Volunteer Application
Dear Prospective Volunteer,

Welcome to the Police Athletic League – New York City! As the first organization of its kind in the country, PAL has provided arts, education and sports opportunities for young people for many years. We want to expand their horizons and help them realize their full potential. Our community members are a vital part of our success, and we thank volunteers like you for helping make PAL the vibrant program that it is.

In our 100 plus year span, our programs have evolved from simple baseball games in vacant lots, to comprise a broad spectrum of services. PAL's programs include: early childhood daycare services, summer youth employment, college readiness programs for teenagers, and juvenile justice services. Volunteers have played a critical role every step of the way.

Today, PAL is the largest, independent non-profit youth agency. PAL serves over 30,000 kids of all ages and backgrounds. If PAL is “The Best Friend A Kid Can Have” then your volunteer efforts make you our best friend.

As part of the application process, you will be asked to provide personal information through a Background Consent form, The Statewide Central Register Check (SCR), and fingerprinting. This information is required by our government funders and will help us provide the best volunteer experience for both you and our kids.

Thank you in advance for helping us to increase the quality of life and effectiveness of education for our city’s neediest children. If you have any questions or concerns, please feel free to contact me at 212-477-9450 ext. 355 or via email at eressegger@palnyc.org

We are honored by your intent to volunteer for the Police Athletic League – New York City!

Sincerely,

Evan Ressegger, Volunteer Manager
Personal Information

Name: ___________________________ D.O.B: ___________________________

Address: ___________________________

Mobile Number: (         )            - Preferred Phone Number: (      )            -

Email Address: ___________________________

How do you prefer to be contacted? (Circle one or both) Email or Phone

Please circle your area(s) of interest: Baseball Volleyball Fitness training Mentoring Dance Music
Computers Board games Arts & Crafts Basketball Martial Arts Coding Track Soccer
Administrative Support Career-Readiness Homework Help Special Events Other:___________

Borough to Volunteer: Staten Island Bronx Queens Brooklyn Manhattan

I am available: Weekday Evenings Weekday Afternoons

Languages Spoken: Long-term or Short Term volunteer service? Long-Term Short Term

Have you done volunteer work before? Where: ________________

How did you hear about PAL? ________________________________

Do you know anyone who currently works at PAL? ________________________________

I understand that this document does not constitute an employment or volunteer contract. I further understand that I must abide by the Police Athletic League’s volunteer conduct and service rules.

Signature: ___________________________

Date: ___________________________

Emergency Contact (Please Print Clearly)

Name: ___________________________ Relationship: ___________________________

Phone: ___________________________

Email: ___________________________

Mailing Address: ___________________________
CRIMINAL BACKGROUND CONSENT FORM

Name: ______________________ Social Security Number: _____________

I certify that the information on my Criminal Background from is true and correct to the best of my knowledge. I understand that as an employee, applicant or volunteer at the Police Athletic League, Inc., I will be required to complete a New York State Central Registry of Child Abuse and Maltreatment (SCR) form and must be completed prior to volunteering.

I understand that as an employee, applicant or volunteer at the Police Athletic League my employment or volunteer service is subject to the following conditions.

1. I will be disqualified/terminated from volunteer service if I:
   a. have willfully or fraudulently made any false statements or omissions;
   b. refuse to grant authorization for a criminal background check;
   c. refuse to complete a New York Central Registry of Child Abuse and Maltreatment (SCR) form;
   d. refuse to be fingerprinted

2. I will be disqualified/terminated from volunteer service based on negative findings of the aforementioned criminal record review and fingerprinting results.

I have been previously fingerprinted. Attached is my proof.

____________________________________________________________________

Signature
CRIMINAL BACKGROUND INFORMATION

Name: __________________________________________ Telephone Number: ____________________________

Address: __________________________________________ First and Last Name

Address, City, State and Zip Code

Center or Borough Location: __________________________ Date: __________________________

a. Have you ever been convicted of a crime? _____ Yes _____ No
Include all convictions, whether resulting in imprisonment, suspended sentence, fine, probation or conditional or unconditional release. If yes, please provide:

Date Convicted: __________________________ Index or Docket No.: ___

_________________________ Court and Location: ______________

_________________________ Disposition: ______________ Penalty: ______

Offense: __________________________________________

b. Are criminal charges currently pending against you? _____ Yes _____ No
Include adjournments in contemplation or dismissals. If yes, please provide:

Date Convicted: __________________________ Index or Docket No.: ___

_________________________ Court and Location: ______________

_________________________ Disposition: ______________ Penalty: ______

Offense: __________________________________________

c. Are you the subject of an indicated child abuse and/or maltreatment report on file with the New York State Central Registry of Child Abuse and Maltreatment (SCR)? _____ Yes _____ No
If yes, please provide:

