NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BUREAU OF CHILD CARE

Agency Stamp

STAFF HEALTH FORM

Initial employment and every 2 years, a health examination is required for all teaching and non-teaching staff members, including volunteers and students who regularly associate with children. Attach any additional documentation to this form.

Date of Employment____/____/____ Date of Exam____/____/____

(Last)	*(First)*	*(Middle)*	**SEX** F M M M	**DATE**	**DATE OF BIRTH** ____/____/____
(No.)	*(Street)*	*(City/Boro)*	*(State)*		*(Zip)*

TELEPHONE:
AC ( )

JOB TITLE

AREA EMPLOYED

PAST MEDICAL HISTORY
Please check YES or NO

YES	NO	
M	M	Hypertension
M	M	Heart Disease
M	M	Diabetes
M	M	Seizure Disorder
M	M	Chronic Lung Disease
M	M	Mental Illness
M	M	Alcohol Abuse
M	M	Substance Abuse
M	M	Physical Disabilities
M	M	Allergies
M	M	Hepatitis
M	M	OTHER (SPECIFY) _____

Please explain any positive findings, list and explain any chronic medications ortherapies: _____

MEDICAL PROVIDER SECTION

PHYSICAL EXAM: *(Please note any conditions or findings considered abnormal or requiring medical follow-up)*

Height_____

Weight _____

Blood Pressure_____/_____

TOBACCO USE	M Current	M Former	M None
If current, referred forcessation services?	M Yes	M No	
Counselled re: No Smoking	M Yes	M No	

Staff Name _____ D.O.B._____/_____/_____

TUBERCULIN TESTING *(Not required for employment)*

TUBERCULIN SKIN TEST: PPD MANTOUX (5 TU)
OR
BLOOD TEST: QUANTEFERON GOLD

DATE TESTED: _____

DATE INTERPRETED: _____

RESULTS: _____

Staff exempt from testing if they
Had a positive reaction to a PPD/Mantoux test or history of TB. DATE: _____

History of BCG vaccine does not exempt a staff member from TB screening. DATE: _____
All positive tuberculin tests in persons whose previous PPD/Mantoux was negative, require a chest X-ray and evaluation if treatment is indicated.
All positive tuberculin tests (PPD Mantoux 10 mm or over) require a report of one chest X-ray, (H.C. 49.06).

CHEST X-RAY: DONE AT: _____ TREATMENT: _____

DATE: _____ RESULTS: _____

IMMUNIZATION RECORD
Staff are required to have evidence of immunity to the diseases below through either documented vaccines, blood test documenting immunity, or provider-documented history of illness (except where shaded in grey). Records should be kept in the staff person's file.

Documentation of Immunity	Vaccine Name	Vaccine Date 1	Vaccine Date 2	Blood Test Documenting Immunity (Yes / No)	Provider-Documented History of Illness (Yes / No)
Tdap (Tetanus-diphtheria-acellular pertussis)					
Rubella					
Measles*					
Mumps*					
Varicella*					

*Two doses of vaccine are required at least 28 days apart

LABORATORY TESTS *(Optional) (Specifytests ordered)*	**DATE**	**RESULTS**

DIAGNOSIS/PROBLEM	**PLAN/FOLLOW-UP** *(For each diagnosis)*
1.	**1.**
2.	**2.**
3.	**3.**
4.	**4.**
5.	**5.**

On the basis of my findings as indicated above and my knowledge of the staff member, I find that the above person is fit to give adequate child care to children in a day care setting at this time.

Provider's Name *(Print)* _____ License No. _____ Telephone No.
(Of Supervisor if NP or PA)

Address: _____ Date of Exam _____

Provider's Signature _____ Staff Signature _____

NOTE TO THE DAY CARE CENTER: Staff Health Records are confidential and must be kept separate from all other records. Records of required medical examinations must be kept on file at the day care center as long as staff members are employed. They must be returned to them upon their request when their employment is terminated. In cases where chest x-rays are required, x-ray reports must be kept on file at the day care center as long as the person is employed and two years thereafter.
(New York City Health Code Section 45.09)

Form W-4 (2017)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A ____
B	Enter "1" if: • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B ____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C ____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D ____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E ____
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F ____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.	G ____
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ►	H ____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2017

1 Your first name and middle initial	Last name	2 **Your social security number**
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	
5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)		5
6 Additional amount, if any, you want withheld from each paycheck		6 $
7 I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►		7

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ► **Date** ►

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $287,650 if you're head of household; $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,700 if married filing jointly or qualifying widow(er); $9,350 if head of household; $6,350 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2017 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2017 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $7,000	0	$0 - $8,000	0
7,001 - 14,000	1	8,001 - 16,000	1
14,001 - 22,000	2	16,001 - 26,000	2
22,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 70,000	5
44,001 - 55,000	6	70,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 95,000	10	140,001 and over	10
95,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

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. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; 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; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. 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 Code 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.

