

POCATELLO CHILD CARE LICENSE APPLICATION



***** USING BLUE OR BLACK INK, COMPLETE EACH SECTION. *****
INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED.

PROVIDER EMPLOYEE RESIDENT/VISITOR VOLUNTEER
NEW RENEWAL Hours worked weekly:

NAME: _____
Last First Middle Name (Maiden & Former Names)

PHYSICAL ADDRESS: _____

City State Zip Phone and/or Cell Phone

YOUR EMAIL ADDRESS: _____

NAME/ADDRESS OF BUSINESS: _____

LIST WHERE YOU HAVE LIVED FOR THE PAST TEN YEARS, ONE LINE PER CITY, BEGIN WITH YOUR CURRENT CITY: (not needed for renewals)

YEARS (example 2002-2012)	CITY	STATE	ZIP CODE

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

CITY AND STATE OF YOUR BIRTH: _____ SEX: _____

HEIGHT: _____ WEIGHT: _____ HAIR: _____ EYES: _____ RACE: _____

DRIVER'S LICENSE #: _____ STATE: _____ CLASS: _____

HAVE YOU BEEN LICENSED TO DRIVE IN ANOTHER STATE? _____ STATE(S) _____

HAVE YOU BEEN LICENSED AS A CHILD CARE EMPLOYEE IN ANOTHER JURISDICTION? _____

IF YES, WHERE: _____

HAVE YOU EVER BEEN CONVICTED OF, PLEAD GUILTY TO, OR ADMITTED TO ANY VIOLATION OF CRIMINAL LAW OR HAD A WITHHELD JUDGEMENT FOR ANY CRIME COMMITTED: _____

IF YES, PROVIDE DATE, VIOLATIONS, AND LOCATION OF OFFENSE BELOW. USE A SEPARATE SHEET, IF NECESSARY

ARE YOU CERTIFIED IN CPR? YES NO
HAVE YOU RECEIVED FORMAL FIRST AID TRAINING? YES NO

IF YOUR ANSWER IS NO, YOU MUST BE CERTIFIED/RECEIVED TRAINING WITHIN 90 DAYS FROM DATE OF HIRE OR COMMENCEMENT OF OPERATION OR YOUR LICENSE WILL BE REVOKED. DO YOU UNDERSTAND THIS REQUIREMENT? YES NO

I HEREBY CERTIFY THAT THERE ARE NO MISREPRESENTATIONS, OMISSIONS, OR FALSIFICATIONS OF THE FOREGOING STATEMENTS OR ANSWERS. EACH AND ALL OF THE STATEMENTS ARE TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF AND ARE MADE IN GOOD FAITH. I FURTHER AGREE AND CONSENT IN ADVANCE TO HAVING MY LICENSE REVOKED WITHOUT CAUSE OR HEARING IF ANY OF THE ABOVE INFORMATION CONTAINS ANY MISREPRESENTATION OR FALSIFICATION OR IF ANY MATERIAL INFORMATION HAS BEEN OMITTED

I HAVE REVIEWED AND UNDERSTAND THE CITY ORDINANCE 5.28 CHILD CARE, AND AGREE TO ADHERE TO THE RULES AND REGULATIONS SET FORTH IN THAT CHAPTER AS WELL AS ALL OTHER APPLICABLE LAWS.

SIGNATURE OF APPLICANT: _____ **Date:** _____

*** NO REFUNDS AFTER SUBMISSION OF THIS APPLICATION ***

***** CITY USE ONLY BELOW*****

RECORDS CHECK COMPLETED BY: _____ DATE: _____

Local: Yes No Attached ISTARs: Yes No Attached

IHOT: Yes No NCIC: Yes No D.L. Valid: Yes No

New applicants only: H/W State Registry/Nurses Registry checks completed by: _____