Date of incident: ______________ Description and Explanation of Incident: __________________

d. Is any child abuse and/or maltreatment allegations currently pending against you? _____ yes _____ no
If yes, please provide:

Date of Alleged incident: ______________ Description and Explanation of Incident: __________

e. Have you ever been terminated, suspended, and placed on probation, reprimanded, or otherwise penalized by an employer for child abuse and/or maltreatment? _____ yes _____ no If yes, please provide:

Employer Name and Address: __________________________

Description and Explanation of Incident: __________________________
INSTRUCTIONS:
- ALL people with the roles below must complete and sign this Criminal Conviction Statement regardless of conviction status
- This form is in addition to being fingerprinted
- Please PRINT clearly

PROGRAM NAME: ___________________________  FACILITY ID NUMBER: ___________________________

PERSON’S NAME: ___________________________  DATE OF BIRTH (mm/dd/yyyy): ___________________________

<table>
<thead>
<tr>
<th>TYPE OF PROGRAM</th>
<th>Family Day Care, Group Family Day Care and Small Day Care Centers</th>
<th>Day Care Center and School-Age Child Care</th>
<th>All Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROLE</td>
<td>□ Provider  □ Substitute</td>
<td>□ Director  □ Group Teacher  □ Assistant Teacher</td>
<td>□ Volunteer  □ Employee</td>
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<tr>
<td></td>
<td>□ Assistant  □ Household Member (GFDC/FDC) (over 18)</td>
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CONVICTION STATEMENT

Have you previously completed a Conviction Statement?
- □ NO, this is the first conviction statement I am signing for child day care.
- □ YES, I have signed a previous conviction statement for child day care and…
  - □ All of the following convictions (if any) were previously reported  OR
  - □ I have added new convictions since the last statement.

CERTIFICATION

In accordance with Section 390-b(1)(b) of the Social Services Law, I certify that to the best of my knowledge and belief:
- □ I HAVE  □ I HAVE NOT been convicted of a crime in New York State or other State or Federal court.

(A crime is a misdemeanor or felony only; this does not include violations. You do not need to disclose crimes that the court designated with a "Youthful Offender" status.)

RECORD OF ALL CONVICTIONS

Complete the information below and submit with record of conviction or certification of court arraignment. In addition, you may provide written justification on the back of this sheet, explaining why you should be allowed to care for children regardless of any conviction.

<table>
<thead>
<tr>
<th>Type of Crime</th>
<th>Penal Code Section</th>
<th>Date of Conviction (mm/dd/yyyy)</th>
<th>County or Court of Arraignment</th>
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To the best of my knowledge the information provided above is true and accurate. I understand that my failure to truthfully and accurately state whether I have been convicted of a crime and/or to provide truthful and accurate information concerning the conviction(s) may constitute grounds for dismissal or denial of employment, or suspension, limitation or revocation of the license or registration to provide child care at this site.

SIGNATURE: ___________________________  DATE: (mm/dd/yyyy): ___________________________

(continued on reverse side)
<table>
<thead>
<tr>
<th>PROGRAM NAME:</th>
<th>FACILITY ID NUMBER:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERSON'S NAME:</td>
<td>DATE OF BIRTH (mm/dd/yyyy):</td>
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</table>

**CRIMINAL CONVICTION STATEMENT** *(continued)*

Please provide your justification below, explaining why you should be allowed a role to care for children despite your conviction history. You may attach your own sheets if you prefer not to use this page.

________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________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INSTRUCTIONS:

- If the only role is household member, complete only the front page. If you are a medical professional, a signature is required on both sides of this form.
- Only a health care provider (physician, physician's assistant, nurse practitioner) may complete/sign the medical status section.
- A registered nurse is NOT authorized to sign the medical status section but CAN sign the TB Test Information on the reverse.
- A health care professional may use an equivalent form as long as the information on this form is included.
- See additional instructions about the tuberculin test on the reverse side.
- Please PRINT clearly.

I attest that I have not forged or altered any information contained in this document. I am aware that the submission and/or possession of forged or altered documents may constitute a crime. In addition to potentially being subject to criminal prosecution, any program found to have submitted and/or possessed such documents may be subject to fines by the NYS Office of Children and Family Services, and/or denial or revocation of a license or registration.

Program name:

Person’s name:

Person’s signature:

**TYPE OF PROGRAM:**

<table>
<thead>
<tr>
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<tr>
<td>Household Member (GFDC/FDC)</td>
<td></td>
<td>Assistant Teacher</td>
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</tbody>
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**Typical child day care duties**

- Lifting and carrying children
- Close contact with children
- Direct supervision of children
- Driver of vehicle
- Food preparation
- Desk work
- Facility maintenance
- Evacuation of children in an emergency

Following to be completed by health care provider ONLY

**Medical status**

To the best of my knowledge of the above-named individual, I find that:

He/She is currently exhibiting signs of a communicable disease that would pose a risk to the health and safety of children in care.

