KD's Klubhouse Child Development Center
12605 Mattawoman Dr Waldorf, MD 20601

Staff File Audit Checklist

- ☐ Application
- ☐ CDA (3 yrs) _____ 90 Hours _____ 45 Hours
- ☐ Continuing Education
- ☐ CJIS Clearance
- ☐ Food Handlers (3 yrs)
- ☐ Evaluations (Annually)
- ☐ Drug & Alcohol (Initial and Random)
- ☐ I.D.
- ☐ Resume
- ☐ Job Description
- ☐ KD's Klubhouse Employee Handbook Signature Page
- ☐ Individual Personnel Information
- ☐ Record of Professional Development Coursework
- ☐ Center Orientation Slip
- ☐ Release of Information
- ☐ Medical Report for Child Care
- ☐

Staff Assignment: _____ Start Date: _____

Person completing the audit: _____

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APPLICATION FORM

IT IS THE POLICY OF **KD's KLUBHOUSE CHILD DEVELOPMENT CENTER** TO PROVIDE EQUAL OPPORTUNITY TO ALL QUALIFIED PERSONS WITHOUT REGARD TO RACE, AGE, COLOR, SEX, RELIGION, NATIONAL ORIGIN, PHYSICAL DISABILITY, SEXUAL ORIENTATION, MARITAL STATUS OR MEDICAL CONDITION.

PLEASE ANSWER ALL QUESTIONS IN EACH SECTION COMPLETELY AND ACCURATELY EVEN WHEN ATTACHING A RESUME. PLEASE PRINT LEGIBILY.

DATE:_____

NAME:_____
Last First MI

ADDRESS:_____

_____
City State Zip Code

TELEPHONE: ( ) _____ MOBILE: ( ) _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

EDUCATION

High School: _____

CDA Endorsement: _____ CDA Certificate Expiration Date: _____

45 Hours Certificate: _____ Yes ____No

90 Hours Certificate: _____ Yes ____No

College: _____ Major: _____

Position applying for:_____

(**NOTE:** *No applicant will be denied employment solely on the grounds of conviction of a criminal offense. The nature of the offense, the data of the offense, the mitigating circumstances and the relevance of the offense to the position(s) applied for may, however, be considered). All successful applicants must provide KD's Klubhouse CDC with a criminal records/background check, no older than thirty (30) days, prior to being hired.*)

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MARYLAND STATE DEPARTMENT OF EDUCATION
Office of Child Care

INDIVIDUAL PERSONNEL INFORMATION

I am applying for: (check all that apply)
___Aide ___Assistant Teacher (school age)
___Teacher: ___ Infant/Toddler ___ Preschool ___ School age
___ Director: ___ Infant/Toddler ___ Preschool ___ School age

This form is to be completed by potential or new staff not previously evaluated or staff requesting re-evaluation. **SEND THE COMPLETED FORM AND ALL SUPPORTING DOCUMENTATION TO THE OFFICE OF CHILD CARE REGIONAL OFFICE. THE EVALUATION WILL BE BASED SOLELY ON DOCUMENTATION SUBMITTED TO OCC.**

NAME: _____
Last First Middle

OTHER NAMES USED _____

HOME ADDRESS: _____
Street P.O. Box or Apt. # City County State Zip Code

PREFERRED CONTACT NUMBER: (_____)_____ Email:_____

BIRTHDATE: _____ **(attach proof of birthdate)** SOCIAL SECURITY #: _____

Have you been evaluated to work in a child care center in the State of Maryland? **If "Yes", attach copy of evaluation and STOP HERE unless requesting re-evaluation.** ☐ Requesting Re-evaluation

EDUCATION:

1. Did you complete high school? ☐ No **If "Yes", attach copy of diploma, equivalency certificate or transcript.**
2. Did you complete any of the following? **If "Yes" check all that apply and attach copies of certificates/transcripts.**

45 hour course: ☐ Infant/Toddler ☐ Preschool ☐ School age ☐ Director Administration Training

90 hour course: ☐ Infant/Toddler ☐ Preschool ☐ School age

Other: ☐ CDA Credential ☐ Military Certificate ☐ ADA ☐ Breastfeeding Practices ☐ 9 hour Communication

3. Did you attend college? ☐ No **If "Yes", number of credits earned** _____ Did you earn a degree? ☐ No ☐ Yes

Major _____ Name of School _____ **(attach copy of transcript)**

4. Do you have a teaching certificate or teaching certification? ☐ No **If "Yes", attach copy of certificate or approval letter.**

5. Do you have Montessori Credentials? ☐ No **If "Yes" attach copy of credential(s).**

EXPERIENCE:

Provide information about your supervised experience working with groups of children in licensed child care centers, public/private schools, as a registered provider or other approved settings. Attach additional pages if necessary. **Attach documentation from each employer, which states the number of hours worked, the ages of the children worked with, the position and the length of time worked.**

Dates Worked From Mo	Yr	To Mo	Yr	Name of Facility (start with present employer)	Address and Phone #	Supervisor	Position	Ages of Children	# of Hours Worked Per Week

I confirm that the above information is true and correct to the best of my knowledge.

