Application for Employment

Date of Application _____

Please Print (Fully complete both pages)

Last four digits of SSN	Last Name	First Name	Middle Name

Address (street number and name)	City	County

State	Zip Code	Phone (home or where you can be reached)	Business Phone

Position Applied For:_____

Date of Birth: _____ N. C. Driver's License Number_____
(month) (day) (year)

Have you ever been convicted of breaking a law other than a minor traffic violation? YES____ NO____ If yes, give the date and explain fully. Use an additional piece of paper if more space is needed:_____

_____

Have you ever had an abuse or neglect or child maltreatment substantiation? YES____ NO____ If yes, list county/State and give the date and explain fully. Use an additional piece of paper if more space is needed:_____

_____

(The offense(s) and how recently you were convicted will be evaluated in relation to the job for which you are applying.)

Education

Circle the highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 GED College 1 2 3 4

Schools	Name and Location	Dates Attended	Coursed of Study	Degree/Diploma
High School				
		to		
College or University		to		
		to		
		to		
		to		
Graduate or Professional				
Educational, Vocational Schools, etc.				

Child care training completed in the last three years (such as First Aid, CPR, Health and Safety Training, ITS-SIDS, CDA etc.):

_____

References

List the names, addresses, and phone numbers of people we may contact as references:

_____

_____

_____

Work History

(List child care/early childhood experience first.)

Current or Last Employer			Address		
Job Title			Supervisor's Name		No. Supervised by you
Date Employed (mo/yr)	Starting Salary $ Per		Ending Salary $ Per	Reason for leaving	May we contact employer? yes no
Date Separated (mo/yr)			Duties:		
Full Time ✔	Years	Months			
Part Time	Years	Months			
If part time, number of hours per week					

Current or Last Employer			Address		
Job Title			Supervisor's Name		No. Supervised by you
Date Employed (mo/yr)	Starting Salary $ Per		Ending Salary $ Per	Reason for leaving	May we contact employer? yes no
Date Separated (mo/yr)			Duties:		
Full Time	Years	Months			
Part Time	Years	Months			
If part time, number of hours per week					

I certify that I have given true, accurate, and complete information on this form to the best of my knowledge. In the event confirmation is needed in connection with my work, I authorize educational institutions, associations, registration, and licensing boards, and others to furnish whatever detail is available concerning my qualifications. I authorize investigations of all statements made in this application and understand that false information of documentation, or a failure to disclose relevant information may be grounds for rejection of my application, disciplinary action, or dismissal if I am employed, and (or) criminal action. I further understand that dismissal on unemployment shall be mandatory if fraudulent disclosures are given to meet position qualifications.

Signature of Applicant_____ Date_____

Tuberculosis Screening Form

10A NCAC 09 .0701 (a) (Centers); .1702 (b)(4) and .1729 (a)(5) & (b) (Family Child Care Homes)

This questionnaire must be administered to all child care providers, by a licensed health care professional, before coming into contact with children. Directors, operators, additional caregivers, substitutes, and individuals who volunteer more than once a week must be screened. Testing should only be performed if the individual answers "yes" to one of the screening questions. Both screening and testing are available at the local health department.

Note to health care professionals: A negative risk and symptom screen should be considered a negative tuberculosis test in such individuals, and no further testing is required. An Interferon Gamma Release Assay is preferred over a tuberculin skin test for otherwise low-risk individuals with a positive response to the risk or symptom screening questionnaires. (See page 2.)

Last name (print clearly)	First name	Middle	Date of Birth

Tuberculosis Risk Questionnaire

1) Were you born outside the USA in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe?	**YES**	**NO**
2) Have you traveled outside the USA and lived for more than one month in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe?	**YES**	**NO**
3) Do you have a compromised immune system such as from any of the following conditions: HIV/AIDS, organ or bone marrow transplantation, diabetes, immunosuppressive medicines (e.g. prednisone, Remicade), leukemia, lymphoma, cancer of the head or neck, gastrectomy or jejeunal bypass, end-stage renal disease (on dialysis), or silicosis?	**YES**	**NO**
4) Have you ever done one of the following: used crack cocaine, injected illegal drugs, worked or resided in jail or prison, worked or resided at a homeless shelter, or worked as a healthcare worker in direct contact with patients?	**YES**	**NO**
5) Have you ever been exposed to anyone with infectious tuberculosis?	**YES**	**NO**