- YES
- NO

He/She has a diagnosed psychiatric or emotional disorder that would pose a risk to the health and safety of children in care.

- YES
- NO

He/She has a physical condition that would prevent him/her from providing typical child day care duties as described above.

- YES
- NO

For any “YES” responses, clarify and/or indicate restrictions:

Signature (physician, physician's assistant, nurse practitioner)

Title

/ / 

Name (please PRINT clearly or use office stamp)

Phone

Date of Exam

/ / 

Date of Signature

(Continued on reverse side)
NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT
CHILD DAY CARE PROGRAMS (continued)

<table>
<thead>
<tr>
<th>Program name:</th>
<th>Facility ID number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person’s name:</td>
<td>Date of birth:</td>
</tr>
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</table>

INSTRUCTIONS:
- Household members in a family-based program that have no other role do not need to have a tuberculin test and do not need to complete this page.
- A health care professional (physician, physician's assistant, nurse practitioner) or a registered nurse as part of his/her duties at a health care facility, may enter the results in the tuberculin test Information section and sign this page.
- Acceptable tuberculin tests include Mantoux or other federally approved tuberculin test.
- Please PRINT clearly.

Following to be completed by health care professional ONLY

---

Tuberculin test information

Test completed
Test read on: / / (mm / dd / yyyy)
Test result: ☐ Positive ☐ Negative mm
If Positive, does this person’s contact with children enrolled in child care pose a risk to the children’s health and safety?
☐ Yes ☐ No

Test not completed
☐ Not tested. Provide reason: ________________________________

Medical exemption or contraindication
If test result was previously Positive, indicate date: / / (mm / dd / yyyy)
If previously Positive, does this person’s contact with children enrolled in child care pose a risk to the children’s health and safety?
☐ Yes ☐ No

---

Signature (physician, physician's assistant, nurse practitioner or registered nurse)

Name (please PRINT clearly or use office stamp) ____________________________ Title ____________________________
( ) - Phone / / Date /

INSTRUCTIONS FOR PROGRAMS TO RETURN THE FORM:
- GFDC/FDC programs: return this completed form to your licensor or registrar.
- DCC/SACC programs: for directors-return this completed form to your licensor or registrar; for all other staff - return the form to the director for evaluation.
# NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
REFERENCES
CHILD DAY CARE PROGRAM

**INSTRUCTIONS:**
- Please provide complete information for three people we can contact as references.
- Relatives may **NOT** be used as references.
- If you have been employed outside the home, please include an employer as one of your references.
- Please **PRINT** clearly.

<table>
<thead>
<tr>
<th>PROGRAM NAME:</th>
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<tbody>
<tr>
<td>NAME:</td>
<td></td>
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<tr>
<th>TYPE OF PROGRAM</th>
<th>FAMILY Day Care, Group Family Care and Small Day Care Centers</th>
<th>Day Care Center and School-Age Child Care</th>
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<tbody>
<tr>
<td>ROLE IN PROGRAM</td>
<td>Provider, Assistant, Substitute</td>
<td>Director, Teacher, Volunteer</td>
</tr>
</tbody>
</table>

**REFERENCE #1**
Please check appropriate reference type: [ ] Personal [ ] Employment

- [ ] MR. [ ] MRS. [ ] MS.

- BUSINESS NAME: ____________________________
  APT: ____________________ FLOOR: ____________

- ADDRESS: ____________________________
  CITY: ____________________________ STATE: ____________ ZIP: ____________

- DAYTIME PHONE: ____________________________
  E-MAIL: ____________________________

- Does reference speak English? [ ] Yes [ ] No If NO, please specify language spoken:

**REFERENCE #2**
Please check appropriate reference type: [ ] Personal [ ] Employment

- [ ] MR. [ ] MRS. [ ] MS.

- BUSINESS NAME: ____________________________
  APT: ____________________ FLOOR: ____________

- ADDRESS: ____________________________
  CITY: ____________________________ STATE: ____________ ZIP: ____________

- DAYTIME PHONE: ____________________________
  E-MAIL: ____________________________

- Does reference speak English? [ ] Yes [ ] No If NO, please specify language spoken:

**REFERENCE #3**
Please check appropriate reference type: [ ] Personal [ ] Employment

- [ ] MR. [ ] MRS. [ ] MS.

