CAPS _____
PS _____
Office Use

Department of Public Health and Human Services
QAD- Child Care Licensing

Person Information Form
(Required for all staff and adult household members)

Facility

Name:_____ **Provider#**_____

Director Name:_____ **Phone #**_____

Person

Name:_____
Last First Middle Maiden

Mailing Address:_____
City State/Zip

Phone#:_____ **Role Type:** _____ **Date of hire:**_____

General Information:

Sex: ☐ **Female** ☐ **Male**

Date of Birth:_____ **Social Security Number:**_____

Immunizations (Please provide the date)

TDAP Date:_____ ***- OR -*** MedicalExemption Date:_____

MMR Date:_____ ***- OR -*** Medical Exemption Date:_____

Training

**** Please note:** You may not be left alone with children until this training has been completed.

If you have not completed training, please provide the scheduled date.

Child CPR/ Expiration Date:_____ ***- OR -*** Scheduled Date:_____
Infant CPR/ Expiration Date:_____ ***- OR -*** Scheduled Date:_____
Adult CPR / Expiration Date:_____ ***- OR -*** Scheduled Date:_____
First Aid / Expiration Date:_____ ***- OR -*** Scheduled Date:_____

Infant Safety Essentials Date:_____

- OR -

Safe Sleep Date:_____ ***- AND -*** **Shaken Baby** Date:_____

Please describe your Education / Experience

(If you are a Primary Caregiver, please submit Education Verification)

_____

_____

Attestation

☐ I understand I am required to complete CPR and First Aid training before providing unsupervised care to children.

☐ All the information provided in this form is true and accurate.

Statement of Health Attestation:
Applicant and providers must meet certain personal health requirements. As the agency responsible for child Care registration/licensing, the Department of Public Health and Human Services must ensure that the health of each provider is adequate to meet the demands of the care being provided.

☐ I attest that I have no disabling chronic conditions; physical, mental, or emotional illness that would prohibit me from meeting the requirements of my role type.

Employee Signature:_____ Date:_____

Please mail or fax completed form to:

DPHHS/QAD/CCL
PO BOX 202953
HELENA, MT 59620

FAX: (406) 444-1742