New Child Care Facility Application Checklist

Palm Beach County Health Dept, Child Care Division
561-837-5984
Childcarelicensing@flhealth.gov

A deficiency letter will be sent to you via email within 30 Business days regarding all outstanding documents. Once all documents have been received and reviewed. Your area supervisor will reach out to you regarding site visit scheduling. The area supervisor will be made aware of your submission

Dear Future Child Care Facility Provider,

Thank you for your interest in opening a Child Care Facility with The Palm Beach County Health Dept. We are thrilled to hear of your passion for providing high-quality child care in our community and are excited about the possibility of partnering with you.

At The Palm Beach County Health Dept., we are committed to supporting individuals like yourself who are dedicated to making a positive impact in the lives of children and their families. We recognize the important role Child Care Facilities play in offering personalized, safe, and nurturing environments for young children to grow and thrive.

We would be happy to provide you with information and guidance on the necessary steps to open a Child Care Facility, including licensing requirements, training opportunities, and resources available through our organization. Our team is here to support you throughout the process and ensure that you have the tools and knowledge to succeed.

Please feel free to contact us at 561-837-5984 or *Childcarelicensing@flhealth.gov* to schedule a meeting or to ask any questions you may have. We look forward to the possibility of working together to create a positive and enriching environment for the children in our community.

Sincerely, The Child Care Licensing Department

General Documents :

Complete each document in its entirety and Make Copies as needed.

Complete Application: **must have sign offs** from building,fire and zoning	
Nighttime application: Based on closing time, anything after 6:00pm	
Corporation/Fictious Name: if applicable	
Proof of Ownership/Lease Agreement	
General and Workers Comp Liability: Certificate Holder: "Palm Beach County Health Department 800 Clematis Street West Palm Beach, FL 33401"	
2 Utility Bills: ex: Water Bill and Light Bill	
Well /Septic Application: if applicable	
Fire Inspection: Completed within the last 3 month	
2 sets of Floor Plan	
Transportation Survey: must be filled out and signed regardless if not applicable	
2 Site Plans Drawn to Scale	
Radon Application and Results	
Site Visit Request form: If Applicable ➢ *Pay $85 Invoice and Area supervisor will contact you for scheduling ➢ Only need to complete if provider is unsure if a location is suitable to become a child care facility and is in need of an in-person guidance from supervisor	

Owner/Director's Documents :

Complete each document in its entirety and Make Copies as needed.

Affidavit of Good Moral Character	
Child Abuse and Neglect Reporting	
Central Abuse Hotline Record Search (CAHRS): filled out in its entirety both pages	
Current Personnel list Affidavit	
Photo ID ➢ Front and Back Clear PDF Format	
OCA Request Form	
DCF Clearing House Eligibility	
DCF Training Transcript	
5 Year Employment History Check	
5 Hour Early Literacy	
Pediatric CPR & First Aid Training: Hands-On Training ➢ * Online Training will NOT be accepted*	
Fire Extinguisher Training	
Rilya Wilson Act	
Water safety training: if applicable	

Non-Active Members :

Complete each document in its entirety and Make Copies as needed.

Non-Active Member Affidavit	

If Transportation will be offered :

Mechanical Inspection: ASE Certified Mechanic	
DCF Transportation Training	
Annual Physical	
Driver's License	
Auto Liability: **Certificate Holder: "Palm Beach County Health Department 800 Clematis Street West Palm Beach, FL 33401"**	
Pediatric CPR & First Aid Training: Hands-On Training ➢ * Online Training will NOT be accepted*	

If Program plans to serve food :

Complete each document in its entirety and Make Copies as needed.

Food Manager Certificate	
Allergy List	
Menu: If Applicable	
Catered food must have permit from caterer	

Additional Documents Needed :

Daily Schedule for each age group	
Discipline and Expulsion Policy	
Allergy List	
Evacuation Route: Alternative and Routine Route	
Emergency Preparedness Procedures ➢ Fire Drill Procedures ➢ Inclement Weather (Hurricane, Tornado, Tropical depression) ➢ Lock Down ➢ Relocation	

PALM BEACH COUNTY CHILD CARE FACILITIES BOARD
FLORIDA DEPARTMENT OF HEALTH - PALM BEACH COUNTY 800 Clematis Street, West Palm Beach, FL 33401

FOR OFFICE USE ONLY
Offender Search
Date:_____
By:_____
Result: Exact match
Yes or No

APPLICATION TO OPERATE A CHILD CARE FACILITY

PLEASE TYPE OR PRINT LEGIBLY

Instructions: All information on this application must be truthful and correct. This three-page application must be completed in its entirety. Incomplete applications will not be accepted. Please contact this office if there are any questions relating to completing this application.

Choose Type of Facility		Choose Type of Request	
❑ Child Care Facility	❑ Drop-In Child Care Facility	❑ New Facility	
❑ Certificate of Compliance Facility	❑ School Age Child Care Facility	❑ Change in Capacity/Use	
❑ Indoor Recreation Facility	❑ Specialized Child Care/Mildly Ill Ill	❑ Change Ownership	❑ Change Director

PART 1: PROGRAM INFORMATION (this section must be completed in its entirety)

pp

Name of Facility as it is appears on license:	LLicense Number	Phone Number: (including area code):

Street Address of Facility (physical address):	City:	County: Palm Beach	Zip Code:

Mailing Address of Facility, if different (include city and zip code):

E-Mail Address:	FAX Number (including area code):

Days and Hours of Operation – please check AM or PM as applicable:

❑ 24 Hour Care

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Opening Time:	❑ AM ❑ PM	❑ AM ❑ PM	❑ AM ❑ PM	❑ AM ❑ PM	❑ AM ❑ PM	❑ AM ❑ PM	❑ AM ❑ PM
Closing Time:	❑ AM ❑ PM	❑ AM ❑ PM	❑ AM ❑ PM	❑ AM ❑ PM	❑ AM ❑ PM	❑ AM ❑ PM	❑ AM ❑ PM

Months of Operation: ❑ School Year Only ❑ 12 Months ❑ Other: _____

Program Designations:

❑ Faith Based ❑ Head Start ❑ Urban Zone ❑ Public/Non-Public School ❑ VPK ❑ School Readiness

Check all service options that apply:

Full Day ❑ Half Day ❑ Drop-In ❑ Night Care ❑ Before School ❑ After School ❑ Weekend ❑

Infant Care (0-12 mos) ❑ Infant Care (12-24 mos) ❑ Food Served ❑ Transportation ❑

Number of children under age 2 proposed to be kept at facility:	Number of children over age 2 proposed to be kept at facility:	Total capacity requested:
_____	_____	_____

ON-SITE DIRECTOR INFORMATION

Name of Director: _____ _____ _____ Date of Birth: _____
First Middle (Maiden) Last

Director's Home Address: _____ Zip Code: _____
(Street or P.O. Box) City

Telephone Number: (_____) _____

Director Credential Certificate Number: _____ Director Credential Level: _____
Certificate Expiration Date: _____

III. LEGAL OWNERSHIP OF CHILD CARE FACILITY (Complete One Section Only)

INDIVIDUAL

Name: First	Middle (Maiden)	Last	
Address (P.O. Box or Street Address)	City	Zip Code	Telephone Number ( )
Role in Child Care Facility Operation (Attach additional sheets if necessary)			

PARTNERSHIP

(Attach a copy of the Partnership Agreement)

Name: First	Middle (Maiden)	Last	
Address (P.O. Box or Street Address)	City	Zip Code	Telephone Number ( )
Role in Child Care Facility Operation (Attach additional sheets if necessary)			

Name: First	Middle (Maiden)	Last	
Address (P.O. Box or Street Address)	City	Zip Code	Telephone Number ( )
Role in Child Care Facility Operation (Attach additional sheets if necessary)			

CORPORATION

(Attach current Articles of Incorporation and Certificate of Status/Certificate of Authorization from Dept. of State)

Name: Telephone Number, including area code:	Corporate #: _____ Incorporated in which state?_____ Is the corporation registered with the Florida Secretary of State? ❑ Yes ❑ No (If no, please register prior to submitting an application.)		
Address (P.O. Box or Street Address)	City	State	Zip Code
Attach a list of Director's names, and the title/office, address, and telephone number for each Director. Also attach the street address of the corporation's registered office, and the name and telephone number of the corporation's registered agent. Failure to continuously maintain a registered office and/or a registered agent in Florida is grounds for revocation of this license.			
All corporations must include a current Certificate of Status (domestic corporation), or a Certificate of Authorization (foreign corporation) with this application. Failure by any corporation to comply with all requirements under Chapter 607, Florida Statutes, is grounds for revocation of this license.			

OTHER ENTITY

(These are programs operated by School Boards, before and after school programs, and other non-incorporated entities.)

Name of Entity:				
Entity's Designated Representative: First	Middle (Maiden)		Last	
Address (P.O. Box or Street Address)	City	State	Zip Code	Telephone Number ( )

IV. OWNER OF REAL PROPERTY

Legal Name: First	Middle (Maiden)	Last	Telephone Number ( )
Address (P.O. Box or Street Address)	City	State	Zip Code

V. ATTESTATION

Has the facility owner, applicant, or director ever had a license denied, revoked or suspended in any state or jurisdiction or has been the subject of a disciplinary action or had been fined while operating a child care facility or family day care home or employed in a childcare facility?

❑ Yes ❑ No *If Yes, please explain:* _____

_____

[Attach additional sheet(s) if necessary]

I hereby attest that the information contained in this section is truthful and correct under penalty of perjury. _____
Initial

Have you or anyone identified as a party to ownership ever held a license (child care, foster care, cosmetology, etc.) with any state agency in any capacity other than a driver's license?

