Application for Employment

Date of Application _____

Please Print (Fully complete both pages)

Last four digits of SSN	Last Name	First Name	Middle Name

Address (street number and name)	City	County

State	Zip Code	Phone (home or where you can be reached)	Business Phone

Position Applied For: _____

Date of Birth: _____ N. C. Driver's License Number _____
(month) (day) (year)

Have you ever been convicted of breaking a law other than a minor traffic violation? YES____ NO____ If yes, give the date and explain fully. Use an additional piece of paper if more space is needed: _____

_____

Have you ever had an abuse or neglect or child maltreatment substantiation? YES____ NO____ If yes, list county/State and give the date and explain fully. Use an additional piece of paper if more space is needed: _____

_____

(The offense(s) and how recently you were convicted will be evaluated in relation to the job for which you are applying.)

Education

Circle the highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 GED College 1 2 3 4

Schools	Name and Location	Dates Attended	Coursed of Study	Degree/Diploma
High School				
		to		
College or University		to		
		to		
		to		
		to		
Graduate or Professional				
Educational, Vocational Schools, etc.				

Child care training completed in the last three years (such as First Aid, CPR, Health and Safety Training, ITS-SIDS, CDA etc.):

_____

References

List the names, addresses, and phone numbers of people we may contact as references:

_____

_____

_____

Work History

(List child care/early childhood experience first.)

Current or Last Employer			Address		
Job Title			Supervisor's Name		No. Supervised by you
Date Employed (mo/yr)	Starting Salary $ Per		Ending Salary $ Per	Reason for leaving	May we contact employer? yes no
Date Separated (mo/yr)			Duties:		
Full Time	Years	Months			
Part Time	Years	Months			
If part time, number of hours per week					

Current or Last Employer			Address		
Job Title			Supervisor's Name		No. Supervised by you
Date Employed (mo/yr)	Starting Salary $ Per		Ending Salary $ Per	Reason for leaving	May we contact employer? yes no
Date Separated (mo/yr)			Duties:		
Full Time	Years	Months			
Part Time	Years	Months			
If part time, number of hours per week					

I certify that I have given true, accurate, and complete information on this form to the best of my knowledge. In the event confirmation is needed in connection with my work, I authorize educational institutions, associations, registration, and licensing boards, and others to furnish whatever detail is available concerning my qualifications. I authorize investigations of all statements made in this application and understand that false information of documentation, or a failure to disclose relevant information may be grounds for rejection of my application, disciplinary action, or dismissal if I am employed, and (or) criminal action. I further understand that dismissal on unemployment shall be mandatory if fraudulent disclosures are given to meet position qualifications.

Signature of Applicant_____ Date_____

Health Questionnaire – Child Care Centers

10A NCAC 09 .0701(a)

All staff, including the director, must complete a health questionnaire annually following the initial medical report. Substitute providers and volunteers must complete a health questionnaire on or before the first day of work and annually thereafter.

Full name of individual:	
Home address:	
Phone number:	Email:

I certify that I am emotionally and physically fit to care for children.

Signature:
Date:

This portion of the form to be completed by the Child Care Center Director

As the director, I understand that I may request another evaluation of a staff member's emotional and physical fitness to care for children when there is reason to believe that there has been deterioration in the staff member's emotional or physical fitness to care for children. This request may be made based upon factors such as observations of myself or other staff members, reports of concern from family, reports from law enforcement, or reports from medical personal. Child Care Rule 10A NCAC 09 .0701(b).

Director's Signature:
Date:

*This information must be included in the staff member's medical file, which must be maintained separately from the staff member's individual personnel file in the center. Child Care Rule 10A NCAC 09 .0701(d)

Tuberculosis Screening Form

10A NCAC 09 .0701 (a) (Centers); .1702 (b)(4) and .1729 (a)(5) & (b) (Family Child Care Homes)

This questionnaire must be administered to all child care providers, by a licensed health care professional, before coming into contact with children. Directors, operators, additional caregivers, substitutes, and individuals who volunteer more than once a week must be screened. Testing should only be performed if the individual answers "yes" to one of the screening questions. Both screening and testing are available at the local health department.

Note to health care professionals: A negative risk and symptom screen should be considered a negative tuberculosis test in such individuals, and no further testing is required. An Interferon Gamma Release Assay is preferred over a tuberculin skin test for otherwise low-risk individuals with a positive response to the risk or symptom screening questionnaires. (See page 2.)

Last name (print clearly)	First name	Middle	Date of Birth

Tuberculosis Risk Questionnaire

1) Were you born outside the USA in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe?	**YES**	**NO**
2) Have you traveled outside the USA and lived for more than one month in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe?	**YES**	**NO**
3) Do you have a compromised immune system such as from any of the following conditions: HIV/AIDS, organ or bone marrow transplantation, diabetes, immunosuppressive medicines (e.g. prednisone, Remicade), leukemia, lymphoma, cancer of the head or neck, gastrectomy or jejeunal bypass, end-stage renal disease (on dialysis), or silicosis?	**YES**	**NO**
4) Have you ever done one of the following: used crack cocaine, injected illegal drugs, worked or resided in jail or prison, worked or resided at a homeless shelter, or worked as a healthcare worker in direct contact with patients?	**YES**	**NO**
5) Have you ever been exposed to anyone with infectious tuberculosis?	**YES**	**NO**

Tuberculosis Symptom Questionnaire

Do you currently have any of the following symptoms?		
1) Unexplained cough lasting more than 3 weeks?	**YES**	**NO**
2) Unexplained fever lasting more than 3 weeks?	**YES**	**NO**
3) Night sweats (sweating that leaves the bedclothes and sheets wet)?	**YES**	**NO**
4) Shortness of breath?	**YES**	**NO**
5) Chest pain?	**YES**	**NO**
6) Unintentional weight loss?	**YES**	**NO**
7) Unexplained fatigue (very tired for no reason)?	**YES**	**NO**

The above health statement is accurate to the best of my knowledge. I will contact my health care professional and/or the health department if my health status changes.