_____ _____
Signature Date

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Office of Child Care

MEDICAL REPORT FOR CHILD CARE

A. Name of the Person Evaluated (Please Print): _____	D. Reason for Examination:
B. Date of Birth: Age:	☐ Initial Employment
C. Name and Address of Child Care Applicant/Provider/Facility:	☐ Biennial (Two Year Update)
	☐ Other

E. PLEASE READ: *This person to be evaluated either provides or plans to provide child care services, lives in a home where child care is provided or will be provided. The Medical Evaluation is to assess this individual's ability to perform the following Child Care Activities:*

- Lifting, carrying children (infants, toddlers, preschool and school age)
- Lifting/moving children furniture/equipment
- Getting up and down from floor
- Close interaction with children
- Food preparation, serving, feeding and holding young infants
- Desk work, reading & writing
- Active indoor and outdoor activities
- Facility maintenance
- Driver of Vehicle (s)
- Other duties associated with assisting children in need, etc.

F. This Section Must Be Completed by a Physician or Registered Physician Assistant or Certified Registered Nurse Practitioner

	Yes	No	Remarks
1. Did you conduct a medical evaluation?			
a. Chronic medical conditions which may limit the ability to care for children, such as Epilepsy, asthma, others			
b. Impairment (Mobility/ Vision/ Hearing/ Speech)			
c. Nervous / Emotional/ Mental health disorder			
d. Drug /Alcohol Abuse			
e. Smoking			
f. Tuberculosis Screening: (1) symptoms check (2) screening: if needed or required by the Local Health Officer: Type of test:_____ Results:_____ Date (s):_____			
g. Communicable/Contagious diseases risk			
h. Immunization status			
2. Medical condition(s) or medication (s) the person is taking that may restrict /prevent the person's ability to perform care activities			
3. Medical limitation(s) or medication(s) the person is taking, that may require special accommodation: Please specify:			
4. Based on your findings, is this individual suitable/able to provide safe care to the children in child care or live in a child care home			

Additional Remarks:

G. Signature of the Health Care Provider: Date:

Printed Name & Credentials:

STAMP OR Complete Address of the Health Care Provider & Telephone Number:

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MARYLAND STATE DEPARTMENT OF EDUCATION

Division of Early Childhood Development - Office of Child Care
Record of Professional Development Coursework

Time Period Covered:

Month ___ Year_____ to Month___ Year_____

Name: _____

Party ID # _____ **Date Registered or Hired** _____

Position: ____**FCC Provider** _____**Director** ____ **Teacher** ____ **Aide**

Credentialing Level _____ **Expiration Date** _____

During the 1st year, Family Child Care Providers must take 18 clock hours of continued training with a minimum of 12 clock hours in the following (4) Core of Knowledge areas: Child Development, Working with Mixed Age Groups, Health, Safety and Nutrition and Professional Practices.

Family Child Care Providers, Directors, and Teachers must take 12 clock hours of continued training annually with a minimum of 6 clock hours in the Core of Knowledge areas. Aides must take 6 clock hours of continued training annually with a minimum of 3 clock hours in the Core of Knowledge areas.

Course Title *(Please add course number if known.)*	***Core of Knowledge Area(s)** (Indicate number of clock hours in the appropriate areas)						**Electives** (no more than 6 hrs)	**Date Completed**	**Totals**
	Child Dev	Curr	HSN	Spec N	Prof	Comm			
TOTALS									

The following mandatory training must remain current.	**Course Title**	**Expiration Date**
First Aid		
CPR ____*Adult* ____*Child* ____ *Infant*		

*Core of Knowledge areas are: Child Development (Child Dev), Curriculum (Curr), Health, Safety and Nutrition (HSN), Special Needs (Spec N), Professionalism (Prof), and Community (Comm)

OCC 100 March 2015 *(replaces the previous edition of OCC Form 100, and OCC Forms 101B and 101C which are obsolete)*

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MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

RELEASE OF INFORMATION – Child Care

Child Care regulations require signed and notarized permission to examine records of child and adult abuse and neglect for information about the applicant/operator (if the applicant/operator is an individual) or family child care provider/co-provider; each child care center employee or staff member; each adult, 18 years old or older, living on the premises of the child care facility or applicant; each family child care substitute and additional adult; each trustee, manager, and board member, who may have frequent contact with children in care, if the applicant/operator is a corporation, agency, association, or other organizational entity; and any other individual identified by the Office.

