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

To be given to the individual examined with a pre-addressed envelope marked "Confidential - Medical".

CERTIFICATE OF MEDICAL EXAMINATION

U.S. OFFICE OF PERSONNEL MANAGEMENT

Form Approved
OMB No. 3206 - 0250

Privacy Act Statement

Solicitation of this information is authorized by Section 552a of Title 5, United States Code, regarding records maintained on individuals; Section 3301 of Title 5, United States Code, regarding determination as to an individual's fitness for employment with regard to age, health, character, knowledge and ability; and Section 3312 of Title 5 United States Code, regarding waiver of physical qualifications for preference eligibles. This form is used to collect medical information about individuals who are incumbents of positions in the Federal Government which require physical fitness testing and medical examinations, or individuals who have been selected for such a position contingent upon successful completion of physical fitness testing and medical examinations as a condition of their employment. The primary use of this information will be to determine the nature of a medical or physical condition that may affect safe and efficient performance of the work described. Additional potential routine uses of this information include using it to ensure fair and consistent treatment of employees and job applicants, to adjudicate requests to pass over preference eligibles, or to adjudicate claims of discrimination under the Rehabilitation Act of 1973, as amended. Completion of this form is voluntary; however, failure to complete the form may result in no further consideration of an applicant, or a determination that an employee is no longer qualified for his or her position. In addition, incomplete, misleading, or untruthful information provided on the form may result in delays in processing the form for employment, termination of employment, or criminal sanction.

Public Burden Statement

We estimate an average of two to three hours per response to complete, including the time for reviewing instructions, getting needed information, and reviewing the completed form. Send comments regarding our estimate or any other aspect of this form, including suggestions for reducing completion time, to the U.S. Office of Personnel Management (OPM), Employee Services, Recruitment and Hiring, Hiring Policy, Medical Policy and Programs Division, Attn: OMB Number (3206-0250), 1900 E Street, NW, Washington, D.C. 20415. The OMB number, 3206-0250, is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

Instructions

There are five parts in this form:

Part A - To be completed by applicant or employee. Signature of the applicant or employee certifies that the information provided is complete and accurate; and that the applicant or employee consents to the release of the examination results to the employing agency.

Part B - To be completed by the appointing officer before the medical examination: identifies the purpose of the examination; the position title, series and grade; generally describes the position; and shows the specific functional requirements and environmental factors that the work requires.

Part C - To be completed and signed by the examining physician, and returned to the employing agency in the pre-paid/ pre-addressed "Confidential-Medical" envelope provided.

Part D - To be completed by the agency medical officer who reviews the examination results and recommends action.

Part E - To be completed by the agency human resources officer in order to document the personnel action that is rendered.

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Part A. TO BE COMPLETED BY APPLICANT OR EMPLOYEE

1. Name (Last, First, Middle Initial)		
2. Federal Employee Number	3. Sex ☐ Male ☐ Female	4. Birth Date *(month, day, year)*

5. Do you have any medical disorder or physical impairment which would interfere in any way with the full performance of the duties shown in Part B, No. 3?

☐ Yes ☐ No

(If your answer is YES, explain fully to the physician performing the examination)

6. Address (including City, State, Zip Code)	
7. E-mail Address	8. Telephone Numbers (with Area Code)

9. Applicant or Employee Consent and Certification

I certify that all of the information I have provided on this form is complete and accurate to the best of my knowledge, and that submitting information that is incomplete, misleading, or untruthful may result in termination, criminal sanctions, or delays in processing this form for employment. Furthermore, consistent with the Privacy Act Statement, I authorize the release to my employing agency of all information contained on this examination form and all other forms generated as a direct result of my examination.

10. Signature (Do not print)	11. Date *(month, day, year)*

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Part B. TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER

1. Purpose of examination	2. Position Title, Series, and Grade
☐ Pre-placement ☒ Other (Specify) Occupational Examination	Family Child Care Provider

3. Brief description of what the position requires the employee to do.

Family Child Care Provider - care for no more than six children under the age of eight with no more than two children under the age of two in their home.

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Part B. CONTINUED - TO BE COMPLETED BEFORE EXAMINATION BY APPOINTING OFFICER

4. Check the box for each functional requirement in section 4a and each environmental factor in section 4b essential to the duties of this position. List any additional essential factors in the blank spaces. Also, if the position involves law enforcement, air traffic control, or fire fighting, attach the specific medical standards for the information of the examining physician.

