

SouthEast Child Development Center

EMPLOYMENT APPLICATION

Name:				Social Security Number:	
Address:				Drivers License Number:	
City:	State:	ZIP:	Phone:	Date of Birth:	

Emergency Contact Information

Person to Call:			Telephone (daytime):		
Address:			Telephone (evening):		
City:	State:	ZIP Code:	Relationship:		

Position Desired

(by child's age)

<input type="checkbox"/> Infants to 12 months	<input type="checkbox"/> 12 to 24 months	<input type="checkbox"/> 2 to 3 years	<input type="checkbox"/> 3 to 4 years	<input type="checkbox"/> 4 to 5 years	<input type="checkbox"/> Elementary school age
<input type="checkbox"/> Director of the preschool		<input type="checkbox"/> Cook		<input type="checkbox"/> _____	

Experience

(list most recent first)

Employer:	Date started: Date ended:	Supervisor:	May we contact this supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No Phone:
Duties:			
Employer:	Date started: Date ended:	Supervisor:	May we contact this supervisor? <input type="checkbox"/> Yes <input type="checkbox"/> No Phone:
Duties:			

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Education

High School:		Date Graduated:	
College attended (undergraduate):	Major course of study:	Degree received:	Date of graduation:
College attended (graduate):	Major course of study:	Degree received:	Date of graduation:

Early Childhood Training

List the courses and other training sessions you have taken to prepare you to work with young children. Be prepared to provide us with copies of certificates that evidence this training.

Date: (List most recent first)	Course title:	What did this course cover?
Date:	Course title:	What did this course cover?
Date:	Course title:	What did this course cover?
Date:	Course title:	What did this course cover?
Date:	Course title:	What did this course cover?

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Other Training

List other training you have received such as CPR, First Aid, lifesaving, etc. that prepares you to work in a public service position. Be prepared to provide us with copies of certificates that evidence this training.

Date: (List most recent first)	Course title:	What did this course cover?
Date:	Course title:	What did this course cover?
Date:	Course title:	What did this course cover?
Date:	Course title:	What did this course cover?
Date:	Course title:	What did this course cover?

Other Relevant Information

Include any other information you believe is relevant to our considering you for a position at SCDC.

SouthEast Child Development Center

1540 Elmtree Road, Columbia, SC 29209

Phone: 803-776-0177 — Fax: 803-776-1569 — email: scdc@sc.rr.com

Employment Verification Form

In accordance with policy and practice, SouthEast Child Development Center may inquire and verify any information contained on my application or attachments thereto. I understand that my current and former employers may release any information contained in my personnel file or otherwise known by them to SouthEast Child Development Center in connection with my application for employment with SouthEast Child Development Center. I specifically release from liability any current or former employers, their agents, representatives, employees, officers, or directors, for giving such information to SouthEast Child Development Center.

Information Provided By Employee	Information Provided By Former Employer Please make corrections to information provided by employee in this column
Employer:	Employer:
Job Title:	Job Title:
Employment Dates: From ____/____/____ To: ____/____/____	Employment Dates: From ____/____/____ To: ____/____/____
Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Other	Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Other
Do you believe you are eligible for rehire? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you believe you are eligible for rehire? <input type="checkbox"/> Yes <input type="checkbox"/> No
Were any allegations of sexual harassment, workplace violence or other acts of illegal discrimination against you validated during your employment? <input type="checkbox"/> No <input type="checkbox"/> Yes	Were any allegations of sexual harassment, workplace violence or other acts of illegal discrimination against you validated during your employment? <input type="checkbox"/> No <input type="checkbox"/> Yes
On a scale of 1-5, how would you rate your work performance for this employer? <input type="checkbox"/> 5 - Outstanding <input type="checkbox"/> 4 - Above Satisfactory <input type="checkbox"/> 3 - Satisfactory <input type="checkbox"/> 2 - Needed Improvement <input type="checkbox"/> 1 - Unsatisfactory	On a scale of 1-5, how would you rate your work performance for this employer? <input type="checkbox"/> 5 - Outstanding <input type="checkbox"/> 4 - Above Satisfactory <input type="checkbox"/> 3 - Satisfactory <input type="checkbox"/> 2 - Needed Improvement <input type="checkbox"/> 1 - Unsatisfactory
	Are you aware of any information that may affect his/her ability to work effectively? <input type="checkbox"/> Yes <input type="checkbox"/> No

