

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 |
| FACILITY ADDRESS |

| | | | |
|----------------|------------------|--------------------|--------------------|
| PERSON'S NAME | AGE | | |
| POSITION TITLE | TYPE OF FACILITY | WORK DAYS PER WEEK | WORK HOURS PER DAY |
| DUTY STATEMENT | | | |

TYPES OF PERSONS SERVED (Check appropriate items)

| | | | |
|--|----------------------------------|---|---|
| <input type="checkbox"/> Infants | <input type="checkbox"/> Adults | <input type="checkbox"/> Developmentally Disabled | <input type="checkbox"/> Physically Handicapped |
| <input type="checkbox"/> Children | <input type="checkbox"/> Elderly | <input type="checkbox"/> Mentally Disordered | <input type="checkbox"/> Drug/Alcohol Addiction |
| <input type="checkbox"/> 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 | <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE | ACTION TAKEN (IF POSITIVE) |
| DATE OF HEALTH SCREENING | NAME OF PHYSICIAN (PHYSICIAN'S STAMP) | DATE |
| HEALTH SCREENING BY: (ORIGINAL SIGNATURE) | TELEPHONE # | DATE |

PERSONNEL RECORD

(Form to be completed by employee)

| |
|----------------------|
| DATE |
| NAME OF FACILITY |
| FACILITY ADDRESS |
| FACILITY FILE NUMBER |

1. PERSONAL

| | |
|---|--|
| NAME (LAST FIRST MIDDLE) | TELEPHONE () |
| ADDRESS | ARE YOU 18 YEARS OF AGE OR OLDER? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, PLEASE STATE YOUR AGE |
| SOCIAL SECURITY NUMBER: (VOLUNTARY FOR ID ONLY) | DATE OF LAST TB TEST |
| DATE OF LAST PHYSICAL EXAMINATION | |

HAVE YOU EVER BEEN EMPLOYED UNDER A DIFFERENT NAME? YES NO IF YES, PLEASE LIST ALL NAMES USED.

| | |
|--|--|
| DO YOU POSSESS A VALID CALIFORNIA DRIVER'S LICENSE? <input type="checkbox"/> YES <input type="checkbox"/> NO | HAS YOUR DRIVER'S LICENSE EVER BEEN SUSPENDED OR REVOKED? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| CDL NUMBER | IF YES, PLEASE EXPLAIN ON BACK OF FORM. |
| NEAREST LIVING RELATIVE — NAME: | TELEPHONE NUMBER RELATIONSHIP |
| ADDRESS | |

2. POSITION

| | | | |
|--------------------|--------|-------|--------------------|
| TITLE | SALARY | HOURS | DATE OF EMPLOYMENT |
| NAME OF SUPERVISOR | | | |

3. PREVIOUS EMPLOYMENT (List most recent experience first. If additional space is needed, please attach a separate page.)

| NAME AND ADDRESS OF EMPLOYER | TELEPHONE NUMBER | JOB TITLE AND TYPE OF WORK | REASON FOR LEAVING | DATES | |
|------------------------------|------------------|----------------------------|--------------------|-------|----|
| | | | | FROM | TO |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

4. EDUCATION

| | | |
|---|---------|--|
| CIRCLE HIGHEST YEAR COMPLETED 6 7 8 9 10 11 12 | DIPLOMA | CURRENTLY ENROLLED IN HIGH SCHOOL COMPLETION COURSE? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, GIVE EXPECTED COMPLETION DATE _____ |
|---|---------|--|

EMPLOYMENT — RELATED EDUCATION COURSES

| COURSE TITLE | NAME OF SCHOOL OR ORGANIZATION AND ADDRESS | NUMBER UNITS COMPLETED | DATE COMPLETED | CURRENTLY ENROLLED |
|--------------|--|------------------------|----------------|--------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

(OVER)

4. EDUCATION (Continued)

| NAME UNIVERSITY, COLLEGE OR BUSINESS SCHOOL AND ADDRESS | MAJOR SUBJECT | NO. OF YEARS COMPLETED | NO. OF UNITS COMPLETED | DIPLOMA DEGREE OR CERTIFICATE | DATE COMPLETED |
|--|------------------|------------------------------|------------------------------|-------------------------------------|-------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

5. REFERENCES

List names of three persons who can give information about your background, character, abilities, etc.

| NAME | ADDRESS | TELEPHONE NUMBER | RELATIONSHIP TO YOU (FRIEND, EMPLOYER, ETC.) |
|------|---------|---------------------|---|
| | | | |
| | | | |
| | | | |

6. PROFESSIONAL AND TECHNICAL QUALIFICATIONS

A. List Licenses or Certificates of Competence held:

B. Names of Professional Associations of which you are a member:

NOTES:

I hereby certify under penalty of perjury that the above statements are true and correct. I give my permission for any necessary verification.