Banking Information

First Name _____

Last Name _____

Name of Bank _____ Routing # _____

Account# _____

☐ Checking

☐ Savings

NEW YORK CITY
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Child Care Provider, Staff and Volunteer Information

CHILD CARE PROGRAMS

Instructions:

- Please **PRINT** clearly. This form **MUST** be completed by every individual identified on form **A-Series**.
- If you are not sure which role to choose, refer to the NYCHC §47 regulations and/or consult with your Borough Office.

PROGRAM NAME:	Permit # & DCID:
DATE: / /	

Group Child Care Staff Role	
☐ Education Director	☐ Owner
☐ Group Teacher	☐ Board Member
☐ Assistant Teacher	☐ Medical Staff
☐ Volunteer/Student	☐ Other _____

Personal Information

NAME *(First, MI, Last):*		
ADDRESS:	APT:	FLOOR:
CITY:	STATE:	ZIP:
PHONE:	E-MAIL:	
	DATE OF BIRTH (mm/dd/yyyy): / /	

Have you ever been known by any other name? ☐ Yes ☐ No

If Yes, list all known names (including maiden name, aliases, pseudonyms)

Have you ever lived outside of New York State in the pastfive years? ☐ Yes ☐ No

If Yes, complete page 2 of this form and enter all out of state addresses where you lived in the past five years.

If No, you do not have to complete page 2.

Type of Fingerprint completed after 9/25/2019? ☐ DOI ☐ DOE

Note: Clearances are incomplete if fingerprints were completed prior to 9/25/2019 or if completed by another agent other than the Department of Investigation (DOI) or Department of Education (DOE) PETS.

Signature_____ **Date** _____

Applicant's Name: ______________________________

Out of state addresses (Previous five years)

Print clearly. <u>All</u> dates must be consecutive *(month/year)*. Be sure to associate address histories accurately.

Previous Street Address	City	State	Zip	From (Mo/Yr)	To (Mo/Yr)
				/	/
				/	/
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Signature______________________________**Date** ______________________________

NEW YORK CITY
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REQUEST FOR STAFF EXCLUSION LIST CHECK

CHILD CARE PROGRAMS

PROGRAM NAME:	Permit # & DCID:

The New York State Justice Center for the Protection of People with Special Needs (Justice Center) maintains a Vulnerable Persons Central Register. That register includes a Staff Exclusion List (SEL) containing the names of individuals who have committed serious acts of abuse. The SEL must be checked as part of the comprehensive background check process for the individuals identified below and on the **A-Series** form.

Instructions:

- This form is used to check the Justice Center's (SEL).
- Group Child Care Programs must submit the SEL for DOHMH.

  Note: If the individual appears on the SEL, a determination will be made whether to hire or allow such a person to have regular and substantial contact with a child in child care programs.

Fill out all information below. Please **PRINT** clearly to avoid delays in processing.

First name:

Last name:

Middle initial:

Social security number: - -

Date of birth *Only if no social security number or alien registration number is available:* / /

Alien registration number *Only if no social security number is available*:

Position applied for:

Signature **Date**

NEW YORK CITY
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

WAIVER REQUEST FOR COMPREHENSIVE BACKGROUND CHECK CLEARANCE

Instructions:
Complete this request to associate an individual's current comprehensive background check with an additional permitted child care provider. All fields are required unless otherwise noted. Incomplete applications will not be processed, and a separate request must be completed for each new childcare provider being associated with an individual. A new SCR and A-2 application will be required if the A-3 is submitted separately. Completed forms must be submitted to the NYC DOHMH Central Clearance Unit (CCU) via email at CCU@health.nyc.gov or faxed to 347-396-8052. Please note that email may not be secure depending on your security settings.

Personal Information

Name of applicant:_____ DOI #/DOE PETS#: _____

Address: _____

Borough:_____ State :_____ Zip Code: _____

Date of Birth:_____ Social Security Number: _____

Original Program Associated with Comprehensive Background Check

Program Name: _____

Program Address: _____

Borough_____ Zip Code_____ Permit/DC ID#_____

☐ I remain active at the above site ☐ I am no longer associated with the above site

☐ I remain active at the organization and will be working under a different "umbrella" permit

Date of Clearance:_____ Date separated from program (if applicable): _____

Employee Eligibility Status: ☐ Eligible ☐ Conditional

CLEARANCE WAIVER REQUEST

New Program Information

Program Name: _____

Program Address: _____

Borough_____ Zip Code_____ Permit/DC ID#_____

Start Date at the New site:_____ Position/Title at New Site: _____

Name of Applicant:_____ Last 4 Digits of SSN: _____

Applicant Signature:_____ Date: _____

Signed (Program Officer):_____ Date:_____

I affirm to the best of my knowledge that the information entered above is true and accurate.

