction of a physician must have been performed not more than one year prior to employment or within seven (7) days after employment.

FACILITY NAME

FACILITY ADDRESS

PERSON'S NAME		AGE	
POSITION TITLE	TYPE OF FACILITY	WORK DAYS PER WEEK	WORK HOURS PER DAY

DUTY STATEMENT

TYPES OF PERSONS SERVED *(Check appropriate items)*

- ☐ Infants
- ☐ Adults
- ☐ Developmentally Disabled
- ☐ Physically Handicapped
- ☐ Children
- ☐ Elderly
- ☐ Mentally Disordered
- ☐ Drug/Alcohol Addiction
- ☐ Other *(specify)* ______

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION CONTAINED IN THIS REPORT.

SIGNATURE OF APPLICANT/LICENSEE OR EMPLOYEE	ADDRESS	DATE
▶		

NOTE TO PHYSICIAN: *Personnel in Residential Care Facilities for the Elderly, Community Care or Child Care Facilities shall be free from communicable disease, and capable of performing assigned tasks. Please complete the following information on the above named person.*

EVALUATION OF GENERAL HEALTH

EVALUATION OF ABILITY TO PERFORM WORK DESCRIBED IN THE ABOVE DUTY STATEMENT

NOTE ANY HEALTH CONDITION THAT WOULD CREATE A HAZARD TO THE PERSON, CLIENTS, CHILDREN OR OTHER PERSONNEL

DATE OF T.B. TEST	☐ POSITIVE ☐ NEGATIVE	ACTION TAKEN (IF POSITIVE)	
DATE OF HEALTH SCREENING	NAME OF PHYSICIAN (PHYSICIAN'S STAMP)		DATE

HEALTH SCREENING BY: (ORIGINAL SIGNATURE)	**TELEPHONE #**	**DATE**
▶		

Intuit QuickBooks Payroll

intuit®

Employee Direct Deposit Authorization

Instructions

Employee: Fill out and return to your employer.

Employer: Save for your files only.

This document must be signed by employees requesting automatic deposit of paychecks and retained on file by the employer. Do **not** send this form to Intuit. Employees must attach a voided check for each of their accounts to help verify their account numbers and bank routing numbers.

Account 1

Account 1 type: Checking Savings

Bank routing number (ABA number): ______

Account number: ______

Percentage or dollar amount to be deposited to this account: ______

Account 2 (remainder to be deposited to this account)

Account 2 type: Checking Savings

Bank routing number (ABA number): ______

Account number: ______

attach a voided check for each account here

Authorization (enter your company name in the blank space below)

This authorizes ______ (the "Company") to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my (our) account(s) indicated below and to other accounts I (we) identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries. I agree that the ACH transactions authorized herein shall comply with all applicable U.S. Law. This authorization will be in effect until the Company receives a written termination notice from myself and has a reasonable opportunity to act on it.

Authorized signature: ______ Employee ID #: ______

Print name: ______ Date: ______