New applicants only: Return from BCI-Fingerprints: _____

RECOMMENDATION TO MAYOR /COUNCIL _____ APPROVE _____ DISAPPROVE

SIGNATURE OF POLICE: _____ DATE: _____

SIGNATURE OF CLERK: _____ DATE: _____

LICENSE # BL (Business): _____ LICENSE # PL (Business): _____

LICENSE # BL (Individual): _____ LICENSE # PL (Individual): _____

POCATELLO POLICE DEPARTMENT

Community Commitment

Roger J. Schei, Chief of Police

911 North 7th Avenue • P.O. Box 2877 • Pocatello, ID 83206-2877 • 208-234-6113 • Fax 208-234-6290
www.pocatello.gov/police

AUTHORITY TO RELEASE INFORMATION

TO WHOM IT MAY CONCERN:

I hereby authorize any officer or other authorized representative of the Pocatello, Idaho Police Department bearing this release, or a copy thereof, within one year of its date, to conduct a fingerprint-based, nationwide criminal history background check and obtain any information regarding criminal history and driving record. I hereby direct you to release such information upon the request of the bearer. This release is executed with full knowledge and understanding that the information is for the official use of the Pocatello Police Department in the course of fulfilling its official responsibilities. I hereby release you, as custodian of such records, or related personnel, both individually and collectively, from any and all liability for damages of whatever kind, which may, at any time, result to me, my heirs, family or associates, because of compliance with this authorization and request to release information, or any attempt to comply with it. I am furnishing my social Security account number on a voluntary basis with the understanding such is not required by Federal Statute or regulation. I have been advised that the disclosure of my Social Security account number is necessary in order to facilitate the criminal history background check and driving record which relate to me. Should there be any question as to the validity of this release, you may contact me as indicated below.

FULL NAME: _____
(Include maiden name and former names if applicable.)

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

CURRENT ADDRESS: _____

TELEPHONE: _____ DATE: _____

SIGNATURE: _____

WITNESS: _____

Idaho Department of Health and Welfare
AUTHORIZATION AND CONSENT TO RELEASE INFORMATION

I, _____, hereby authorize and direct the Idaho Department of Health and Welfare to conduct a name search to determine if I am listed on the Child Abuse and Neglect Central Registry as a person responsible for a substantiated case of abuse, abandonment, or neglect of a child or vulnerable adult.

I further authorize and direct the Idaho Department of Health and Welfare to release the results of this search of the Child Abuse and Neglect Central Registry to: THE POCA TELLO POLICE DEPARTMENT.

I understand that the results and information about me contained in the Child Abuse and Neglect Central Registry may prove to be unfavorable to me and that a history of substantiated child abuse or neglect will effect my ability to work with children or vulnerable adults. I further understand that this information may later be disclosed by the individual/organization listed above. I do hereby fully, finally and forever discharge, release, acquit, and hold harmless the Idaho Department of Health and Welfare, its officers, agents, employees, and staff from any and all claims, liens, demands, liability, suits, judgments, or actions of whatever kind, whether known or unknown, which I may have at any time associated with the release of information I have requested using this form. If it appears to me that the information in the Child Abuse and Neglect Central Registry has not been updated or appears inaccurate, I will notify the Idaho Department of Health and Welfare immediately. This authorization and consent shall be binding upon my heirs, representatives, executors, administrators, assigns, and successors and no promise, inducement or agreement not herein expressed has been made to me. The terms of this authorization and consent are contractual in nature and are not mere recitals. This is a continuing authorization and consent which shall remain effective until revoked by me in writing. THE UNDERSIGNED HAVE READ THE FOREGOING AND FULLY UNDERSTAND IT.

Please Print – Complete spelling of the name is required – no initials		
Name:	Date of Birth:	Sex:
Maiden/Former Name/Aliases:	Social Security Number:	
Signature:		Date:

~This section to be completed by the authorized Idaho Department of Health and Welfare employee only~

Results of the search of the Idaho Child Abuse and Neglect Registry

- The above name **is not listed** in the Child Abuse and Neglect Central Registry.
- The above name **is listed** in the Child Abuse and Neglect Central Registry as having abused or neglected a child.
- Other-See attached correspondence for additional information.

Signature of Authorized UDHW Employee

Date