LDSS-3370 (Rev. 08/2019) DCCS version FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STATEWIDE CENTRAL REGISTER DATABASE CHECK

Agency Use Only

SCR USE ONLY
REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE:	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY (Use alpha codes on reverse):	PHONE NUMBER (Area Code):
				( ) -

PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER:

AGENCY NAME:

AGENCY LIAISON:

STREET ADDRESS:

CITY: **STATE:** **ZIP CODE:**

The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box above, are also on the reverse side of this form.

FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS/MARRIAGE SECTIONS THAT APPLY. IF NONE, STATE "NONE" *List RELATIONSHIP in the fields below.*

(see reverse side for instructions) Attach additional page if necessary.

The purpose of collecting the demographic data on *other persons in your household* who are not screened pursuant to Section 424-a of the Social Services Law is to enable the NYS Office of Children and Family Services to identify with the greatest degree of certainty whether the person(s) being screened is the subject of an indicated child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA **PLEASE TYPE OR PRINT CLEARLY**

☐ **IF THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK THIS BOX.**

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	Sex M/F	DATE OF BIRTH
APPLICANT			☐ M ☐ F	
APPLICANT MAIDEN/ALIAS/ MARRIED NAME			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	

Please provide your current address and any other addresses at which you have resided for the last 28-years, including street, street number, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 years of age or older.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /

I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE	DATE / /

APPLICANT'S SIGNATURE	DATE / /

EIGHTEEN-YEARS OF AGE OR OLDER:

I understand that as a person 18 years of age or older in a home of an applicant to become an Adoptive or a Foster Parent or a Family or Group Family Day Care provider, the information I have provided will be used to inquire of the Statewide Central Register to determine if I am the subject of an indicated report of child abuse or maltreatment.

SIGNATURE	DATE / /

SIGNATURE	DATE / /

STAPLE TO LDSS-3370, DCCS version *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM
ADDITIONAL PAGE

(Use only if the space on the form, **LDSS-3370,** DCCS version is not sufficient)

APPLICANT NAME: _____

Print clearly, all dates must be consecutive *(month/year)*. Be sure to associate address histories with particular individuals.

Previous Street Address	City	State	Zip	From (Mo/Yr)	To (Mo/Yr)
				/	/
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FINGERPRINTING IDENTIFICATION AND AUTHORIZATION FORM
(FPIA/DOHMH)

1. Section **A** of this form must be completed by the employee or applicant being fingerprinted by the New York City Department of Investigation (DOI). Section **B** must be completed by the Clearance Liaison or Alternate Liaison of the Child Care Service. Section **C** will be completed by Department of Investigation (DOI).
2. DOI fingerprints are by appointment only and will provide the applicant a copy of the completed FPIA. To schedule an appointment, log onto https://www1.nyc.gov/site/doi/offices/fingerprint-unit.page or call 212-825-5960.
3. The applicant must provide the completed FPIA to the Clearance Liaison or the Alternate Liaison who will retain the form on file at the Child Care Service.
4. To be fingerprinted, applicants must bring one photo identification from the approved list found on DOI's website at https://www1.nyc.gov/site/doi/offices/fingerprint-unit.page .
5. The fingerprint processing fee can be paid by credit card (plus credit card processing fee) or by Postal Money Order from the United States Post Office made payable to the New York City Department of Investigation (other types of money orders will not be accepted).

A. APPLICANT INFORMATION (all fields are required)

Social Security #: _____ _____
(**Signature of Applicant**)

Name: _____ _____
(Last) (First) (Middle) (Alias or Maiden Name)

Address: _____
(Street Number) (City/State) (Borough) (Zip Code)

Phone: _____ _____ _____
Job Title/Role Start Date

Date of Birth: _____ Age: _____ Place of Birth: _____
(State and Country)

Sex: _____ Race: _____ Skin Tone: _____ Hair: _____ Eyes: _____ Weight: _____ Height: _____
(Lbs) (Ft.) (In.)

B. CHILD CARE SERVICE / PROGRAM INFORMATION (all fields are required)

Program Type: **(Select One)** Direct Head Start Non-DOE Group Child Care Non-DOE School Based Child Care

\- Summer Youth Public Service Other: _____

Child Care Service / Provider Name: Young Minds in Motion Permit # / DC#: DC32971

Child Care Service Address: 556 Richmond Rd, Staten Island NY Zip Code: 10304

Child Care Director / Liaison Name: Priscilla James Phone: 347.709.9646

Child Care Director/ Liaison Signature: Priscilla James Date: _____

C. DEPARTMENT OF INVESTIGATION INFORMATION (FOR DOI USE ONLY)

DOI#: _____

Date Applicant Fingerprinted: _____

Signature of DOI Staff Member: _____