Former Employer - Please Complete this Section

Printed name of person completing this form: _____
 Signature: _____
 Date: ____/____/____
 Title: _____

Employee's Name: _____
 Signature: _____
 Date: ____/____/____

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Information Provided By Employee	Information Provided By Former Employer Please make corrections to information provided by employee in this column
Employer:	Employer:
Job Title:	Job Title:
Employment Dates: From ____/____/____ To: ____/____/____	Employment Dates: From ____/____/____ To: ____/____/____
Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Other	Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Other
Do you believe you are eligible for rehire? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you believe you are eligible for rehire? <input type="checkbox"/> Yes <input type="checkbox"/> No
Were any allegations of sexual harassment, workplace violence or other acts of illegal discrimination against you validated during your employment? <input type="checkbox"/> No <input type="checkbox"/> Yes	Were any allegations of sexual harassment, workplace violence or other acts of illegal discrimination against you validated during your employment? <input type="checkbox"/> No <input type="checkbox"/> Yes
On a scale of 1-5, how would you rate your work performance for this employer? <input type="checkbox"/> 5 - Outstanding <input type="checkbox"/> 4 - Above Satisfactory <input type="checkbox"/> 3 - Satisfactory <input type="checkbox"/> 2 - Needed Improvement <input type="checkbox"/> 1 - Unsatisfactory	On a scale of 1-5, how would you rate your work performance for this employer? <input type="checkbox"/> 5 - Outstanding <input type="checkbox"/> 4 - Above Satisfactory <input type="checkbox"/> 3 - Satisfactory <input type="checkbox"/> 2 - Needed Improvement <input type="checkbox"/> 1 - Unsatisfactory
	Are you aware of any information that may affect his/her ability to work effectively? <input type="checkbox"/> Yes <input type="checkbox"/> No

Former Employer - Please Complete this Section

Printed name of person completing this form: _____
 Signature: _____
 Date: ____/____/____
 Title: _____

Employee's Name: _____
 Signature: _____
 Date: ____/____/____

REPLACE THIS PAGE WITH:

A COPY OF YOUR HIGH SCHOOL DIPLOMA

**A COPY OF ALL YOUR CHILD CARE TRAINING CERTIFICATES FOR TRAINING
TAKEN THE PAST TWO YEARS**

A COPY OF YOUR CPR AND FIRST AID TRAINING CARDS

Employment Eligibility Verification

INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1 - Employee. All employees, citizens and noncitizens, hired after November 6, 1986, must complete Section 1 of this form at the time of hire, which is the actual beginning of employment. **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Preparer/Translator Certification. The Preparer/Translator Certification must be completed if Section 1 is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete Section 1 on his/her own. However, the employee must still sign Section 1 personally.

Section 2 - Employer. For the purpose of completing this form, the term "employer" includes those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors.

Employers must complete Section 2 by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, Section 2 must be completed at the time employment begins. **Employers must record: 1) document title; 2) issuing authority; 3) document number, 4) expiration date, if any; and 5) the date employment begins.** Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the I-9. **However, employers are still responsible for completing the I-9.**

Section 3 - Updating and Reverification. Employers must complete Section 3 when updating and/or reverifying the I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in Section 1. Employers **CANNOT** specify which document(s) they will accept from an employee.

- If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B and:

- examine any document that reflects that the employee is authorized to work in the U.S. (see List A **or** C),
- record the document title, document number and expiration date (if any) in Block C, and
- complete the signature block.

Photocopying and Retaining Form I-9. A blank I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed I-9s for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

For more detailed information, you may refer to the Department of Homeland Security (DHS) Handbook for Employers, (Form M-274). You may obtain the handbook at your local U.S. Citizenship and Immigration Services (USCIS) office.

