

## Provider Application Form for Family Child Care Registration

Please print all information. Attach additional sheets if more space is needed. If you have any questions about this application form, please call \_\_\_\_\_.

The information received from or about you will be open to public review, except for medical records, any child abuse/neglect records, criminal conviction disclosure statements, names of enrolled children, and records of any investigations that are still in progress.

### 1. GENERAL INFORMATION

Applicant's name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_ Today's date \_\_\_\_\_

Landline Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Business name, if any \_\_\_\_\_

Mailing address if different from above \_\_\_\_\_

Are you a \_\_\_\_\_ new applicant \_\_\_\_\_ renewal applicant? (check one)

I certify that I am at least 18 years old. \_\_\_\_\_ (yes or no)

### 2. HOUSEHOLD MEMBERS

Do any children under 13 years old live with you in your home? (yes or no)

If yes, list each child's name, date of birth and relationship to you.

Child's name	Date of Birth	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do any adults and/or children 13 years old or older live with you in your home? \_\_\_\_\_ (yes or no)  
 If yes, give name and relationship to you. Put a check next to the name of any person who will assist you in caring for children.

Name	Relationship	In home during hours of operation?	
		Yes	No
_____	_____		
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No

**3. PETS**

Do you have any pets in the home? . (yes or no)  
 If yes, how many and what kind?

Are all your pets domesticated, non-aggressive and free from disease? \_\_\_\_\_ (yes or no) If no, please explain:

**4. DAYS AND HOURS OF SCHEDULED OPERATION**

Day	Yes	No	Hours of Service	Time Caregiver(s) Scheduled		
				Provider	Assistant	Alternate
Sunday						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						

Scheduled vacation / dates closed: \_\_\_\_\_

Are you now providing child care in your home? \_\_\_\_\_ (yes or no)

**5. SUBSTITUTE**

A substitute must be at least 18 years old. The substitute must submit a Child Abuse Record Information (CARI) form, and a Criminal Conviction Disclosure.

Who will provide substitute care in your home if you are unavailable?

Substitute's name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_ Telephone \_\_\_\_\_

I certify that this person is at least 18 years old. \_\_\_\_\_ (yes or no)

Will you provide care for the substitute's child or children in your home? \_\_\_\_\_ (yes or no)

If yes, will you charge a fee for this care? \_\_\_\_\_ (yes or no)

**6. ASSISTANT**

An assistant is required under certain conditions outlined in the Manual of Requirements. The assistant must be at least 14 years old. An assistant under 16 years old who is not your own child must have working papers. The assistant must submit a physician's statement, Mantoux TB test results, a Child Abuse Record Information (CARI) form, and a Criminal Conviction Disclosure.

Will you have an assistant? \_\_\_\_\_ (yes or no)

If yes, please complete the following:

Assistant's name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_ Telephone \_\_\_\_\_

I certify that this person is at least 14 years old. \_\_\_\_\_ (yes or no)

Age of assistant, if under 18 years old \_\_\_\_\_

Assistant's relationship to you, if any \_\_\_\_\_

Will you provide care for the assistant's child or children in your home? \_\_\_\_\_ (yes or no)

If yes, will you charge a fee for this care? \_\_\_\_\_ (yes or no)

**7. ALTERNATE**

You may have an alternate if you wish to share child care responsibilities with someone else. The alternate must be at least 18 years old. The alternate must attend training and submit a physician's statement, Mantoux TB test results, two references, a Child Abuse Record Information (CARI) form, and a Criminal Conviction Disclosure.

