Incarnation Children's Center
INTERNSHIP APPLICATION
Art Therapy, Child Life, Drama Therapy, Recreation Therapy

Name: _____ Date: _____

Address: _____ Phone (H): _____

_____ Phone (C): _____

Email: _____ Phone (W): _____

Social security #: _____

Current Employer: _____ Business Phone: _____

Business address: _____ Job title: _____

_____

Previous employers:	Dates of employment:	Job title:
_____	_____	_____
_____	_____	_____

Please attach resume

Education:

Undergraduate College: _____

Major: _____

Minor: _____

College/University: _____

Major Field of Study: _____

Expected date of graduation: _____

Dates of internship placement::

From: _____ To:_____

How many hours are required for this placement?:

_____

When are you available to volunteer? Please list days and times:

List courses in Health, Science, Education, Psychology, Sociology or Development that will be helpful to you in this program:

How did you learn about Incarnation Children's Center?

There are many places where you can work with children. Why did you choose to work here?

Please list prior experience you have had working with children:

Do you have any physical, medical or psychological condition(s) we should be aware of?

What were your reactions to illness in the past?

What kinds of situations do you think you may see and experience here at Incarnation Children's Center?

How do you think you would handle your feelings if you were working with (1) an acutely ill or (2) a terminally ill child?

(1)

(2)

You will be under supervision most of the time during your placement here. How do you feel about this?

What do you hope to gain from this experience?

List any special skills/talents:

PERSONAL STATEMENT

Please briefly discuss your background and tentative career plans. Include in the statement your reasons for desiring a placement with Incarnation Children's Center, and how these reasons relate to a potential career.

Any additional comments or concerns:

In case of emergency, contact:

Name: _____

Phone (H): _____

Phone (W): _____

Signature: _____

Contact Jasmine Edwards at 212-928-2590 x173 or
jedwardsl@incarnationchidrenscenter.org with any further questions or concerns.
Return completed application and paperwork to
142 Audubon Avenue, New York, NY 10032
or fax to 212-928-1500.

Incarnation Children's Center
Therapeutic Recreation Internship
Internship Responsibilities and Contract

- Internships will involve a minimum of twenty hours per week for a minimum period of three months, unless otherwise noted.
- Interns are expected to be on time on scheduled days, unless arranged previously by supervisor.
- Individual supervision will be provided one hour weekly with a registered certified recreation therapist.
- Interns will regularly attend interdisciplinary rounds and meetings.
- Interns will plan and lead/co-lead a minimum of four recreation therapy groups per week, which will include a variety of activities and level of functioning.
- Interns will work with individual patients as assigned, as necessary, and as appropriate.
- Interns will be responsible for daily statistics of assigned groups, one weekly chart note and submission of weekly journal and monthly one-t-one summaries according to MDS/CCP schedule to be submitted to supervisor for review.
- Interns will be required to work with interdisciplinary staff and supervise volunteers.
- Interns are required to read all clinical and training material as assigned by supervisor.
- All incoming interns will secure liability insurance (if not provided by school) and will submit prior to start date.
- Interns are expected to dress and act professionally and observe institution's rules and regulations.
- Interns will contribute to the organization and maintenance of supplies.
- Interns will successfully complete a one-month probation period, and will receive evaluations as required by school.

I have read and agreed to the above requirements.

Intern's signature: _____ Date: _____

Supervisor's signature: _____ Date: _____

Incarnation Children's Center
Volunteer Health Information

In order to volunteer at Incarnation Children's Center, state law and/or ICC requires that a physician/licensed clinical provider provide the following information *(please see helpful information on the back of this page)*:

Volunteer name: _____ **Date of birth**: _____

Are there any reasons why this person might be unable to volunteer? YES* NO

Two PPD Tests administered within 7- 21 days of the other: (must be read by a licensed provider: MD, NP, PA, RN, LPN, and result expressed in mm)

Date of 1st PPD: _____
1st PPD results: _____mm
Interpretation: positive* negative (circle)

Date of 2nd PPD: _____
2nd PPD results: _____mm
Interpretation: positive* negative (circle)

Is there any history of exposure to an active TB case? YES* NO

Is there any clinical suspicion of current, active, infectious TB disease? YES* NO

Dates of MMR vaccinations: 1) _____
**2 required,* 2) _____
OR
Result & date of Titer (IgG): Measles: _____ (attach copy)
Rubella: _____ (attach copy)

Hepatitis B Immunizations** (2-3, depending on which formulation was given) Hepatitis B Vaccine: #1 _____
#2 _____
#3 _____
OR
Result & date of anti-Hep B Surface Antibody Titer (IgG): _____ (attach copy)

***Completion of Hepatitis B immunization or demonstration of immunity (with positive Hep B surface Antibody IgG titer) is STRONGLY RECOMMENDED!!!*

Hepatitis C Disease History or Titer (IgG): Hepatitis C: _____ (attach titer copy)

VZV/Varicella/Chickenpox:
Disease History: VZV disease date: _____
OR VZV Vaccination dates (2): VZV vaccine #1: _____ #2 _____
OR VZV Titer (IgG): VZV Titer/date: _____ (attach copy)

Influenza Vaccine: Please attach copy/documentation during Flu season (approx. Sept-June).

before signing, PLEASE BE SURE ALL REQUESTED INFORMATION HAS BEEN PROVIDED!!!

