

Children's Camp Facility and Staff Description

Instructions

Complete the items that are applicable to the camp's operation; use additional sheets if necessary. Submit the completed form and other required application materials to the local health department (LHD) at least 60 days prior to camp operation. Information that is not available should be identified as "Pending." For expired certifications, the date of scheduled re-certification courses may be listed when staff are registered to attend. Pending information and confirmation of staff re-certification must be sent to the LHD when available.

Facility

Facility Name: _____
 Facility Code: _____ Date Open: ___/___/___ Date Close: ___/___/___ Are 20% or more of the campers developmentally disabled? Yes No

Activities available to campers

For activities identified with a "*", please further specify the activity in the space provided.

<input type="checkbox"/> Amusement Parks	<input type="checkbox"/> Classroom Instruction	<input type="checkbox"/> Ice Skating	<input type="checkbox"/> Roller Skating/Blading	<input type="checkbox"/> Other Water Activities*
<input type="checkbox"/> Aquatic Theme Parks	<input type="checkbox"/> Cooking	<input type="checkbox"/> Martial Arts	<input type="checkbox"/> Ropes/Challenge Course	<input type="checkbox"/> Other* _____
<input type="checkbox"/> Archery	<input type="checkbox"/> Dancing/Acting	<input type="checkbox"/> Mountain Boarding	<input type="checkbox"/> Skate Boarding	_____
<input type="checkbox"/> Arts and Crafts	<input type="checkbox"/> Gymnastics	<input type="checkbox"/> Nature Study	<input type="checkbox"/> Sports	_____
<input type="checkbox"/> Bicycling	<input type="checkbox"/> High Adventure*	<input type="checkbox"/> Organized Games (Play)	<input type="checkbox"/> Swimming – On-Site	_____
<input type="checkbox"/> Boating/Canoeing/Rafting	<input type="checkbox"/> Hiking	<input type="checkbox"/> Petting Zoo	<input type="checkbox"/> Swimming – Off-Site	_____
<input type="checkbox"/> Camp Trips	<input type="checkbox"/> Horseback Riding	<input type="checkbox"/> Riflery	<input type="checkbox"/> Swimming – Wilderness	_____

Camper Capacity

For each session, select the camp type, specify the number of days in the session and provide camper capacity information. Use separate session rows if both a day camp and overnight camp operate at the same time. **Use actual attendance data from last season.** If the camp did not operate last season, use estimates and check this box . Attach additional sheets if needed.

	Camp Type		Number of Days	Age Group												
	Day	Overnight		1 to 5		6 & 7		8 to 12		13 to 15		16 & 17		CITs **		
				male	female	male	female	male	female	male	female	male	female	male	female	
Session 1	<input type="checkbox"/>	<input type="checkbox"/>														
Session 2	<input type="checkbox"/>	<input type="checkbox"/>														
Session 3	<input type="checkbox"/>	<input type="checkbox"/>														
Session 4	<input type="checkbox"/>	<input type="checkbox"/>														
Session 5	<input type="checkbox"/>	<input type="checkbox"/>														
Session 6	<input type="checkbox"/>	<input type="checkbox"/>														
Session 7	<input type="checkbox"/>	<input type="checkbox"/>														
Session 8	<input type="checkbox"/>	<input type="checkbox"/>														
Session 9	<input type="checkbox"/>	<input type="checkbox"/>														
Session 10	<input type="checkbox"/>	<input type="checkbox"/>														

** A counselor-in-training (CIT) must be 15 years old at a day camp and 16 or 17 years old at an overnight camp. CITs that do not meet the minimum age requirements must be accounted for as a camper.

Camp Director

Name of Camp Director: _____ Date of Birth: ___/___/___
 Education: _____
 Qualifying Experience: _____

A "State Central Register Database Check" form (LDSS-3370) and a "Prospective Children's Camp Director Certified Statement" form (DOH-2271) must be completed by the Camp Director and submitted to the LHD with this form.