4a. Functional Requirements

- ☐ Heavy lifting, 45 pounds and over
- ☒ Moderate lifting, 15-44 pounds
- ☐ Light lifting, under 15 pounds
- ☐ Heavy carrying, 45 pounds and over
- ☒ Moderate carrying, 15-44 pounds
- ☐ Light carrying, under 15 pounds
- ☒ Straight pulling (.5 hours)
- ☐ Pulling hand over hand (_____ hours)
- ☒ Pushing (.5 hours)
- ☒ Reaching above shoulder
- ☒ Use of fingers
- ☒ Both hands required
- ☒ Walking (2 hours)
- ☒ Standing (4 hours)
- ☒ Crawling (.5 hours)
- ☒ Kneeling (.5 hours)
- ☒ Repeated bending (2 hours)
- ☐ Climbing, legs only (_____ hours)
- ☐ Climbing, use of legs and arms
- ☒ Both legs required
- ☐ Operation of crane, truck, tractor, or motor vehicle
- ☒ Ability for rapid mental and muscular coordination simultaneously
- ☐ Ability to use and desirability of using firearms
- ☐ Near vision correctable at 13" to 16" to Jaeger 1 to 4
- ☒ Far vision correctable in one eye to 20/20 and to 20/40 in the other
- ☐ Specific visual requirement (specify)

  _____
- ☒ Both eyes required
- ☒ Depth perception
- ☒ Ability to distinguish basic colors
- ☒ Ability to distinguish shades of colors
- ☒ Hearing (aid permitted)
- ☐ Hearing without aid
- ☐ Specific hearing requirements (specify)

  _____

Other (specify)

- ☒ Healthy dental hygiene
- ☒ Current Immunization
- ☒ Mental and Emotional stability
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

4b. Environmental Factors

- ☐ Outside
- ☒ Outside and inside
- ☐ Excessive heat
- ☐ Excessive cold
- ☐ Excessive humidity
- ☐ Excessive dampness or chilling
- ☐ Dry atmospheric conditions
- ☐ Excessive noise, intermittent
- ☒ Constant noise
- ☐ Dust
- ☐ Silica, asbestos, etc.
- ☐ Fumes, smoke, or gases
- ☐ Solvents (degreasing agents)
- ☐ Grease and oils
- ☐ Radiant energy
- ☐ Electrical energy
- ☒ Slippery or uneven walking surfaces
- ☐ Working around machinery with moving parts
- ☐ Working around moving objects or vehicles
- ☐ Working on ladders or scaffolding
- ☐ Working below ground
- ☐ Unusual fatigue factors (specify)

  _____
- ☒ Working with hands in water
- ☐ Explosives
- ☐ Vibration
- ☒ Working closely with others
- ☒ Working alone
- ☐ Protracted or irregular hours of work

Other (specify)

- ☒ Contact with body fluids
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

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Part C. TO BE COMPLETED BY EXAMINING PHYSICIAN

NOTE TO EXAMINING PHYSICIAN: The person you are about to examine will have to cope with the functional requirements and environmental factors checked in Part 4 of this form. Please take these, and the brief description of the job duties, into consideration as you make your examination and report your findings and conclusions.

1. Height _____ Feet, _____ Inches. Weight: _____ Pounds.

2. Eyes:

a. Distant vision (Snellen): without corrective lenses: right 20 ____ left 20 ____; with corrective lenses, if worn; right 20 ____ left 20 ____

b. Depth perception

Type of test: _____

_____ Seconds of Arc

Number correct: _____ of _____ tested

Interpretation ☐ Normal ☐ Abnormal

c. Peripheral vision

Right Nasal _____ degrees Temporal _____ degrees

Left Nasal _____ degrees Temporal _____ degrees

d. What is the longest and shortest distance at which the following specimen of Jaeger No. 2 type can be read by the applicant?

Test each eye separately.