❑ Yes ❑ No *If Yes, where, what type of license, license number, and under what name?*

_____

[Attach additional sheet(s) if necessary]

It is agreed that the undersigned has received a copy of Chapter 77-620, Laws of Florida, as amended, the Palm Beach County Rules and Regulations Governing Child Care Facilities and other applicable regulations adopted by reference therein, and will adhere to the provisions of these Statutes, Rules, and Regulations.

Pursuant to the Palm Beach County Rules and Regulations Governing Child Care Facilities, child enrichment service providers shall be of good moral character based upon screening, using Level 2 standards in Chapter 435, F. S. If this facility utilizes a child enrichment service provider, it is the responsibility of the director to ensure that the child enrichment service provider is screened accordingly and parents/guardians provide written consent before a child may participate in activities conducted by the child enrichment service provider. Your signature on this application indicates your understanding and compliance with the law.

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), personally identifiable health information must be protected from disclosure and maintained in a manner to prevent inadvertent disclosure to the public and to otherwise assure the privacy of such information. Your signature on this application indicates that you agree to comply with the requirements of HIPAA by protecting the confidentiality of employee and children's health records in your possession.

Pursuant to section 435.05(3), F.S., each employer must attest via signed affidavit compliance with the provisions of chapter 435.04, F.S. By signing below, I _____, Applicant of _____ Child Care Facility, do hereby affirm that all child care personnel meet the statutory requirements for background screening.

Falsification of application information is grounds for denial or revocation of the license to operate a child care facility. Under penalty of perjury I hereby attest that the information contained in this application is truthful and correct.

This application may be withdrawn at any time the applicant so desires. _____DATE_____
Signature of Owner or Organization's Designated Representative

Sworn to and subscribed before me this _____ day of _____, 20_____

_____ _____
SIGNATURE OF NOTARY PUBLIC, STATE OF FLORIDA — Print, Type, or Stamp Commissioned Name of Notary Public

❑ Affiant personally known to notary OR

❑ Affiant produced the following identification: _____

THIS APPLICATION REQUIRES THE WRITTEN APPROVAL OF THE FOLLOWING AGENCIES:

Building Department: _____ _____ Date: _____
Print Name — Signature

Comments: _____

Zoning Department: _____ _____ Date: _____
Print Name — Signature

Approved Capacity: _____ Comments:_____

Fire Department: _____ _____ Date:_____
Print Name — Signature

Comments: _____

CHILD CARE ADVISORY COUNCIL: _____Date: _____

Palm Beach County Child Care Licensing

CHILD CARE FACILITY APPLICATION FOR NIGHT TIME CARE APPROVAL

Authority: Palm Beach County Rules and Regulations Governing Child Care Facilities, adopted pursuant to Chapter 2010-249, Special Acts, Laws of Florida.

FACILITY NAME _____

ADDRESS _____ LICENSE NUMBER: _____

OPERATOR/DIRECTOR _____ PHONE _____

This application for nighttime care approval is being made pursuant to Article XVI of Palm Beach County Rules and Regulations Governing Child Care Facilities, which has been read, and the requirements fully understood by the applicant.

Requested Days & Hours of Night Time Care: _____

Current Days & Hours of Operation: _____

I understand that my child care facility may be inspected by representatives of the Palm Beach County Health Department or Child Care Facilities Board at any time during the hours of operation while children are in care.

I understand that falsification of application information is grounds for denial or revocation of the license to operate a child care facility. Under penalty of perjury I hereby attest that the information contained in this application is truthful and correct.

_____ _____

Signature of Owner Signature of Director

THIS APPLICATION FOR NIGHTTIME OPERATION *REQUIRES THE WRITTEN APPROVAL OF THE FOLLOWING LOCAL GOVERNMENT OFFICIALS:*

Building Department: _____ _____ Date: _____

Print Name Signature

Comments: _____

Zoning Department: _____ _____ Date: _____

Print Name Signature

Approved Capacity: _____ Hours of Operation (if restricted): _____ : _____

Comments _____

Fire Department: _____ _____ Date: _____

Print Name Signature

Comments: _____

CHILD CARE ADVISORY COUNCIL: _____ Date: _____

OSTDS APPLICATION CHECKLIST FOR EXISTING SYSTEM APPROVAL

This checklist is used when making additions to a property on septic which do not result in an increase of estimated sewage flow. This includes but is not limited to the addition of a swimming pool, shed, concrete slab, garage, patio, pole barn, gazebo, electrical generators, LP gas tanks, driveway, or residential additions/modifications where the number of bedrooms is not increasing.

_____ **Application Form (DEP 4015 page 1)**
Signed and dated by the owner or the owner's authorized representative (agent authorization letter required), or a contractor licensed under Florida Statute Chapter 489. Please include email address.

_____ **Floor Plan (for enclosed structures)**
Showing the number of bedrooms. Must show the total building area of the structure or be drawn to scale with outside dimensions.

_____ **Septic Survey/Site Plan**
Showing the existing septic tank and drainfield, respectively, and the proposed addition. This information can be hand-drawn on an existing survey or site plan, however, please ensure all information is updated and accurate. Setback dimensions must be provided on drawings that are not to scale.

_____ **$85.00** – Application fee payable to Florida Department of Health in Palm Beach County.

Florida Department of Health, Palm Beach County
Division of Environmental Public Health
P.O. Box 29, 800 Clematis Street, West Palm Beach, FL 33402
PHONE: 561-837-5900 • FAX: 561-837-5294
FloridaHealth.gov / palmbeach.floridahealth.gov

OSTDS APPLICATION CHECKLIST FOR **NEW SYSTEM CONSTRUCTION**

Please provide 2 copies of the following per Florida Administrative Code (FAC) 62-2 & Palm Beach County Unified Land Development Code, Article 15, Environmental Control Rule I (ECR-I):

_____ **Application Form (DEP 4015 page 1)**
Signed and dated by the owner, the owner's authorized representative (agent authorization letter required), or a contractor licensed under Florida Statute Chapter 489. Please include email address.

_____ **Site Evaluation & System Specifications Form (DEP 4015 page 3)**
Performed by one of the following:

a) Professional Engineer registered in the State of Florida with training in soils
b) Person certified under F.S. § 381.0101 (Certified Environmental Health Professional or Registered Sanitarian)
c) Master septic tank contractor licensed under F.S. Ch. 489
d) Professional soil scientist certified and registered by the Florida Association of Environmental Soil Scientists (FAESS)

_____ **Floor Plan(s)**
Showing the number of bedrooms. Must show the total building area of the structure or be drawn to scale with outside dimensions.

_____ **Septic Survey / Site Plan**
Prepared by a professional land surveyor. A professional engineer may prepare the site plan, however, a survey is required to provide, at a minimum, a certified benchmark with elevation, Mean Annual Flood Line (MAFL) for permanent non-tidal surface water bodies (PNSWB), and Mean High Water Line (MHWL) for tidally influenced surface water bodies per statutory and code requirements. See 62-6 FAC and ECR-I for specific site plan requirements.

_____ **$360.00** – Application and permit fee payable to Florida Department of Health in Palm Beach County.

STATE OF FLORIDA
DEPARTMENT OF ENVIRONMENTAL PROTECTION
ONSITE SEWAGE TREATMENT AND DISPOSAL SYSTEM (OSTDS)

PERMIT NO. _____
DATE PAID: _____
FEE PAID: _____
RECEIPT #: _____

APPLICATION FOR CONSTRUCTION PERMIT

APPLICATION FOR:
[ ] New System [ ] Existing System [ ] Holding Tank [ ] Innovative
[ ] Repair [ ] Abandonment [ ] Temporary [ ] _____

APPLICANT: _____ EMAIL: _____

AGENT: _____ TELEPHONE: _____

MAILING ADDRESS: _____

==========

TO BE COMPLETED BY APPLICANT OR APPLICANT'S AUTHORIZED AGENT. SYSTEMS MUST BE CONSTRUCTED BY A PERSON LICENSED PURSUANT TO 489.105(3)(m) OR 489.552, FLORIDA STATUTES. IT IS THE APPLICANT'S RESPONSIBILITY TO PROVIDE DOCUMENTATION OF THE DATE THE LOT WAS CREATED OR PLATTED (MM/DD/YY) IF REQUESTING CONSIDERATION OF STATUTORY GRANDFATHER PROVISIONS.

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PROPERTY INFORMATION OSTDS REMEDIATION PLAN? [Y / N]

LOT: _____ BLOCK: _____ SUBDIVISION: _____ PLATTED: _____

PROPERTY ID #: _____ ZONING: _____ I/M OR EQUIVALENT: [Y / N]

PROPERTY SIZE: _____ ACRES WATER SUPPLY: [ ] PRIVATE PUBLIC [ ]<=2000GPD [ ]>2000GPD

IS SEWER AVAILABLE AS PER 381.0065, FS? [Y / N] DISTANCE TO SEWER: _____ FT

PROPERTY ADDRESS: _____

DIRECTIONS TO PROPERTY: _____

_____

_____

BUILDING INFORMATION [ ] RESIDENTIAL [ ] COMMERCIAL

Unit No.	Type of Establishment	No. of Bedrooms	Building Area Sqft	Commercial/Institutional System Design Table I, Chapter 62-6, FAC
1				
2				
3				
4				

