FAMILY CHILD CARE LICENSE/AFFILIATION APPLICATION

Print Form

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 8013, Secretary of the Air Force: Powers and duties; delegation by E.O. 9397; implemented by DODI 6060.2 and AFPD 34-7.
PURPOSE: To record essential information on prospective Family Child Care (FCC) Providers and to be used in conjunction with background checks
ROUTINE USE: None
DISCLOSURE IS VOLUNTARY: Furnishing the information is voluntary; not providing all of the information will prevent issuing of a FCC License/Affiliation

APPLICANT AND SPONSOR'S INFORMATION

APPLICANT'S NAME (LAST, FIRST, MIDDLE)	FORMER SURNAME(S)		SOCIAL SECURITY NUMBER (SSN)		HOME PHONE
ADDRESS	CITY		STATE	ZIP CODE	CELL PHONE
SPONSOR'S NAME (LAST, FIRST, MIDDLE)	RANK	SPONSOR'S DUTY SECTION		SPONSOR'S SSN	DUTY PHONE

HOUSEHOLD MEMBERS' INFORMATION - OTHER THAN APPLICANT AND SPONSOR

NAME (LAST, FIRST, MIDDLE)	BIRTHDATE	AGE	RELATIONSHIP	SCHOOL	SSN

PREVIOUS HOME ADDRESS(ES) OF LAST 2 YEARS IF DIFFERENT FROM CURRENT

ADDRESS	CITY	STATE	ZIP CODE	INSTALLATION
ADDRESS	CITY	STATE	ZIP CODE	INSTALLATION

REFERENCES - PLEASE DO NOT USE RELATIVES

1 REFERENCE NAME (LAST, FIRST)	RELATIONSHIP	ADDRESS	CITY	STATE	ZIP CODE
2 REFERENCE NAME (LAST, FIRST)	RELATIONSHIP	ADDRESS	CITY	STATE	ZIP CODE

1 REFERENCE EMAIL ADDRESS	HOME PHONE	2 REFERENCE EMAIL ADDRESS	HOME PHONE

EDUCATION AND CHILD CARE EXPERIENCE/TRAINING

Attach a copy of your High School or General Education Development (GED) Credential	Date Received

PREVIOUS EXPERIENCE - MAY ATTACH A RESUME	PREVIOUS TRAINING - MAY ATTACH A RESUME

We understand by signing this application, we are authorizing the United States Air Force to conduct background investigations for initial licensing/affiliation. This may include previous installation(s) and continued licensing/affiliation on ourselves and all household members ages 12 and up.

- An Installation Records Check (IRC) on the current installation and previous installation(s), if applicable, to include: Security Forces, Housing, Life Skills, Substance Abuse, and Family Advocacy with a check of the Air Force Central Services Registry - Initially; annually; and when a child turns 12 years old
- A Defense Central Index of Investigations (DCII) - Initially; every 5 years; and when a household member turns 18 years old
- A written statement from the Sponsor's Supervisor or Commander - Initially
- A statement(s) from the School Principal/Guidance Counselor for child(ren) ages 12 years and up - Initially; annually; and when a child turns 12 years old
- An IRC and DCII will be conducted on anyone, 12 years and up, who joins and remains in the household for more than 30 days

APPLICANT'S SIGNATURE	DATE
SPONSOR'S SIGNATURE	DATE
SIGNATURE OF ANY HOUSEHOLD MEMBER OVER 18 YEARS OLD	DATE

Print Form

Air Force Family Child Care License Application Continuation
Statement of Conviction

In accordance with Department of Defense Instruction (DODI) 1402.5, *Criminal History Background on Individuals in Child Care Services,* paragraph E7.4.1, Family Child Care (FCC) Provider Applicants, all adults, and all children 12 years and older, who reside in the household will answer the questions listed below.