Privacy Act Notice. The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of the U.S. Immigration and Customs Enforcement, Department of Labor and Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Reporting Burden. We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: **1) learning about this form, 5 minutes; 2) completing the form, 5 minutes; and 3) assembling and filing (recordkeeping) the form, 5 minutes, for an average of 15 minutes per response.** If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., Washington, DC 20529. OMB No. 1615-0047.

NOTE: This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

**EMPLOYERS MUST RETAIN COMPLETED FORM I-9
PLEASE DO NOT MAIL COMPLETED FORM I-9 TO ICE OR USCIS**

Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. **ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification. To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.	I attest, under penalty of perjury, that I am (check one of the following):
	<input type="checkbox"/> A citizen or national of the United States
	<input type="checkbox"/> A Lawful Permanent Resident (Alien #) A _____
	<input type="checkbox"/> An alien authorized to work until _____ (Alien # or Admission #) _____

Employee's Signature	Date (month/day/year)
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Preparer and/or Translator Certification. (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	Date (month/day/year)

Section 2. Employer Review and Verification. To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): _____		_____		_____

CERTIFICATION - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) _____ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name	Address (Street Name and Number, City, State, Zip Code)	Date (month/day/year)

Section 3. Updating and Reverification. To be completed and signed by employer.

A. New Name (if applicable)	B. Date of Rehire (month/day/year) (if applicable)
C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility. Document Title: _____ Document #: _____ Expiration Date (if any): _____	

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date (month/day/year)
--	-----------------------

LISTS OF ACCEPTABLE DOCUMENTS

LIST A	LIST B	LIST C
Documents that Establish Both Identity and Employment Eligibility	Documents that Establish Identity	Documents that Establish Employment Eligibility
<ol style="list-style-type: none"> 1. U.S. Passport (unexpired or expired) 2. Certificate of U.S. Citizenship (<i>Form N-560 or N-561</i>) 3. Certificate of Naturalization (<i>Form N-550 or N-570</i>) 4. Unexpired foreign passport, with <i>I-551 stamp</i> or attached <i>Form I-94</i> indicating unexpired employment authorization 5. Permanent Resident Card or Alien Registration Receipt Card with photograph (<i>Form I-151 or I-551</i>) 6. Unexpired Temporary Resident Card (<i>Form I-688</i>) 7. Unexpired Employment Authorization Card (<i>Form I-688A</i>) 8. Unexpired Reentry Permit (<i>Form I-327</i>) 9. Unexpired Refugee Travel Document (<i>Form 1-571</i>) 10. Unexpired Employment Authorization Document issued by DHS that contains a photograph (<i>Form I-688B</i>) 	OR	<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <p style="text-align: center; font-weight: bold;">For persons under age 18 who are unable to present a document listed above:</p> <ol style="list-style-type: none"> 10. School record or report card 11. Clinic, doctor or hospital record 12. Day-care or nursery school record
	AND	<ol style="list-style-type: none"> 1. U.S. social security card issued by the Social Security Administration (<i>other than a card stating it is not valid for employment</i>) 2. Certification of Birth Abroad issued by the Department of State (<i>Form FS-545 or Form DS-1350</i>) 3. Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (<i>Form I-197</i>) 6. ID Card for use of Resident Citizen in the United States (<i>Form I-179</i>) 7. Unexpired employment authorization document issued by DHS (<i>other than those listed under List A</i>)

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

School Employee/Individual Certificate of Evaluation for Tuberculosis

Name: Last First M.I. Residence Address City County

Public or private school, kindergarten, nursery or day care center Date Employed
of current employment or other employer or individual