- BUSINESS NAME: ____________________________
  APT: ____________________ FLOOR: ____________

- ADDRESS: ____________________________
  CITY: ____________________________ STATE: ____________ ZIP: ____________

- DAYTIME PHONE: ____________________________
  E-MAIL: ____________________________

- Does reference speak English? [ ] Yes [ ] No If NO, please specify language spoken:
The New York State Office of Children and Family Services (OCFS) child day care regulations identify qualifications and minimum requirements for caregiving staff in child day care programs. The information is included in section .13 of the Regulations. Regulations can be obtained at ocfs.ny.gov/main/childcare/default.asp and from your licensor/registrar.

**INSTRUCTIONS:**
- Consult OCFS Regulations for qualification and minimum requirements for your role.
- Complete sections that apply to your role in the program. You may attach a resume.
- You may be asked to submit additional documentation to demonstrate education, training, or childcare experience.
- Please PRINT clearly

<table>
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<tr>
<th>TYPE OF PROGRAM:</th>
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<th>Day Care Center and School-Age Child Care</th>
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</thead>
</table>
| ROLE IN PROGRAM  | □ Provider  
 □ Assistant  
 □ Substitute | □ Director  
 □ Group Teacher  
 □ Assistant Teacher |

**Education/Training** (if applicable for pending role)

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Degree, Major, Name of Credential, or Training</th>
<th>Institution</th>
<th>Number of Credits (if applicable)</th>
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**Child Care Experience**

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Description</th>
<th>Location</th>
<th>Age of Children</th>
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**Supervisory Experience** (applicable for pending role of Director at Day Care Center/School-Age Child Care Program)

<table>
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<tr>
<th>Date Range</th>
<th>Description</th>
<th>Location</th>
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Instructions for Completing the Statewide Central Register Database Check Form

LDSS-3370

- ALL information on the form must be easily read so that data entry and results are accurate. Each SCR Database Check submitted should be reviewed for completeness and legibility by the program/agency liaison. If the form is incomplete or illegible, it will be returned to the agency for corrections.

THE PROPER WAY TO COMPLETE THE FORM:

AGENCY INFORMATION

TOP LINE OF FORM:
- The three-digit agency code must be placed in the top left-hand box, followed by the Resource I.D. (RID) in the next box to the right. (Contact the licensing agency if there are any questions about these.)
- Daycare providers must place their Child Care Facility System (CCFS) Number in the box next to Resource ID (RID), in lieu of Resource ID number. (Contact your licensing agency/Regional Office if you have any questions).
- Clearance Category letter code (see back of Form LDSS-3370) must be placed in the middle box.
- Phone number (with area code) enables the SCR to contact the agency liaison if this becomes necessary.
- The Request ID Box is for SCR use only.

AGENCY ADDRESS AREA:
- Agency Name: Please use full name, no abbreviations
- Agency Liaison is the contact person at the inquiring agency. (*The SCR response will be addressed to the liaison.) The liaison cannot be the applicant or a relative of the applicant.
- Agency Address: Must include street, city

APPLICANT/HOUSEHOLD MEMBER AREA:
- ALL HOUSEHOLD MEMBERS, ADULTS AND CHILDREN, WHETHER RELATED TO THE APPLICANT OR NOT, ARE TO BE LISTED IN THIS AREA OF THE FORM.
- Remember to write clearly or type all information in order to assist in obtaining an accurate response. Record all names with the last name first, then the first name, and middle name.
- First line: Applicant's name. If there is more than one applicant place the additional name(s) on the lines below the maiden name line.
- Second line: Any maiden names, previous married names, or aliases by which the applicant is or has been known. Use additional lines if there is more than one maiden married/alias name to be listed.
- Remaining lines: Names of all other household members. (Attach an additional page if needed.)

If there are no other household members, indicate NONE on the line below “Maiden/Alias”.

- First column: indicate the relationship to the applicant of each person listed. (Spouse, son, daughter, mother, father, friend, etc.)
- Sex M/F column: fill in either M (Male) or F (Female) for every person listed.
- Date of Birth column: fill in complete date of birth (mm/dd/yy) for everyone listed on the form.

ADDRESS AREA:

The information required varies depending on the particular category:
- For Adoption, Foster Care and Family and Group Family Day Care (see back of form for categories), provide addresses for the applicant and any household member who is 18 and older. We need this information for the last 28 years. Attach supplemental pages if necessary, but do not use another LDSS-3370 form to list this additional information. Be sure to associate address histories with particular individuals (i.e., indicate which addresses are for which household members).
- For all other categories, only the applicant’s address history is required – for the last 28 years.
- Complete addresses are required. Include street name and city/town/village. Also include street number and apartment number. Post Office Box numbers are not acceptable. If the applicant has lived abroad, indicate country and dates of residence. If the applicant has spent time in the military, list base names and locations along with dates. Be sure that there are no periods of time unaccounted for.
- The top line is for the current address. The previous address should be listed on the second line downward, and so on to the back of the form for the last 28 years. Staple the attached supplemental page to the form if more space is needed, but do not use another copy of the LDSS-3370 for this additional information.