FCC Applicant's Name	______________	Spouse's Name	______________
Household Member #1's Name	______________	Household Member #2's Name	______________
Household Member #3's Name	______________	Household Member #4's Name	______________

1. Have you ever been arrested for or charged with a crime involving a child?

Applicant	☐ Yes	☐ No	Spouse	☐ Yes	☐ No
Household Member #1	☐ Yes	☐ No	Household Member #2	☐ Yes	☐ No
Household Member #3	☐ Yes	☐ No	Household Member #4	☐ Yes	☐ No

2. Have you ever been asked to resign because of or been decertified for a sexual offense?

Applicant	☐ Yes	☐ No	Spouse	☐ Yes	☐ No
Household Member #1	☐ Yes	☐ No	Household Member #2	☐ Yes	☐ No
Household Member #3	☐ Yes	☐ No	Household Member #4	☐ Yes	☐ No

DISCLOSURE: In accordance with DODI 1402.5, paragraph E7.4.2, we understand by signing below we are signing under penalty of perjury. In addition, a false statement rendered may result in adverse action up to and including removal as a FCC Provider.

Applicant's Signature______________________________ Date______________

Spouse's Signature______________________________ Date______________

#1 Household Signature______________________________ Date______________

#2 Household Signature______________________________ Date______________

#3 Household Signature______________________________ Date______________

#4 Household Signature______________________________ Date______________

In accordance with Air Force Instruction 34-276, *Family Child Care Program*, paragraph, A5.36.4, "There is no evidence of illegal drug use, child abuse, or domestic violence current or past in the household. The provider reports any such incidents to the FCC Coordinator." My signature below verifies there has been no current or past illegal drug use, child abuse, or domestic violence in our household. I agree to report any such incidents or knowledge of previous and/or future incidents to the FCC Coordinator.

Applicant's Signature______________________________ Date______________

If you answered yes to either question #1 or #2 above, please provide a description of the case disposition below. If there is a current or past incident of illegal drug use, child abuse or domestic violence, please provide a brief description of below:

AIR FORCE FAMILY CHILD CARE (FCC) PROVIDER'S HEALTH ASSESSMENT

☐ Initial Health Assessment ☐ Renewal Health Assessment

FCC Applicant/Provider's Name _____

In accordance with Air Force Instruction 34-276, *Family Child Care Programs,* paragraph 1.10.3, providers "Are physically and mentally capable of providing care" and paragraph A6.14.10, "The provider has a documented physical examination at least every two years." This "health assessment" should be related to the duties and activities of caring for children. The following includes but is not limited to activities FCC Providers may be required to do in order to fulfill the responsibility of a child care provider. FCC Providers need to move quickly to supervise and assist young children; lift children, equipment, and supplies; sit on the floor and on child-sized furniture; eat the same food as that served to the children (unless the FCC Provider has dietary restrictions); hear and see at a distance required for supervision or driving; be absent from work for illness no more often than a typical adult, and be able to provide continuity of care giving relationships for children in care. **NOTE: FCC Provider must be seen by a health care professional; a review of the FCC Provider's medical record does not suffice.**

Date of Physical Examination ____________________

FCC Providers must be in good health in order to provide a nurturing and stable environment for children. Based on your professional examination:

☐ **This patient is cleared to work with children.**

☐ **This patient has not been cleared to work with children. Explanation attached.**

Health Care Professional's Name/Title ______________________________________

Health Care Professional's Signature ______________________________________

Telephone (___)______________ Date ________________

AIR FORCE FAMILY CHILD CARE (FCC) PROVIDER'S IMMUNIZATIONS

In accordance with Air Force Instruction (AFI) 34-276, *Family Child Care Programs:*

Paragraph 2.33.2 requires, "Ensure Family Child Care (FCC) program staff, FCC providers and their household members, and children using FCC homes have the immunizations required by Air Force Joint Instruction (AFJI) 48-110, Immunizations and Chemoprophylaxis."

Paragraph A5.32.1 requires, "The need for tuberculosis skin testing should be established in accordance with AFI 48-115, The Tuberculosis Detection and Control Program, 3. Program Elements." (Note: AFI 48-105, Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance supersedes AFI 48-115.)

In lieu of completing this form, providers may furnish a copy of their immunization records documenting all required immunizations.