[ ] Floor/Equipment Drains [ ] Other (Specify) _____

SIGNATURE: _____ DATE: _____

APPLICANT:	Property owner's full name.
AGENT:	Property owner's legally authorized representative.
EMAIL:	Email address for applicant or agent.
TELEPHONE:	Telephone number for applicant or agent.
MAILING ADDRESS:	P.O. box or street, city, state and zip code mailing address for applicant or agent.
OSTDS REMEDIATION PLAN:	Is the property subject to the requirements of an Onsite Sewage Treatment and Disposal System (OSTDS) Remediation Plan developed pursuant to 403.067(7)(a), Florida Statutes?
LOT, BLOCK, SUBDIVISION:	Lot, block, and subdivision for lot (recorded or unrecorded subdivision). If lot is not in a recorded subdivision, a copy of the lot legal description or deed must be attached.
DATE OF SUBDIVISION:	Official date of subdivision recorded in county plat books (month/day/year) or date lot originally recorded. Dividing an approved lot into two or more parcels for the purpose of conveying ownership shall be considered a subdivision of the lot.
PROPERTY ID#:	27-character number for property. County Health Department may require property appraiser ID # or section/township/range/parcel number.
ZONING:	Specify zoning and whether or not property is in I/M zoning or equivalent usage.
PROPERTY SIZE:	Area of lot in acres (square footage divided by 43,560 square feet). List only the square footage contained within the bounds of the legal description.
WATER SUPPLY:	Check private or public <= 2000 gallons per day or public > 2000 gallons per day.
SEWER AVAILABILITY:	Is sewer available as per 381.0065, Florida Statutes, and distance to sewer in feet?
PROPERTY ADDRESS:	Street address for property. For lots without an assigned street address, indicate street or road and locale in county.
DIRECTIONS:	Provide detailed instructions to lot or attach an area map showing lot location.
BUILDING INFORMATION:	Check residential or commercial.
TYPE ESTABLISHMENT:	List type of establishment from Table I, Chapter 62-6, FAC. Examples: single family, single wide mobile home, restaurant, doctor's office and number of occupants.
NO. BEDROOMS:	Count all rooms designed primarily for sleeping and those areas expected to routinely provide sleeping accommodations for occupants per 381.0065(2)(b), Florida Statutes.
BUILDING AREA:	Total square footage of enclosed habitable area of dwelling unit, excluding garage, carport, exterior storage shed, or open or fully screened patios or decks. Based on outside measurements for each story of structure.
BUSINESS ACTIVITY:	For commercial/institutional applications only. List number of employees, shifts, and hours of operation, or other information required by Table I, Chapter 62-6, FAC.
FIXTURES:	Mark Floor/Equipment Drains or Others and specify item or "NA" if not applicable.
SIGNATURE / DATE:	Signature of applicant or agent. Date application submitted to the County Health Department with appropriatefees and attachments.

ATTACHMENTS: A site plan drawn to scale, showing boundaries with dimensions, locations of residences or buildings, swimming pools, recorded easements, onsite sewage disposal system components and location, slope of property, any existing or proposed wells, drainage features, filled areas, obstructed areas, and surface water. Location of wells, onsite sewage disposal systems, surface waters, and other pertinent facilities or features on adjacent property, if the features are within 75 feet of the applicant lot. Location of any public well within 200 feet of lot. For residences, a floor plan (residences) showing number of bedrooms and building area of each unit. For nonresidential establishments, a floorplan showing the square footage of the establishment, all plumbing drains and fixture types, and other features necessary to determine composition and quantity of wastewater.

STATE OF FLORIDA
DEPARTMENT OF ENVIRONMENTAL PROTECTION
APPLICATION FOR CONSTRUCTION PERMIT

Permit Application Number_____

- PART II - SITEPLAN -

Scale: Each block represents 10 feet and 1 inch = 40 feet.

Notes: _____

_____

_____

_____

Site Plan submitted by:_____ _____

Plan Approved_____ Not Approved_____ Date_____

By_____County Health Department

ALL CHANGES MUST BE APPROVED BY THE COUNTY HEALTH DEPARTMENT

FOR NEW/EXISTING/MODIFICATION SYSTEM APPLICATIONS: The plan must be **DRAWN TO SCALE** and must be for the property where the system is to be installed.

1. The site plan must **SHOW BOUNDARIES WITH DIMENSIONS** and any of the following **FEATURES THAT EXIST OR THAT ARE PROPOSED**:

☐ a. Structures;
☐ b. Swimming pools;
☐ c. Recorded easements;
☐ d. Onsite sewage treatment and disposal system components;
☐ e. Slope of the property;
☐ f. Wells;
☐ g. Potable and non-potable water lines and valves;
☐ h. Drainage features;
☐ i. Filled areas;
☐ j. Excavated areas for onsite sewage systems;
☐ k. Obstructed areas;
☐ l. Surface water bodies *Requires a surveyor to set the Mean High Water Line boundary for tidally influenced surface water bodies. Requires a surveyor or department staff to set the Mean Annual Flood Line for permanent non-tidal surfacewater bodies.*
☐ m. Location of the reference point for system elevation.

☐ 2. If the county health department is responsible for performing the site evaluation, the applicant or applicant's authorized representative must **indicate the approximate location of wells, onsite sewage treatment and disposal systems, surface water bodies and other pertinent facilities or features on contiguous or adjacent property. If the features are within 75 feet of the applicant lot, the estimated distance to the feature must be shown but need not be drawn to scale.**

☐ 3. If the county health department will not be performing the site evaluation, the applicant or authorized agent isresponsible for the measurements to all features, including the pertinent features within 75 feet of the applicant lot. **The location of any public drinking water well, as defined in paragraph 62-6.002(44)(b), F.A.C., within 200 feet of the applicant's lot must also be shown, with the distance indicated from the system to the well.**

☐ 4. If an individual lot is five acres or greater, the applicant may draw a minimum one acre parcel to scale showing all required features, or the minimum size drawing necessary to properly exhibit all required features, whichever is larger. The applicant must also show the location of that one acre or larger parcel inside the total site ownership. *The to scale parcel must be large enough to provide sufficient authorized flow.*

☐ 5. All information that is necessary to determine the total sewage flow and proper setbacks on the site ownership must be submitted with the application. The applicant lot shall be clearly identified. **A copy of the legal description or surveymust accompany the application for confirmation of property dimensions only.**

FOR REPAIR APPLICATIONS: A site plan (*NOT REQUIRED TO BE DRAWN TO SCALE)* showing:

☐ property dimensions
☐ the existing and proposed system configuration and location on the property
☐ the building location
☐ potable and non-potable water lines, within the existing and proposed drainfield repair area
☐ the general slope of the property
☐ property lines and easements
☐ any obstructed areas
☐ any private well *show private potable wells if within 100 feet of system, non-potable within 75 feet*
☐ any public wells *show if within 200 feet of system*
☐ any surface water bodies and stormwater systems *show if within 100 feet of system. Requires a surveyor to set theMean High Water Line boundary for tidally influenced surface water bodies. Requires a surveyor or department staff toset the Mean Annual Flood Line for permanent non-tidal surface water bodies.*
☐ The existing drainfield type shall be described. For ex., mineral aggregate, non-mineral aggregate, chambers, or other.
☐ **Any unusual site conditions which may influence the system design or function** such as sloping property, drainage structures such as roof drains or curtain drains, and any obstructions such as patios, decks, swimming pools or parking areas.

FOR ALL SITE PLANS (IF APPLICABLE)

☐ A Coastal Construction Control Line Permit or an exemption notice from the Department of Environmental Protection if any component of the onsite sewage treatment and disposal system or the shoulders or slopes of the system mound will be seaward of the Coastal Construction Control Line, established under Section 161.053, F.S. Should the location of the proposed onsite system relative to the control line not be able to be definitively determined based on the site plan and theonline products available on the DEP website, the applicant shall provide a survey prepared by a certified professional surveyor and mapper showing the location of the control line on the subject property.
☐ All plans and forms submitted by a licensed engineer shall be dated, signed and sealed.
☐ The evaluator shall document the **locations of all soil profiles** on the site plan.

STATE OF FLORIDA
DEPARTMENT OF ENVIRONMENTAL PROTECTION
ONSITE SEWAGE TREATMENT AND DISPOSAL SYSTEM

PERMIT NO. _____

_____

SITE EVALUATION AND SYSTEM SPECIFICATIONS

APPLICANT: _____ AGENT: _____

LOT: _____ BLOCK: _____ SUBDIVISION: _____

PROPERTY ID #: _____ [Section/Township/Parcel No. or Tax ID Number]

TO BE COMPLETED BY ENGINEER, HEALTH DEPARTMENT EMPLOYEE,OR OTHER QUALIFIED PERSON. ENGINEERS MUST PROVIDE REGISTRATION NUMBER AND SIGN AND SEAL EACH PAGE OF SUBMITTAL. COMPLETE ALL ITEMS.

PROPERTY SIZE CONFORMS TO SITE PLAN: [ ] YES [ ] NO NET USABLE AREA AVAILABLE: _____ ACRES
TOTAL ESTIMATED SEWAGE FLOW: _____ GALLONS PER DAY [TABLE I / OTHER]
AUTHORIZED SEWAGE FLOW: _____ GALLONS PER DAY [1500 GPD/ACRE OR 2500 GPD/ACRE]
UNOBSTRUCTED AREA AVAILABLE: _____ SQFT UNOBSTRUCTED AREA REQUIRED: _____ SQFT

BENCHMARK/REFERENCE POINT LOCATION: _____
ELEVATION OF PROPOSED SYSTEM SITE IS _____ [INCHES/FT] [ABOVE/BELOW] BENCHMARK/REFERENCE POINT

THE MINIMUM SETBACK WHICH CAN BE MAINTAINED FROM THE PROPOSED SYSTEM TO THE FOLLOWING FEATURES
SURFACE WATER: _____ FT DITCHES/SWALES: _____ FT NORMALLY WET? [ ] YES [ ] NO
WELLS: PUBLIC: _____ FT LIMITED USE: _____ FT PRIVATE: _____ FT NON-POTABLE: _____ FT
BUILDING FOUNDATIONS: _____ FT PROPERTY LINES: _____ FT POTABLE WATER LINES: _____ FT

SITE SUBJECT TO FREQUENT FLOODING: [ ] YES [ ] NO 10 YEAR FLOODING? [ ] YES [ ] NO
10 YEAR FLOOD ELEVATION FOR SITE: _____ FT MSL/NGVD SITE ELEVATION: _____ FT MSL/NGVD

