MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

ASSISTANT APPROVAL REQUEST

RETURN COPY TO YOUR CHILD CARE FACILITY SPECIALIST.

SAVE
PRINT
RESET

LEGAL NAME OF FACILITY	FACILITY OWNER	FACILITY DVN
ADDRESS (STREET, CITY, STATE, ZIP)		TELEPHONE NUMBER ( )

PROPOSED ASSISTANT (ADULT)

NAME	TELEPHONE NUMBER ( )	DATE OF BIRTH
ADDRESS (STREET, CITY, STATE, ZIP)		
EMAIL ADDRESS		

TWO REFERENCES FOR PROPOSED ASSISTANT (NOT RELATED TO THE ASSISTANT)

NAME	TELEPHONE NUMBER ( )
ADDRESS (STREET, CITY, STATE, ZIP)	
EMAIL ADDRESS	

NAME	TELEPHONE NUMBER ( )
ADDRESS (STREET, CITY, STATE, ZIP)	
EMAIL ADDRESS	

BACKGROUND CHECK (REQUIRED FOR ALL ASSISTANTS)

COPY OF BACKGROUND CHECK RESULTS **ATTACHED**. ☐ NO ☐ YES	DATE OF BACKGROUND CHECK RESULTS

WORK STATUS

EMPLOYED OR VOLUNTEERS MORE THAN 20 HOURS PER MONTH.
☐ NO ☐ YES (Medical and TB Report on file. Will obtain 12 clock hours/year of training.)

FIRST AID/CPR TRAINING: MUST HAVE CURRENT CERTIFICATION TO BE LEFT ALONE WITH CHILDREN ☐ NO ☐ YES	EXPIRATION DATE
DEPARTMENT-APPROVED SAFE SLEEP TRAINING. ☐ NO ☐ YES	EXPIRATION DATE

AGREEMENT SECTION

BY MY SIGNATURE BELOW, AS LICENSEE, I AGREE:

- To have a copy of the 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.
- To have an assistant's required medical and TB report on file at my facility with 30 days of the first day of work that exceeds 20 hours per month.
- To maintain documentation of training for assistants who work more than 20 hours per month, as required.
- To maintain accurate daily attendance records on file at my facility for all caregivers.
- To have evidence of current First Aid/CPR training on file, as required.
- To have an assistant complete department-approved safe sleep training, as required.

SIGNATURE

OWNER/LICENSEE/DESIGNEE	DATE

OFFICE USE ONLY

NOTE: One caregiver with current First Aid/CPR certification must be on site at all times.

ASSISTANT APPROVED
☐ NO ☐ YES

COMMENTS

CHILD CARE FACILITY SPECIALIST	DATE