SIGNATURE OF EMPLOYEE

DATE

STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT SUSPECTED ABUSE OF DEPENDENT ADULTS AND ELDERS

NOTE: RETAIN IN EMPLOYEE/ VOLUNTEER FILE

NAME _____

POSITION _____

FACILITY _____

California law REQUIRES certain persons to report known or suspected abuse of dependent adults or elders. As an employee or volunteer at a licensed facility, you are one of those persons - a "mandated reporter."

PERSONS WHO ARE REQUIRED TO REPORT ABUSE

Mandated reporters include care custodians and any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not paid for that responsibility. [Welfare & Institutions Code ("W&I") section 15630(a)] Care custodians include administrators or employees of any CDSS licensed facility, including support and maintenance staff, or persons providing care or services for elders or dependent adults. [W&I §§ 15610.17(e)&(j)]

PERSONS WHO ARE THE SUBJECT OF THE REPORT

Elder means any California resident, 65 years or older. [W&I § 15610.27]
Dependent adult means any California resident, aged 18 through 64, who has physical or mental limitations that restrict his/her ability to carry out normal activities or to protect his/her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. [W&I § 15610.23]

WHEN REPORTING ABUSE IS REQUIRED

Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse, shall report the known or suspected instance of abuse. This must be done BY TELEPHONE IMMEDIATELY or as soon as practically possible, and BY WRITTEN REPORT WITHIN TWO (2) WORKING DAYS. [W&I § 15630(b)]

PENALTY FOR FAILURE TO REPORT ABUSE

Failure to report abuse of an elder or dependent adult is a MISDEMEANOR CRIME, punishable by jail time, fine or both. [W&I § 15630(h)]

CONFIDENTIALITY OF REPORTER AND OF ABUSE REPORTS

The duties of mandated reporters are individual and no supervisor or administrator shall impede or inhibit the reporting duties, and no person making the report shall be subject to any sanction for making the report. However, internal procedures to facilitate reporting, ensure confidentiality, and apprise supervisors and administrators of reports may be established, provided they are not inconsistent with the reporting law. [W&I § 15630(f)]

The reporting person, the report, and the information on the report, shall be kept confidential and may be disclosed ONLY as provided by law. Any violation of confidentiality is a MISDEMEANOR CRIME. [W&I § 15633(a)]

ABUSE THAT MUST BE REPORTED

Abuse of an elder or dependent adult that must be reported includes: 1) physical abuse; 2) neglect; 3) financial abuse; 4) abandonment; 5) isolation; and 6) abduction. [W&I § 15630(b)]

DEFINITIONS OF ABUSE

Physical abuse means any of the following: (1) assault (an unlawful attempt, coupled with a present ability, to commit a violent injury on another person); or assault with a deadly weapon; (2) battery (willful and unlawful use of force or violence upon another person); (3) unreasonable physical constraint, or prolonged or continual deprivation of food or water; (4) sexual assault (as defined in the Penal Code); or (5) use of a physical or chemical restraint or psychotropic medication for (a) punishment, or (b) a period beyond that for which the medication was ordered, or (c) any purpose not authorized by the physician and surgeon. [W&I § 15610.63]

Neglect means the negligent failure of any person having the care or custody of an elder or dependent adult to exercise that degree of care that a reasonable person in a like position would exercise. [W&I § 15610.57(a)] Neglect includes, but is not limited to, the following: (a) failure to assist in personal hygiene, or in the provision of food, clothing, or shelter; (b) failure to provide medical care for physical and mental health needs (unless the sole reason is voluntarily relying on treatment by spiritual means through prayer alone in lieu of medical treatment); (c) failure to protect from health and safety hazards; or (d) failure to prevent malnutrition or dehydration. [W&I § 15610.57(b)]

Financial abuse occurs when a person or entity does any of the following: (1) takes, secretes, appropriates, or retains real or personal property of an elder or dependent adult to a wrongful use or with intent to defraud, or both; or (2) assists in any of these acts. [W&I § 15610.30(a)]