SOIL PROFILE INFORMATION SITE 1

MUNSELL #/COLOR	TEXTURE	DEPTH
		TO
		TO
		TO
		TO
		TO
		TO
		TO
		TO
		TO
		TO

USDA SOIL SERIES: _____

SOIL PROFILE INFORMATION SITE 2

MUNSELL #/COLOR	TEXTURE	DEPTH
		TO
		TO
		TO
		TO
		TO
		TO
		TO
		TO
		TO
		TO

USDA SOIL SERIES: _____

OBSERVED WATER TABLE: _____ INCHES [ABOVE / BELOW] EXISTING GRADE. TYPE:[PERCHED / APPARENT]
ESTIMATED WET SEASON WATER TABLE ELEVATION: _____ INCHES [ABOVE / BELOW] EXISTING GRADE
HIGH WATER TABLE VEGETATION: [ ] YES [ ] NO WSWT INDICATOR: [ ] YES [ ] NO DEPTH: ___ INCHES

SOIL TEXTURE/LOADING RATE FOR SYSTEM SIZING: _____ DEPTH OF EXCAVATION: _____ INCHES
DRAINFIELD CONFIGURATION: [ ] TRENCH [ ] BED [ ] OTHER (SPECIFY) _____
REMARKS/ADDITIONAL CRITERIA: _____

SITE EVALUATED BY: _____ DATE: _____

INSTRUCTIONS:

PERMIT #:	Permit tracking number assigned by County Health Department.
APPLICANT:	Property owner's full name.
AGENT:	Property owner's legally authorized representative.
LOT, BLOCK, SUBDIVISION:	Lot, block, and subdivision for lot.
PROPERTY ID#:	27-character number for property (property appraiser ID # or section/township/range/parcel number).
PROPERTY SIZE:	Check if property size at site conforms to submitted site plan and legal description.
NET USABLE AREA:	Record net usable area available per Rule 62-6.005(7)(c), F.A.C. Net usable area does not include paved areas and prepared road beds within public rights-of-way or easements and does not include surface water bodies. Contiguous unpaved and non-compacted road rights-of-way and easements with no subsurface obstructions that would affect the operation of drainfield systems may be included.
SEWAGE FLOW:	Record the total estimated sewage flow for the establishment from Chapter 62-6.008(1)(a) or (b), F.A.C. Record the authorized sewage flow for the lot based on net usable area and water supply (1500 gallons per day per acre for private water supplies and 2500 gallons per day per acre for public water supplies). If authorized sewage flow does not equal or exceed the estimated sewage flow, the application must be denied.
UNOBSTRUCTED AREA:	Record the square feet of unobstructed area available and the amount required. Unobstructed area must be at least 1.5 times as large as the drainfield absorption area and must meet minimum setbacks in Chapter 62-6, FAC. The unobstructed area must be contiguous to the drainfield.
BENCHMARK INFORMATION:	Record the location of the benchmark. If using a surveyor's benchmark record the actual elevation. Record the elevation of the proposed system site in relation (above or below) to the benchmark for the most restrictive profile.
MINIMUM SETBACKS:	Record minimum setbacks which can be met to all listed features. Actual measurements must be recorded or "NA" for non- applicable features. Features on site plan or within 75 feet of the applicant lot must be measured. The location of any public drinking well within 200 feet of the applicant's lot must also be verified.
FLOOD INFORMATION:	Record information on lot's subject to flooding. For lots subject to flooding record 10 year flood elevation for site and actual site elevation.
SOIL PROFILE INFORMATION:	Two soil profiles within the proposed absorption area to a minimum depth of 6 feet or refusal are required. Soil identification will use USDA Soil Classification methodology (Munsell colors and USDA soil textures). Refusals must be clearly documented. Provide USDA soil series if available, record "UNK" if the series cannot be determined.
WATER TABLE:	Record the depth of the observed water table at the time of the evaluation. Mark "perched" or "apparent" as appropriate. Record the estimated wet season water table (WSWT) elevation based on site evaluation, USDA soil maps, and historical information. Indicate if there is high water table vegetation present and list in comments. Indicate presence and depth of shallowest WSWT indicator.
SOIL TEXTURE:	Record soil texture or loading rate for system sizing based on the most restrictive profile.
DEPTH OF EXCAVATION:	If applicable record depth of excavation required based on the most restrictive profile. Record "NA" if not applicable.
DRAINFIELD CONFIGURATION:	Check drainfield configuration required. If other, specify type.
ADDITIONAL CRITERIA:	Record any additional remarks pertinent to site or installation. Ex. Dosing required and document any WSWT indicators.
SITE EVALUATED BY:	Signature of evaluator, title, and date of evaluation. Professional engineers must seal all documentation submitted.

ELEVATION WORKSHEET ELEVATION OF BENCHMARK OR REFERENCE POINT IS: _____

BENCHMARK	_____	SITE 1		SITE 2		SITE 3	
[+] SHOT	_____	H.I.	_____	H.I.	_____	H.I.	_____
H.I.	_____	[-] SHOT	_____	[-] SHOT	_____	[-] SHOT	_____
	_____		_____		_____		_____

STATE OF FLORIDA
DEPARTMENT OF ENVIRONMENTAL PROTECTION
ONSITE SEWAGE TREATMENT AND DISPOSAL SYSTEM

PERMIT NO. _____

_____

EXISTING SYSTEM AND SYSTEM REPAIR EVALUATION

APPLICANT: _____

CONTRACTOR / AGENT: _____

LOT: _____ BLOCK: _____ SUBDIV: _____ ID#: _____

==========

TO BE COMPLETED BY FLORIDA REGISTERED ENGINEER, DEPARTMENT EMPLOYEE, SEPTIC TANK CONTRACTOR OR OTHER CERTIFIED PERSON. SIGN AND SEAL ALL SUBMITTED DOCUMENTS. COMPLETE ALL APPLICABLE ITEMS. COMPLETE TANK CERTIFICATION BELOW OR NOTE IN REMARKS WHY THE TANKS CANNOT BE CERTIFIED.

==========

EXISTING TANK INFORMATION

[ ] GALLONS SEPTIC TANK/GPD ATU LEGEND: _____ MATERIAL: _____ BAFFLED:[Y / N]
[ ] GALLONS SEPTIC TANK/GPD ATU LEGEND: _____ MATERIAL: _____ BAFFLED:[Y / N]
[ ] GALLONS GREASE INTERCEPTOR LEGEND: _____ MATERIAL: _____
[ ] GALLONS DOSING TANK LEGEND: _____ MATERIAL: _____ # PUMPS:[ ]

==========

I CERTIFY THAT THE LISTED TANKS WERE PUMPED ON ___/___/___ BY _____, HAVE THE VOLUMES SPECIFIED AS DETERMINED BY [DIMENSIONS / FILLING / LEGEND], ARE FREE OF OBSERVABLE DEFECTS OR LEAKS, AND HAVE A [SOLIDS DEFLECTION DEVICE / OUTLET FILTER DEVICE] INSTALLED.

_____ _____ _____
SIGNATURE OF LICENSED CONTRACTOR BUSINESS NAME DATE

==========

EXISTING DRAINFIELD INFORMATION

[ ] SQUARE FEET PRIMARY DRAINFIELD SYSTEM NO. OF TRENCHES [ ] DIMENSIONS: _____X_____
[ ] SQUARE FEET _____ SYSTEM NO. OF TRENCHES [ ] DIMENSIONS: _____X_____
TYPE OF SYSTEM: [ ] STANDARD [ ] FILLED [ ] MOUND [ ] _____
CONFIGURATION: [ ] TRENCH [ ] BED [ ] _____
DESIGN: [ ] HEADER [ ] D-BOX [ ] GRAVITY SYSTEM [ ] DOSED SYSTEM
ELEVATION OF BOTTOM OF DRAINFIELD IN RELATION TO NATURAL GRADE _____ INCHES [ABOVE / BELOW]

SYSTEM FAILURE AND REPAIR INFORMATION

[ ] SYSTEM INSTALLATION DATE TYPE OF WASTE [ ] DOMESTIC [ ] COMMERCIAL
[ ] GPD ESTIMATED SEWAGE FLOW BASED ON [ ] METERED WATER [ ] TABLE I, 62-6, FAC

SITE CONDITIONS: [ ] DRAINAGE STRUCTURES [ ] POOL [ ] PATIO / DECK [ ] PARKING
[ ] SLOPING PROPERTY [ ] _____

NATURE OF FAILURE: [ ] HYDRAULIC OVERLOAD [ ] SOILS [ ] MAINTENANCE [ ] SYSTEM DAMAGE
[ ] DRAINAGE / RUN OFF [ ] ROOTS [ ] WATER TABLE [ ] _____

FAILURE SYMPTOM: [ ] SEWAGE ON GROUND [ ] TANK [ ] D BOX/HEADER [ ] DRAINFIELD
[ ] PLUMBING BACKUP [ ] _____

REMARKS/ADDITIONAL CRITERIA _____

SUBMITTED BY: _____ TITLE/LICENSE _____ DATE: _____

INSTRUCTIONS:

PERMIT #	Permit tracking number assigned by department.
APPLICANT	Property owner's full name.
CONTRACTOR/AGENT	Licensed contractor or property owner's legal agent.
LOT, BLOCK, SUBDIVISION	Legal description for property.
ID #	Property appraiser identification number for property.

EXISTING TANK:

TANK 1	Complete tank size in gallons or gpd and mark appropriately. Complete LEGEND (approval number), MATERIAL (concrete, fiberglass, polyethylene) and whether or not tank is BAFFLED.
TANK 2	Same as TANK 1.
GREASE INTERCEPTOR	Same as TANK 1.
DOSING TANK	Same as TANK 1. Complete # PUMPS installed.
TANK CERTIFICATION	Completed by registered septic tank contractor, state-licensed plumber, certified EH professional, or master septic tank contractor. Show the date the tanks were pumped, the name of the pumping company, how the tank volumes were determined (measurement of tank dimensions and calculation of volume, filling the tank from a metered water source, or recording the tank legend for known tanks). If tank dimensions are used, list the tank dimensions in the remarks section. Indicate whether the tank has a solids deflection device or an outlet filter. If the tanks cannot be certified, note that fact in the remarks section.

EXISTING DRAINFIELD:

FIELD 1	Complete size of drainfield in square feet, NO. OF TRENCHES (if applicable) and DIMENSION (bed width and length or trench width and total length of trenches).
FIELD 2	Same as FIELD 1.
TYPE OF SYSTEM	Mark appropriate block.
CONFIGURATION	Mark appropriate block.
DESIGN	Mark appropriate blocks.
ELEVATION	Record elevation of lowest point of bottom of drainfield in reference to natural grade.

FAILURE / REPAIR INFORMATION:

INSTALLATION DATE	Record year of original system installation.
TYPE OF WASTE	Mark appropriate block.
GPD	Provide estimated sewage flow to system based on metered water flow data (if available) or Table I, whichever is greater.
SITE CONDITIONS	Mark all applicable blocks. Record any other significant conditions.
NATURE OF FAILURE	Mark all applicable blocks.
FAILURE SYMPTOM	Mark all applicable blocks.
REMARKS	Record any other significant criteria that may impact system design. If dimensions are used to determine tank volumes, list the tank dimensions in the remarks section. If the tanks cannot be certified as free of observable defects or leaks, explain in remarks.
SUBMITTED BY	Signature of person performing evaluation.
TITLE/LICENSE	Title of department person or license number of other evaluators.
DATE	Date of evaluation.

Palm Beach County Child Care Licensing

Child Child Care Transportation Survey

Directions: Please complete this form as part of the license renewal or application process. This will satisfy the requirement for notifying the Department about transportation services in accordance with Article XIV(A) of the Family Child Care Rules and Regulations.

Facility Name: License #:

1. **Transportation Provided**: ◯ Yes ◯ No (***CHECK ONE***)

2. **Number and Types of Vehicles Owned or Leased**

Vehicle Type (Bus, Van, etc.)	**Make**	**Year**	**Color**	**Tag Number**	**Type of Child Safety Alarm Installed**

3. **Type of transportation services provided or planned. (Check all that apply.)**

☐ Field trips ONLY — **Use of Own Vehicles:** ☐ **Use of Parents' Vehicles:** ☐ **Use of Chartered Bus:** ☐

☐ School to Facility ☐ Facility to School

☐ Child's Home to Facility ☐ Facility to Child's Home

☐ Bus Stop to Facility ☐ Facility to Bus Stop

☐ Facility to Other Destination: (specify:_____)

☐ Other Location (specify: _____) to Facility.

☐ Other (specify: _____).

Completed By: _____ _____
NAME / SIGNATURE ***DATE***

CHILD CARE VEHICLE INSPECTION

Pursuant to the Palm Beach County Rules and Regulations Governing Child Care Facilities, Article XVII, Section A.6., all child care facilities must, on an annual basis, have all vehicles regularly used to transport children inspected by a mechanic to certify proper working order. The items listed below set forth minimum standards only and are additional and supplemental to any and all requirements found in Florida Statutes, Chapter 316 and the Rules promulgated thereunder.

Child Care/Owner: _____
Address: _____
_____
Phone No.: _____ Seating Capacity: _____
Chassis Make: _____ Year: _____
Body Make: _____ Year: _____
V.I.N. _____
Tag Number: _____ Expires: _____

P - Proper working order N/A - Not applicable

	P	N/A		P	N/A
Headlights			Inside Rearview Mirror		
Parking Lights			Outside Rearview Mirror		
Tail Lights			Sideview Mirror		
Brake Lights			Crossover Mirror		
Directional Lights			Emergency Warning Devices		
Hazardous Warning Signals			Windshield		
Clearance Lamps			Windows		
Side Marker Lamps			Rub Rails		
Identification Lamps			Bumpers		
Reflectors			Pupil Warning Lamp System		
Brakes			Stop Arm		
Steering System			Drive Shaft Guards		
Suspension			Neutral Safety Switch		
Windshield Wipers			Tires		
Horns			Wheels		
Exhaust System			Seat Belts		
Fuel System			Interior Lights		
Engine			Electrical System		
Service Door			Tag Light		
Emergency Door			Child Safety Alarm System		
Emergency Exits			Air Conditioning		

The above items have been checked and found to be in proper working order.

Inspected By: _____ ASE Certificate # _____ Date: _____

Business Name: _____

Address: _____

Florida HEALTH

Bureau of Environmental Health
Radon Program
Mandatory Measurements
NONRESIDENTIAL RADON MEASUREMENT REPORT

FOR BUILDINGS OTHER THAN SINGLE OR MULTI FAMILY DWELLING

SECTION 1: FACILITY AND OWNER INFORMATION

Facility Information:

Facility Name (as licensed, registered, or listed with state)

Physical location (Street Address) of Facility Site

City County Zip

Name of Contact Person

Title ( ) Phone Number

Owner Information:

Name of Owner

Street Address

City State Zip

( ) Phone Number

Facility type as licensed or registered (Submit individual facilities separate. I.E. A Day Care and School at the same place):

- ☐ Assisted Living Facility (previously ACLF)
- ☐ Alcohol, Drug Abuse or Mental Health
- ☐ Correctional Facility or Jail
- ☐ **Day Care** Center (pre kindergarden)
- ☐ Delinquency Program (Ex: Start Center, Training School)
- ☐ OTHER (specify) _____
- ☐ Hospitals (Acute Care, Physical Rehab., Psychiatric, or Intensive Residential Treatment)
- ☐ Nursing Home/Skilled Nursing Facility
- ☐ **Public School** (K-12)
- ☐ **Private School** (K-12)

SECTION 2: BUILDING INFORMATION

Building Name or ID Number (If Applicable)

Street Address of Building (If Different From Facility Site)

Buildings per address ___; Building No. ___ of ___ requiring testing.

Number of measurements required in this building during this testing period: _____ Initial _____ 5-year retest _____ Follow-up

Cumulative number of measurements reported for this testing period: _____ Initial _____ 5-year retest _____ Follow-up

CHECK ALL THAT APPLY

Foundation/Floor System:

- ☐ Slab
- ☐ Crawlspace
- ☐ Pier
- ☐ Floored Basement
- ☐ Bare Earth Basement
- ☐ Other (specify) _____

Year Built ____
No. of Stories ____
No. Stories occupied __

SECTION 3: RESULTS

Measurement Type: ☐ Initial or 5 Year Retest, ☐ Follow-up

Dates of Measurement: FROM / / TO / /

Name of Person who performed Measurement (Placed Device) _____ Certificate No. (If Applicable) _____

Story	Room	Result	Units†	Device‡	Time in Hours

† P for pCi/L or W for WL

‡ AC-Activated Carbon Adsorption, AT-Alpha Track, CR-Continuous Radon Monitor, CW-Continuous Working Level Monitor, EL-Electret Ion Chamber Long Term, ES-Electret Ion Chamber Short Term, LS-Liquid Scintillation, RP-RPISU, UT-Unfiltered Alpha Track

SECTION 4

COMPLETE ONLY IF MEASUREMENTS ARE PERFORMED BY A RADON MEASUREMENT BUSINESS

Name of Business and Cert. No. _____

Name of Specialist and Cert. No. _____

Signature of Specialist _____

SECTION 5

COMPLETE ONLY IF MEASUREMENTS ARE PERFORMED BY STAFF EMPLOYED BY THE FACILITY

I hereby certify that the Radon measurements reported herein have been performed in accordance with Chapter 64E-5, Florida Administrative Code, and Chapter 404, Florida Statutes.

Authorized Representative of Facility _____ Date _____

Upon completion of this form, **send to**:
Department of Health
Bureau of Environmental Health / Radon Program
4052 Bald Cypress Way, Bin #A08
Tallahassee, FL 32399-1720
You may scan the report and email it to RadonReports@FLhealth.gov

For assistance in completing this form call 1-800-543-8279

Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Florida HEALTH Palm Beach County

Ron DeSantis
Governor

Joseph A. Ladapo, MD, PhD
State Surgeon General

Site Visit Request for Child Care Licensing

Applicant/Owner:		
Site Address:		
E-mail:		
Contact Phone Number and name if different from Applicant/Owner:		
◉ **Child Care Facility (Commercial Location)**	○ **Family Child Care Home (Private Home Location)**	○ **Substantial Compliance Facility (Co-located with K-12 School)**

What age children will your program serve? Check all that apply.			
☐ Infants (0-1 year)	☐ Infant (1-2 year)	☐ Preschool	☐ School Age

When will your program operate? Check all that apply.		
☐ Daytime	☐ Nighttime (after 7:00 PM)	☐ Weekends

What services would you like to offer?			
☐ Before School	☐ Afterschool	☐ Food Service	☐ Transportation

Signature of Applicant	**Date:**

Submit to Child Care Licensing:

- E-mail: PBChildcare@flhealth.gov
- Mail: Child Care Licensing
  - 800 Clematis Street
  - West Palm Beach, FL 33401
- Fax: 561-837-5084

- **An invoice will be e-mailed with instructions for payment of $85.00**
- **Once payment has been processed, a supervisor will contact you to schedule the site visit.**

For Office Use Only		
Fee: $85.00	Date Paid:	Receipt # 50-BID-

AFFIDAVIT OF GOOD MORAL CHARACTER

State of Florida County of _____

Before me this day personally appeared _____ who, being duly
(Applicant's/Employee's Name)
sworn, deposes and says:

As an applicant for employment with, an employee of, a volunteer for, or an applicant for certification with _____, I affirm and attest under penalty of perjury that I meet the moral character requirements for employment, as required by the Florida Statutes and rules, in that:

I have not been arrested with disposition pending or found guilty of, regardless of adjudication, or entered a plea of nolo contender or guilty to or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction for any of the offenses listed below:

	Relating to:
Section: 39.205	failure to report child abuse, abandonment, or neglect
Section: 393.135	sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct
Section: 394.4593	sexual misconduct with certain mental health patients and reporting of such sexual misconduct
Section: 414.39	fraud, if the offense was a felony
Section: 415.111	adult abuse, neglect, or exploitation of aged persons or disabled adults or failure to report of such abuse
Section: 741.28	criminal offenses that constitute domestic violence, whether committed in Florida or another jurisdiction
Section: 777.04	attempts, solicitation, and conspiracy to commit an offense listed in this subsection
Section: 782.04	murder
Section: 782.07	manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child
Section: 782.071	vehicular homicide
Section: 782.09	killing an unborn child by injury to the mother
Chapter: 784	assault, battery, and culpable negligence, if the offense was a felony
Section: 784.011	assault, if the victim of the offense was a minor
Section: 784.021	aggravated assault
Section: 784.03	battery, if the victim of the offense was a minor
Section: 784.045	aggravated battery
Section: 784.075	battery on staff or a detention or commitment facility or on a juvenile probation officer
Section: 787.01	kidnapping
Section: 787.02	false imprisonment
Section: 787.025	luring or enticing a child
Section: 787.04(2)	taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceeding
Section: 787.04(3)	carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person
Section: 787.06	human trafficking
Section: 787.07	human smuggling
Section: 790.115(1)	exhibiting firearms or weapons within 1,000 feet of a school
Section: 790.115(2) (b)	possessing an electric weapon or device, destructive device, or other weapon on school property
Section: 794.011	sexual battery
Former Section: 794.041	prohibited acts of persons in familial or custodial authority
Section: 794.05	unlawful sexual activity with certain minors
Section: 794.08	relating to female genital mutilation
Chapter: 796	prostitution
Section: 798.02	lewd and lascivious behavior
Chapter: 800	lewdness and indecent exposure
Section: 806.01	arson

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Section: 810.02	burglary
Section: 810.14	voyeurism, if the offense is a felony
Section: 810.145	video voyeurism, if the offense is a felony
Chapter 812	relating to theft, robbery, and related crimes, if the offense was a felony
Section: 817.563	fraudulent sale of controlled substances, only if the offense was a felony
Section: 825.102	abuse, aggravated abuse, or neglect of an elderly person or disabled adult
Section: 825.1025	lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult
Section: 825.103	exploitation of disabled adults or elderly persons, if the offense was a felony
Section: 826.04	incest
Section: 827.03	child abuse, aggravated child abuse, or neglect of a child
Section: 827.04	contributing to the delinquency or dependency of a child
Former Section: 827.05	negligent treatment of children
Section: 827.071	sexual performance by a child
Section: 831.311	unlawful sale, manufacture, alteration, delivery, uttering, or possession of counterfeit-resistant prescription blanks for controlled substances
Section: 836.10	written or electronic threats to kill, do bodily injury, or conduct a mass shooting or an act of terrorism
Section: 843.01	resisting arrest with violence
Section: 843.025	depriving a law enforcement, correctional, or correctional probation officer means of protection or communication
Section: 843.12	aiding in an escape
Section: 843.13	aiding in the escape of juvenile inmates in correctional institution
Chapter: 847	obscene literature
Section: 859.01	poisoning food or water
Section: 873.01	prohibition on the purchase or sale of human organs and tissues
Section: 874.05	encouraging or recruiting another to join a criminal gang
Chapter: 893	drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor
Section: 916.1075	sexual misconduct with certain forensic clients and reporting of such sexual conduct
Section: 944.35(3)	inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm
Section: 944.40	escape
Section: 944.46	harboring, concealing, or aiding an escaped prisoner
Section: 944.47	introduction of contraband into a correctional facility
Section: 985.701	sexual misconduct in juvenile justice programs
Section: 985.711	contraband introduced into detention facilities

THE FOLLOWING APPLIES ONLY TO THOSE APPLICANTS FOR POSITIONS REQUIRED TO BE SCREENED UNDER SECTION 408.809, FLORIDA STATUTES:

In addition to the Chapter 435, F.S. listed offenses the following offenses are also applicable for any licensure or employment required in the applicable statutes.

	Relating to:
Chapter: 408	felony offenses contained in Chapter 408
Section: 409.920	Medicaid provider fraud
Section: 409.9201	Medicaid fraud
Section: 741.28	domestic violence
Section: 777.04	attempts, solicitation, and conspiracy to commit an offense listed in this subsection
Section: 784.03	battery, if the victim is a vulnerable adult as defined in s. 415.102 or a patient or resident of a facility licensed under chapter 395, chapter 400, or chapter 429
Section: 817.034	fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems
Section: 817.234	false and fraudulent insurance claims
Section: 817.481	obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony
Section: 817.50	fraudulently obtaining goods or services from a health care provider
Section: 817.505	patient brokering
Section: 817.568	criminal use of personal identification information
Section: 817.60	obtaining a credit card through fraudulent means
Section: 817.61	fraudulent use of credit cards, if the offense was a felony
Section: 831.01	forgery
Section: 831.02	uttering forged instruments
Section: 831.07	forging bank bills, checks, drafts or promissory notes
Section: 831.09	uttering forged bank bills, checks, drafts, or promissory notes
Section: 831.30	fraud in obtaining medicinal drugs
Section: 831.31	the sale, manufacture, delivery, or possession with the intent to sell, manufacture, deliver any counterfeit controlled substance, if the offense was a felony
Section: 895.03	racketeering and collection of unlawful debts
Section: 896.101	the Florida Money Laundering Act

CONTINUED ON NEXT PAGE

I also affirm that I have not been designated as a sexual predator pursuant to s. 775.21; a career offender pursuant to s. 775.261; or a sexual offender pursuant to s. 943.0435, unless the requirement to register as a sexual offender has been removed pursuant to s. 943.04354.

SIGNATURE OF AFFIANT:_____

I understand that I must acknowledge the existence of any applicable criminal record relating to the above lists of offenses including those under any similar statute of another jurisdiction, regardless of whether or not those records have been sealed or expunged.

SIGNATURE OF AFFIANT:_____

I understand that, while employed or volunteering at _____ in any position that requires background screening as a condition of employment, I must immediately notify my supervisor/employer of any arrest and any changes in my criminal record involving any of the above listed provisions of Florida Statutes or similar statutes of another jurisdiction whether a misdemeanor or felony. This notice must be made within one business day of such arrest or charge. Failure to do so could be grounds for termination.

SIGNATURE OF AFFIANT:_____

CONTINUED ON NEXT PAGE

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I attest that I have read the above carefully and state that my attestation here is true and correct that **my record does not contain any of the above listed offenses.** I also understand that it is my responsibility to obtain clarification on anything contained in this affidavit which I do not understand prior to signing. I am aware that any omissions, falsifications, misstatements or misrepresentations may disqualify me from employment consideration and, if I am hired, may be grounds for termination or denial of an exemption at a later date.

SIGNATURE OF AFFIANT:_____

Sign Above OR Below, DO NOT Sign Both Lines

To the best of my knowledge and belief, **my record contains one or more of the applicable disqualifying acts or offenses listed above. I have placed a check mark by the offense(s) contained in my record.** (If you have previously been granted an exemption for this disqualifying offense, please attach a copy of the letter granting such exemption.) (Please circle the number which corresponds to the offense(s) contained in your record.)

SIGNATURE OF AFFIANT:_____

Sworn to and subscribed before me this _____day of _____, 20___.

_____
SIGNATURE OF NOTARY PUBLIC, STATE OF FLORIDA

_____
(Print, Type, or Stamp Commissioned Name of Notary Public)

(Check one)

☐ Affiant personally known to notary

OR

☐ Affiant produced identification
Type of identification produced:_____

CF 1649, February 2025 (Obsoletes previous editions which may not be used)

Child Abuse & Neglect Reporting Requirements

All child care personnel are mandated by law to report their <u>suspicions</u> of child abuse, neglect, or abandonment to the Florida Abuse Hotline in accordance with s. 39.201 of the Florida Statutes (F.S.).

* Child care personnel must be alert to the physical and behavioral indicators of child abuse and neglect. "Child Abuse or Neglect" is defined in s. 39.201, F.S., as "harm or threatened harm" to a child's health (mental or physical) or welfare by the acts or omissions by a parent, adult household member, other person responsible for the child's welfare, or for purposes of reporting requirements by any person.

  Categories include:
  - Physical Abuse or Neglect (i.e. unexplained bruises, hunger, lack of supervision...)
  - Emotional Abuse or Neglect (i.e. impairment in the ability to function, depression...)
  - Sexual Abuse (i.e. withdrawal, excessive crying, physical symptoms...)

* Reports must be made immediately to the Florida Abuse Hotline Information System by
  - Telephone at 1-800-96-ABUSE (1-800-962-2873), or
  - Fax at 1-800-914-0004, or
  - Online at http://www.dcf.state.fl.us/abuse/report/.

* Failure to perform duties of a mandatory reporter pursuant to s. 39.201, F.S. constitutes a violation of the standards in ss. 402.301-319, F.S. and is a felony of the third degree. **<u>Remember</u>**, it is each child care personnel's responsibility to report suspected abuse and/or neglect.

* All reports are confidential. However, persons who are mandated reporters (child care personnel) are required to give their name when making a report.

* It is important to give as much identifying and factual information as possible when making a report.

* Any person, when acting in good faith, is immune from liability in accordance with s. 39.203(1)(a), F.S.

* For more information about child abuse and neglect, visit the Department's website at www.myflfamilies.com/childcare and select "Training & Credentialing." The Department offers a 4-hour *Identifying and Reporting Child Abuse and Neglect* course for child care providers. This course is an overview of the various types of abuse and neglect, indicators that may be observed, the legal responsibility of mandatory reporters, and the proper procedure for reporting abuse and neglect, as required by ss. 402.305(2) and 402.313(1), F.S. The course is offered both online and instructor-based throughout Florida.

This statement is to verify that on _____, 20___, I, _____
Date Print Name of Employee

Read and understood the information and my mandated reporting requirements.

_____ _____
Signature of Employee (for facility or large family child care home) Signature of Operator

Central Abuse Hotline Record Search

STATE OF FLORIDA
DEPARTMENT OF CHILDREN & FAMILIES

Local Licensing Agency :
PBC Child Care Facilities Board -
Palm Beach County Health Dept.

I/we, _____ and _____
*(**please print** – first, middle, last name)* *(**please print** – spouse first, middle, last name, if applicable)*

as an applicant for adoption, an applicant for licensing/registration, or a DCF employee, authorize a search for reports of abuse, neglect or abandonment investigated pursuant to Chapter 39, Florida Statutes in which my name appears and there were "some indication" or "verified indicators" of maltreatment of a child(ren). I understand I will be given the opportunity to discuss the findings of the report(s). I further understand that the central abuse hotline search is only one part of the preliminary report to the court for adoption, one of the requirements reviewed by an agency with the authority to license or approve homes for the care of developmentally disabled persons and children, including family child care homes and facilities, or for DCF employment. This consent is valid solely for the requesting agency/facility listed below on this form.

Applicant Signature:_____ Date:_____ Phone:_____

Spouse Signature:_____ Date:_____ Phone:_____

Applicant: SSN:_____ DOB:_____ Race:____ Sex:____

Spouse: SSN:_____ DOB:_____ Race:____ Sex:____ Prior Name(s):_____

	Address	*City*	*County*	*State*	*Zip*	*Dates at Address*
Current Address:						
Previous Address:						
Previous Address:						

Reason for Record Search: ☐ Adoption Applicant (Chapter 63) ☐ DCF Employee (Chapter 39)
☐ Licensing/Registration Applicant (Chapters 39, 415, 402 or 409)

(**NOTE:** Searches of the Central Abuse Hotline may ***not*** be used for any employee except those working for DCF.)
Family child care, foster/shelter/group home or adoption applicants must list all household members on page two of this form. ***Do not include any foster care children.***

TO BE COMPLETED BY REQUESTING AGENCY

☐ Child Care Center ☑ Family Child Care Home ☐ Foster/Shelter/Small Group Home ☐ Adoption
☐ Child-Caring Agency ☐ Child-Placing Agency ☐ DD Foster/Small Group Home

OCA and/or Facility ID:_____

Facility/Agency Name:_____ Phone:_____

Address:_____
Mailing Address City Zip Code

I understand it is a misdemeanor of the first degree for any agency to use or release abuse, neglect or abandonment information to others. The information is **CONFIDENTIAL** and may be used only for the purpose for which it was obtained.

_____ _____
Signature of Requesting Facility/Agency Representative Date

STATE OF FLORIDA
DEPARTMENT OF CHILDREN & FAMILIES

Central Abuse Hotline Record Search

APPLICANTS FOR FAMILY DAY CARE, CHILDCARE FACILITIES PLEASE ENTER INFORMATION FOR ALL HOUSEHOLD MEMBERS ***EXCEPT FOSTER CHILDREN.***

Last Name	First Name	Middle Initial	DOB	Race		Sex	SSN	

RESULTS (Department or Agency Conducting Search Use ***Only*****)**

☐ No records found with verified findings where the applicant was the caretaker responsible in the final role or for licensing, any role in the reports within a five year period.

☐ Records found for review are listed below:

Report Number	Report Date	County

Date of Search:_____

Employee Conducting Search:_____ Phone:_____
Signature

Florida Department of Health – Palm Beach
Child Care Licensing Program

Palm Beach County Rules and Regulations Governing Child Care Facilities and Palm Beach County Rules and Regulations Governing Family Child Care Homes and Large Family Child Care Homes, Adopted Pursuant to Chapter 2010-249, Laws of Florida

CHILD CARE FACILITY/CURRENT PERSONNEL LIST AFFIDAVIT

I, _____ individually on behalf
(Operator/Director)

of _____ located at
(Name of Facility)

_____do hereby
(Address)

affirm under penalty of perjury that all child care personnel, including the **facility owner and operator and all employees and volunteers** of the above-named facility who come in contact with children, or may be present at the facility while children are in care, are listed below, and that they have been screened and meet the **Standards of Good Moral Character** as specified in Chapter 402.305, Florida Statutes. Screening consists of the process of employment history checks, character references, criminal and abuse history checks through the Florida Care Provider Background Screening Clearinghouse, completion of an **Affidavit of Good Moral Character**, and other checks as may be prescribed by the Health Department. The facility must receive and maintain on file the results from the appropriate agencies to verify that all owners and other personnel are eligible to work with children in a child care setting. **The completed Child Care Personnel Demographic Form is attached showing a complete list of facility personnel and their relevant demographic information.**

_____
Signature of Director/Operator

Sworn to and subscribed before me this _____day of _____20_____.

_____ _____
My Commission Expires NOTARY PUBLIC, STATE OF FLORIDA

My signature, as a Notary Public, verifies the affiant's identification has been validated by:

DCF Program Office Contacts

DCF Background Screening
Website: http://www.dcf.state.fl.us/programs/backgroundscreening
Email: hgw.bgs.helpdesk@myflfamilies.com
Phone: (888) 352-2849

DCF Office of Child Care Regulation
Website: www.myflfamilies.com/service-programs/child-care
Phone: (850) 488-4900

DCF Substance Abuse and Mental Health
Website: www.myflfamilies.com/service-programs/substance-abuse/information-for-providers

Florida Department of Children and Families

Background Screening
OCA Number Request Form

A completed OCA request form must be accompanied by a government issued ID

Select 1A or 1B

1A: I DO NOT HAVE A DCF OCA NUMBER

☐ **OCA Numbers are issued by or with the permission of the licensing or regulatory authority. If no regulatory authority exists, DCF Background Screening will issue OCA Numbers for those facility types.**
Complete 1A, 1C, 2

1B: I HAVE A DCF OCA NUMBER, AND

☐ **I need to make a change and update the facility or provider profile with the Department**
Complete 1B, 2, 3

☐ **I am making notification of facility closure**
Complete 1B, 1C, 4

☐ **My facility provides services for more than one provider type and I need a new OCA**
Complete 1B, 1C, 2

3. Updated Facility Contact Information

4. Facility Closure

Facility OCA Number:

Date Facility Closed:

Licensing Office Location:

Licensing or Regulation Contact:

1C: Select one

Child Welfare

Submit completed forms to DCF Background Screening

- ☐ Foster Care
- ☐ Child Placing Agency
- ☐ Child Caring Agency ☐ Group Home
- ☐ Agencies contracted to provide services for DCF

Mental Health

Submit completed forms as directed by Mental Health Licensing or Regulatory Entity

- ☐ BOTH Substance Abuse and Mental Health
- ☐ Mental Health ONLY

Summer Camp

Submit completed forms to DCF Background Screening

- ☐ Summer Camp

DCF General/Other

Submit completed forms to DCF Background Screening

- ☐ Non-Licensed After School or Enrichment Program
- ☐ Homeless, Emergency or Day Shelter
- ☐ Membership Organizations

Child Care

Submit completed forms to DCF Office of Child Care Regulation

- ☐ Licensed Child Care or Day Care
- ☐ Family Day Care Home
- ☐ Religious Exempt
- ☐ Licensed After School or Enrichment Program

Child Care Personnel Employment History Check

Facility Name: _____

Address: _____

Applicant's Name: _____Position Applied For: _____Date: _____

It is a requirement for all child care personnel to have employment history checks completed as a part of the screening process. Complete Parts A and B below, and attach three (3) letters of reference.

A copy of this completed form for each employee (including substitutes) must be kept on file at the facility.

A. EMPLOYMENT HISTORY FOR LAST FIVE (5) YEARS (or more).

Employer's Name	Full Address	Position Held & Description of Duties	Begin & End Dates	Supervisor's Name	Phone Number

Attach additional sheet(s) if necessary.

B. CHARACTER REFERENCES (Three (3) letters of reference are required, and at least two of the letters must be from non-relatives.) List the name, address, and phone number(s) of each person who wrote an attached letter of reference.

Name (Full 1st and last names)	Address (include Street Address, City and Zip Code)	Phone Number

Child Care Personnel Employment History Check

The employer must complete this page.

FOR USE BY EMPLOYER OR **CHILD CARE LICENSING STAFF ONLY.**

Child Care facility owners are responsible for conducting employment history checks for all EMPLOYEES and SUSTITUTES as part of the background screening process. **These checks involve confirming job titles, duties, employment dates, and levels of job performance.** Failed attempts to obtain this information must be documented, including dates, times, and the reason(s) the information could not be obtained. In addition, the Florida Department of Health – Palm Beach will check employment history for child care facility OWNERS AND DIRECTORS. A copy of this completed form must be kept on file at the facility for all child care employees.