TEST RESULTS	TUBERCULIN SKIN TEST _____ Date Given	CHEST X-RAY	REMARKS
	5 TU PPD MANTOUX METHOD	Date:	
	_____ mm _____ Date Interpreted	Interpretation:	
DISPOSITION	<input type="checkbox"/> No tuberculosis infection per 5 TU PPD ¹ <input type="checkbox"/> Tuberculosis infection, no evidence of disease <input type="checkbox"/> Prevention treatment started _____ and completed _____ ¹ <input type="checkbox"/> Prevention treatment started _____ but not completed _____ ² <input type="checkbox"/> Prevention treatment not prescribed/refused ² <input type="checkbox"/> History of tuberculosis disease Treatment started _____ and completed _____ ¹ <input type="checkbox"/> Current tuberculosis disease <input type="checkbox"/> Non contagious as of _____ and medically cleared to start/resume school other employment on _____ ²		
	¹ No further routine screening required ² Remains at lifelong risk of developing tuberculosis		
CERTIFICATION	<input type="checkbox"/> This is to certify that I have examined the school employee named herein for tuberculosis and report my finding as indicated above pursuant to the Code of Laws of South Carolina, 1976, as amended April 24, 1979 <input type="checkbox"/> This is to certify that I have examined the individual named herein for tuberculosis and report my findings as indicated above.		
	_____ Physician's Signature	_____ Date	

DHEC 1420 (08/1998) DISPOSITION: This form shall be retained in the files of the current employer or individual following evaluation and certification.

SCHOOL EMPLOYEE/INDIVIDUAL CERTIFICATE OF EVALUATION FOR TUBERCULOSIS: this form may be used for school employees or other individuals who need documentation of tuberculosis evaluation. It should be maintained in the current employer's file for school employees and by employer or individual for other needs.

CODE OF LAWS OF SOUTH CAROLINA, 1976, AS AMENDED APRIL 1979, SECTION 44-29-150. No person will be initially hired to work in any public or private school, kindergarten, nursery or day care center for infants and children until appropriately evaluated for tuberculosis according to guidelines approved by the south Carolina department of Health and Environmental Control. Reevaluation will not be required for employment in consecutive years unless otherwise indicated by such guidelines.

SECTION 44-29-160. Any person applying for a position in any of the public or private schools, kindergartens, nurseries, or day care centers for infants and children of the State shall, as a prerequisite to employment, secure a health certificate from a licensed physician certifying that such person does not have tuberculosis in an active state.

SECTION 44-29-170. the physician shall make the aforesaid certificate on a form supplied by the Department of Health and Environmental control, whose duty it shall be to provide such forms upon request of the applicant.

SUMMARY OF GUIDELINES OF THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL. (Regulation 61-22) Each employee shall have, prior to employment, and unless so previously tested, as a condition for further employment, a tuberculin skin test performed by intradermal injection of 5 tuberculin units of purified protein derivative of tuberculin (Mantoux test with 5 TU of PPD). Employees with test reactions measuring less than 10mm or more shall have a chest x-ray, shall be recorded on the DHEC for 1420 which shall be kept in the files of the school principal/designee. These forms shall be subject to review by DHEC. If the chest x-ray (and examination of sputum, if necessary) shows evidence of current tuberculosis disease, the employee shall not be allowed to work until she/she receives written certification for DHEC that he/she is not contagious. Employees whose skin text reactions measure 10mm or more and who have a normal chest x-ray shall be evaluated for preventive therapy for their tuberculous infection. If preventive therapy is not prescribed, or is prescribed, but refused, a notation shall be made on the employee's certificate that he/she is considered to be infected with tubercle bacilli and remains at lifelong risk, of developing tuberculosis disease. Testing other than the described above, shall be required only if there is epidemiological evidence that employees, attendees, or students in the school, nursery, day care center, or kindergarten have become infected with tuberculosis.

**South Carolina Department of Social Services
Child Care Licensing and Regulatory Services
CONSENT TO RELEASE INFORMATION**

This serves as my consent to authorize the South Carolina Department of Social Services, Division of Human Services, to conduct a search of the Child Abuse and Neglect Central Registry on myself. I understand that the information may prove unfavorable to me. I agree to hold any source of information blameless for any error in reporting this information. I release all persons and the South Carolina Department of Social Services from any liability arising out of or resulting from the release of this information. This consent is effective for search of the Central Registry for the purpose of working in any child care facility in the State.

Name of Child Care Facility: SouthEast Child Development Center

Name of Director/Operator: Mrs Shakeela Aslam

Address of Facility: 1540 Elmtree Rd

City: Columbia Zip: 29209 County: Richland

Please Print or Type: (Complete spelling of name required; no initials.)

