STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

1. ORI: *(Check ✓ one)* Code assigned by DOJ ☑ CCLD A0448 ☐ Trustline A1157

2. Type of Application: *(Check ✓ one)* ☑ Employment ☐ License, Certification, Permit ☐ Volunteer

3. Job Title or Type of License, Certification or Permit:
teacher, child care center

4. Agency Address Set Contributing Agency:

CA Dept of Social Services			**03502**
Agency authorized to receive criminal history information			Mail Code *(five-digit code assigned by DOJ)*
PO BOX 944243	**Mail Station 19-62**		**N/A**
Street No.	Street or PO Box		Contact Name *(Mandatory for all school submissions)*
Sacramento,	**CA**	**94244-2430**	( ) **N/A**
City	State	Zip Code	Contact Telephone No.

5. Applicant Information:

Name of Applicant: *(Please print)* _____ (LAST) _____ (FIRST) _____ (MI)

AKA's: _____ (LAST) _____ (FIRST)

CDL No. _____

DOB: _____ SEX: ☐ Male ☐ Female

Misc. No. BIL - _____ (AGENCY BILLING NUMBER *(IF APPLICABLE)*)

HT: _____ WT: _____

Misc. No.: _____ (ALIEN REGISTRATION, OUT OF STATE DRIVER'S LICENSE OR I.D.)

EYE Color: _____ HAIR Color: _____

Home Address: *(All applicants must complete)*

POB: _____

_____ (STREET OR PO BOX)

SOC: _____

_____ (CITY, STATE AND ZIP CODE)

6. Facility Number: lic # 376700377 and 376700376 Level of Service ☑ DOJ ☐ FBI

If resubmission (select R2), list Original ATI No. _____

7. ***NOTE:*** *NOT APPLICABLE FOR TRUSTLINE APPLICANTS*

Employer: *(Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)*

CCLC Center for Children and Families CSUSM
Employer Name

453 La Moree Rd			A0448
Street No.	Street or PO Box		Mail Code *(five digit code assigned by DOJ)*
San Marcos	CA	92078	760-750-8750
City	State	Zip Code	Agency Telephone No. *(Optional)*

8.

Live Scan Transaction Completed By: _____ (Name of Operator) Date _____

Transmitting Agency	LSID#	ATI No.	Amount Collected/Billed

LIC 9163 (5/05)

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

HEALTH SCREENING REPORT - FACILITY PERSONNEL

All personnel, including applicant, licensee or employed staff of Residential Care Facilities for the Elderly, Community Care or Child Care Facilities must demonstrate that their health condition allows them to perform the type of work required. This health appraisal is to be completed by or under the direction of a physician.

A health screening, by or under the direction of a physician must have been performed not more than one year prior to employment or within seven (7) days after employment.

FACILITY NAME
CENTER FOR CHILDREN AND FAMILIES

FACILITY ADDRESS
453 LA MOREE ROAD SAN MARCOS CA 92078

PERSON'S NAME		AGE	
POSITION TITLE STUDENT TEACHER/INTERN	TYPE OF FACILITY CHILD CARE	WORK DAYS PER WEEK	WORK HOURS PER DAY

DUTY STATEMENT
OBSERVE AND PARTICIPATE IN CLASSROOM ACTIVITIES WITH PRESCHOOL CHILDREN

TYPES OF PERSONS SERVED *(Check appropriate items)*

- ☑ Infants
- ☐ Adults
- ☐ Developmentally Disabled
- ☐ Physically Handicapped
- ☑ Children
- ☐ Elderly
- ☐ Mentally Disordered
- ☐ Drug/Alcohol Addiction
- ☐ Other *(specify)* _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION CONTAINED IN THIS REPORT.

SIGNATURE OF APPLICANT/LICENSEE OR EMPLOYEE ▶	ADDRESS	DATE

NOTE TO PHYSICIAN: *Personnel in Residential Care Facilities for the Elderly, Community Care or Child Care Facilities shall be free from communicable disease, and capable of performing assigned tasks. Please complete the following information on the above named person.*

EVALUATION OF GENERAL HEALTH

EVALUATION OF ABILITY TO PERFORM WORK DESCRIBED IN THE ABOVE DUTY STATEMENT

NOTE ANY HEALTH CONDITION THAT WOULD CREATE A HAZARD TO THE PERSON, CLIENTS, CHILDREN OR OTHER PERSONNEL

DATE OF T.B. TEST	☐ POSITIVE ☐ NEGATIVE	ACTION TAKEN (IF POSITIVE)

DATE OF HEALTH SCREENING	NAME OF PHYSICIAN (PHYSICIAN'S STAMP)	DATE

HEALTH SCREENING BY: (ORIGINAL SIGNATURE) ▶	TELEPHONE #	DATE