Jaeger No. 2 Type

The President may -

(1) prescribe such regulations for the admission of individuals into the civil service in the executive branch as will best promote the efficiency of that service; (2) ascertain the fitness of applicants as to age, health, character, knowledge, and ability for the employment sought; and (3) appoint and prescribe the duties of individuals to make inquiries for the purpose of this section.
(Title 5 U.S. Code 3301)

	without corrective lenses:	with corrective lenses, if used:
L	_____ in. to _____ in.	_____ in. to _____ in.
R	_____ in. to _____ in.	_____ in. to _____ in.

e. Color vision: Is color vision normal by Ishihara or other color plate test? ☐ Yes ☐ No

If not, can applicant pass lantern test? ☐ Yes ☐ No

Can see red/green/yellow? ☐ Yes ☐ No

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Part C. CONTINUED - TO BE COMPLETED BY EXAMINING PHYSICIAN

3. Ears: (Consider denominators indicated here as normal. Record as numerators the greatest distance heard.)

Ordinary conversation:

Right Ear _____ ;
20 ft.

Left Ear _____
20 ft.

Audiometer in dB (if given) for Right Ear:									
250	500	1000	2000	3000	4000	5000	6000	7000	8000

Audiometer in dB (if given) for Left Ear:									
250	500	1000	2000	3000	4000	5000	6000	7000	8000

4. Other Findings: Describe any abnormality (including diseases, scars, and disfigurations). Include brief pertinent history. If normal, so indicate.

a. Eyes, ears, nose, and throat (including tooth and oral hygiene)

b. Abdomen

c. Head and back (including face, hair, and scalp)

d. Peripheral blood vessels

e. Speech (note any malfunction)

f. Extremities (including strength, range of motion)

g. Skin and lymph nodes (including thyroid gland)

h. Urinalysis (if indicated)

SP. Gr. _____ Sugar _____ Blood _____

Albumen _____ Casts _____ Pus _____

i. Respiratory tract (X-ray if indicated)

j. Heart (size, rate, rhythm, function)

Blood pressure _____

Pulse _____

EKG (if indicated)

k. Back (special consideration for positions involving heavy lifting and other strenuous duties)

l. Neurological (including reflexes, sensation) and mental health

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Part C. CONTINUED - TO BE COMPLETED BY EXAMINING PHYSICIAN

5. Conclusions: Summarize below any medical findings that in your opinion, would limit this person's ability to perform these job duties or make them a hazard to themselves or others. If none, so indicate.

☐ No limiting conditions for this job

☐ Limiting conditions as follows:

6. Examining Physician's Name	7. E-Mail Address
8. Address (Including Street, City, State and ZIP Code)	9. Telephone Number
10. Signature of Examining Physician	11. Date (Month, Day, Year)

IMPORTANT: After signing, return the entire form intact in the pre-addressed "Confidential-Medical" envelope which the person you examined gave you.

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FOR AGENCY USE ONLY

Part D. TO BE COMPLETED BY AGENCY MEDICAL OFFICER (if one is available)
NOTE: Review the attached certificate of medical examination and make your recommendations in item 1 below.

1. Recommendation:

☐ Applicant/ employee has been determined medically qualified. Please specify restrictions if any.

☐ Applicant/ employee has been determined not medically qualified; explain why.

2. Agency Medical Officer's Name	3. E-Mail Address
4. Address (Including Street, City, State and ZIP Code)	5. Telephone Number
6. Signature of Agency Medical Officer	7. Date (Month, Day, Year)

FOR AGENCY USE ONLY

Part E. TO BE COMPLETED BY AGENCY HUMAN RESOURCES OFFICER

1. Action Taken:

☐ Hired or Retained

☐ Non-Selected for Appointment, or Eligibility Objected To

☐ Action Taken to Separate

2. Agency Human Resources Officer's Name	3. E-Mail Address
4. Address (Including Street, City, State and ZIP Code)	5. Telephone Number
6. Signature of Agency Human Resources Officer	7. Date (Month, Day, Year)

BASIC CRIMINAL HISTORY AND STATEMENT OF ADMISSION
(Department of Defense Child Care Services Programs)

OMB No. 0704-0516
OMB approval expires: 20241031

The public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-informationcollections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PRIVACY ACT STATEMENT

AUTHORITY: 34 U.S.C 20351, Child Care Worker Employee Background Checks Requirements for Background Checks; Public Law 115-91, Section 925, (NDAA for FY2018) Background and Security Investigations for Department of Defense Personnel (10 U.S.C. 1564 note); 5 U.S.C. 9101, Access to Criminal History Records for National Security and Other Purposes; Executive Order 10450 Security Requirements for Government Employees; DoD Instruction 1402.05, Background Checks on Individuals in DoD Child Care Services Programs; DoD Manual 1402.05, Background Checks on Individuals in Department of Defense Child Development and Youth Programs.