SIGNATURE AREA:

Signatures required depend upon the particular category:
- For Adoption, Foster Care and Family and Group Family Day Care (see back of form for category), signatures are needed from the applicant and any household member who is 18 or older.
- For all other categories, only the applicant’s signature is required.
- All signatures must correspond to the names recorded in the Applicant/Household Member Area-for example; Mary Smith should not sign Mary Ann Smith. Victoria Smith should not sign Vicki.
- Applicants must sign in the boxes marked “Applicant’s Signature”, household members over 18 who are not applicants must sign in the boxes at the extreme bottom of the page marked “Signature”.
- All signatures must be dated (mm/dd/yy). The SCR will not accept a form with a signature date more than 6 months old.

If you have questions regarding proper completion of this form, please call the SCR at 518-474-5297.

SUBMIT YOUR COMPLETED LDSS-3370 FORM TO YOUR LICENSOR OR REGISTRAR
BE SURE TO INCLUDE THE REQUIRED FEE

TO ORDER A SUPPLY OF LDSS-3370 FORMS:

Instructions for Completing the State Central Register Database Check Form

Please note that all applicants must provide their complete addresses which they have resided for the last 28 YEARS.

It is extremely important that all information on the form can be easily read, so that data entry and results are accurate. Each SCR Database Check submitted should be reviewed for completeness and legibility by the camp program. If the form is incomplete or illegible, it will be returned to you for corrections.

APPLICANT/HOUSEHOLD MEMBER AREA:

- First line: Indicate your name. Last name first.
- Second line: Any maiden names, previous married names, or aliases by which you have been known. Circle whether it’s maiden or alias. Use additional lines if there is more than one maiden/married/alias name to be listed.
- Indicate “NONE” if there are no maiden or alias names.
- If there are no other household members, check off box □ if you live alone below the “Maiden/Alias” line.
- Remaining lines: Indicate the names of all household members. All household members that live with you are to be listed in this area of the form, regardless if they are related or not. Include all adults, children and roommates. (Attach an additional page if needed.)
  - First column: indicate the relationship to the applicant, of each person listed as spouse, child, family member, or other.
  - Third column: indicate the sex. Fill in either M (Male) or F (Female) for each person listed.
  - Last column: fill in date of birth (mm/dd/yy) for each person listed.

ADDRESS AREA:

- Indicate all addresses that you have resided for the last 28 years or since birth in date order.
- Complete addresses are required. Include building number, street name/number, city/town/village and zip code. Post Office box numbers are not acceptable.
- If the applicant has lived abroad, indicate country and dates of residence. If the applicant has spent time in the military, list base names and locations along with dates. Be sure that there are no periods of time unaccounted for.
- The top line is for the current address. The previous address should be listed on the second line downward, and so on going back 28 years or since birth. (Attach an additional page if needed.)

SIGNATURE AREA:

- Only the applicant’s signature is required.
- The signatures should match the applicant’s name. For example, William Smith should not sign Will Smith.
- All signatures must be dated (mm/dd/yyyy). The SCR will not accept a form with a signature date more than 6 months old.
**NEW YORK STATE**
OFFICE OF CHILDREN AND FAMILY SERVICES
STATEWIDE CENTRAL REGISTER DATABASE CHECK
Agency Use Only

**ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE**

<table>
<thead>
<tr>
<th>AGENCY CODE</th>
<th>RESOURCE I.D. (RID)</th>
<th>CHILD CARE FACILITY SYSTEM (CCFS) NUMBER</th>
<th>CATEGORY USE ALPHA CODE</th>
<th>PHONE NUMBER (Area Code):</th>
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<tbody>
<tr>
<td>DOHMH</td>
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</table>

**PRINT BELOW THE ADDRESS TO WHICH YOU WANT THE RESPONSE RETURNED:**

<table>
<thead>
<tr>
<th>AGENCY NAME:</th>
<th>Bureau of Child Care</th>
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</thead>
<tbody>
<tr>
<td>CITY:</td>
<td>New York</td>
</tr>
<tr>
<td>STREET:</td>
<td>125 Worth Street CN Box 40</td>
</tr>
<tr>
<td>ZIP CODE:</td>
<td>10013</td>
</tr>
</tbody>
</table>

The particular classifications of persons who must be screened are set forth on the reverse side of this document. The alpha codes to complete the “Category” box also are also on the reverse side of this form.

FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your children and any other persons you believe in your home at the present time. BE SURE YOU COMPLETE ALL MAIL-BORN NAME AS SEEN BY STAFF OR APPLICANT. IF NONE, STIPULATE THE RELATIONSHIP in the fields below (see reverse side for instructions) Attach additional page if necessary.

**APPLICANT/HOUSEHOLD MEMBER AREA**

<table>
<thead>
<tr>
<th>Relationship to Applicant</th>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>SEX</th>
<th>DATE OF BIRTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPLICANT / MAIDEN ALIAS</td>
<td>DOE</td>
<td>JANE</td>
<td>F</td>
<td>5 9 63</td>
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<td></td>
<td>SMITH</td>
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<td>SPOUSE</td>
<td>DOE</td>
<td>JOHN</td>
<td>M</td>
<td>2 1 54</td>
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<td>SON</td>
<td>DOE</td>
<td>JOHNNY</td>
<td>M</td>
<td>7 7 83</td>
</tr>
<tr>
<td>DAUGHTER</td>
<td>DOE</td>
<td>JANICE</td>
<td>F</td>
<td>3 20 02</td>
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</tbody>
</table>

Please provide your current address and any other addresses at which you have resided for the last 28 years, including street, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 and older. Attach additional pages if necessary.

<table>
<thead>
<tr>
<th>CURRENT STREET ADDRESS</th>
<th>APT #</th>
<th>CITY</th>
<th>STATE</th>
<th>ZIP CODE</th>
<th>FROM</th>
<th>TO</th>
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</thead>
<tbody>
<tr>
<td>10 STRAWBERRY STREET</td>
<td>1 FL</td>
<td>APPLETON</td>
<td>NY</td>
<td>10599</td>
<td>8/01</td>
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</tr>
<tr>
<td>PREVIOUS STREET ADDRESS</td>
<td>APT #</td>
<td>CITY</td>
<td>STATE</td>
<td>ZIP CODE</td>
<td>FROM</td>
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<td>2 LAKE PLACE</td>
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<td>PH</td>
<td>NY</td>
<td>10799</td>
<td>5/93</td>
<td>7/01</td>
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<tr>
<td>378 BROAD AVENUE</td>
<td>APT #</td>
<td>CITY</td>
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<td>ZIP CODE</td>
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<td>LONGWOOD</td>
<td>NY</td>
<td>10999</td>
<td>1/89</td>
<td>5/93</td>
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<tr>
<td>123 ORANGE ROAD</td>
<td>APT #</td>
<td>CITY</td>
<td>STATE</td>
<td>ZIP CODE</td>
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<td>6F</td>
<td>LEMONTOWN</td>
<td>NY</td>
<td>10699</td>
<td>1/87</td>
<td>12/88</td>
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</tbody>
</table>

I affirm that all the information provided on this form is true. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

**APPLICANT'S SIGNATURE**

Jane Doe

**DATE**

1/15/2015

**APPLICANT'S SIGNATURE**

**DATE**

**Camp Name:** Johnny B Good Day Camp

**CAMIS/RECORD ID#:** 42322125

**Camp Address:** 75 South Camp Road, Down Town, NY 10699
ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

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PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER:

AGENCY NAME: _______________________________________

AGENCY LIAISON: ____________________________________

STREET ADDRESS: ___________________________________

CITY: ________________________ STATE: ________ ZIP CODE: __________

The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the “Category” box above are also on the reverse side of this form.

FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS SECTIONS THAT APPLY. IF NONE, STATE “NONE” List RELATIONSHIP in the fields below.

(see reverse side for instructions) Attach additional page if necessary.

The purpose of collecting the demographic data on other persons in your household who are not screened pursuant to Section 424-a of the Social Services Law is to enable the N.Y.S. Office of Children and Family Services to identify with the greatest degree of certainty whether the person(s) being screened is the subject of an indicated child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA

<table>
<thead>
<tr>
<th>RELATIONSHIP TO APPLICANT</th>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>SEX (M/F)</th>
<th>DATE OF BIRTH</th>
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<tr>
<td>APPLICANT</td>
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<tr>
<td>MAIDEN/ALIAS</td>
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</table>

Please provide your current address and any other addresses at which you have resided for the last 28 years, including street, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 of age and older.

<table>
<thead>
<tr>
<th>CURRENT STREET ADDRESS</th>
<th>APT #</th>
<th>CITY</th>
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I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT’S SIGNATURE ___________________________ DATE __________________

APPLICANT’S SIGNATURE ___________________________ DATE __________________

EIGHTEEN YEARS OLD OR OVER:

I understand that as a person eighteen years of age or over in a home of an applicant to become an Adoptive or a Foster Parent or a Family or Group Family Day Care provider, the information I have provided will be used to inquire of the Statewide Central Register to determine if I am the subject of an indicated report of child abuse or maltreatment.