Abandonment means the desertion or willful forsaking of an elder or dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody. [W&I § 15610.65]

Isolation means any of the following: (1) acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls; (2) telling a caller or prospective visitor that an elder or dependent adult is not present or does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is false, is contrary to the express wishes of the elder or dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons (3) false imprisonment (the unlawful violation of the personal liberty of another); or (4) physical restraint for the purpose of preventing the elder or dependent adult from meeting with visitors. [W&I § 15610.43(a)] These acts shall not constitute isolation if they are performed in response to a reasonably perceived threat of danger to property or physical safety. [W&I § 15610.43(c)]

Abduction means the removal from California and the restraint from returning, or the restraint from returning, of any elder or dependent adult who does not have the capacity to consent to the removal or restraint. [W&I § 15610.06]

WHERE TO CALL IN AND SEND THE WRITTEN ABUSE REPORT

If the abuse is alleged to have occurred in a long-term care facility, including a licensed or unlicensed residential facility serving adults or elders or an adult day program, you must report to either local law enforcement or the local long-term care ombudsman. [W&I § 15630(b)(1)(A)] If the abuse is alleged to have occurred anywhere other than a long-term care facility, you must report to either local law enforcement or county adult protective services. [W&I § 15630(b)(1)(C)]

AS AN EMPLOYEE OR VOLUNTEER OF THIS FACILITY, YOU MUST COMPLY WITH THE DEPENDENT ADULT AND ELDER ABUSE REQUIREMENTS, AS STATED ABOVE. IF YOU DO NOT COMPLY, YOU MAY BE SUBJECT TO CRIMINAL PENALTY.

I, _____, have read and understand my responsibility to report known or suspected abuse of dependent adults or elders. I will comply with the reporting requirements.

SIGNATURE

DATE

STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT CHILD ABUSE*NOTE: RETAIN IN EMPLOYEE/LICENSEE FILE*

NAME

POSITION

FACILITY NUMBER

California law **REQUIRES** certain persons to report known or suspected child abuse. As a licensee or an employee at a licensed facility or a child care institution, **YOU** are one of those persons - a "mandated reporter."

PERSONS WHO ARE REQUIRED TO REPORT ABUSE

Mandated reporters include a licensee, an administrator, or an employee of a licensed community care or child day care facility. [Penal Code ("PC") § 11165.7(a)(10)] Mandated reporters also include an employee of a child care institution, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities. [PC § 11165.7(a)(14)] No supervisor or administrator may impede or inhibit an individual's reporting duties or subject the mandated reporter to any sanction for making the report. [PC § 11166(h)]

WHEN REPORTING ABUSE IS REQUIRED

A mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has knowledge of or observes a person under the age of 18 years whom he or she knows or reasonably suspects has been the victim of child abuse or neglect must report the suspected incident. The reporter must contact a designated agency immediately or as soon as practically possible by telephone, and shall prepare and send a written report within 36 hours of receiving the information concerning the incident. [PC § 11166(a)]

ABUSE THAT MUST BE REPORTED

Physical injury inflicted by other than accidental means on a child. [PC § 11165.6]

Sexual abuse meaning sexual assault or sexual exploitation of a child. [PC § 11165.1]

Neglect meaning the negligent treatment, lack of treatment, or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. [PC § 11165.2]

Willful harming or injuring or endangering a child meaning a situation in which any person inflicts, or willfully causes or permits a child to suffer, unjustifiable physical pain or mental suffering, or causes or permits a child be placed in a situation in which the child or child's health is endangered. [PC § 11165.3]

Unlawful corporal punishment or injury willfully inflicted upon a child and resulting in a traumatic condition. [PC § 11165.4]

WHERE TO CALL IN AND SEND THE WRITTEN ABUSE REPORT

Reports of suspected child abuse or neglect must be made to any police department or sheriff's department (not including a school district police or security department), county probation department, if designated by the county to receive mandated reports, or the county welfare department. [PC § 11165.9] The written report must include the information described in Penal Code section 11167(a) and may be submitted on form SS 8572.