Physician's Name & License #: _____ Phone Number: _____

Signature: _____ Date: _____

Please provide additional information for these answers.

Please return to Dr. Cathy Painter, Medical Director, ICC, Phone 212-928-2590; Fax 212-928-1500.

For Office Use Only: Med. Dir. Approval/Clearance: _____

ADDITIONAL INFORMATION:

Two PPDs are required, unless a PPD has been done in the past 12 months. In this case document the past PPD, and perform one new current PPD.

One current (within 30 days) Quantiferon TB Gold result may be substituted for the PPD(s). Please attach the result.

The New York State Department of Health **REQUIRES** Health Care Workers, including volunteers and students/interns to have received 2 vaccinations against BOTH Measles and Rubella. For most individuals, this is accomplished with 2 MMR vaccines. Individuals who have not been vaccinated in the past and who do not demonstrate immunity, should be given the1st MMR vaccine in order to start at ICC; they must receive the second MMR vaccine 4 weeks later to continue at ICC.

An individual who has not had a full Hepatitis B vaccine series or does not demonstrate immunity (with a positive Hep B surface antibody IgG titer) is *STRONGLY ENCOURAGED* to complete the vaccination series. Those non-vaccinated and/or non-immune individuals who do NOT accept vaccination will be required to sign a form formally declining Hep B vaccination.

During Influenza season, those who are not vaccinated will be required to wear a face mask during the period of time when Influenza is deemed prevalent by the NYS DOH Commissioner.

Volunteers should request any needed vaccines from their provider's office/clinic.

Students/Interns should request any needed vaccines from their school's office of student health.

Antibody titers to demonstrate immunity must be IgG (NOT IgM). (Clinicians, please note that anti-Hep B surface antibody IgG *may not be included in your labs routine Acute Hepatitis Panel; send an IgG titer.)*

Any concerns can be addressed to Dr. Painter.

Incarnation Children's Center

Catherine Painter, MD-PhD, FAAP, AAHIVS
Medical Director
142 Audubon Avenue, New York, NY 10032
P (212) 928-2590 ext 123 · F (212) 928-1500 · M (973) 568-8429
cpainter@incarnationchildrenscenter.org
www.incarnationchildrenscenter.org

APPLICANT'S AUTHORIZATION and CONFIDENTIALITY STATEMENT

~Please read carefully~

I hereby affirm that the information contained in this application (and accompanying documents) is true and complete to the best of my knowledge. I also agree that any misstatement, falsified information or omission deemed significant by Incarnation Children's Center might disqualify me from further consideration for volunteering.

I understand, furthermore, my volunteering is subject to satisfying the health requirements of Incarnation Children's Center in accordance with the New York City Department of Health and the New York City Department of Social Services.

The Department of Volunteer Services reserves the right to suspend a volunteer for any reason, at any time.

Every patient has the legal right to expect that the confidentiality of his or her medical and psychosocial information will be preserved and respected. A variety of federal and state laws protect this confidentiality. The unlawful use or disclosure of any patient's medical or psychosocial information is subject to civil and criminal liability.

Confidentiality is an ethical responsibility of every volunteer. I understand the right to patient confidentiality. Any information I may learn about a patient will remain strictly confidential. I will never, at any time during or after volunteering, discuss a patient's condition, disclose any information or make copies of any documents relating to a patient's medical psychosocial situation. This confidentiality agreement applies to both inside and outside Incarnation Children's Center.

I will never discus my own medical experience with a patient. I understand that it is considered unethical to give any advice or opinion about a diagnosis or medical treatment without the qualification of medical staff.

In signing this statement, you indicate your understanding of and adherence to the volunteer policies of Incarnation Children's Center.

Applicant's signature _____ Date _____

_____

Print name

Terence Cardinal Cooke Health Care Center

Human Resources Department
1249 Fifth Avenue, New York, N.Y. 10029
(646) 633-4400
(212) 360-3928 FAX

Section 424a of the New York State Social Services law enables this agency, as a provider of services for children in facilities operated or certified by the Office of Mental Retardation and Developmental Disabilities (OMRDD), to inquire whether an employee who has the potential for regular and substantial contact with the children this agency serves, is the subject of an indicated report of child abuse or maltreatment on file with the State Central Register of Child Abuse and maltreatment (Department of Social Services).

