DPHHS-QAD/CCL-020
(Revised 8-07)

Department of Public Health and Human Services
Quality Assurance Division - Licensure Bureau
Child Care Licensing

Employee Cover Sheet

Facility Name: ______________________ Provider # ______________

Director Name: ______________________ Phone # ______________

Address: ______________________ City: __________ Zip: __________

Directions on Back

Employee Name:
(Include First, Middle, Last) ______________________________

Mailing Address: ______________________ City: __________ ZIP: _____

Position/ Staff Role Type: ______________________ Date of Hire: __________

General Information	Dates Immunizations Given	CPR / First Aid Expires
Sex: [ ] Female [ ]Male	Td: __________	Adult: __________
Date of Birth: __________	MMR: __________	Child: __________
SS#: __________	Rubella: __________	Infant: __________
		1st Aid: __________

Completed Annual Training: [ ] Yes [ ] No Dates:
Education / Experience:

For Office Use Only – Do Not Write Below this line

Release Of Information Received: __________			Out of State Check: [ ] Yes [ ] No		
	Result of Check	**Date Received**	**State**	**Received**	**Result**
DOJ Dept Of Justice	[ ] YES CH Record [ ] NO CH Record				[ ] YES CH [ ] NO CH
CPS Protective Services	[ ] YES PS Record [ ] NO PS Record				[ ] YES CH [ ] NO CH
DMV Motor Vehicle	[ ] YES MV Record [ ] NO MV Record				[ ] YES CH [ ] NO CH

Health Statement Received: __________	**CAPS#:**	**PS#:**
33A needed?: [ ] Yes [ ] No		

Comments:

DIRECTIONS

Day Care Centers		Family & Group Day Care Homes	
Care Giving Staff Role Types	**Non-Care Giving Staff Role Types**	**Care Giving Staff Role Types**	**Non-Care Giving Staff Role Types**
Director*	Non-Provider Staff	Director*	Spouse
Primary Caregiver*	Volunteer	Caregiver*	Other Adult
Aide*		Substitute*	Non-Provider Staff
Substitute*		Volunteer	
* These are the provider staff types that interface with The Early Childhood Project and as such will receive PS# Cards.			

Family and Group Day Care Providers:

Please complete this entire form when submitting new employee paperwork (within 15 days of hire).

Please attach the following documentation:

Release of Information (DPHHS-QAD/CCL-20A – Revised 05-04)
Statement of Health (DPHHS-QAD/CCL-20B – Revised 07-2001)
Td [(Tetanus Diphtheria)(Current within the last ten Years)]
MMR (if born after 1-1-1957) **or** **Rubella Titer or MMR** (if born before 1-1-1957)
Infant CPR (covers Infants– age 0-1 year)
Child CPR (covers children – ages 1 to 7 years)
Adult CPR (covers children to adults – age 8 and over)
} **Must have all three courses regardless of ages of children served.**
First Aid Certification

Center Facilities:

Please complete this entire form when:

- submitting new employee paperwork (within 15 days of hire)
- submitting staff paperwork with your renewal packet

Please indicate the position that each employee holds using the provider staff role type table above.

Please attach the following documentation:

Release of Information form (DPHHS-QAD/CCL-20A – Revised 05-04)
Statement of Health form (DPHHS-QAD/CCL-20B – Revised 07-2001)
Background check results for Criminal History, Protective Service, and Motor Vehicle. The department will perform these checks if the DCC holds an extended registration.

All other documentation should be entered on the Employee Cover Sheet and then kept on file at the facility. Your local licensing worker may audit your staff files at any time.