SIGNATURE ___________________________ DATE __________________

SIGNATURE ___________________________ DATE __________________
APPlicant NAME:  

Print clearly, All dates must be consecutive. Be sure to associate address histories with particular individuals

<table>
<thead>
<tr>
<th>Previous Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>From</th>
<th>To</th>
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</table>
STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM
ADDITIONAL PAGE
(Use only if the space on the LDSS-3370 form is not sufficient)

APPLEICANT NAME:

<table>
<thead>
<tr>
<th>SCR Use Only</th>
<th>Relationship To Applicant</th>
<th>Last Name</th>
<th>First Name</th>
<th>Sex</th>
<th>Date of Birth</th>
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</table>

Other Household Members are (please print clearly):
The New York State Justice Center for the Protection of People with Special Needs (Justice Center) maintains a Vulnerable Persons’ Central Register. That register includes a Staff Exclusion List (SEL) containing the names of individuals who have committed serious acts of abuse or neglect.

This form is used to check the Justice Center’s SEL for those who are applying for a position or license/registration after 6/30/13. If the individual appears on the SEL, a determination will need to be made whether to hire or allow such a person to have regular and substantial contact with a child in child care programs.

- The licensor/registrar is responsible for making this determination for:
  - all roles at family day care and group family day care programs requiring this check.
  - for applicants and directors at school age child care programs and day care centers.

- The director at a day care center or school age child care program is responsible for making this determination for:
  - all roles in the day care center or school age program requiring this check except for the role of director.

Instructions:
- To determine where to submit this form, find the type of program and the individual’s role in the list below.

<table>
<thead>
<tr>
<th>Type of Program / Role in the Program</th>
<th>Where to submit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Day Care, Group Family Day Care Center (Applicants, Caregivers, Household Members 18 and Older) *</td>
<td>The licensor/registrar of the program.</td>
</tr>
<tr>
<td>Day Care Center and School Age Child Care (Directors)</td>
<td>The licensor/registrar of the program.</td>
</tr>
<tr>
<td>Day Care Center and School Age Child Care (all roles requiring this check except for the role of director) **</td>
<td>The director of the program.</td>
</tr>
</tbody>
</table>

* Volunteers in FDC and GFDC are excluded from the requirement for an SEL check and may not be left unsupervised with children or count in ratio.

** Volunteers who are parents of an enrolled child are exempt from the requirement for an SEL check and may not be left unsupervised with children or count in ratio.

Fill out all information below. PRINT clearly to avoid delays in processing.

First Name:
Last Name:
Middle Initial:
Social Security Number: - - -
Alien Registration Number Only If no Social Security Number is available:
Date of Birth Only if no Social Security Number or Alien Registration Number is available: / / 
Position applied for:
Enrollment Information:
Applicant must have an appointment to be fingerprinted. At the appointment, the applicant will need to bring this form and acceptable ID.

Appointments can be made by contacting the vendor at one of the following:
Website: [https://uenroll.identogo.com/workflows/15441V](https://uenroll.identogo.com/workflows/15441V) or the Call Center: 877-472-6915

Contributor Agency Section:
Service Code: 15441V  Contributor Agency: NYS Office of Children and Family Services-Child Day Care Programs
Facility/Agency ID Number: ____________________________________________________________
Facility Name/Address: ____________________________________________________________

Fingerprint Applicant Section:  
☐ New Submission  ☐ Resubmission

Name of Applicant: ____________________________________________________________
Alias / Maiden Name: ____________________________________________________________
Street Address: _________________________________________________________________
City, State, & Zip: _______________________________________________________________
Date of Birth: __/__/____________  Sex: ☐ Male  ☐ Female  ☐ Other
Ethnicity: ☐ Hispanic  ☐ Non-Hispanic
Race: ☐ White  ☐ Black  ☐ American Indian/Alaskan Native  ☐ Asian/Pacific Islander
☐ Other  ☐ Unknown
Skin Tone: ____________________________  Eye Color: ____________________________  Hair Color: ____________________________
Height: _______ ft. _______ in.  Weight: _______ lbs.
State/Country of Birth: ____________________________________________________________

Role of Fingerprint Applicant (please check one):
CHILDL DAY CARE: ☐ Director (D)  ☐ Provider (F)  ☐ Employee/Teacher (T)  ☐ Volunteer (V)
☐ Household Member over the age of 18 (HM)

Fingerprint Applicant Affirmation Section
I hereby affirm that the information contained in the application and the supporting documents are true and do not contain any false statements or omissions of any material information or facts. I understand that the making of false written statements in this application is punishable as a class A misdemeanor under Section 175.30 and/or Section 210.45 of the New York Penal Law.

