

Preschool Plus

4453 Atlanta Hwy
 Montgomery, AL 36109
 334-356-0016

APPLICATION FORM FOR STAFF

(including caregivers, employees, teachers, substitutes, volunteers, cooks, bus drivers, domestic workers)

Date _____

Position _____

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

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
()
State
Zip Code
Area Code
Telephone Number

Name: _____
Last
First
Middle

Address: _____
Street
City
()
State
Zip Code
Area Code
Telephone Number

Name: _____
Last
First
Middle

Address: _____
Street
City
()
State
Zip Code
Area Code
Telephone Number

Criminal History Background Information Checks:

In accordance with Alabama law, (Act 2000-775, 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.

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.

Signature

Date

E. Reference form

DHR-CDC-1948

REFERENCE FORM

Date: _____

To: _____
(Reference Contact)

Address: _____
(Street) (City) (State) (Zip Code)

_____ has applied to work in a child care facility as a
(Name of applicant)
_____. He/she has given your name as a person to be contacted for
(Position)
information regarding his/her character, suitability to work with children and previous or prospective job performance. Please answer the following questions and provide any additional comments that could be helpful. Your response will be kept confidential.

1. How long have you known this person? _____
2. What is/was your relationship with this person? (friend, employer, pastor, neighbor, etc.)

3. In your opinion, is this person: Comments: _____
Dependable? Yes No _____
Honest? Yes No _____
Even-tempered? Yes No _____

4. To your knowledge, does this person: Comments: _____
Use drugs? Yes No _____
Drink excessively? Yes No _____
Use abusive language? Yes No _____

5. If you are/were an employer of this person, describe the type of work the person does/did and the quality of the work he/she performed. What was the reason for the person leaving your employment, if applicable?

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.

7. To your knowledge, does this person have qualities, traits, or abilities that make him/her particularly suitable to care for children? Yes No Please explain.

8. Do you know of any reason why this person might not be suitable to care for children? Yes No If yes, please explain.

9. If you have any additional comments about this person you feel would be useful when considering his/her application for employment in a child care facility, please state below.

Signature

Date

Telephone number

Please return this form to:

Name of person requesting information: _____

Name of day care/nighttime facility: _____

Address of facility:

Street: _____

City: _____

State: _____ Zip Code: _____

Telephone Number: (____) _____

If you prefer **not** to provide a reference for this person, please sign here and return this form to the address above.

Signature

Date



Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 08/31/2019

▶ **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [][] - [][] - [][][][]		Employee's E-mail Address		Employee's Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input type="checkbox"/> 1. A citizen of the United States	QR Code - Section 1 Do Not Write In This Space
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i> <i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i> 1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____	

Signature of Employee	Today's Date (mm/dd/yyyy)
-----------------------	---------------------------

Preparer and/or Translator Certification (check one):
 I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code

SIC- **Employer Completes Next Page** -SIC-



Employment Eligibility Verification
 Department of Homeland Security
 U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 08/31/2019

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		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

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
--	---------------------------	---

MEDICAL REPORT FOR CHILD PLACING AGENCIES / RESIDENTIAL CHILD CARE FACILITIES

Name _____ Date of Birth _____

Address _____

Employment Agency / Facility Name _____

Position _____

To the Examining Physician:

This examination is needed to determine my physical, psychological, and emotional ability to care for children and perform services in a child placing agency / residential child care facility. I hereby authorize you to furnish a report of my examination to the above-named agency / facility.

Signature _____ Date _____

Tests (Initial TB test to be completed with repeat test every two years if no extenuating circumstances exist)

Date and result of Intradermal Tuberculin Test (Mantoux) _____

If Mantoux was positive, date and result of chest x-ray _____

Medications Is this person currently taking a medication that will affect alertness, reactions, or driving skills?

No Yes If "Yes," please describe _____

Physical Limitations Are there any physical limitation that may affect this person's ability to perform duties?

No Yes If "Yes," please describe _____

Have you observed any psychological or emotional behaviors that will limit this person's ability to care for children?

No Yes If "Yes," please describe _____

If this person needs a referral to another health professional, please describe in the "Comments" section.

Comments _____

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 and perform services in a child placing agency / residential child care facility.

Name of medical doctor, physician's assistant, or certified nurse practitioner completing exam (**Please print**) _____

Signature _____ Date _____