Camp Health Director

Name of Camp Health Director(s): _____
 Attach additional sheets if more than one Health Director is used.
 Qualifications (certification, licenses, etc.) Doctor Nurse Practitioner Physician Assistant RN LPN EMT Other _____
 NYS License Number: _____ For day camps only: Will the Health Director be located on-site or off-site? On-site Off-site

Certifications

List the Course Provider, Course Title and certification issuance date for each certification held by the Camp Health Director or Designated Assistant. (See Section 7-2.8 for requirements)

Certifications	Staff Possessing Certification	Course Provider	Course Title	Issue Date
CPR	<input type="checkbox"/> Health Director <input type="checkbox"/> Assistant			/ /
First Aid	<input type="checkbox"/> Health Director <input type="checkbox"/> Assistant			/ /

Aquatics Director

Name of Camp Aquatics Director: _____ Date of Birth: ____/____/____

Certifications

List the Course Provider, Course Title and certification issuance date for each certification held by the Camp Aquatics Director. (See Section 7-2.5(e) for minimum qualifications)

Certifications	Course Provider	Course Title	Issue Date
Lifeguard Supervision and Management*			/ /
Lifeguarding			/ /
Progressive Swimming Instructor			/ /
CPR*			/ /
First Aid			/ /

* The Camp Aquatics Director must possess these certifications to qualify.

Aquatic Experience (check qualifying experience below)

- One season of previous experience as a camp aquatics director at a New York State children's camp.
- Two seasons of previous experience consisting cumulatively of at least 12 weeks as a children's camp lifeguard, as specified in Section 7-2.5(g), at a swimming pool or bathing beach which had more than one lifeguard supervising it at a time.
- At least 18 weeks of previous experience as a lifeguard, as specified in Section 7-2.5(g)(2), at a swimming pool or bathing beach which had more than one lifeguard supervising it at a time.

Other Staff Requirements

Subpart 7-2 of the New York State Sanitary Code (Children's Camps) specifies minimum staff ratios and qualifications for counselors, lifeguards, progressive swimming instructors, riflery instructors, and additional first aid and CPR certified staff. When staff are required to possess special certification, a course standard or criteria is specified in the regulation. Certification courses which have been reviewed and meet or exceed the Children's Camp Code standard/criteria, are listed on New York State Department of Health (NYSDOH) "fact sheets." The fact sheets are available from the LHD and at the NYSDOH's website at www.health.ny.gov. Camp operators are responsible for ensuring that required staff are present and possess acceptable certification. A LHD may require a children's camp operator to document staff ratios and qualifications by submitting a Children's Camp Additional Staff Qualifications form (DOH-367a) and/or copies of certification cards. Copies of all required certifications must be maintained on file at the camp.

Written Safety Plan, Facility Additions/Modifications, and Itinerary of Camp Trips**1. Written Safety Plan as required by Section 7-2.5(n)**

- Plan attached
- Previously submitted on ____/____/____. This plan remains up to date and complete.
- Update to plan attached

2. Facility Addition/Modifications

Provide a list of additions or modification to the camp that have been made since last season or that are planned prior to this season. Include additions or modifications to buildings (cabins, kitchens, dining halls, infirmary, assembly areas, privies and toilets, etc.), potable water and sewage disposal systems, swimming pools, bathing beaches, activity areas (challenge course, archery and rifle ranges, etc.), emergency access and egress roads and any other camp facilities.

- List attached
- No Addition/Modifications
- Not Applicable. Camp did not operate last season.

3. Itinerary of Camp Trips

Attach a list of camp trips. Describe the activities that will take place (swimming, canoeing, hiking, etc.) and include the trip date(s) when known.

- List attached
- No trips

Section 7-2.5(p) requires a written statement or brochure outlining the rights and responsibilities of campers and camp operators to be provided to parents or guardians of campers by the camp operator with any enrollment application forms and/or enrollment contract forms. Either a statement or brochure prepared by the camp and approved by the permit-issuing official or the Department of Health brochure "Children's Camps in New York State" may be used. Please check the appropriate box below for the brochure sent with your application materials.

- A statement (brochure) which has been submitted to the DOH and approved
- "Children's Camps in New York State" Brochure (#3601)

I certify that the information given in this form is true.

Signature of Camp Operator: _____

Print Name: _____ Title: _____ Date: ____/____/____

Instructions:

Local health departments (LHD) may require children’s camp operators to document staff ratios and qualifications by submitting this form and /or copies of certification cards. Complete the applicable items and submit this form for review as directed by the LHD that has jurisdiction in the county where the camp is located. Use additional sheets if necessary. Information that is not available should be identified as “Pending”. For expired certifications, the date of scheduled re-certification courses may be listed when staff are registered to attend. Pending information and confirmation of staff re-certification must be sent to the LHD when available. Copies of all required certifications must be maintained on file at the camp. All code citations refer to Subpart 7-2 of the New York State Sanitary Code.

Facility Name: _____ Facility Code: _____

Date Open: __/__/__ Date Close: __/__/__

Progressive Swimming Instructor (PSI): Required for assessing camper swimming ability. Refer to Section 7-2.5(f).

Staff Name	Provider	Course Title	Issue Date
			/ /
			/ /
			/ /

Lifeguard Certification: Required for camps with swimming activities. Refer to Sections 7-2.5(g) and 7-2.11(a) for minimum qualifications and ratios.

See DOH fact sheets for acceptable certifications.

Lifeguarding- Certifications must be acceptable for the bathing facility type used.

CPR- Certification required for each Lifeguard. Certification may not exceed one year in duration.

Staff Name and Date of Birth	Provider / Course Title	Issue Date	Provider / Course Title	Issue Date
/ /		/ /		/ /
/ /		/ /		/ /
/ /		/ /		/ /
/ /		/ /		/ /
/ /		/ /		/ /
/ /		/ /		/ /
/ /		/ /		/ /
/ /		/ /		/ /
/ /		/ /		/ /
/ /		/ /		/ /
/ /		/ /		/ /

Additional First Aid and CPR Staff: Required for all camps as specified in Section 7-2.8.

See DOH fact sheets for acceptable certifications.

First Aid – A minimum of one staff for each 200 campers*

CPR- A minimum of one staff for each 200 campers.* Certification may not exceed one year in duration.

Staff Name and Date of Birth	Provider / Course Title	Issue Date	Provider / Course Title	Issue Date
/ /		/ /		/ /
/ /		/ /		/ /
/ /		/ /		/ /
/ /		/ /		/ /
/ /		/ /		/ /
/ /		/ /		/ /
/ /		/ /		/ /

*Trip and Activity Leaders may also require certification in First Aid and CPR depending on the activity and location. Refer to Sections 7-2.5(h) and 7-2.5(i).

Counselor Data: Required for all camps. List the number of counselors proposed for the camp session with the most campers. Refer to Sections 7-2.5 and 7-2.11 for counselor qualification and ratio requirements.

Staff Ages	Counselors	
	Male	Female
16 (Day camps only)		
17		
18 & Over		

Riflery Instructor: Required for all camps with riflery activities. Refer to Section 7-2.5(j).

Name: _____

Date of Birth: ___/___/___

Certification: _____

Date Issued: ___/___/___

I certify that the information given in this form is true.

Signature of the individual operator or official operating person: _____

Print Name: _____ Title: _____ Date: ___/___/___

**THIS STATEMENT IS RELATIVE TO CONVICTION OF A CRIME
OR THE EXISTENCE OF A PENDING CRIMINAL ACTION.**

Name (children's camp director) _____ Date of Birth Mo / Day / Yr _____

Address STREET _____

CITY _____ STATE _____ ZIP _____

Have you ever been convicted of a crime (i.e., a misdemeanor or a felony) or do you presently have a criminal action pending against you? YES NO

If YES, for each such conviction or pending action provide the following information:

1. The date of the incident which resulted in the criminal conviction or charge:	Mo / Day / Yr	
2. The date of the conviction or charge:	Mo / Day / Yr	
3. The crime you were convicted of or are presently charged with:		
4. The nature of the incident which resulted in the criminal conviction or charge:		
5. The city, county and state you were convicted in or are presently charged in:	CITY COUNTY STATE	
6. The name of the court you were convicted in or are presently charged in:		
7. The penalties imposed as a result of the conviction (i.e., fine, jail term, restitution, etc.):		
8. For each of the penalties imposed, list the date the penalty was complied with (i.e., date fine or restitution was paid in full, date jail term was completed, etc.):		
Date(s) Of Fine	Restitution Paid in Full	Date(s) Jail Term Completed
Mo / Day / Yr	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mo / Day / Yr
Mo / Day / Yr	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mo / Day / Yr

I _____, certify under penalty of perjury that the above information is complete and accurate. Print Name

Signature of Children's Camp Director Mo / Day / Yr _____

GENERAL INSTRUCTIONS

Complete all items that apply to your establishment.