RESULTS OF EMPLOYMENT HISTORY CHECKS

Employer's Name	Phone Number Called	Date	Work History Confirmed (YES or NO) If "NO" explain	Ask: How would you rate the employee's job performance?	Would Employer rehire? (Yes or No)	Check Completed By

CHARACTER REFERENCES VERIFIED

Name of Reference	Date Contacted	Verified (YES or NO)	Verified By

Rilya Wilson Act

Pursuant to s. 39.604, Florida Statutes, a child from birth to the age of school entry, who is under court-ordered protective supervision or in out-of-home care and is enrolled in an early education or child care program must attend the program 5 days a week unless the court grants an exemption. A child enrolled in an early education or child care program who meets the requirements of this act may not be withdrawn from the program without prior written approval of the Department or community-based care lead agency. If a child covered by this act is absent, the program shall report any unexcused absence or seven excused absences to the Department or the community-based care lead agency by the end of the business day following the unexcused absence or seventh consecutive excused absence.

Educational stability and transition are key components of this act to minimize disruptions, secure attachments and maintain stable relationships with supportive caregivers of children from birth to school age. Successful partnerships are imperative to ensure that these attachments are not disrupted due to placement in out-of-home care or subsequent changes in out-of-home placement. A child must be allowed to remain in the child care or early education setting that he/she attended before entry into out-of-home care, unless the program is not in the best interest of the child. If a child from birth to school-age leaves a child care or early education program, a transition plan needs to be developed that involves cooperation and sharing of information among all persons involved, respects the child's developmental stage and associated psychological needs, and allows for a gradual transition from one setting to another.

This law provides priority for child care services for specified children who are at risk of abuse, neglect, or abandonment. *These children are also known as Protective Services children.*

Rilya Wilson Act Requirements:

- ✓ Protective services children **MUST** be enrolled to participate 5 days per week.
- ✓ Protective services children **MAY NOT** be withdrawn without prior written approval from the Department of Children and Families (DCF) or Community Based Care (CBC).
- ✓ If a Protective Services child has 7 consecutive excused or any unexcused absence, the child care provider **MUST** notify the appropriate community based care staff.
- ✓ The Department and child care providers **MUST** follow local protocols set up by the CBC to ensure continuity.
- ✓ If it is not in the best interest of the child to remain at the child care or early education program, the caregiver **MUST** work with the Case Manager, Guardian Ad Litem, child care and educational staff, and educational surrogate, if one has been appointed, to determine the best setting for the child.

X_____ Date_____

Community-Based Care Lead Agencies Contact Information:
https://www.myflfamilies.com/service-programs/community-based-care/docs/leadagencycontacts.pdf

** If you have concerns regarding any child that you may care for, please contact the Florida Abuse Hotline at 1-800-96-ABUSE**

NON-ACTIVE MEMBER AFFIDAVIT (CORPORATION/LIMITED LIABILITY COMPANY)

Before me this day personally appeared _____ who, being duly sworn, deposes and says:
(Print Name)

As a member (Office, Director, and/or Registered Agent) of _____
(Corporation/Limited Liability Company Name)

that is the owner of _____
(Child Care Facility/Home Name)

I affirm and attest under penalty of perjury that I have a non-active role at the child care program.

I understand that a non-active corporate or limited liability company member means an individual who does not have contact with the children, does not go onsite of the program operation during operating hours, and whose role does not involve the day-to-day operation of the child care program.

Further, I understand that I must immediately notify the licensing authority at any time in the future my role changes to an active role and complete background screening pursuant to s. 402.302, 402.305, and 402.3055, Florida Statutes.

SIGNATURE OF AFFIANT:_____

Sworn to and subscribed before me this _____ day of _____, 20___.

_____
SIGNATURE OF NOTARY PUBLIC

_____
(Print, Type, or Stamp Commissioned Name of Notary Public)

(Check one)

Affiant personally known to notary

OR

Affiant produced identification
Type of identification produced:_____

PHYSICAL EXAMINATION FORM FOR DRIVER APPLICANT

I. The examining physician must answer the following questions.

A. What serious illness has the applicant had in the past five years?
B. What injuries has the applicant had?
C. Does the applicant take any drugs regularly? If so, name and give reason.
D. Is the applicant required to wear corrected lenses? If so, when were they last checked?
E. Does the applicant wear a hearing aid?
F. Is the applicant excessively overweight?

II. This examination was established by the State Board of Education. If the answers to any of the following items are "yes" the applicant does not meet the general qualifications of a school bus driver as specified in Section 1012.45, Florida Statutes.

A. Record vision without corrective lenses in every case and with corrective lenses when required. Visual acuity must not be less than 20/20 in one eye and 20/40 in the other or 20/40 in each eye separately either with or without corrective lenses. Vision test based on Snellen's Test Chart at twenty feet.

Vision w/out corrective lenses:	Vision with corrective lenses:
Left eye 20/_____	Left eye 20/_____
Right eye 20/_____	Right eye 20/_____

B. Applicant is deficient in the ability to recognize the colors of traffic signals and devices showing standard red, green and amber? Yes □ No □

C. Applicant has inadequate field of vision (less than 70 degrees in the horizontal meridian in each eye)? Yes □ No □

D. Applicant has impaired hearing (standard: 1. must first perceive forced whispered voice $\geq$ 5 ft., with or w/out hearing aid, or 2. Average hearing loss in better ear $\leq$ 40 dB.? Yes □ No □

E. Applicant has less than normal functioning of hand or foot, or loss of sight in one eye? Yes □ No □

F. Applicant has severe heart disease? Yes □ No □

G. Applicant has a mental or emotional abnormality which would interfere with proper judgement in the operation of a school bus? Yes □ No □

H. Applicant has a history of seizures, convulsions, epilepsy, or blackouts? Yes □ No□

I. Applicant has unacceptable blood pressure (systolic above 180 and/or diastolic above 100)? Yes □ No □

J. Applicant has a communicable disease which is highly contagious in its present state or endangers the health of school children? Yes □ No □

K. Applicant has diabetes and is necessary for insulin to control the diabetic condition? Yes □ No □

L. Applicant has some other unacceptable physical conditions or factors that would interfere with applicant's performance or duty as a school bus driver? Yes □ No □

M. Applicant has some other unacceptable physical conditions or factors that would interfere with applicant's performance or duty as a school bus driver? Yes □ No □

Other Remarks: _____

_____

_____

PHYSICIAN'S CERTIFICATION

This is to certify that on _____, 20__, _____ was examined by me and his/her physical condition was found to be as indicated in Part II of this Physical Examination Form.

IN YOUR BEST JUDGEMENT, CAN YOU CERTIFY THAT THIS APPLICANT IS PHYSICALLY AND EMOTIONALLY QUALIFIED TO OPERATE SAFELY A VEHICLE WITHOUT HAZARD TO HIMSELF OR OTHERS? Yes □ No □
If no, please explain: _____

_____

_____

_____

_____

_____

_____

_____

_____
Signature of Medical Examiner Telephone # Date

_____
Medical Examiner's Name (Print)

MD □ DO □ Physician Assistant □
Chiropractor □ Advance Practice Nurse □

This information provided regarding this physical examination is true and complete. This certificate is valid for a period of 12 months from the date of examination.

_____
Medical Examiner's License Or Certificate No./Issuing State

_____
Signature of Driver Date

_____
Driver's Name (Print) Driver's License No.

HEALTH EXAMINATION
FOR CHILD CARE FACILITY PERSONNEL

_____

Facility's Name

On _____ I have examined _____

Date ***Name***

and found him or her physically qualified to care for children.

TB RISK ASSESSMENT COMPLETED **Yes ☐ No ☐**

Signature/Title of Health Care Provider	***Date***	***Address (Please print or stamp)***
	___/____/___	
Name (Please print or stamp)		

<u>Tuberculosis Targeted Testing Guidelines</u>

Tuberculosis Infection Risk:

Review the following risks and administer a Tb Skin Test if this person is in one or more of the Following categories.

- Recent immigrant (< 5 years) or Frequent visitor to TB endemic area
- Close contact to active TB case
- Frequent contact with others at high risk for the disease, HIV+, homeless, incarcerated, illicit drug user
- HIV+, or has other medical conditions that increase the risk to progress from infection to disease, e.g., chronic renal failure, diabetes, hematologic or any other malignancy, weight loss>10% of ideal body weight, on immunosuppressive medications.

Active TB Disease Risk:

- Does the person exhibit signs/symptoms of Tuberculosis (e.g. cough for three (3) weeks or longer, weight loss, loss of appetite)?
- If symptoms are present, work-up or refer for TB disease evaluation.

NOTE: This form must be completed fully and signed and dated.

PLEASE RETURN ONLY THIS PAGE TO CLIENT.

CONFIDENTIAL INFORMATION

Physician: Please keep this page for client's medical records

Patient's Name_____ Date: _____

TB RISK ASSESSMENT

The following questions are to be answered by patients with coughing symptoms:

1. How long have you been coughing? Number of weeks _____

(Check the appropriate answer)

2. Have you been coughing up blood? **Yes ☐ No ☐**

3. Have you had unexplained weight loss or decrease in appetite during the past two (2) months? **Yes ☐ No ☐**

4. Do you experience night sweats? **Yes ☐ No ☐**

5. Have you had persistent low-grade fever? **Yes ☐ No ☐**

6. Have you lived or worked with anyone with any of these symptoms? **Yes ☐ No ☐**

7. Have you ever had a positive skin test for TB? If yes, when _____ **Yes ☐ No ☐**

8. Have you lived or worked with anyone who was sick with TB within the last two (2) years? **Yes ☐ No ☐**

9. Have you ever been treated for active TB in the past? If yes, when_____ **Yes ☐ No ☐**

10. Do you have any condition that may weaken your immune system (i.e. cancer, HIV, rheumatoid arthritis, emphysema, diabetes, alcoholism, silicosis)? **Yes ☐ No ☐**

11. Do you take cortisone? **Yes ☐ No ☐**

12. Have you had stomach surgery? **Yes ☐ No ☐**

_____

Signature of Interviewer Date