PRINCIPAL PURPOSE(S): To collect criminal history information of DoD personnel or contractors seeking to work with children in DoD child care services programs. Information received may be used to assess preliminary interim, on-going, or final suitability/fitness of DoD personnel or contractors working with children in these programs.

ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. 522a(b) of the Privacy Act of 1974, these records may specifically be disclosed outside of DoD pursuant to 552a(b)(3), including as follows: To designated officers and employees of Federal, State, local, territorial, tribal, international, or foreign agencies, or other public authorities, or to other offices or establishments in the executive, legislative, or judicial branches of the Federal Government, in connection with the hiring or retention of an employee, the conduct of a suitability, credentialing, or security investigation, the classifying of jobs, the letting of a contract, or the issuance of a license, grant or other benefit by the requesting agency, to the extent that the information is relevant and necessary to the requesting agency's decision on the matter and the Department deems appropriate; to the appropriate Federal, State, local, territorial, tribal, foreign, or international law enforcement authority or other appropriate entity where a record, either alone or in conjunction with other information, indicates a violation or potential violation of law.

A complete list of routine uses may be found in the applicable System of Records Notice (SORN), DUSDI-02 DoD, Personnel Vetting Records System, at https://dpcld.defense.gov/Portals/49/Documents/Privacy/SORNs/OSDJS/DUSDI-02-DoD.pdf

DISCLOSURE: Voluntary. However, failure to provide all requested information may result in an unfavorable adjudication or determination regarding suitability or fitness to work with children.

1. NAME *(Last, First, and Middle Name) (Do not use initials or abridgements.)*	2. OTHER NAME(S) USED

3. DATE OF BIRTH *(YYYYMMDD)*	4. INSTALLATION/PROGRAM NAME	5. DATE OF HIRE *(YYYYMMDD)*

6. Have you EVER been apprehended, arrested, charged, or convicted by Federal, State, or local authorities for any violation of any Federal law (including the Uniform Code of Military Justice), State law, County law or Municipal law? (Do not include traffic fines of less than $300.) In addition, are you aware of a current allegation/investigation of child abuse/neglect or domestic violence by you, or have you otherwise been involved in any act or received notification from the Family Advocacy Program of an incident that met Department of Defense criteria for child maltreatment or domestic abuse? Mark Yes or No for each category. For any YES answers, complete columns 1-6 and provide a complete summary of the incident on page 2, block 9. Summary should include any disposition or potential mitigating information.

CHILD ABUSE/ NEGLECT: ☐ Yes ☐ No DRUG OR ALCOHOL: ☐ Yes ☐ No VIOLENT CRIME/ ASSAULTIVE BEHAVIOR: ☐ Yes ☐ No

SEX CRIME: ☐ Yes ☐ No DOMESTIC VIOLENCE: ☐ Yes ☐ No OTHER: ☐ Yes ☐ No

(a) Month/ Year *(MM/YYYY)*	(b) Offense	(c) Action Taken	(d) Court or Law Enforcement Agency *(City & Country if outside the United States)*	(e) State	(f) Zip Code	(g) Date of Self-Report *(YYYYMMDD)*

7. I certify that the information provided above is accurate. I understand that I must immediately report to my employer/supervisor or Child and Youth Program representative if I am apprehended, arrested, charged, or convicted by Federal, State, or local authorities for any violation of any Federal law (including the Uniform Code of Military Justice), State law, County law, or Municipal law referenced in block 6. In addition, I will immediately report when I am aware of a current allegation/investigation of child abuse/neglect or domestic violence, or have otherwise been involved in any act or received notification from the Family Advocacy Program of an incident that met Department of Defense criteria for child maltreatment or domestic abuse? Mark Yes or No for each category.

a. SIGNATURE	b. DATE *(YYYYMMDD)*

8. **ANNUAL CERTIFICATIONS** *(Required by Child Development and Youth Program Staff and Volunteers. Certify for the most year recent only.)*
In the past year, have you been apprehended, arrested, charged, or convicted by Federal, State, or local authorities for any violation of any Federal law (including the Uniform Code of Military Justice), State law, County law, or Municipal law? (Do not include traffic fines of less than $300.) In addition, are you aware of a current allegation/investigation of child abuse/neglect or domestic violence by you, or have you otherwise been involved in any act or received notification from the Family Advocacy Program of an incident that met Department of Defense criteria for child maltreatment or domestic abuse? Mark Yes or No for each category.

Failure to disclose accurate information may be grounds for dismissal, termination, or debarment from participating in the program.

a. 2nd YEAR *(Yes or No)*	(1) SIGNATURE	(2) DATE *(YYYYMMDD)*	b. 3rd YEAR *(Yes or No)*	(1) SIGNATURE	(2) DATE *(YYYYMMDD)*
c. 4th YEAR *(Yes or No)*	**(1) SIGNATURE**	**(2) DATE** *(YYYYMMDD)*	**d. 5th YEAR** *(Yes or No)*	**(1) SIGNATURE**	**(2) DATE** *(YYYYMMDD)*

Failure to provide information may result in an unfavorable adjudication decision.

BASIC CRIMINAL HISTORY AND STATEMENT OF ADMISSION
(Department of Defense Child Care Services Programs)

9. NOTES *(Use this space to enter additional comments.)*

10. AUTHORIZATION AND RELEASE CERTIFICATION

I hereby authorize the Department of Defense and other authorized federal agencies to obtain any information required from the Federal government, state agencies, and/or foreign governments, including but not limited to, the Federal Bureau of Investigation (FBI), the Defense Counterintelligence and Security Agency (DCSA), the U.S. Office of Personnel Management (OPM), the Department of Homeland Security (DHS), (if applicable), and from the State Criminal History Repository for each state where I have resided. This authorization is valid for one year from the date this form was signed or until termination of my affiliation with the Federal Government, whichever is sooner.

I have been notified of any employer's or Agency's right to require a criminal history records check as a condition of employment, or affiliation with DoD Child Care Services Programs. I understand that I may request a copy of such records as may be available to me under the law. I understand that I have a right to challenge the accuracy and completeness of any information contained in the criminal history records check report. I also understand that pursuant to the Privacy Act, the information collected will be safeguarded, including for the purpose of conducting the background check.

I release any individual, including records custodians, any component of the United States Government or the individual State Criminal History Repository supplying information, from all liability for damages that may result on account of good-faith compliance, or any good-faith attempts to comply with this authorization. This release is binding, now and in the future, on my heirs, assigns, associates, and personal representative(s) of any nature. Copies of this authorization that show my signature are as valid as the original release signed by me.

I declare under penalty of perjury that the statements made by me on this form are true, complete and correct. In addition to the annual certification, I understand that it is my responsibility to immediately inform my employer/supervisor or Child and Youth Programs representative if I am apprehended, arrested, charged, or convicted by Federal, State, or local authorities for any violation of any Federal law (including the Uniform Code of Military Justice), State law, County law, or Municipal law with a crime referenced in block 6. (Do not include traffic fines of less than $300.). In addition, I will immediately report when I am aware of a current allegation/investigation of child abuse/neglect or domestic violence, or have otherwise been involved in any act or received notification from the Family Advocacy Program of an incident that met Department of Defense criteria for child maltreatment or domestic abuse? Mark Yes or No for each category. I also understand that if I am a family child care provider that I will make the same report for the same offenses for members in my household.

WARNING: False statements are punishable by law and could result in fines and/or imprisonment for up to five years.

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*

11. PARENT CONSENT FOR MINORS:

If the applicant is a minor, a Parent or Legal Guardian must grant permission below for the background checks. The Parent/Legal Guardian is certifying they understand the purposes of these checks and hereby provide consent for the background checks.

a. SIGNATURE OF PARENT/GUARDIAN *(if under age 18)*	b. DATE SIGNED *(YYYYMMDD)*

BASIC CRIMINAL HISTORY AND STATEMENT OF ADMISSION
(Department of Defense Child Care Services Programs)

OMB No. 0704-0516
OMB approval expires: 20241031

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ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. 522a(b) of the Privacy Act of 1974, these records may specifically be disclosed outside of DoD pursuant to 552a(b)(3), including as follows: To designated officers and employees of Federal, State, local, territorial, tribal, international, or foreign agencies, or other public authorities, or to other offices or establishments in the executive, legislative, or judicial branches of the Federal Government, in connection with the hiring or retention of an employee, the conduct of a suitability, credentialing, or security investigation, the classifying of jobs, the letting of a contract, or the issuance of a license, grant or other benefit by the requesting agency, to the extent that the information is relevant and necessary to the requesting agency's decision on the matter and the Department deems appropriate; to the appropriate Federal, State, local, territorial, tribal, foreign, or international law enforcement authority or other appropriate entity where a record, either alone or in conjunction with other information, indicates a violation or potential violation of law.

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1. NAME *(Last, First, and Middle Name) (Do not use initials or abridgements.)*	2. OTHER NAME(S) USED

3. DATE OF BIRTH *(YYYYMMDD)*	4. INSTALLATION/PROGRAM NAME	5. DATE OF HIRE *(YYYYMMDD)*

6. Have you EVER been apprehended, arrested, charged, or convicted by Federal, State, or local authorities for any violation of any Federal law (including the Uniform Code of Military Justice), State law, County law or Municipal law? (Do not include traffic fines of less than $300.) In addition, are you aware of a current allegation/investigation of child abuse/neglect or domestic violence by you, or have you otherwise been involved in any act or received notification from the Family Advocacy Program of an incident that met Department of Defense criteria for child maltreatment or domestic abuse? Mark Yes or No for each category. For any YES answers, complete columns 1-6 and provide a complete summary of the incident on page 2, block 9. Summary should include any disposition or potential mitigating information.

CHILD ABUSE/ NEGLECT: ☐ Yes ☐ No DRUG OR ALCOHOL: ☐ Yes ☐ No VIOLENT CRIME/ ASSAULTIVE BEHAVIOR: ☐ Yes ☐ No

SEX CRIME: ☐ Yes ☐ No DOMESTIC VIOLENCE: ☐ Yes ☐ No OTHER: ☐ Yes ☐ No

(a) Month/ Year *(MM/YYYY)*	(b) Offense	(c) Action Taken	(d) Court or Law Enforcement Agency *(City & Country if outside the United States)*	(e) State	(f) Zip Code	(g) Date of Self-Report *(YYYYMMDD)*

7. I certify that the information provided above is accurate. I understand that I must immediately report to my employer/supervisor or Child and Youth Program representative if I am apprehended, arrested, charged, or convicted by Federal, State, or local authorities for any violation of any Federal law (including the Uniform Code of Military Justice), State law, County law, or Municipal law referenced in block 6. In addition, I will immediately report when I am aware of a current allegation/investigation of child abuse/neglect or domestic violence, or have otherwise been involved in any act or received notification from the Family Advocacy Program of an incident that met Department of Defense criteria for child maltreatment or domestic abuse? Mark Yes or No for each category.

a. SIGNATURE	b. DATE *(YYYYMMDD)*

8. **ANNUAL CERTIFICATIONS** *(Required by Child Development and Youth Program Staff and Volunteers. Certify for the most year recent only.)*
In the past year, have you been apprehended, arrested, charged, or convicted by Federal, State, or local authorities for any violation of any Federal law (including the Uniform Code of Military Justice), State law, County law, or Municipal law? (Do not include traffic fines of less than $300.) In addition, are you aware of a current allegation/investigation of child abuse/neglect or domestic violence by you, or have you otherwise been involved in any act or received notification from the Family Advocacy Program of an incident that met Department of Defense criteria for child maltreatment or domestic abuse? Mark Yes or No for each category.

Failure to disclose accurate information may be grounds for dismissal, termination, or debarment from participating in the program.

a. 2nd YEAR *(Yes or No)*	(1) SIGNATURE	(2) DATE *(YYYYMMDD)*	b. 3rd YEAR *(Yes or No)*	(1) SIGNATURE	(2) DATE *(YYYYMMDD)*
c. 4th YEAR *(Yes or No)*	**(1) SIGNATURE**	**(2) DATE** *(YYYYMMDD)*	**d. 5th YEAR** *(Yes or No)*	**(1) SIGNATURE**	**(2) DATE** *(YYYYMMDD)*

Failure to provide information may result in an unfavorable adjudication decision.

BASIC CRIMINAL HISTORY AND STATEMENT OF ADMISSION
(Department of Defense Child Care Services Programs)

9. NOTES *(Use this space to enter additional comments.)*

10. AUTHORIZATION AND RELEASE CERTIFICATION

I hereby authorize the Department of Defense and other authorized federal agencies to obtain any information required from the Federal government, state agencies, and/or foreign governments, including but not limited to, the Federal Bureau of Investigation (FBI), the Defense Counterintelligence and Security Agency (DCSA), the U.S. Office of Personnel Management (OPM), the Department of Homeland Security (DHS), (if applicable), and from the State Criminal History Repository for each state where I have resided. This authorization is valid for one year from the date this form was signed or until termination of my affiliation with the Federal Government, whichever is sooner.

I have been notified of any employer's or Agency's right to require a criminal history records check as a condition of employment, or affiliation with DoD Child Care Services Programs. I understand that I may request a copy of such records as may be available to me under the law. I understand that I have a right to challenge the accuracy and completeness of any information contained in the criminal history records check report. I also understand that pursuant to the Privacy Act, the information collected will be safeguarded, including for the purpose of conducting the background check.

I release any individual, including records custodians, any component of the United States Government or the individual State Criminal History Repository supplying information, from all liability for damages that may result on account of good-faith compliance, or any good-faith attempts to comply with this authorization. This release is binding, now and in the future, on my heirs, assigns, associates, and personal representative(s) of any nature. Copies of this authorization that show my signature are as valid as the original release signed by me.

I declare under penalty of perjury that the statements made by me on this form are true, complete and correct. In addition to the annual certification, I understand that it is my responsibility to immediately inform my employer/supervisor or Child and Youth Programs representative if I am apprehended, arrested, charged, or convicted by Federal, State, or local authorities for any violation of any Federal law (including the Uniform Code of Military Justice), State law, County law, or Municipal law with a crime referenced in block 6. (Do not include traffic fines of less than $300.). In addition, I will immediately report when I am aware of a current allegation/investigation of child abuse/neglect or domestic violence, or have otherwise been involved in any act or received notification from the Family Advocacy Program of an incident that met Department of Defense criteria for child maltreatment or domestic abuse? Mark Yes or No for each category. I also understand that if I am a family child care provider that I will make the same report for the same offenses for members in my household.

WARNING: False statements are punishable by law and could result in fines and/or imprisonment for up to five years.

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*

11. PARENT CONSENT FOR MINORS:

If the applicant is a minor, a Parent or Legal Guardian must grant permission below for the background checks. The Parent/Legal Guardian is certifying they understand the purposes of these checks and hereby provide consent for the background checks.

a. SIGNATURE OF PARENT/GUARDIAN *(if under age 18)*	b. DATE SIGNED *(YYYYMMDD)*

family child care
Air Force Services
A Home Away From Home

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.**

family child care
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A Home Away From Home

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.**

DEPARTMENT OF AIR FORCE

FAMILY CHILD CARE

AIR FORCE FAMILY CHILD CARE (FCC) INDIVIDUAL PET ASSESSMENT

_____
Date

NOTE: One form for each pet.

FCC Applicant/Provider's Name _____

Name of pet _____ Type of pet _____

In accordance with *Caring for Our Children*, Standard, 3.042, "Any pet or animal present at the FCC Home shall be in good health, show no evidence of carrying any disease, be fully immunized, and be maintained on a flea, tick, and worm control program. A current (time-specified) certificate from a veterinarian shall be on file in the home, stating that the specific pet meets these conditions." Standard 3.043 states, "The FCC home shall not keep or bring in ferrets, turtles, iguanas, lizards or other reptiles, psittacine birds (birds of the parrot family), or any wild or dangerous animals."

☐ **There is no evidence this pet is carrying any disease(s).**

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

Date rabies vaccination expires _____

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

Date distemper vaccination expires _____

☐ **This pet is free of parasites and fleas.**

I have examined the above named pet and certify that it meets all the conditions stated above.

This Pet Certificate expires on _____

Veterinarian's Name _____

Veterinarian's Signature _____

Telephone (___)_____ Date _____