All applicants must complete sections A, B, G, & H. If you have any questions, contact the local health department that issues your permit.

SECTION A: Facility Information

Facility Name, Facility Address, Telephone Number, Fax Number and Municipality: Self explanatory

Capacity

- A. Food services: enter actual seating capacity, or enter 00 for take out only.
- B. Recreational vehicle parks, campsites, agricultural fairgrounds and mobile home parks: enter the number of actual sites.
- C. Children's camp: enter the maximum number of campers the camp is approved for at one time.
- D. Temporary residences and migrant farmworker labor camps, swimming pools, bathing beaches, mass gatherings: enter the maximum number of people the facility is approved to hold.
- E. Recreational aquatic spray ground: enter 00.
- F. Tanning Facility: enter the total number of tanning devices.

Facility Status: Check either profit or nonprofit. If nonprofit, submission of documentation (incorporation paper) verifying status may be required.

Facility Type: From the list below enter the facility type that best describes the main or primary operation of the facility. Some multiple operation facilities may require submission of separate permit application(s). Please consult the health department that issues your permit with any questions.

Facility Types:

Agricultural Fairgrounds

Bathing Beaches

- Freshwater River
- Impoundment/Pond
- Lake
- Ocean Surf
- Other Saltwater

Campground/Recreational Vehicle Park

Children's Camps

- Day Camp
- Day Camp – Developmentally Disabled
- Day Camp – Municipal
- Day Camp – Traveling
- Overnight Camp
- Overnight Camp – Developmentally Disabled
- Overnight Camp - Municipal

Food Service Establishment

- Restaurant
- Caterer
- School
- Institution
- State Office for the Aging (SOFA) – Prep Site
- State Office for the Aging (SOFA) – Satellite Site
- Summer Feeding Program (USDA) – Prep Site
- Summer Feeding Program (USDA) – Satellite Site

Mass Gathering

Migrant Farm Worker Housing

- Farm Labor Housing

Mobile Home Parks

Mobile Food

Recreational Aquatic Spray Grounds

- Indoor
- Outdoor

Swimming Pools

- Indoor
- Outdoor
- Indoor/Outdoor
- Wave Pool – Indoor
- Wave Pool – Outdoor
- Wave Pool – Indoor/Outdoor
- Aquatic Amusement – Indoor
- Aquatic Amusement – Outdoor
- Aquatic Amusement – Indoor/Outdoor
- Spa

Tanning Facility

Temporary Food

Temporary Residences

- Labor Camps other than Migrant
- Interior Corridor – Single Story
- Interior Corridor – Two Story
- Interior Corridor – Three Story
- Interior Corridor – Four or more Story
- Exterior Corridor – Single Story
- Exterior Corridor – Two Story
- Exterior Corridor – Three Story
- Exterior Corridor – Four or more Story
- Cabin or Bungalow Colony

Vending Food Machines

State Agency Licensed Facilities

- State Licensed Inspected Facility
- State Owned Operated Facility
- Day Care Center – Residential
- Day Care Center – Non-Residential

Water Supply/Sewage System: Check "public" if the facility is serviced by a municipal or public system. Check "private" (onsite) if the system(s) and its operation is onsite and only for this facility. A water/sewage system that is commonly used by several establishments (i.e.: a mall operation) would be a public system.

Operations under this registration: Provide the number of specific operations that apply to this registration. Complete even if the primary or main operation of the facility was identified under the facility type. A swimming complex with one spa, one beach, one indoor and two outdoor pools would report a facility type swimming pool-indoor and enter 1 for spa, 1 for bathing beach, 1 for indoor pool and 2 for outdoor pools in the operations under this registration Section A. For tanning facilities enter the number of beds and booths. Some facilities with multiple operations require separate applications, (i.e., a food service operated at a swimming pool complex would require a separate swimming pool and food service application, and would report their specific operations on the appropriate application forms).

Expected Opening/Closing Date: Enter the expected opening and closing dates (i.e., June 1 is 06/01). If the operation is year-round, enter 01/01 for opening and 12/31 for closing.