Name: _____ DOB: _____ Sex: _____

Maiden/Former Name: _____ Race: _____

Place of Birth: _____ SSN: _____

Current Address: _____

Previous Address: _____

Signature of Applicant

Date

Witnessed by the Director/Operator

Date

Results of Search of the Child Abuse and Neglect Central Registry

(This section to be completed by authorized DSS employee only.)

- The name is not listed as a perpetrator in the Child Abuse and Neglect Central Registry.
- The name is listed as a perpetrator in the Child Abuse and Neglect Central Registry. According to state law, being named as a perpetrator prohibits an individual from being a licensed foster parent or operating or working in a child day care facility or being employed, operating or volunteering in a residential child care facility. Further, being a perpetrator may affect an individual's capacity to adopt a child.
- Your request has been received. Please allow an additional 30 to 60 days to process your inquiry.
- Other – See attached correspondence for additional information.

Central Registry Check Completed By: _____

Authorized DSS Employee

Date

Name(s) not found in the sexual offender registry.

Name(s) found in the sexual offender registry.

Written notification sent to Director/Operator.

Sexual Offender Registry Check Completed By: _____

Authorized DSS Employee

Date

**South Carolina Department of Social Services
Division of Child Day Care Licensing and Regulatory Services
DIRECTOR/STAFF EVIDENCE OF NON-CONVICTION AND
STATEMENT OF COMPLIANCE**

This form must be completed by all persons applying for employment with, or employed by, or seeks to provide caregiver services in, or is a caregiver at a child day care facility. Submit the original form to the department and keep a copy for your facility file. This form is to be reviewed and updated at each renewal.

The South Carolina Child Care Licensing Law, Section 20-7-2725 D. et seq., Code of Laws states, "To be employed by or to provide caregiver services at a day care facility licensed, registered, or approved under this sub-article, a person first shall undergo a state fingerprint review to be conducted by the State Law Enforcement Division to determine any state criminal history and fingerprint review to be conducted by the Federal Bureau of Investigation to determine any other criminal history. A person may be provisionally employed or may provisionally provide caregiver services after the favorable completion of the State Law Enforcement Division fingerprint review and until such time as the Federal Bureau of Investigation review is completed if the person affirms in writing on a form provided by the department that he or she has not been convicted of any crime enumerated in this section (DSS Form 2925, JUL 01). The results of the fingerprint reviews are valid and reviews are not required to be repeated as long as the person remains employed by or continues providing caregiver services in a day care center, group day care home, family day care home, or church or religious day care center; however, if a person is not employed or does not provide caregiver services for one year or longer, the fingerprint reviews must be repeated."

This questionnaire and certification is deemed to be continuous in nature and any future violation or noncompliance with the applicable state statute herein must be reported immediately to the Division of Child Day Care Licensing and Regulatory Services.

I have read and become familiar with S.C. Code Section 20-7-2725 (as amended), which provides the requirements for employment in a child day care facility.

I affirm that I am an employee, employer, or seeking employment in a child day care facility, and that I am in compliance with the provisions of S.C. Code Section 20-7-2725 (as amended).

I understand that if I am found to be in violation of S.C. Code Section 20-7-2725 (as amended), such noncompliance will affect the issuance or status of the licensure/approval/registration of this facility.

I understand, in accordance with the requirements of S.C. Code Section 20-7-2725 (B) (as amended) that all application forms provided for employment at a child day care facility must include, at the top of the application form in large bold type, a statement indicating that a person who has been convicted of a crime enumerated in Subsection (A) who applies for employment with, is employed by, or seeks to provide caregiver services in, or is a caregiver at such facility, is guilty of a misdemeanor, and, upon conviction, must be fined not more than five thousand dollars, or imprisoned not more than one year, or both.

Name: (Print) _____

Address: _____

Facility Name: SouthEast Child Development Center

Facility Address: 1540 Elmtree Road

Facility City: Columbia

Director: Shakeela Aslam

County: Richland

Facility Approval/License/Registration No.: License #: 17,892

I AFFIRM TO THE ABOVE NON-CONVICTION AND STATEMENT OF COMPLIANCE.

Staff's Signature: _____ Staff's Title: _____

SWORN TO AND SUBSCRIBED BEFORE ME

this _____ day of _____, 20_____.

Notary Public for South Carolina

My Commission Expires: _____

STAFF HEALTH ASSESSMENT

NAME: _____ DOB: _____

Type of Activity in Child Care (*Check all applicable*)
 Adult Member of Household Food Preparation Caring for children Desk Work
 Driver of Vehicle Facility Maintenance

THIS SECTION TO BE COMPLETED BY HEALTH PROFESSIONAL WHO DOES HEALTH ASSESSMENT

PART I – MEDICAL HISTORY – Does this person have any of the following medical problems?

	Yes*	No
History of myocardial infarction, angina pectoris, coronary insufficiency?		
History of epilepsy?		
Diabetes?		
Current drug or alcohol dependency?		
Disabling emotional disorder?		
Other special medical problem or chronic disease which requires restriction of activity, medication or which might affect his/her work role? If so, specify on reverse of form.		
Does this person have any special medical problems which might interfere with the health of the children or that might prohibit this person from providing adequate care for the children. If yes, explain on reverse of form.		
Speech disorder?		
Significant physical findings/chronic medical condition or physical impairment?		

*EXPLAIN ALL "YES" RESPONSES ON REVERSE OF FORM, GIVING PLAN FOR FOLLOW-UP, IF ANY.

PART II – As shown by physical examination, does the individual have

	Yes	No*
At least 20/20 combined vision, corrected by glasses if needed?		
Normal hearing?		
Normal blood pressure?		

*EXPLAIN ALL "NO" RESPONSES ON REVERSE OF FORM

PART III – Communicable diseases – Does this person have a communicable disease which would prohibit him/her from working in a child care facility?

Yes No If yes, please comment: _____

Tuberculosis Certification (<i>if medically recommended or required by the Local Health Officer</i>)		
TYPE OF TEST:	READING:	DATE:

Immunization Status	
Facility staff are at risk of exposure to childhood diseases. Prospective employees who will work with infants should have a review of their immunization status. Employees are also at risk of exposure to live virus, such as polio and CMV. Immunization status reviewed: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Comments: _____	

Name & Address of Health Care Provider _____ Telephone Number _____

Signature of Health Care Provider _____ Date of Examination _____

**South Carolina Department of Social Services
 CONSENT TO RELEASE INFORMATION**

My signature below serves as my consent to authorize the South Carolina Department of Social Services, Division of Human Services, to conduct a search of the Child Abuse and Neglect Central Registry on myself and release the information to the individual/organization listed below. I also understand that all information provided on this form will be released to the individual/organization listed below. I understand that the information may prove unfavorable to me. I agree to hold the South Carolina Department of Social Services and its staff harmless from liability associated with the release of information I have requested using this form. If it appears to me that the information in the Registry has not been updated or appears inaccurate, I will notify the Department immediately.

This consent is effective for a one time search of the Central Registry for the purpose of: Child Care Worker

Mail Results To: SouthEast Child Development Center
1540 Elmtree Rd
Columbia, SC 29209

Central Registry Check Fee: (Check one and attach appropriate payment by check or money order.)

- | | | | |
|--|---------|--|---------|
| <input type="checkbox"/> Non-Profit Entities | \$8.00 | <input type="checkbox"/> Schools | \$15.00 |
| <input type="checkbox"/> Private Adoption Investigations | \$25.00 | <input checked="" type="checkbox"/> Child Care | \$8.00 |
| <input type="checkbox"/> For-Profit Entities | \$25.00 | <input type="checkbox"/> Other (Individuals, all others not named above) | \$8.00 |
| <input type="checkbox"/> State Agencies | \$15.00 | | |

Please Print or Type: (Complete spelling of name required, first, middle and last – **no initials.**)

Name: _____ DOB: _____ Sex: _____ Race: _____

Maiden/Former Name: _____ Name Change: _____

Place of Birth: _____ SSN: _____

Current Address: _____ Previous Address: _____

This form MUST be witnessed (may be notarized). Submit appropriate payment and form for processing to:
 South Carolina Department of Social Services, Attention: Cashier, P.O. Box 1520, Columbia, South Carolina 29202-1520;
 Telephone (803) 898-7318.

