



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
SECTION FOR CHILD CARE REGULATION  
**ASSISTANT APPROVAL REQUEST**

RETURN BOTH COPIES TO YOUR CHILD CARE  
FACILITY SPECIALIST AT THE LOCAL SECTION  
FOR CHILD CARE REGULATION OFFICE

LEGAL NAME OF FACILITY	FACILITY OWNER	FACILITY DVN
ADDRESS (STREET, CITY, STATE, ZIP)		TELEPHONE NUMBER (     )
<b>PROPOSED ASSISTANT (ADULT)</b>		
NAME	TELEPHONE NUMBER (     )	DATE OF BIRTH
ADDRESS (STREET, CITY, STATE, ZIP)		
<b>TWO REFERENCES FOR PROPOSED ASSISTANT (NOT RELATED TO THE ASSISTANT)</b>		
NAME	TELEPHONE NUMBER (     )	
ADDRESS (STREET, CITY, STATE, ZIP)		
NAME	TELEPHONE NUMBER (     )	
ADDRESS (STREET, CITY, STATE, ZIP)		
<b>BACKGROUND CHECK (REQUIRED FOR ALL ASSISTANTS)</b>		
COPY OF BACKGROUND CHECK RESULTS <b>ATTACHED</b> . <input type="checkbox"/> NO <input type="checkbox"/> YES		DATE OF BACKGROUND RESULTS
<b>WORK STATUS</b>		
EMPLOYED OR VOLUNTEERS MORE THAN 20 HOURS PER MONTH. <input type="checkbox"/> NO <input type="checkbox"/> YES, Medical and TB report on file. Will obtain 12 clock hours/year training.		
FIRST AID/CPR TRAINING: MUST HAVE CURRENT CERTIFICATION TO BE LEFT ALONE WITH CHILDREN <input type="checkbox"/> NO <input type="checkbox"/> YES		EXPIRATION DATE
<b>AGREEMENT SECTION</b>		
BY MY SIGNATURE BELOW, AS LICENSEE, I AGREE:		
<ul style="list-style-type: none"> <li>• To have a copy of child care home licensing rules available and to assure that any assistant employed or volunteering in my facility has reviewed and is knowledgeable of those rules.</li> <li>• To have an assistant's required medical and TB report on file at my facility within 30 days of first day of work that exceeds 20 hours per month.</li> <li>• To maintain documentation of training for assistants who work more than 20 hours per month, as required.</li> <li>• To maintain accurate daily attendance records on file at my facility for all caregivers.</li> <li>• To have evidence of current First Aid/CPR training on file, as required.</li> </ul>		
<b>SIGNATURE</b>		
OWNER/LICENSEE/DESIGNEE		DATE
<b>OFFICE USE ONLY</b>		
<b>NOTE:</b> One caregiver with current First Aid/CPR certification must be on site at all times.		
ASSISTANT APPROVED <input type="checkbox"/> YES <input type="checkbox"/> NO		
COMMENTS  _____  _____  _____		
CHILD CARE FACILITY SPECIALIST		DATE