Days of Operation: Check each box for the day(s) the facility will be open under routine operation.

Hours of Operation: Enter the hour the facility is expected to open and close under routine operation. Circle AM or PM as appropriate.

SECTION B: Operator/Owner Information

Name of Legal Operator or Operating Corporation (Person in Charge): Enter name of the legal entity that operates the facility. If the facility is operated by a corporation, enter the name of the operating corporation and the name of the person in charge of the day to day operation. Provide the name(s) of the corporate officers/partners in Section F.

Permanent Address of Operator and Telephone Number: Enter the mailing address including street, city, state and zip code where the legal operator wants to receive mailed correspondence. Enter the telephone and fax number of the legal operator.

Employer Identification/Social Security Number: Enter the **Employer Identification or Social Security Number** of the operator of the facility.

Email Address and Fax No.: Enter the email address and fax no. where important health and safety alert messages should be sent during an emergency.

Name of Owner: Enter the name of the owner of the facility if different from the operator.

Permanent Address of Owner and Telephone Number: Enter the mailing address and telephone number of the owner if different from the operator.

SECTION C: Complete only for temporary food service establishments, regulated under Subpart 14-2 NYSSC

SECTION D: Complete only for mobile food service vehicles or pushcarts, regulated under Subpart 14-4 NYSSC

Check the appropriate type of unit. If motorized, provide the license plate number. Provide the name and address of the commissary where the food is prepared. Attach a separate list of the types of food(s) and/or beverages to be served.

SECTION E: Complete only for food/beverage vending machines, regulated under Subpart 14-5 NYSSC

Attach a list of the number and type of food dispensing machines including the address and telephone number of each site under this permit.

SECTION F: Partners and Corporation Officers

If a facility is operated by a partnership or corporation, provide the name, title, permanent mailing address and telephone number of all corporate officers or partners involved in the operation or ownership of the facility.

SECTION G: Workers' Compensation and Disability Insurance

Provide copies of appropriate forms documenting compliance with the Worker's Compensation Law for (1) both Workers' Compensation and New York State Disability Insurance coverage, **or** (2) exemption from coverage.

SECTION H: Signature

Provide the signature of the individual operator, a corporate officer or other authorized identified official in Section F. Please print the name, title and date in the space provided. **Failure to sign the form may delay issuance of your permit to operate. Operation without a valid permit is a violation of the State Sanitary Code and is punishable by fines.**

Application for a Permit to Operate

Complete all items that apply to your establishment (all applicants must complete Sections A, B, G and H), sign on the back page and return with the appropriate fee at least 30 days prior to the expected opening date to:

SECTION A: Facility Information (Entire section must be completed by all applicants.)

Facility name _____

Facility address _____

City _____ State _____ Zip _____ Telephone no. (____) _____ Fax no. (____) _____

Municipality _____ [T] [V] [C] Capacity [_____] Facility Status [] Profit [] Non-profit

Facility Type [_____] Indicate days operation is open S M T W T F S

Expected opening date [][] [][] [][] Expected closing date [][] [][] [][] Hours of operation [][] [][] [][] AM PM [][] [][] AM PM
Month/Day Month/Day Open Close

- Water Supply** **Sewage System** **Number of operations under this registration**
- Public (municipal) Public (municipal) Indoor Pools Bathing Beaches Food Services Day Camps
- Private (onsite) Private (onsite) Outdoor Pools Spa Pools Recreational Aquatic Spray Grounds
- Tanning Devices

SECTION B: Operator/Owner Information (Entire section must be completed by all applicants.)

Legal **operator** or operating corporation _____
(If corporation or partnership, Section F must be completed.)

Person in charge _____ Telephone no. (____) _____ Fax no. (____) _____

Permanent address _____ Email address _____

City _____ State _____ Zip _____ Employee Identification Number [][] [][] [][] [][] [][] [][] [][] [][]

Or Social Security Number [][] [][] [][] - [][] [][] - [][] [][] [][] [][]

Owner _____ Telephone (____) _____

Permanent address _____ City _____ State _____ Zip _____

SECTION C: Complete for temporary food service establishments only (attach additional sheets as necessary).