IMMUNITY AND CONFIDENTIALITY OF REPORTER AND OF ABUSE REPORTS

Persons legally mandated to report suspected child abuse have immunity from criminal or civil liability for reporting as required or authorized by law. [PC § 11172(a)] The identity of a mandated reporter is confidential and disclosed only among agencies receiving or investigating reports, and other designated agencies. [PC § 11167(d)(1)] Reports are confidential and may be disclosed only to specified persons and agencies. Any violation of confidentiality is a misdemeanor punishable by imprisonment, fine, or both. [PC § 11167.5(a)-(b)]

PENALTY FOR FAILURE TO REPORT ABUSE

A mandated reporter who fails to make a required report is guilty of a **misdemeanor** punishable by up to six months in jail, a fine of \$1000, or both. [PC § 11166(b)]

COPY OF THE LAW

Prior to my employment in a licensed community care or child day care facility, or child care institution, my employer provided me with a copy of Penal Code sections 11165.7, 11166, and 11167. [PC § 11166.5(a)]

ACKNOWLEDGMENT OF RESPONSIBILITY

I, _____, have knowledge of my responsibility to report known or suspected child abuse in compliance with Penal Code section 11166. [PC § 11166.5(a)]

| | |
|-----------|------|
| SIGNATURE | DATE |
|-----------|------|

CHILD ABUSE CENTRAL INDEX CHECK FOR COUNTY LICENSED FACILITIES

FOR COUNTY LICENSING OFFICE USE ONLY

| |
|---------------------------------------|
| COUNTY LICENSING OFFICE ADDRESS STAMP |
|---------------------------------------|

Complete **ALL** items checked (✓)

Include \$15.00 for each Child Abuse Central Index Check. (There is no exemption from this fee) Make check or money order payable to the Department of Justice.

NOTE: APPLICANT/LICENSEE MUST NOT SEND THIS FORM DIRECTLY TO DEPARTMENT OF JUSTICE

(This form is to be processed through your county licensing office)

We are required by law to check the names of all persons who apply for a license or seek employment in a child day care or residential facility caring for children against the Child Abuse Central Index. Persons required to submit fingerprints for a child care facility (day or residential) must also fill out this form. Please complete the information below. The Licensee is responsible for submitting fingerprints and this form along with the Child Abuse Central Index Check processing fee to the county licensing office.

TYPE OR PRINT INFORMATION

✓ DATE SENT

| | | |
|------------|-------|--------|
| NAME: LAST | FIRST | MIDDLE |
|------------|-------|--------|

✓

List all other names you have ever used such as maiden name or aliases:

| | |
|-------|-------|
| NAME: | NAME: |
|-------|-------|

✓

| | |
|-------|-------|
| NAME: | NAME: |
|-------|-------|

✓

| | | | | |
|-----------------|--------|------|-------|----------|
| CURRENT ADDRESS | STREET | CITY | STATE | ZIP CODE |
|-----------------|--------|------|-------|----------|

✓

| | | | | | | |
|-------------------------------|---------------------------------|----------|----------|--------------|-------------|---------------------------|
| <input type="checkbox"/> MALE | <input type="checkbox"/> FEMALE | HEIGHT ✓ | WEIGHT ✓ | HAIR COLOR ✓ | EYE COLOR ✓ | DRIVER'S LICENSE NUMBER ✓ |
|-------------------------------|---------------------------------|----------|----------|--------------|-------------|---------------------------|

✓

DATE OF BIRTH ✓
MO. DAY YEAR

SOCIAL SECURITY NUMBER ✓

| | | |
|-----|-----|------|
| MO. | DAY | YEAR |
|-----|-----|------|

| | | |
|-----|-----|-----|
| SSN | SSN | SSN |
|-----|-----|-----|

✓ FACILITY NUMBER: _____

✓ FACILITY NAME: _____

✓ FACILITY ADDRESS: _____

| | | | |
|--------|------|-------|----------|
| STREET | CITY | STATE | ZIP CODE |
|--------|------|-------|----------|

FOR LICENSING OFFICE USE ONLY DO NOT FILL IN BELOW

Date Sent _____ Date Re-sent _____

This is a recheck. See attached Criminal Record Report

FOR DEPARTMENT OF JUSTICE USE ONLY

The result of a name search in the Child Abuse Central Index is as follows:

The subject of the attached report **MAY** be the same as the subject of your inquiry.

No record on the above listed person.

Too many possible matches to identify. See attached listing.