In addition, this same section of the law requires that all employees be notified that if you have the potential for regular and substantial contact with children, you may be requested to complete a form specifically designed for the purpose of making such an inquiry. This agency would then submit the form to the State Central Register to begin the inquiry process. If the result of an inquiry shows that you are the subject of an indicated report of child abuse or maltreatment, you would be notified of this by the State Central Register. This agency would also be advised of the findings.

If the State Central Register replies to our inquiry that you are the subject of an indicated report of child abuse or maltreatment, this agency must consider that factor, along with other background information, in determining whether to retain you as an employee, to retain you in another employment capacity, or to retain you in your current position. You may be asked to provide details of the situation(s) that gave rise to the indicated report. You will also be asked to sign a release allowing this agency to receive a copy of the indicated report on file with the State Central Register. Your refusal to sign this release will be taken to mean that you do not wish to continue your employment here.

If your employment is terminated, and such termination is based, in whole or in part on the existence of an indicated report of child abuse or maltreatment, you will be provided a written statement explaining the reason for the denial. You will also be informed, at that time, of your right, pursuant to Sections 22 and 424-a of the Social Service Law, to request a hearing before the New York State Department of Social Services on the indicated report on file with the State Central Register.

All information obtained through this process is confidential.

Given to: _____
Signature of Employee

By: Terence Cardinal Cooke Health Care Center

NYS Justice Center for the Protection of People with Special Needs (Justice Center) Criminal Background Check Unit 161 Delaware Avenue Delmar, NY 12054 Fax: 518-549-0464	**Request for Staff Exclusion List Check Form**	

The Justice Center maintains a Vulnerable Persons Central Register (VPCR) that includes a Staff Exclusion List (SEL) containing the names of individuals who have committed serious acts of abuse and are deemed ineligible to work in a position involving regular and substantial contact with a service recipient. Providers must request the Justice Center to conduct a check of the SEL before determining whether to hire or otherwise allow "any person" to have regular and substantial contact with a service recipient. "Any person" can include an employee, administrator, consultant, intern, volunteer, or contractor.

Instructions:

1. The provider's Authorized Person must complete this form and fax it to the Justice Center's Criminal Background Check (CBC) unit for an applicant under serious consideration to be hired or otherwise permitted to have regular and substantial contact with a service recipient.
2. The Justice Center's CBC unit will send the Authorized Person an email indicating the results of the SEL check.
3. If the Applicant is on the SEL, he or she may not be hired in a position involving regular and substantial contact with a service recipient in a facility or provider agency defined in Social Services Law §488(4) or by other providers of services in programs licensed or certified by the Office of Mental Health, Office for People With Developmental Disabilities, Office of Alcohol and Substance Abuse Services, Office of Children and Family Services, Department of Health and State Education Department.
4. If the Applicant is on the SEL, certain other providers have discretion whether to hire the individual as provided in Social Services Law §495(3).
5. If the Applicant is not on the SEL, a criminal background check through the Justice Center, if required, and an inquiry of the Statewide Central Register of Child Abuse and Maltreatment through the Office of Children and Family Services, if required, must be conducted.

Part 1. Applicant Information (Please Print)

Last Name:	First Name:	MI:
Date of Birth:	Social Security Number:	Alien Reg#:
Applicant address:	Applicant type:	
Facility/Provider Name: Terence Cardinal Cooke Health Care Center Address: 249 5th Avenue, New York, NY 10029		
State Oversight Agency: OMH (OPWDD) OCFS DOH SED OASAS		Please circle appropriate agency(ies)

Part 2. Authorized Person Information Please print clearly

Name: (Please Print)		Email:	
Signature:		Phone:	
Facility/Provider name:	Terence Cardinal Cooke Health Care Center	Address:	249 5th Avenue, New York, NY 10029

NYS Justice Center for the Protection of People with Special Needs (Justice Center) Criminal Background Check Unit	**Applicant Consent Form for Fingerprinting for Justice Center Criminal Background Check (CBC)**	

Part 1. Applicant Information (Please Print)

Last Name:	First Name:	MI:
Date of Birth:	Social Security Number:	
Applicant address:	Applicant type: Employee	
Facility/Provider: Terence Cardinal Cooke Health Care Center		
State Oversight Agency: OMH (OPWDD) OCFS		Circle all that apply