Will you have an alternate? \_\_\_\_\_ (yes or no)

If yes, please complete the following:

Alternate's name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_ Telephone \_\_\_\_\_

I certify that this person is at least 18 years old. \_\_\_\_\_ (yes or no)

Will you provide care for the alternate's child or children in your home? \_\_\_\_\_ (yes or no)

If yes, will you charge a fee for this care? \_\_\_\_\_ (yes or no)

**8. DISCLOSURES**

Have you ever received a certificate as a registered family day care provider in New Jersey? \_\_\_\_\_  
(yes or no)

If yes, in what county? \_\_\_\_\_

In what year? \_\_\_\_\_

Has your application to be a family day care provider ever been denied, or has your license, certificate, or other approval as a family day care provider ever been suspended, revoked, or refused for renewal in New Jersey or another state? \_\_\_\_\_ (yes or no)

If yes, please explain:

\_\_\_\_\_  
\_\_\_\_\_

You are required to tell us whether or not you have ever been convicted of a crime. Disclosures of criminal convictions must also be given to us by your substitute, your assistant, your alternate, and all members of your household who are at least 14 years old. This information will be reviewed and kept in a confidential file. Your application will not necessarily be affected by these disclosures. Please give us this information on the enclosed form marked Criminal Conviction Disclosures.

You are also required to consent to have the Department of Children and Families conduct a Child Abuse Record Information background check (CARI) to determine whether a report of child abuse or neglect has been substantiated against you or anyone living or working in your home. Your sex, race, and date of birth are needed for this check. This information and consent must also be given to us by your substitute, your assistant, your alternate, and all members of your household who are at least 14 years old. Your application for registration or renewal will be rejected if this consent is not given, or if an allegation of child abuse or neglect by you or anyone in your home has been substantiated by the State of New Jersey. Please give us this information on the enclosed form marked Child Abuse Record Information Consent Form.

**9. LISTINGS**

**A. NEW JERSEY CHILD CARE RESOURCE AND REFERRAL SYSTEM**

Do you wish to be listed with the New Jersey Child Care Resource and Referral System to have your name and telephone number given to parents who need child care? \_\_\_\_\_ (yes or no)

**B. OFFICE OF LICENSING FAMILY CHILD CARE LISTING**

The Office of Licensing (OOL), in the Department of Children and Families (DCF), makes available to the public a listing of registered family day care providers who choose to be included. You are not required to be included in this listing, and your application will not be affected by your answer to this question. If you answer "yes", your name, address and telephone number will be included in a listing of registered providers that is available to the public. There is no charge for a provider to be included in this listing. Those requesting such a listing from the OOL may be any member of the public, such as businesses that offer products or services related to child care; professional child care organizations; private resource and referral agencies that may give your name to parents who need child care; individual parents who need child care; and others. If you answer "no", your name, address and telephone number will only be given to the Office of Licensing and the Child Care Workers Union (CCWU) but will not be released to the public.

Do you wish to be included in a list of registered providers that is made available to the public by the DCF Office of Licensing? \_\_\_\_\_ (yes or no)

You may change your answer to any question in item 9A or B at any time by writing to your sponsoring organization at the address shown on the last page of this application form.

**10. SIGNATURE**

I certify that the information entered on this application is true to the best of my knowledge and belief. I understand that the deliberate inclusion of false information on this application form may result in the denial of this application, or the suspension, revocation or non-renewal of my Certificate of Registration.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**11. ADDITIONAL INFORMATION**

Please return this form with the following:

1. References information sheets for yourself and your alternate (New applicants only);
  2. Physician's statements for yourself, your alternate and your assistant;
  3. Mantoux TB test forms for yourself, your alternate and your assistant (separate TB test forms are not needed if the Mantoux TB test is included in the physician's statement) (New applicants only);
  4. Criminal conviction disclosures for yourself, your alternate, your assistant, your substitute, and all members of your household who are at least 14 years old; and
  5. Child Abuse Record Information (CARI) consent forms for yourself, your alternate, your assistant, your substitute, and all members of your household who are at least 14 years old.
  6. Proof of current pet vaccination(s) as documented by a veterinarian.
  7. Dates, times and locations of training sessions you have attended since your last Certificate was issued (Renewal applicants only).
  8. Documentation for yourself, and alternate, if any, of current certification in Cardiopulmonary Resuscitation (CPR) and completion of a first aid course taken within the last three years if there is no expiration date.
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**RETURN APPLICATION TO:**



Family Day Care Registration  
Criminal Conviction Disclosures

225 Long Avenue · Hillside, NJ 07205  
Phone: (973) 923-1433 Fax: (973) 923-1311  
www.cccunion.org

Return this form to the sponsoring organization along with your application for registration. This information will be kept confidential.

Provider applicant's name \_\_\_\_\_

Have you ever been convicted of a crime? \_\_\_\_\_ (yes or no)

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please Have Your Substitute Complete This Section

Substitute provider's name \_\_\_\_\_

Have you ever been convicted of a crime? \_\_\_\_\_ (yes or no)

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please Have Your Assistant (if any) Complete This Section

Assistant's name \_\_\_\_\_

Have you ever been convicted of a crime? \_\_\_\_\_ (yes or no)

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please Have Your Alternate (if any) Complete This Section**

Alternate's name \_\_\_\_\_

Have you ever been convicted of a crime? \_\_\_\_\_ ( yes or no )

If yes, please explain \_\_\_\_\_

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please Have All Members of Your Household Who Are 14 Year Old or Older  
Complete This Section**

Household member's name \_\_\_\_\_

Relationship to provider \_\_\_\_\_

Have you ever been convicted of a crime? \_\_\_\_\_ ( yes or no )

If yes, please explain \_\_\_\_\_

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

Household member's name \_\_\_\_\_

Relationship to provider \_\_\_\_\_

Have you ever been convicted of a crime? \_\_\_\_\_ ( yes or no )

If yes, please explain \_\_\_\_\_

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

Household member's name \_\_\_\_\_

Relationship to provider \_\_\_\_\_

Have you ever been convicted of a crime? \_\_\_\_\_ ( yes or no )

If yes, please explain \_\_\_\_\_

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

# CHILD ABUSE RECORD INFORMATION CONSENT FORM

DEPARTMENT OF CHILDREN AND FAMILIES  
OFFICE OF LICENSING  
FAMILY CHILD CARE REGISTRATION

PLEASE PRINT CLEARLY IN INK. COMPLETE THIS FORM ON BOTH SIDES AND RETURN IT TO THE SPONSORING ORGANIZATION. ATTACH ADDITIONAL SHEETS IF MORE SPACE IS NEEDED. SEPARATE COPIES OF THIS FORM MUST BE COMPLETED BY THE PROVIDER OR APPLICANT, THE SUBSTITUTE, ALTERNATE AND ASSISTANT (IF ANY), AND ALL HOUSEHOLD MEMBERS AT LEAST 14 YEARS OLD.

Print your full name (first, middle, last): \_\_\_\_\_

Previous name, maiden name or nicknames: \_\_\_\_\_

Date of name change or date of marriage: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Race: \_\_\_\_\_

Social Security number: \_\_\_\_\_ Sex: \_\_\_\_\_

NOTE: Pursuant to the Federal Privacy Act of 1974 (P.L. 93-579), the disclosure of your Social Security number is voluntary. Your Social Security number, race, date of birth, and sex will only be used for the purpose of conducting a Child Abuse Record Information background check as authorized by the New Jersey Family Child Care Registration Law (N.J.S.A. 30:5B-16 et seq.).

Full names and ages of all children below 14 years old living in your home, if any:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your previous addresses since July 1995 and the dates you lived at each address:

1) \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_  
(month) (year) (month) (year)

2) \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_  
(month) (year) (month) (year)

3) \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_  
(month) (year) (month) (year)

4) \_\_\_\_\_

From: \_\_\_\_\_ To: \_\_\_\_\_  
(month) (year) (month) (year)

(Please print)

Please check whether you are a: \_\_\_\_\_ new applicant for family child care registration  
\_\_\_\_\_ renewing provider \_\_\_\_\_ substitute \_\_\_\_\_ assistant \_\_\_\_\_ alternate  
\_\_\_\_\_ household member of a new applicant, renewing provider or current provider

If you are a substitute, assistant, alternate, or household member, please indicate the name of the  
applicant or provider: \_\_\_\_\_  
(Please print)

All persons completing this form must read the following and sign below:

I consent to have the Department of Human Services conduct a Child Abuse Record Information check to determine whether an allegation of child abuse or neglect has been substantiated against me. I certify that I am not currently being investigated for any allegation of child abuse or neglect. I understand that if a record of substantiated child abuse or neglect is found, or if I refuse to sign this consent form, the provider or applicant will not be permitted to become or remain a registered family child care provider. I certify that all information I have given on this form is accurate and complete to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

FOR SPONSORING ORGANIZATION USE ONLY

Sponsoring organization: **COMMUNITY COORDINATED CHILD CARE**  
Cost code: **001019** County: **UNION**  
Number of persons at least 14 years old living or working in this family day care home, including applicant/provider, spouse, resident children, substitute, assistant and alternate: \_\_\_\_\_

FOR OFFICE OF LICENSING USE ONLY

OOL staff initials \_\_\_\_\_

# Physician Statement



225 Long Avenue; Hillside, NJ 07205  
Phone: (973) 923-1433 Fax: (973) 923-1311  
[www.cccunion.org](http://www.cccunion.org)

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**Please have this form stamped by physician, or it will be returned and cause a delay in your paperwork.**

***To be completed by Family Child Care provider, assistant and/or alternate:***

Patient's name: \_\_\_\_\_

I am applying to be a  registered provider  provider assistant  alternate  Substitute (***if substitute is home during business hours***) (check one)

I authorize Dr.: \_\_\_\_\_ to release medical information concerning me to (sponsoring organization) ***Community Coordinated Child Care of Union County*** in connection with my application for my family child care registration.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If patient is a provider assistant or alternate, give providers' name and town:

\_\_\_\_\_

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**To be completed by physician:**

The above named patient is applying for registration as a family day care provider or provider assistant. New Jersey State regulations require a physician's statement verifying the applicant is in good health, free from communicable disease and able to care for children. To assist us in evaluating the applicant, we are asking you to answer the questions below to the best of your knowledge. For further information, please contact: **Sandra Lee-Chow at Community Coordinated Child Care** (telephone): (973) 923-1433 ext. 137.

1. Has the patient been tested for communicable TB? (yes or no) If yes, please state: Date: \_\_\_\_\_ Test: \_\_\_\_\_ Results \_\_\_\_\_

(Note: A Mantoux test is required with 5 TU of PPD tuberculin. A tine test is not acceptable. A chest x-ray is required if the patient has had a previous positive Mantoux test.)

2. Does the patient regularly take medication? \_\_\_\_\_ Yes or \_\_\_\_\_ No. If yes, could this medication adversely affect his or her ability to care for children? \_\_\_\_\_ (yes or no) if yes, please explain why: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Does the patient have a current communicable disease? \_\_\_\_\_ (yes or no) if yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. How would you describe the patient's general physical and mental health?

(check A, B or C)

A. \_\_\_\_\_ Good physical and mental health, no limitations for work with children.

B. \_\_\_\_\_ Health problem, but no limitations for work with children.

Please explain: \_\_\_\_\_  
\_\_\_\_\_

C. \_\_\_\_\_ Health problem that would limit ability to work with children.

Please explain: \_\_\_\_\_  
\_\_\_\_\_

Physician's signature: \_\_\_\_\_

Physician's name (please print): \_\_\_\_\_

Office address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of examination \_\_\_\_\_

Please list the names, addresses and telephone numbers of at least two people who have agreed to provide references. Both people must be unrelated to you. At least one of these people must be able to tell us about your character, reputation and suitability to work with children. This person may be a friend, neighbor, clergy person or anyone else who knows you well. The second reference may be from a former employer or teacher or the parent of a child you have cared for. If you have not worked or cared for children before, list another friend, neighbor or unrelated person.

1. Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone \_\_\_\_\_ How does this person know you?  
\_\_\_\_\_

2. Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone \_\_\_\_\_ How does this person know you?  
\_\_\_\_\_

3. Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone \_\_\_\_\_ How does this person know you?  
\_\_\_\_\_