Signature:	Date:

Screening administered by licensed health care professional:

Printed name and location:	
Signature:	Date:

*This information must be included in the operator or staff member's medical file, which must be maintained separately from the operator or staff member's individual personnel file that is kept on site.

Tuberculosis Testing Form

10A NCAC 09 .0701 (a) (Centers); .1702 (b)(4) and .1729 (a)(5) & (b) (Family Child Care Homes)

Record of Tuberculosis Test

Last name (print clearly)	First name	Middle	Date of birth

Type of test:

☐ Tuberculin

Date given	
Date read	
Results	MM reading: _____ ☐ Negative ☐ Positive

☐ Interferon Gamma Release Assay

Date	
Results	

Comments:

Signature of Authorized Health Professional	Date	Location

*This information must be included in the operator or staff member's medical file, which must be maintained separately from the operator or staff member's individual personnel file that is kept on site.

The North Carolina Child Care Health and Safety Resource Center
NC DHHS DPH - Communicable Disease Branch and DCDEE
Updated June 2019

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

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		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*.
City or town, state, and ZIP code		

(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)

Specific Instructions *(continued)*

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include amounts from any job(s) or pension/annuity payments. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your pension, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 6, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes itemized deductions, the additional standard deduction for those 65 and over, and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from **each payment**. Entering an amount here will reduce your payments and will either increase your refund or reduce any amount of tax that you owe.

Note: If you don't give Form W-4P to your payer, you don't provide an SSN, or the IRS notifies the payer that you gave an incorrect SSN, then the payer will withhold tax from your payments as if your filing status is single with no adjustments in Steps 2 through 4. For payments that began before 2023, your current withholding election (or your default rate) remains in effect unless you submit a new Form W-4P.

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1	Enter an estimate of your 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income	1	$
2	Enter: • $27,700 if you're married filing jointly or a qualifying surviving spouse • $20,800 if you're head of household • $13,850 if you're single or married filing separately	2	$
3	If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-"	3	$
4	If line 3 equals zero, and you (or your spouse) are 65 or older, enter: • $1,850 if you're single or head of household. • $1,500 if you're married filing separately. • $1,500 if you're a qualifying surviving spouse or you're married filing jointly and one of you is under age 65. • $3,000 if you're married filing jointly and both of you are age 65 or older. Otherwise, enter "-0-". See Pub. 505 for more information	4	$
5	Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information	5	$
6	**Add** lines 3 through 5. Enter the result here and in **Step 4(b)** on Form W-4P	6	$

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. You are required to provide this information only if you want to (a) request federal income tax withholding from pension or annuity payments based on your filing status and adjustments; (b) request additional federal income tax withholding from your pension or annuity payments; (c) choose not to have federal income tax withheld, when permitted; or (d) change a previous Form W-4P. To do any of the aforementioned, you are required by sections 3405(e) and 6109 and their regulations to provide the information requested on this form. Failure to provide this information may result in inaccurate withholding on your payment(s). Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

APPLICANT INFORMATION for CHILD CARE

Please print name as shown on photo Identification Card you will take to Law Enforcement Agency.

Name: Last: _____ ***Date of Birth:*** _____

First: _____ ***Place of Birth:*** _____

Middle: _____ ***Residence:*** _____

Maiden Name: _____ _____

Aliases: _____

_____

Sex: *Male____Female_____*

Race: _____

(Write the appropriate letter in the space provided)

W -White B -Black I -American Indian

A -Asian or Pacific Islander U -Unknown

Employer and Address:

DOCD

2201 Mail Service Center

Raleigh, NC 27699

Reason Fingerprinted:

State and Federal Check

NC Day Care Provider

NCGS 114-9.5, 110-90.1 to 110.91

Height: _____ ***Social Security Number:*** _____

Weight: _____

Eye Color: _____

(Write the appropriate letters in the space provided)

BLK -Black GRY -Gray MAR -Maroon

BLU -Blue BRO -Brown GRN -Green

HAZ -Hazel PNK -Pink XXX -Unknown

Your Case NO. (OCA): DOCD000000

Type of Transaction: **Non-Federal User Fee**

NCFP Card Type: **Child Care Provider**

Hair Color: _____

(Write the appropriate letters in the space provided)

BAL -Bald BLK -Black BLN -Blond or strawberry

BRO -Brown GRY -Gray or partially

RED -Red or Auburn SDY -Sandy

This form is to be taken to the Law Enforcement Agency when you visit to be fingerprinted.

Do NOT send this form to the SBI.

YOUR NAME MUST MATCH ON ALL FORMS

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

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**12.** Day-care or nursery school record		

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Emergency Information – Staff

10A NCAC 09 .0701(a)

Child care providers, including the director, uncompensated providers, substitute providers, and volunteers must provide this information on or before the first day of work. Emergency information must be updated as changes occur and at least annually.

Date completed:	
Full name of individual:	
Home address:	
Phone number:	Email:

Person(s) to be contacted in case of an emergency:
Primary contact
Name:
Address:
Phone number:
Secondary contact
Name:
Address:
Phone number:

Choice of health care professional:
Address:
Telephone number: