

Department of Public Health and Human Services  
Quality Assurance Division - Licensure Bureau  
Child Care Licensing

**Employee Cover Sheet**

Facility Name: \_\_\_\_\_ Provider # \_\_\_\_\_  
 Director Name: \_\_\_\_\_ Phone # \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Employee Name:  
(Include First, Middle, Last) \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Position/ Staff Role Type: \_\_\_\_\_ Date of Hire: \_\_\_\_\_

General Information	Dates Immunizations Given	CPR / First Aid Expires
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Td: _____	Adult: _____
Date of Birth: _____	MMR: _____	Child: _____
SS#: _____	Rubella: _____	Infant: _____
		1 <sup>st</sup> Aid: _____

Completed Annual Training:  Yes Date: \_\_\_\_\_ Completed Safe Sleep Training:  Yes Date: \_\_\_\_\_  
 Education / Experience: \_\_\_\_\_

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 For Office Use Only – Do Not Write Below this line  
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Release Of Information Received: _____			Out of State Check: <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Result of Check	Date Received	State	Received	Result
DOJ Dept. of Justice	<input type="checkbox"/> YES CH Record <input type="checkbox"/> NO CH Record				<input type="checkbox"/> YES CH <input type="checkbox"/> NO CH
CPS Protective Services	<input type="checkbox"/> YES PS Record <input type="checkbox"/> NO PS Record				<input type="checkbox"/> YES CH <input type="checkbox"/> NO CH
DMV Motor Vehicle	<input type="checkbox"/> YES MV Record <input type="checkbox"/> NO MV Record				<input type="checkbox"/> YES CH <input type="checkbox"/> NO CH
Statement of Health Received:			CAPS#:		PS#:
33A needed?: <input type="checkbox"/> Yes <input type="checkbox"/> No					

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

## DIRECTIONS

Day Care Centers		Family & Group Day Care Homes	
Care Giving Staff Role Types	Non-Care Giving Staff Role Types	Care Giving Staff Role Types	Non-Care Giving Staff Role Types
Director*	Non-Provider Staff	Director*	Spouse
Primary Caregiver*	Volunteer	Caregiver*	Other Adult
Aide*		Substitute*	Non-Provider Staff
Substitute*		Volunteer	

\* These are the provider staff types that interface with The Early Childhood Project and as such will receive PS# Cards.

### Family and Group Day Care Providers:

Complete employee coversheet form when submitting new employee paperwork within 15 days of hire.

**Attach the following documentation:**

**Release of Information** (DPHHS-QAD/CCL-20A – Revised 05-04)

**Statement of Health** (DPHHS-QAD/CCL-20B – Revised 07-2001)

**Td** (Tetanus Diphtheria- Current within the last ten Years)

**MMR** (if born after 1-1-1957) **or Rubella Titer or MMR** (if born before 1-1-1957)

**Infant CPR** (covers Infants– age 0-1 year)

**Child CPR** (covers children – ages 1 to 7 years)

**Adult CPR** (covers children to adults – age 8 and over)

**Must have all three courses regardless of ages of children served.**

**First Aid Certification**

**Safe Sleep Training Verification-** required within 60 days of hire

### Center Facilities:

Complete the entire employee cover sheet form when:

- ❖ submitting new employee paperwork (within 15 days of hire)
- ❖ submitting staff paperwork with a renewal packet

Indicate the position that each employee holds using the provider staff role type table above.

**Attach the following documentation:**

**Release of Information** (DPHHS-QAD/CCL-20A – Revised 05-04)

**Statement of Health** (DPHHS-QAD/CCL-20B – Revised 07-2001)

**Background check results-** for Criminal History, Protective Service, and Motor Vehicle.

The department will perform these checks for daycare center(s) that hold an extended registration.

**All other documentation should be entered on the Employee Cover Sheet and then kept on file at the facility. Your local licensing worker may audit your staff files at any time.**