CRIMINAL BACKGROUND CLEARANCE TRANSFER REQUEST

Active criminal record clearances may be transferred from one state licensed facility to another by a license applicant or licensee. Clearances cannot be transferred from a state licensed facility to a county licensed facility, or from county to state. **The transfer request must be submitted to the Department before the individual who is the subject of the transfer has client contact or the facility will be in violation of the law and subject to a \$100 civil penalty.**

The license applicant or licensee who is seeking the transfer must verify the individual's identity and include a copy of the person's driver's license or a valid photo identification issued by the California Department of Motor Vehicles or by another state or the United States government if the person is not a California resident. Additionally, a Child Abuse Central Index (CACI) check must be submitted if the transfer is to a facility serving children and the individual has not previously submitted a CACI check or the date of the previous CACI inquiry was made prior to January 1, 1999. The CACI must be mailed directly to the Department of Justice with the applicable fee. *Note: This transfer request is for clearances only. Contact your licensing office for information about exemption transfers.*

| | |
|-------------------------------------|-------|
| PLEASE TYPE OR PRINT LEGIBLY | DATE: |
|-------------------------------------|-------|

PLEASE TRANSFER THE CRIMINAL RECORD CLEARANCE FOR THE FOLLOWING INDIVIDUAL:

| | | |
|-----------------------------------|------------|-----------------|
| LAST NAME | FIRST NAME | MIDDLE INITIAL |
| CA DRIVER'S LICENSE #/OR ID #: | | DOB: |
| LICENSING INFORMATION SYSTEM ID#: | | SSN: (OPTIONAL) |

FROM THE FOLLOWING FACILITY:

| | | |
|-------------------|------------------|-----------|
| NAME OF FACILITY: | FACILITY NUMBER: | |
| STREET ADDRESS: | | |
| CITY | STATE | ZIP CODE: |

TO THE FOLLOWING FACILITY: **PLEASE ALSO KEEP THIS INDIVIDUAL ASSOCIATED WITH ABOVE FACILITY.**

| | | |
|--|------------------------------------|---|
| NAME OF FACILITY: | Transferee Association Type | |
| FACILITY NUMBER: | DATE OF EMPLOYMENT: | <input type="checkbox"/> Facility Administrator <input type="checkbox"/> Corporation Board Member <input type="checkbox"/> Employee <input type="checkbox"/> Certified Home <input type="checkbox"/> Licensee/Applicant <input type="checkbox"/> Non-client Adult Resident <input type="checkbox"/> Partnership Member <input type="checkbox"/> Spouse of Licensee |
| STREET ADDRESS: | | |
| CITY | STATE | ZIP CODE: |
| <i>I certify I have verified the above individual's identity and have enclosed a copy of the individual's photo I.D.</i> | | Title (licensee, administrator, director) |
| Signature | | |

FOR DISTRICT OFFICE USE ONLY

| | |
|-------------------------|--------------------------------------|
| DATE OF TRANSFER ENTRY: | INITIAL OF PERSON ENTERING TRANSFER: |
|-------------------------|--------------------------------------|

CRIMINAL RECORD STATEMENT

State law requires that persons associated with licensed facilities be fingerprinted and disclose any conviction. A conviction is any plea of guilty or nolo contendere (no contest) or a verdict of guilty. The fingerprints will be used to obtain a copy of any criminal history you may have.

Have you ever been convicted of a crime in California ? YES NO

Have you ever been convicted of a crime from another state, federal court, military or jurisdiction outside of U.S.? YES NO

Criminal convictions from another State or Federal court are considered the same as criminal convictions in California.

If you answer YES, give details on the back of this page indicating the nature and circumstances of each crime and the date and the location in which each crime occurred.

You must disclose convictions, including reckless and drunk driving convictions even if:

1. It happened a long time ago;
2. It was only a misdemeanor;
3. You didn't have to go to court (your attorney went for you);
4. You had no jail time or the sentence was only a fine or probation;
5. You received a certificate of rehabilitation;
6. The conviction was later dismissed, set aside or the sentence was suspended.

