

ASSISTANT/SUBSTITUTE PROVIDER RECORD

FULL NAME OF CAREGIVER: _____ <input type="checkbox"/> ASSISTANT <input type="checkbox"/> SUBSTITUTE	
Street: _____	City: _____ State: _____ ZIP: _____
TELEPHONE NUMBER: _____	AGE: _____ (Attach Verification)
SPOUSE, PARENT, SIBLING OR CHILD OF THE PROVIDER <input type="checkbox"/> YES <input type="checkbox"/> NO	
PERSON TO BE CONTACTED IN CASE OF EMERGENCY:	
Name: _____	Telephone Number: _____
Street: _____	City: _____ State: _____ ZIP: _____
EDUCATION (For substitute provider):	
(Attach Verification)	
PROGRAMMATIC EXPERIENCE (For substitute provider):	
(Attach Verification)	
DATE OF EMPLOYMENT/VOLUNTEERING: _____	
TERMINATION DATE: _____	

ADDITIONAL REQUIREMENTS:

- TWO WRITTEN REFERENCES OR NOTATIONS OF VERBAL REFERENCES. (Obtained prior to employment for an assistant or substitute provider who is not the spouse, parent, sibling or child of the provider)

ORIGINAL BACKGROUND CHECKS

Renewed every five years

- SWORN DISCLOSURE STATEMENT INDICATING NO BARRIER CRIME (In caregiver record by the first day of employment)
- FINGERPRINT ELIGIBILITY LETTER (In the caregiver record by the first day of employment)
- CHILD PROTECTIVE SERVICES REGISTRY REPORT INDICATING NO FOUNDED COMPLAINT (In the caregiver record by the 30<sup>th</sup> day of employment)
- OUT OF STATE CHILD ABUSE AND NEGLECT SEARCH RESULTS (If person has lived out of state in the past five years) (In the caregiver record by the 30<sup>th</sup> day of employment)
- OUT OF STATE SEX OFFENDER SEARCH RESULTS (If person has lived out of state in the past five years) (In the caregiver record by the first day of employment)
- OUT OF STATE CHILD ABUSE AND NEGLECT SEARCH RESULTS (If person has lived out of state in the past five years) (Request submitted within 30 days of employment and results in the record within 45 days of making the request)

**REPORT OF TUBERCULOSIS SCREENING (Obtained every two years)**

\_\_\_\_\_  
**Expiration Date**

**DOCUMENTATION OF ORIENTATION TRAINING**

**DOCUMENTATION OF ANNUAL TRAINING (including annual emergency response training)**

**Current CPR certification (Renewed every two-three years)**

\_\_\_\_\_  
**Expiration Date**

**Current First Aid certification (Renewed every three years)** \_\_\_\_\_ (or documentation of licensure to administer prescription medications)  
**Expiration Date**

**Current MAT certification (Renewed every three years)** \_\_\_\_\_ (or documentation of licensure to administer prescription medications)  
**Expiration Date**

**FOR SUBSTITUTES, DOCUMENTATION OF TIME OF ARRIVALS AND DEPARTURES**

**FOR CAREGIVERS PROVIDING TRANSPORTATION, VALID DRIVER'S LICENSE**