IMMUNIZATIONS	DATE DD MMM YY	DATE DD MMM YY	DATE DD MMM YY
Documented Tuberculosis (TB) Skin Test There is no requirement to periodically retest those with negative TB unless it's clinically indicated (retest those with signs/symptoms) or required by the state or local health department. □ REQUIRED ANNUALLY □ NOT REQUIRED ANNUALLY			
Measles, Mumps, and Rubella (MMR) For Rubella, immunity is based only on documentation of immunization or laboratory evidence of immunity. □ VACCINE □ IMMUNITY*			
Diphtheria, Pertussis, and Tetanus (DPT/DTaP) (Td)			
Polio (IPV or OPV)			
Varicella □ VACCINE □ IMMUNITY* HAD CHICKEN POX			
Hepatitis B (Hep B) – 3 series			
Hepatitis A (Hep A) – 2 series □ REQUIRED □ NOT REQUIRED			
Annual Influenza (Flu)			

I, ______________________________, have been immunized or certified immune for the above immunizations.

Provider's Signature ______________________________ Date ____________________

***Immunity defined as "already immune" is based on documented receipt of vaccine series or physician-diagnosed illness or medically administratively exempt.**

AIR FORCE FAMILY CHILD CARE (FCC) HOUSEHOLD MEMBER'S - AGES 18 AND UP IMMUNIZATIONS

In accordance with Air Force Instruction (AFI) 34-276, *Family Child Care Programs:*

Paragraph 2.33.2 requires, "Ensure Family Child Care (FCC) program staff, FCC providers and their household members, and children using FCC homes have the immunizations required by Air Force Joint Instruction (AFJI) 48-110, Immunizations and Chemoprophylaxis."

Paragraph A5.32.1 requires, "The need for tuberculosis skin testing should be established in accordance with AFI 48-115, The Tuberculosis Detection and Control Program, 3. Program Elements." (Note: AFI 48-105, Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance supersedes AFI 48-115.)

In lieu of completing this form, providers may furnish a copy of their household member's immunization records documenting all required immunizations.

IMMUNIZATIONS	DATE DD MMM YY	DATE DD MMM YY	DATE DD MMM YY
Documented Tuberculosis (TB) Skin Test There is no requirement to periodically retest those with negative TB unless it's clinically indicated (retest those with signs/symptoms) or required by the state or local health department. □ REQUIRED ANNUALLY □ NOT REQUIRED ANNUALLY			
Measles, Mumps, and Rubella (MMR) For Rubella, immunity is based only on documentation of immunization or laboratory evidence of immunity. □ VACCINE □ IMMUNITY*			
Diphtheria, Pertussis, and Tetanus (DPT/DTaP) (Td)			
Polio (IPV or OPV)			
Varicella □ VACCINE □ IMMUNITY* HAD CHICKEN POX			
Hepatitis B (Hep B) – 3 series			
Hepatitis A (Hep A) – 2 series □ REQUIRED □ NOT REQUIRED			
Annual Influenza (Flu)			

____________________________ has been immunized or certified immune for the above immunizations.

Provider's Signature ____________________________ Date ____________________

***Immunity defined as "already immune" is based on documented receipt of vaccine series or physician-diagnosed illness or medically administratively exempt.**

AIR FORCE FAMILY CHILD CARE (FCC) INDIVIDUAL PET ASSESSMENT

____
Date

NOTE: One form for each pet must be completed to determine health as part of an Air Force Family Child Care home.

FCC Applicant/Provider's Name ____

Name of pet ____________________ Type of pet (Spp/breed/sex) ____________________

- ☐ **This pet appears to be free of any communicable disease(s) at this time.**
- ☐ **If applicable, this pet has been immunized against rabies.**

  Date next rabies vaccination is due__________________

- ☐ **If applicable, this pet has been immunized against distemper.**

  Date next distemper vaccination is due __________________

- ☐ **This pet shows no evidence of parasites and fleas at this time.**

I have examined the above named pet and certify that it appears to meet all the conditions stated above.

This Pet Certificate is valid as of the date signed below and the pet should be re-assessed no

later than __________________________ (enter date).

Veterinarian/Veterinary Technician's Name ____

Veterinarian/Veterinary Technician's Signature ____

Telephone (___)________________ Date __________________