NOTE: IF THE CRIMINAL BACKGROUND CHECK REVEALS ANY CONVICTION(S) THAT YOU DID NOT DISCLOSE ON THIS FORM, YOUR FAILURE TO DISCLOSE THE CONVICTION(S) WILL RESULT IN AN EXEMPTION DENIAL, LICENSE APPLICATION DENIAL, LICENSE REVOCATION, OR EXCLUSION FROM A LICENSED FACILITY.

| | | | |
|---|---------------|--------------------|-----|
| <p>I declare under penalty of perjury under the laws of the State of California that I have read and understand the information contained in this affidavit and that my responses and any accompanying attachments are true and correct.</p> | | | |
| FACILITY NAME | | FACILITY NUMBER | |
| YOUR NAME (PRINT CLEARLY) | YOUR ADDRESS | CITY | ZIP |
| SOCIAL SECURITY NUMBER (SEE PRIVACY STATEMENT ON REVERSE SIDE) | DATE OF BIRTH | DMV LICENSE NUMBER | |
| SIGNATURE | | DATE | |

I. Instructions to Respondents:

If you have been convicted of a crime in California or from another state or in federal court, provide the following information:

What was the offense? _____

In which state and city did you commit the offense? _____

When did this occur? _____

Tell us what happened. (Use additional sheets of paper if needed) _____

I certify under penalty of perjury that the above information is true and correct to the best of my knowledge.

Signature _____ **Date** _____

II. Instructions to Licensees:

If the person discloses a criminal conviction, review the person's statement and discuss it with your Licensing Program Analyst (LPA). Maintain this form in your facility personnel file and send a copy to your LPA.

PRIVACY STATEMENT

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code section 1798 et seq.), notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person's SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

In order to be licensed, work at, or be present at, a licensed facility, the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17 and 1596.871) The Department will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.). Under the California Public Records Act, the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

NOTE: IMPORTANT INFORMATION

The Department is required to tell people who ask, including the press, if some one in a licensed facility has a criminal record exemption. The Department must also tell people who ask, the name of a licensed facility that has a licensee, employee, resident, or other person with a criminal record exemption.

If you have any questions about this form, please contact your local licensing regional office.

DIRECT CARE STAFF ORIENTATION AND TRAINING CHECKLIST

(TITLE 17 - 56038)

YEAR: 20 _____

Facility Name: _____

Employee Name: _____ Title: _____ Hire Date: _____

I. On-Site Orientation within the first 40 hours of employment:

| | <u>Trainer's Name</u> | <u>Date</u> | <u>Initials of employee documenting he/she received this training</u> |
|--|-----------------------|-------------|---|
| A. Facility program design | _____ | _____ | _____ |
| B. Individual program plan | _____ | _____ | _____ |
| C. Clients' rights | _____ | _____ | _____ |
| D. Medication assistance | _____ | _____ | _____ |
| E. Health and emergency procedures | _____ | _____ | _____ |
| F. Special incident reporting | _____ | _____ | _____ |
| G. Client abuse identification and reporting | _____ | _____ | _____ |

II. Direct Support Profesional (DSP) requirement

| | <u>Date of completion</u> |
|---|---------------------------|
| Year One Training Course / Challenge Test | _____ |
| Year Two Training Course / Challenge Test | _____ |

III. On-the-job training as necessary to impelment IPPs (i.e., IPP staffings).

| | <u>No. Hours</u> | <u>Trainer's Name</u> | <u>Topic</u> | <u>Date</u> | <u>Initials of employee documenting he/she received this training</u> |
|---|------------------|-----------------------|--------------|-------------|---|
| 1 | _____ | _____ | _____ | _____ | _____ |
| 2 | _____ | _____ | _____ | _____ | _____ |
| 3 | _____ | _____ | _____ | _____ | _____ |
| 4 | _____ | _____ | _____ | _____ | _____ |
| 5 | _____ | _____ | _____ | _____ | _____ |
| 6 | _____ | _____ | _____ | _____ | _____ |

IV. Continuing education units (L2 - 8 hours annually; L3/L4 - 12 hours annually; additional 12 hours for L4 staff without prior experience)

| | <u>No. Hours</u> | <u>Trainer's Name</u> | <u>Topic</u> | <u>Date</u> | <u>Initials of employee documenting he/she received this training</u> |
|---|------------------|-----------------------|--------------|-------------|---|
| 1 | _____ | _____ | _____ | _____ | _____ |
| 2 | _____ | _____ | _____ | _____ | _____ |
| 3 | _____ | _____ | _____ | _____ | _____ |
| 4 | _____ | _____ | _____ | _____ | _____ |
| 5 | _____ | _____ | _____ | _____ | _____ |
| 6 | _____ | _____ | _____ | _____ | _____ |

Please attach certificates for CEUs!