 Signature of Applicant Date

 Signature of Notary or Witness Date

RESULTS OF SEARCH OF THE CHILD ABUSE AND NEGLECT CENTRAL REGISTRY

(This section to be completed by an authorized DSS employee only – Division of Human Services.)

- The name is not listed as a perpetrator in the Child Abuse and Neglect Central Registry.
- The name is listed as a perpetrator in the Child Abuse and Neglect Central Registry. According to state law, being named as a perpetrator prohibits an individual from being a guardian ad litem, member of the Foster Care Review Board, licensed foster parent or operating or working in a child day care facility or being employed, operating or volunteering in a residential child care facility. Further, being named as a perpetrator may affect an individual's capacity to adopt a child.
- Your request has been received. Please allow an additional 30 to 60 days to process your inquiry.
- Other – See attached correspondence.

 Authorized DSS Employee Date

INSTRUCTIONS FOR DSS FORM 3072

Purpose:

Provides authorization for the Department of Social Services to conduct a search of the State Central Registry of Child Abuse and Neglect and release the results. State law provides that in order to serve on the Foster Care Review Board, be a guardian ad litem, be licensed as a foster parent or operate or work in a day care facility or be employed, operate or volunteer in a residential child care facility, a State Central Registry of Child Abuse and Neglect search must be conducted.

Note:

An amendment to the South Carolina Code of Laws affects the status of individuals named as perpetrators in the State Central Registry of Child Abuse and Neglect. Effective July 2002, a name legally listed on the Central Registry will remain indefinitely.

Specific Instructions for Applicant/Organization Submitting Form:

Please ensure that you type or stamp the return address on this form. Check appropriate fee box and submit payment with form to: South Carolina Department of Social Services, Attention: Cashier, P.O. Box 1520, Columbia, South Carolina 29202-1520.

Specific Instructions for Applicant: (Print or Type)

All the information requested on this form is necessary in order to conduct a thorough search.

1. Purpose of Search: Fill in whether screening is for employment, to be become a foster parent, volunteer, etc.
2. Name: Provide complete spelling of name to include the first, middle and last name. No initials.
3. Name Change: List name you are changing to. Item number 2 must be completed also.
4. Date of Birth, Sex, Race, Social Security Number: Self-explanatory.
5. Place of Birth: Provide the name of the state you were born in.
6. Current Address: Your current residence.
7. Previous Address: List other addresses, states, countries you have resided in for the past seven years.
8. Signature of Applicant: Original signature of the individual requesting to have their name searched.
9. Signature of Witness or Notary: To witness the signature of the applicant.

This form must be signed by the applicant and witnessed (may be notarized) prior to submitting for processing.

Specific Instructions for Authorized DSS Employee:

After receipt by cashier and processing of payment, the Central Registry check will be completed by authorized DSS personnel in the Division of Human Services.

1. Check appropriate box.
2. Sign, date, stamp confidential on envelope and mail to return address.

Distribution:

Results of the search will be sent to the individual or organization specified on the form.

Form W-4 (2007)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2007 expires February 16, 2008. See Pub. 505, Tax Withholding and Estimated Tax.

Note. You cannot claim exemption from withholding if (a) your income exceeds \$850 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 adjust your withholding allowances based on

itemized deductions, certain credits, adjustments to income, or two-earner/multiple job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax

for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners/Multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2007. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent **A** _____

B Enter "1" if:
 { • You are single and have only one job; or
 • You are married, have only one job, and your spouse does not work; or
 • Your wages from a second job or your spouse's wages (or the total of both) are \$1,000 or less. } **B** _____

C Enter "1" for your **spouse**. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) **C** _____

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return **D** _____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) **E** _____

F Enter "1" if you have at least \$1,500 of **child or dependent care expenses** for which you plan to claim a credit **F** _____

(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G Child Tax Credit (including additional child tax credit). See Pub 972, Child Tax Credit, for more information.
 • If your total income will be less than \$57,000 (\$85,000 if married), enter "2" for each eligible child.
 • If your total income will be between \$57,000 and \$84,000 (\$85,000 and \$119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have 4 or more eligible children. **G** _____

H Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ► **H** _____

For accuracy, **complete all worksheets that apply.**
 { • If you plan to **itemize or claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
 • If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed \$40,000 (\$25,000 if married) see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
 • If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

Form W-4 <small>Department of the Treasury Internal Revenue Service</small>	Employee's Withholding Allowance Certificate ► Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.	OMB No. 1545-0074 2007
1 Type or print your first name and middle initial. Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. <small>Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.</small>
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ► <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 _____
6 Additional amount, if any, you want withheld from each paycheck		6 \$ _____
7 I claim exemption from withholding for 2007, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ►		7 _____
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature <small>(Form is not valid unless you sign it.) ►</small>		Date ►
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional) 10 Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions, claim certain credits, or claim adjustments to income on your 2007 tax return.

1 Enter an estimate of your 2007 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2007, you may have to reduce your itemized deductions if your income is over \$156,400 (\$78,200 if married filing separately). See *Worksheet 2* in Pub. 919 for details.) . . . **1** \$ _____

2 Enter: $\left\{ \begin{array}{l} \$10,700 \text{ if married filing jointly or qualifying widow(er)} \\ \$7,850 \text{ if head of household} \\ \$5,350 \text{ if single or married filing separately} \end{array} \right\}$ **2** \$ _____

3 **Subtract** line 2 from line 1. If zero or less, enter “-0-” **3** \$ _____

4 Enter an estimate of your 2007 adjustments to income, including alimony, deductible IRA contributions, and student loan interest **4** \$ _____

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 8* in Pub. 919) **5** \$ _____

6 Enter an estimate of your 2007 nonwage income (such as dividends or interest) **6** \$ _____

7 **Subtract** line 6 from line 5. If zero or less, enter “-0-” **7** \$ _____

8 **Divide** the amount on line 7 by \$3,400 and enter the result here. Drop any fraction **8** _____

9 Enter the number from the **Personal Allowances Worksheet**, line H, page 1 **9** _____

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet**, also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 **10** _____

Two-Earners/Multiple Jobs Worksheet (See *Two earners/multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) **1** _____

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However**, if you are married filing jointly and wages from the highest paying job are \$50,000 or less, do not enter more than “3.” **2** _____

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter “-0-”) and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet **3** _____

Note. If line 1 is *less than* line 2, enter “-0-” on Form W-4, line 5, page 1. Complete lines 4–9 below to calculate the additional withholding amount necessary to avoid a year-end tax bill.

4 Enter the number from line 2 of this worksheet **4** _____

5 Enter the number from line 1 of this worksheet **5** _____

6 **Subtract** line 5 from line 4 **6** _____

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here **7** \$ _____

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed **8** \$ _____

9 Divide line 8 by the number of pay periods remaining in 2007. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2006. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck **9** \$ _____

Table 1

Table 2

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$4,500	0	\$0 - \$6,000	0	\$0 - \$65,000	\$510	\$0 - \$35,000	\$510
4,501 - 9,000	1	6,001 - 12,000	1	65,001 - 120,000	850	35,001 - 80,000	850
9,001 - 18,000	2	12,001 - 19,000	2	120,001 - 170,000	950	80,001 - 150,000	950
18,001 - 22,000	3	19,001 - 26,000	3	170,001 - 300,000	1,120	150,001 - 340,000	1,120
22,001 - 26,000	4	26,001 - 35,000	4	300,001 and over	1,190	340,001 and over	1,190
26,001 - 32,000	5	35,001 - 50,000	5				
32,001 - 38,000	6	50,001 - 65,000	6				
38,001 - 46,000	7	65,001 - 80,000	7				
46,001 - 55,000	8	80,001 - 90,000	8				
55,001 - 60,000	9	90,001 - 120,000	9				
60,001 - 65,000	10	120,001 and over	10				
65,001 - 75,000	11						
75,001 - 95,000	12						
95,001 - 105,000	13						
105,001 - 120,000	14						
120,001 and over	15						

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may also subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, and the District of Columbia for use in administering their tax laws, and using it in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.