



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Community Based Regulation Section

APPLICATION AND RENEWAL APPLICATION

FAMILY DAY CARE HOME STAFF

Date: _____

Applicant's Name: _____

Street Address: _____

Town, State, Zip: _____

Home Telephone #: (_____) _____ Date of Birth: _____

Work Telephone #: (_____) _____ Social Security #: _____

1. I am applying to be the:

- SUBSTITUTE, a person twenty (20) years of age or older, who may assume the licensed day care provider's responsibilities when he or she is absent. New Renewal
- ASSISTANT, a person eighteen (18) years of age or older, who assists the licensed provider or the substitute in caring for children in the licensed facility, while the provider or substitute is present. (An assistant enables a provider to care for additional children under the age of two years.) New Renewal

2. I plan to work for:

Provider's Name: _____ Town: _____

3. ALONG WITH THIS APPLICATION, YOU MUST INCLUDE:

- A. Yes No A completed medical form with the results of a tuberculin test within the last 12 months (TB test required for new applicants only) and updated every two years for renewal.
- B. Yes No A copy of a certificate, front and back, documenting the successful completion of an approved course in first aid appropriate for child care providers. (For substitutes only - list enclosed.)
- C. Yes No The complete names and addresses of four (4) personal references. (New Applicants Only.)

FOR NEW APPLICANTS ONLY

- 4. **Releases and fingerprint cards for background checks: *All new staff employed after 8/31/2000 are required to submit releases and fingerprint cards for background checks. Send this information to the following address: State of Connecticut, Department of Public Health, 410 Capitol Avenue, MS#12 LEG, P.O. Box 340308, Hartford, CT 06134-0308. (If you obtained this application over the Internet, please call the Day Care Licensing Unit to obtain background check/fingerprint cards.)***



Phone: (860) 509-8045, Fax: (860) 509-7541
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12CBR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

5. List all former names you have been known by:

6. Yes No Have you ever applied for a child day care license in Connecticut or in any other state?
If yes, when and where? _____

7. Yes No Have you ever held a child care license in Connecticut or in any other state?
If yes, when and where? _____

Agency contact information:

8. Yes No Have you ever applied for a foster care or adoption license in Connecticut or in any other state? If yes, when and where? _____

Agency contact information:

9. Yes No Have you ever been licensed for foster care or adoption in Connecticut or in any other state? If yes, when and where? _____

Agency contact information:

10. Yes No Have you ever been investigated/questioned by representatives of the Department of Children and Families (DCF) or any other child protection agency, concerning the care of children, including alleged child abuse or neglect in Connecticut or any other state? If yes, please explain: _____

11. Yes No Have you ever been employed at a licensed child day care facility? If yes, when and where?
Agency contact information:

12. Yes No Have you ever been convicted of any crime in Connecticut or any state? If yes, please explain:

13. Yes No Do you have any known medical or emotional illness or disorder that would pose a risk to children in care or would interfere with or jeopardize providing them with proper care? If yes, please explain: _____

14. Yes No Do you take any medication(s) that would affect your ability to provide for the proper care of children? If yes, please explain: _____

ALL NEW APPLICANTS ONLY:

15. Yes No List four persons (no more than one relative) who have known you for at least three years. Include people who know how you interact and care for young children. These references will be contacted by this Department.

Name	Relation to You	Complete Mailing Address Including Zip Code	Telephone
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**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FAMILY DAY CARE PROGRAM APPLICATION**

STATEMENT OF COMPLIANCE

Applicant's Name: _____
First Middle Last

Address of Facility: _____
Street Town State Zip

I understand that it is my responsibility to contact the Department of Public Health at least sixty (60) days prior to the expiration date to request a staff relicensure application.

I certify that I have read and understand the regulations for the licensure of family day care homes adopted by the Commissioner of Public Health pursuant to Connecticut General Statutes Section 19a-87b(c). I will maintain the family day care home in compliance with these regulations, and I will allow home visits by Department staff to the family day care home when I am present at the family day care home.

NOTICE OF PENALTY FOR FALSE STATEMENTS

Under the law, all information provided on this application form, or in any statements accompanying this application, must be truthful. Any false statements could cause the denial of this application and may be punished as a Class A Misdemeanor under Section 53a-157b of the Penal Code. This notice is given as required by the Connecticut General Statutes, Section 19a-87b(a).

Understanding the penalties for false statements, I attest that my statements in this application are true, to the best of my knowledge and belief.

X _____
(Signature of Applicant) (Date)