Facility Name and address: KD's Klubhouse CDC
(Name of Family Child Care Provider or Facility)

STATEMENT OF PERMISSION

I hereby authorize the Local Department of Social Services (DSS) to release to the Office of Child Care (OCC) any files or records of child and adult abuse or neglect in order to help OCC evaluate my suitability for employment in or by a child care center, or determine whether to approve the issuance or maintenance of an initial or continuing license, letter of compliance or registration for the above named facility.
Furthermore, I understand that the information obtained by OCC from the State or Local Department of Social Services may provide grounds for OCC to prohibit or require termination of my employment at the child care center, or deny, suspend, or revoke the license, letter of compliance, registration or application of the Child Care Center, Family Child Care Provider or Applicant/Operator named above.

Print Name First Middle Maiden Last | **Other Names Used**

Address: Street City State Zip Code

Telephone Number **Social Security Number** **Date of Birth** **Email Address**

Prior Addresses (List all within the last 5 years outside of Maryland. Use additional pages as needed)

Street Address City, State, Zip Code Dates of Residence

Street Address City, State, Zip Code Dates of Residence

☐ Male ☐ Female Primary Language Spoken: _____ Position _____
Employee, Resident, Substitute, Volunteer, etc.

Race (check all that apply): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other (specify): _____ Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

If I am not the Applicant/Operator or Provider, I authorize OCC to release this information to an authorized representative of the Child Care Center, or to the Family Child Care Provider or the Applicant/Operator.

Signature **Date**

Notary Signature **My commission Expires:** _____

Background Clearance Findings (*for OCC use only*) **Person Conducting Search** _____ **Date:** _____

☐ 1. The individual whose name is being searched is NOT identified in the Central Confidential Database for abuse or neglect.

☐ 2. Based on the information provided by the Local Department of Social Services, we have determined that the individual is listed in the Central Confidential Database as being ☐ Indicated or ☐ Unsubstantiated for ☐ abuse or ☐ neglect in reference to an investigation conducted in _____.

☐ 3. 181 and/or summary was received from Local Department of Social Services on _____.

☐ 4. The above named individual ☐ is or ☐ is not cleared for involvement in the Child Care Facility with the following restrictions: _____.

Regional Manager/Designee Signature Date

OCC 1260 – Revised 6/18 – All previous editions are obsolete

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MARYLAND STATE DEPARTMENT OF EDUCATION – Office of Child Care

RELEASE OF INFORMATION – Child Care

Name:_____

To ensure that the information obtained is for the correct individual, please provide additional family history information requested below.

Full names and birth dates of your child(ren) including, if any, whether living with you or not: **NOTE: If none, check this box** ☐

Child's First Name	Middle Name	Last Name	Date of Birth

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Staff Orientation Verification

Child Care Center (COMAR 13A.16.06.02) and Large Family Child Care Home (COMAR 13A.18.06.02) state, "On or before assignment, an operator shall ensure and document that each employee and staff member has been informed in writing about all areas pertinent to the health and safety of the children. . ."

Facility Name/Operator_____

*has informed me, in writing, of the following regulatory requirements pertinent to child health and safety in Child Care Centers **OR** Large Family Child Care Homes, as applicable.*

Check one: ☐ Child Care Center ☐ Large Family Child Care Home

(Check each item discussed below)

1. Location of the following:

   A. ☐ Telephone and emergency telephone numbers.
   B. ☐ First aid supplies.
   C. ☐ Emergency forms for children in care.
   D. ☐ Emergency on-call adults and staff who are required to be available to provide emergency coverage.

2. ☐ Medication administration and the identity of staff members who have completed approved training in medication administration.
3. ☐ Individuals who have been trained and hold a current certificate in First Aid and CPR.
4. ☐ Modified diet information, if applicable.
5. ☐ Emergency evacuation procedures and disaster plan.
6. ☐ Child discipline policy.
7. ☐ Authorized child release procedures.
8. ☐ Procedures for documenting and reporting injuries and accidents.
9. ☐ Approved hand washing and diapering procedures.
10. ☐ Requirements and procedures for reporting suspected child abuse and neglect.

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11. ☐ Signs and symptoms of child abuse and neglect.

12. ☐ Supervision appropriate to age and activity.

13. ☐ Community resources available to the family of a child who may have special needs.

14. Other Information:

☐ _____ ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ _____

15. ☐ The content of the most current edition of the COMAR 13A.16 Child Care Centers or COMAR 13A.18 Large Family Child Care Homes, as applicable. They may be accessed on the Maryland State Department of Education website at:

www.marylandpublicschools.org/MSDE/divisions/child_care/regulat

16. During the absence of the operator, a substitute is responsible for meeting the requirements of the regulations that include:

☐ Supervision and protection of each child in care.

☐ Operation of the facility.

I received an orientation about the above items on _____
Date

_____ _____
Printed name of the Employee/Staff Member Position

_____ _____
Signature of Employee/Staff Member Date

_____ _____
Signature of Operator Date

Please place completed form in employee record.