Applicant's signature:  X  Date: / /

Payment Section:
Agency Billing Account
Accepted Forms of Identification to bring to your appointment (must be valid and not expired):

- Driver license issued by a state or outlying possession of the United States, U.S.
- Driver license PERMIT issued by a state or outlying possession of the U.S.
- ID card issued by a federal, state, or local government agency or by a territory of the U.S.
- State ID card (or outlying possession of the U.S.) with a seal or logo from state or state agency
- Commercial driver license, issued by a state or outlying possession of the U.S.
- Department of defense common access card
- Employment authorization document that contains a photograph
- Foreign driver license (Mexico and Canada only)
- Foreign passport
- Military dependent's identification card
- Permanent resident card or alien registration receipt card (form I-551)
- U.S. Coast Guard Merchant Mariner Credential
- U.S. Military identification card
- U.S. passport
- U.S. Tribal card (enhanced only) or U.S. Bureau of Indian Affairs identification card
- U.S. visa issued by the U.S. Department of Consular Affairs for travel to or within, or residence within, the U.S.
- Uniformed Services identification card (form DD-1172-2)

Identification if under 18 and nothing else available:

Persons under the age of 18 who are unable to present an acceptable photograph document listed above shall provide a Social Security card or a birth certificate. The New York Photo ID Waiver for Minors, developed by the New York State Division of Criminal Justice Services, must be completed and signed by a parent or guardian at the time of fingerprinting at the fingerprinting site location.

Do not sign this form in advance.

NOTE: Staff with fingerprint images on file with OCFS may be eligible for a waiver. Contact the licensor/registrar or director of the program for more information.

Hard-to-Print Applicants

Please contact the Criminal History Review Unit at 518-473-8595 for instructions.
Adoption of this form does not constitute a conclusive defense to charges of unlawful sexual harassment. Each claim of sexual harassment will be determined in accordance with existing legal standards, with due consideration of the particular facts and circumstances of the claim, including but not limited to the existence of an effective anti-harassment policy and procedure.

The Police Athletic League

New York State Labor Law requires all employers to adopt a sexual harassment prevention policy that includes a complaint form to report alleged incidents of sexual harassment.

If you believe that you have been subjected to sexual harassment, you are encouraged to complete this form and submit it to the Chief of Administration and Human Resources. You will not be retaliated against for filing a complaint.

If you are more comfortable reporting verbally or in another manner, your employer should complete this form, provide you with a copy and follow its sexual harassment prevention policy by investigating the claims as outlined at the end of this form.

For additional resources, visit: ny.gov/programs/combating-sexual-harassment-workplace

COMPLAINANT INFORMATION

Name: 

Work Address: Work Phone: 

Job Title: Email: 

Select Preferred Communication Method: □Email □Phone □In person 

SUPERVISORY INFORMATION

Immediate Supervisor’s Name: 

Title: 

Work Phone: Work Address: 

Adoption of this form does not constitute a conclusive defense to charges of unlawful sexual harassment. Each claim of sexual harassment will be determined in accordance with existing legal standards, with due consideration of the particular facts and circumstances of the claim, including but not limited to the existence of an effective anti-harassment policy and procedure.
COMPLAINT INFORMATION

1. Your complaint of Sexual Harassment is made about:
   
   Name: 
   Title: 
   
   Work Address: 
   Work Phone: 
   
   Relationship to you: □ Supervisor  □ Subordinate  □ Co-Worker  □ Other

2. Please describe what happened and how it is affecting you and your work. Please use additional sheets of paper if necessary and attach any relevant documents or evidence.

3. Date(s) sexual harassment occurred:
   
   Is the sexual harassment continuing? □ Yes □ No

4. Please list the name and contact information of any witnesses or individuals who may have information related to your complaint:

The last question is optional, but may help the investigation.

5. Have you previously complained or provided information (verbal or written) about related incidents? If yes, when and to whom did you complain or provide information?

If you have retained legal counsel and would like us to work with them, please provide their contact information.

Signature: __________________________  Date: ____________________
Instructions for Employers

If you receive a complaint about alleged sexual harassment, follow your sexual harassment prevention policy.

An investigation involves:
- Speaking with the employee
- Speaking with the alleged harasser
- Interviewing witnesses
- Collecting and reviewing any related documents

While the process may vary from case to case, all allegations should be investigated promptly and resolved as quickly as possible. The investigation should be kept confidential to the extent possible.

Document the findings of the investigation and basis for your decision along with any corrective actions taken and notify the employee and the individual(s) against whom the complaint was made. This may be done via email.