Name and location of event _____

Name of Foods Supplier of ingredients Where and how foods will be prepared and served

Name of Foods	Supplier of ingredients	Where and how foods will be prepared and served

SECTION D: Complete for mobile food service establishments or pushcarts only.

Type of vehicle Motorized Pushcart Other (specify) _____

Motor vehicle license number (motorized vehicles only) _____

Commissary name _____ Telephone No. (____) _____

Address _____ City _____ State _____ Zip _____

List on a separate sheet of paper the type of food and beverages served.

SECTION E: Food and beverage machines only. Attach a list of all machine locations and food dispensed.

SECTION F: Partners and Corporate Officers

List all partners and corporate officers in the operation of the facility. Include vice president(s), secretary, treasurer. Attach DOH-2135 (or additional sheets) as necessary.

Name	Title	Address	Telephone No.

SECTION G: Workers' Compensation and Disability Insurance (All applicants must complete this section.)

Check the appropriate lines and submit copies of the following documentation with the application to document compliance with the Worker's Compensation Law:

A. Workers Compensation and Disability Insurance Coverage **Provided**

Workers Compensation

Form C-105.2 – Certificate of Worker's Compensation Insurance **OR**

Form U-26.3 – Certificate of Workers' Compensation Insurance **OR**

Form SI-12 – Certificate of Workers' Compensation Self-Insurance **OR**

GSI – 105.2 – Certificate of Participation in Workers' Compensation Group Self-Insurance

AND

Disability Insurance

DB-120.1 - Certificate of Disability Benefits **OR**

Form DB-155 – Certificate of Disability Benefits Self-Insurance

B. Workers Compensation and Disability Insurance Coverage **NOT Provided**

Form CE-200 – Certificate of Attestation of Exemption from NYS Workers' Compensation and/or Disability Benefits Coverage

SECTION H: Signature (Entire section must be completed by all applicants.)

FALSE STATEMENTS MADE ON THIS APPLICATION ARE PUNISHABLE UNDER THE PENAL LAW.

Failure to sign this form may delay issuance of your permit to operate. Operation without a valid permit is a violation of the State Sanitary Code.

Signature of individual operator or authorized official _____

Print name of person signing _____ Title _____ Date _____

SECTION I: FOR OFFICE USE ONLY

Permit issuance recommended? Yes No Permit Effective Date [__][__][__] Permit Expiration Date [__][__][__]

Conditions of approval

Signature _____ Title _____ Date _____

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
STATEWIDE CENTRAL REGISTER DATABASE CHECK
Agency Use Only

SCR USE ONLY
REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE:	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY USE ALPHA CODE:	PHONE NUMBER (Area Code): () -
PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS			The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box above are also on the reverse side of this form <u>FOR ALL CATEGORIES:</u> Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS/MARRIAGE SECTIONS THAT APPLY. IF NONE, STATE "NONE" List RELATIONSHIP in the fields below <i>(see reverse side for instructions) Attach additional page if necessary.</i>	
AGENCY NAME: _____				
AGENCY LIAISON: _____				
STREET ADDRESS: _____				
CITY: _____	STATE: _____	ZIP CODE: _____		

The purpose of collecting the demographic data on *other persons in your household* who are not screened pursuant to Section 424-a of the Social Services Law is to enable the N.Y.S. Office of Children and Family Services to identify with the greatest degree of certainty whether the person(s) being screened is the subject of an indicated child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA

***PLEASE TYPE OR PRINT CLEARLY**

IF THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK THIS BOX.

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH		
APPLICANT						
APPLICANT MAIDEN/ALIAS/MARRIED NAME						

Please provide your current address and any other addresses at which you have resided for the last 28 years, including street, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 of age and older.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /

I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE	DATE	APPLICANT'S SIGNATURE	DATE
-----------------------	------	-----------------------	------

EIGHTEEN YEARS OLD OR OVER:

I understand that as a person eighteen years of age or over in a home of an applicant to become an Adoptive or a Foster Parent or a Family or Group Family Day Care provider, the information I have provided will be used to inquire of the Statewide Central Register to determine if I am the subject of an indicated report of child abuse or maltreatment.

SIGNATURE	DATE	SIGNATURE	DATE
-----------	------	-----------	------