Tuberculosis Symptom Questionnaire

Do you currently have any of the following symptoms?		
1) Unexplained cough lasting more than 3 weeks?	**YES**	**NO**
2) Unexplained fever lasting more than 3 weeks?	**YES**	**NO**
3) Night sweats (sweating that leaves the bedclothes and sheets wet)?	**YES**	**NO**
4) Shortness of breath?	**YES**	**NO**
5) Chest pain?	**YES**	**NO**
6) Unintentional weight loss?	**YES**	**NO**
7) Unexplained fatigue (very tired for no reason)?	**YES**	**NO**

The above health statement is accurate to the best of my knowledge. I will contact my health care professional and/or the health department if my health status changes.

Signature:	Date:

Screening administered by licensed health care professional:

Printed name and location:	
Signature:	Date:

*This information must be included in the operator or staff member's medical file, which must be maintained separately from the operator or staff member's individual personnel file that is kept on site.

Tuberculosis Testing Form

10A NCAC 09 .0701 (a) (Centers); .1702 (b)(4) and .1729 (a)(5) & (b) (Family Child Care Homes)

Record of Tuberculosis Test

Last name (print clearly)	First name	Middle	Date of birth

Type of test:

☐ Tuberculin

Date given	
Date read	
Results	MM reading: _____ ☐ Negative ☐ Positive

☐ Interferon Gamma Release Assay

Date	
Results	

Comments:

Signature of Authorized Health Professional	Date	Location

*This information must be included in the operator or staff member's medical file, which must be maintained separately from the operator or staff member's individual personnel file that is kept on site.

Emergency Information – Staff

10A NCAC 09 .0701(a)

Child care providers, including the director, uncompensated providers, substitute providers, and volunteers must provide this information on or before the first day of work. Emergency information must be updated as changes occur and at least annually.

Date completed:	
Full name of individual:	
Home address:	
Phone number:	Email:

Person(s) to be contacted in case of an emergency:

Primary contact
Name:
Address:
Phone number:
Secondary contact
Name:
Address:
Phone number:

Choice of health care professional:
Address:
Telephone number:

Health Questionnaire – Child Care Centers

10A NCAC 09 .0701(a)

All staff, including the director, must complete a health questionnaire annually following the initial medical report. Substitute providers and volunteers must complete a health questionnaire on or before the first day of work and annually thereafter.

Full name of individual:	
Home address:	
Phone number:	Email:

I certify that I am emotionally and physically fit to care for children.

Signature:
Date:

This portion of the form to be completed by the Child Care Center Director

As the director, I understand that I may request another evaluation of a staff member's emotional and physical fitness to care for children when there is reason to believe that there has been deterioration in the staff member's emotional or physical fitness to care for children. This request may be made based upon factors such as observations of myself or other staff members, reports of concern from family, reports from law enforcement, or reports from medical personal. Child Care Rule 10A NCAC 09 .0701(b).

Director's Signature:
Date:

*This information must be included in the staff member's medical file, which must be maintained separately from the staff member's individual personnel file in the center. Child Care Rule 10A NCAC 09 .0701(d)

Staff Health Assessment/Medical Report

10A NCAC 09 .0701 (Child Care Centers)

This document, completed by a health care professional prior to employment, indicates that the individual listed is emotionally and physically fit to care for children. This form must have been completed within the last twelve months.

Full name of individual:	
Home address:	
Phone number:	Email:

To be completed by a health care professional

Date of assessment:
Does this applicant have any physical condition that would limit their ability to work with children? ☐ Yes ☐ No If yes, please describe:
Is this applicant currently under treatment that would limit their ability to work with children? ☐ Yes ☐ No If yes, please describe:
Is this applicant currently taking any medication that would affect his/her work with children? ☐ Yes ☐ No If yes, please describe:
In your opinion, is this applicant emotionally and physically capable to care for children on a daily basis? ☐ Yes ☐ No

Name of health care professional:	Date:
Signature of health care professional:	
Address:	
Phone number:	

*This information must be included in the staff member's medical file, which must be maintained separately from the staff member's individual personnel file in the center. Child Care Rule 10A NCAC 09 .0701(d).