Part 2. Attestation

1. I have been advised that as part of the application process, the law requires the facility or provider agency listed above to request a criminal history information check with the NYS Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI) and authorizes the Justice Center to review and evaluate the results of the criminal history information check received by DCJS and FBI. The Justice Center will provide a summary of NYS criminal history, if any, to the facility or provider agency. A conviction for certain crimes may affect my suitability for employment in this position.
2. I consent to having my fingerprints taken and submitted for the purpose of a criminal history information check to DCJS and the FBI and consent to the Justice Center sharing with the facility or provider agency listed above a summary of the NYS criminal history information, if any, returned by DCJS, as part of its background investigation of my suitability for employment or volunteer service, or for certification as a natural person operator.
3. I have been advised that procedures exist for me to obtain, review and, if necessary, seek correction of my criminal history information pursuant to regulations established by DCJS in 9 NYCRR Part 6050, and the FBI, as applicable.
4. I have been advised that I have the right to withdraw my application for employment or volunteer service, or certification as a natural person operator, without prejudice, any time before employment, volunteer service, or certification as a natural person operator is offered or declined, regardless of whether the authorized person of the facility or provider agency has reviewed the summary of any criminal history information.
5. I have been advised that the results of the criminal history information check forwarded to the Justice Center by DCJS and the FBI shall be confidential pursuant to the applicable federal and state laws, rules and regulations, and shall only be disclosed to persons authorized by law. Criminal history information will be considered pursuant to Article 23-A of the NYS Correction Law in making hiring determinations.
6. I affirm that the fingerprints submitted will be my own and that the information I have provided is true, complete and accurate.
7. I certify to the best of my knowledge that I: (check as appropriate)
   ____ have been convicted of a crime in New York State or any other jurisdiction.
   ____ have pending arrest charges.
   If checked, provide details:_____
   _____
8. I have been advised that my social security number is being requested so that the Justice Center may check whether I am on the Staff Exclusion List which is maintained as part of the Vulnerable Persons' Central Register and that such check is required by Social Services Law §495 and will be performed prior to the criminal history information check. 14 NYCRR Part 702 provides for the collection of social security numbers for this purpose and the failure to provide my social security number may preclude me from being considered for the position applied for.

Applicant Signature		Date:
Signature Parent/ Guardian if Applicant under 18 years		Date:
Part 3	**Facility or Provider Agency Authorized Person Information**	
Name:		Title:
Signature:		Email:

JC CBC 4 (7/13)

LDSS-3370 (Rev. 04/2009)

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 INFORMATION

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.**

MAIL YOUR COMPLETED LDSS-3370 FORM TO:

STATEWIDE CENTRAL REGISTER
P.O. BOX 4480
ALBANY, N.Y. 12204-0480

TO ORDER A SUPPLY OF LDSS-3370 FORMS:

Please access the (OCFS-4627) **Request for Forms and Publications**, from the Intranet: http://ocfs.state.nyenet/admin/forms/SCR/ Internet: http://www.ocfs.state.ny.us/main/forms/cps/ and mail the completed OCFS-4627 Request for Forms and Publications, to: **THE OFFICE OF CHILDREN AND FAMILY SERVICES, RESOURCE DISTRIBUTION CENTER, 11 FOURTH AVE, RENSSELAER, NY 12144.**

LDSS-3370 (Rev. 09/2014) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STATEWIDE CENTRAL REGISTER DATABASE CHECK

Agency Use Only

SCR USE ONLY
REQUEST ID #

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE:	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY USE ALPHA CODE:	PHONE NUMBER (Area Code):
				( ) -

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

AGENCY NAME: Terence Cardinal Cooke Health Care Center

AGENCY LIAISON: Stephanie Chouloute

STREET ADDRESS: 1249 5th Avenue

CITY: New York | STATE: NY | ZIP CODE: 10029

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 *PLEASE TYPE OR PRINT CLEARLY

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH		
APPLICANT						
MAIDEN/ALIAS						

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.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO

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

LDSS-3370 (Rev. 04/2009)

STAPLE TO LDSS-3370 *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM
ADDITIONAL PAGE

(Use only if the space on the LDSS-3370 form is not sufficient)

APPLICANT NAME: _____

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

Previous Street Address	City	State	Zip	From	To

LDSS-3370 (Rev. 04/2009)

STAPLE TO LDSS-3370 *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM
ADDITIONAL PAGE

(Use only if the space on the LDSS-3370 form is not sufficient)

APPLICANT NAME: ____

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

Previous Street Address	City	State	Zip	From	To

LDSS-3370 (Rev. 04/2009)

STAPLE TO LDSS-3370 *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM
ADDITIONAL PAGE

(Use only if the space on the LDSS-3370 form is not sufficient)

APPLICANT NAME: ____

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

Previous Street Address	City	State	Zip	From	To