

**C. Medical report for persons giving care to children****MEDICAL REPORT FOR PERSONS GIVING CARE TO CHILDREN**

Name:	Date of birth:
Address:	Position in child care facility:

**To the examining medical doctor, physician's assistant, or certified nurse practitioner:**

**This examination is needed to determine my physical ability to care for children or to perform services in a child care facility (home or center) or to have contact with children in care. I hereby authorize you to furnish a report of my examination to:**

\_\_\_\_\_  
**Name of child care facility or Department of Human Resources**

\_\_\_\_\_  
 Signature / Date

**TESTS** (to be completed if other verification is not attached):

Date and result of Intradermal Tuberculin Test (Mantoux): \_\_\_\_\_

(Required for initial examination only)

Date and result of chest x-ray if Mantoux was positive: \_\_\_\_\_

**HISTORY** of any chronic disease or disability that may affect his/her ability to care for children or perform services in a child care facility: Yes ☐; No ☐.

**PHYSICAL LIMITATIONS** that may affect his/her ability to care for children or perform services in a child care facility (home or center): Yes ☐; No ☐.

If "YES", to either question, please explain:

\_\_\_\_\_  
 \_\_\_\_\_

In my opinion, the physical examination reveals that the above-named person is free of any infectious or contagious disease and is physically fit to care for children, to perform services in a child care facility, or to have contact with children.

If not, please explain:

\_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Signature of medical doctor, physician's assistant, or certified nurse practitioner / Date

**D. Application form for staff****DHR–CDC-1947****APPLICATION FORM FOR STAFF****(including caregivers, employees, teachers, substitutes, volunteers, cooks, bus drivers, domestic workers)**

Date of Application \_\_\_\_\_

Position \_\_\_\_\_

Date Hired \_\_\_\_\_

<b>Name:</b>	_____ Last First Middle Maiden (if applicable)			
<b>Address:</b>	Street: _____ City: _____ State: _____ Zip Code _____			
<b>Telephone Number: (     )</b>		<b>Date of Birth:</b>		
<b>Driver's License Number:</b>		<b>Expiration Date of Driver's license:</b>		

**EDUCATION:**

EDUCATION	School/Institution	Dates Attended	Diploma/Degree/Certificate
Elementary			
High School			
College			
Graduate			
Other			

**CHILD CARE TRAINING:**

List all courses, workshops, and conferences related to child development and early childhood education. Attach additional pages if necessary. Attach copies of certificates received.

Title of course/Workshop/conference	Sponsor	Location	Date(s)	Number of hours

**EMPLOYMENT HISTORY:**

List in order beginning with your most recent employment. Attach additional pages if necessary.

Employer	Employer's Address	Position/Job	Date(s) Worked	Reason for leaving

## REFERENCES:

List at least three persons who are not related to you by blood, marriage, or adoption. to be contacted as references.

**At least one must be a former employer.** Addresses must be complete and accurate.

**Name of Former Employer:** \_\_\_\_\_

Last	First	Middle

**Address:** \_\_\_\_\_

Street	City
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\_\_\_\_\_  
**State                      Zip Code                      (           )                      Area Code                      Telephone Number**

**Name:** \_\_\_\_\_

<b>Last</b>	<b>First</b>	<b>Middle</b>
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**Address:** \_\_\_\_\_

Street	City
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\_\_\_\_\_  
**State                      Zip Code                      (                      )                      Telephone Number**

**Name:** \_\_\_\_\_

<b>Last</b>	<b>First</b>	<b>Middle</b>
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**Address:** \_\_\_\_\_

Street	City
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\_\_\_\_\_  
**State                      Zip Code                      (                      )                      Telephone Number**

**Criminal History Background Information Checks:**

In accordance with Alabama law, (Code of Alabama 1975, Title 38, Chapter 13, effective November 1, 2000), the criminal history background information check shall be completed on each substitute, caregiver, volunteer, and domestic worker, as well as any other person who has contact with the children or unsupervised access to the children shall be reviewed.

**Current Criminal Charges:**

Are there any current criminal charges against you? \_\_\_\_\_ If yes, give details. \_\_\_\_\_

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**Clearance of State Central Registry on Child Abuse/Neglect:**

A completed REQUEST FOR CLEARANCE OF STATE CENTRAL REGISTRY ON CHILD ABUSE/NEGLECT (DHR-DFC-1598) shall be obtained for each caregiver, substitute, volunteer, domestic worker, and any other person who has contact with the children or unsupervised access to the children.

**By signing this form, I am affirming that the above statements I have made are true and factual to the best of my knowledge; and I am granting permission for all persons, organizations, or agencies listed above to be contacted for information regarding my background.**

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**Signature**

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**Date**

## DHR-CDC-1948

## Date: \_\_\_\_\_

Address: \_\_\_\_\_  
*(Street) (City) (State) (Zip Code)*

as a \_\_\_\_\_ (Position). He/she has given your name as a person to be

1. How long have you known this person?

3. In your opinion, is this person:

Dependable?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Honest?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Even-tempered?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. To your knowledge, does this person:

Use drugs?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Drink excessively?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Use abusive language?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. If you have young children, would you leave your own child/children in the care of this person? Yes ☐ No ☐ If no, please explain.