GOVERNMENT OF BERMUDA

Ministry of Health

Department of Health

DAY CARE CENTRE PERSONNEL APPLICATION FORM

SECTION A: DOCUMENTATION REQUIREMENTS	
• **Photos of Documents are NOT Accepted** • Degree's supported by Transcripts are required for **PROOF** of Early Childhood Education • Change of Information Form, Application Form and Child to Staff Ratio Form must be submitted to the Child Care Regulation Programme within the **First Two Weeks** of employment. All other documents must be submitted within **3 months of employment**. • All staff documents must be maintained on staff files at the Day Care Centre and updated according to timelines provided below.	
All Day Care Centre Personnel – must have the following on file as well as the information for the position identified below. *Required for persons older than 18-years-old.	1. Change of Information Form 2. Child to Staff Ratio Form 3. Application Form (Signed by the Personnel) 4. Copy of Photo ID 5. Two Reference Questionnaires (Template in this application) 6. Current Resume (Must be up to date) 7. Criminal Background Check – Bermuda Police Service or Magistrate Court (Issued within the last **2** years)* 8. Medical Certificate for Child Care Providers (Completed by your doctor and issued in the last **5** years)* 9. SCARS Certificate (Issued in the last **3** years)* 10. CPR/First Aid (Issued in the last **2** years)* 11. Department of Child and Family Services Background Check (Issued in last **2** years)*
Person in Charge	1. Associates Degree in Early Childhood Education or equivalent, **AND** proof of 3-years post qualification experience, or 2. A degree other than an Associate Degree that included 4 courses in Early Childhood Education, **AND** proof of 1 years post qualification experience or 3. Bachelor's Degree in Early Childhood Education or equivalent **AND** Proof of 1 years post qualification experience
Deputy Person in Charge	1. A minimum of the Bermuda College Certificate for Child Care Assistants, or equivalent **AND** 3 years post-qualification experience; or 2. An associate degree in Early Childhood Education or equivalent **AND** 1 year post-qualification experience.
Staff	Bermuda College Certificate for Child Care Assistants or equivalent
Assistant	1. Must be older than 16 and supervised by a qualified staff 2. Documents for all Day Care Centre Personnel
Volunteer/Non-Instructional	Documents for all Day Care Centre Personnel
Summer Students	Documents for all Day Care Centre Personnel
Substitute	Same documents are required as the person/position they are substituting for.

Child Care Regulation Programme, Department of Health
Continental Building, 25 Church Street, Hamilton, HM 12
Phone: (+1 441) 278-4900 Email: childcare@gov.bm

Section B: Applicant Information			
Name of Applicant:			D.O.B (d/m/yr):
Day Care Centre:			
Position Seeking:	☐ **Person in Charge** ☐ **Deputy** ☐ **Teacher** ☐ **Non-Instructional** ☐ **Summer Student** ☐ **Volunteer** ☐ **Substitute** ☐ **Assistant**		
Home Address:			
Parish:		Postal Code:	
Telephone:		Cell Phone:	
Email:			

Section C: Education – (transcripts for degrees to support the role sought, must be attached)		
School Attended	**Degree/Certificate Attained**	**Year Completed**

Section D: Employment Information			
Current Position:			
Business Name:			
Start Date (d/m/yr):		End Date (d/m/yr):	
Previous Position:			
Business Name:			
Start Date (d/m/yr):		End Date (d/m/yr):	
Previous Position:			
Business Name:			
Start Date (d/m/yr):		End Date (d/m/yr):	

Section E: Screening Questions - Circle Yes or No for all questions. If you answer yes to any of the following questions provide an explanation below.		
1. Have you been convicted of, pled guilty or no contest to a crime in Bermuda or any other country?	Yes	No
Explanation:		
2. Have you had any disciplinary or probationary action taken against you by any licensing authority in Bermuda or another country? This includes probation, suspension, revocation or denial of a license.	Yes	No
Explanation:		
3. Have you had any form of investigation or disciplinary action by any health or social services related agency in Bermuda or another country?	Yes	No
Explanation:		
4. Do you have a mental or physical condition and/or drug or alcohol use which could interfere with your current ability to be a day care provider?	Yes	No
Explanation:		

Section F: Declaration Statement – (check each box after reading and sign below)

By my signature: _____

- ☐ I agree the information in this application and the information in any required or following documentation is true and accurate to the best of my knowledge. I understand that false statements may result in the removal from the Day Care Centre.
- ☐ I understand my application to be a staff member at a day care centre, if approved, may be suspended or revoked at any time there is significant concern, evidence, or allegation regarding fraudulent activities, abuse or neglect.
- ☐ I agree to notify the Child Care Regulation Programme of any changes to the information provided in this registration form.
- ☐ I agree for Child Care Regulation Programme and/or MOH to contact relevant persons (including but not limited to regulatory and government entities) to verify the information provided in this application.

PATI disclaimer: This correspondence and any response thereof is subject to public disclosure under the Public Access to Information Act 2010. Most exempt records may be disclosed if it is in the public interest (s.21). Personal information, such as names and personal details of service users, patients, complaints, children and vulnerable adults, is exempt from disclosure (s.23). Information of people receiving discretionary benefit such as a licence is not personal information and can be disclosed (s.24 (1)). Commercial information and information received in confidence may be disclosed if it is in the public interest (s.25&s. 26).

I certify to the best of my knowledge that the information contained in this application is true and factual.

_____

Printed Name of Applicant

_____ _____

Signature of Applicant **Date**

INCOMPLETE APPLICATIONS WILL NOT BE REVIEWED

Completed applications are mailed/delivered to:

Child Care Regulation Programme,
Department of Health, Ground floor
25 Church St. Hamilton, HM12; or
childcare@gov.bm

DAY CARE PERSONAL REFERENCE QUESTIONAIRE

This reference is required by the Child Care Regulation Programme for Day Care Personnel Applications. It is to be completed and submitted by the person providing the reference, not the applicant. Please rate the applicant based on your experience and interactions. Complete and submit in sealed envelope to ensure confidentiality to the following address:
Child Care Regulation Programme, Continental Building, 25 Church Street, Hamilton HM12.

Name: _____

Occupation: _____

Telephone: _____ **Email:** _____

Name of Applicant (Person you are providing a reference for):

_____

1. How do you know the applicant? _____
2. How long have you known the applicant? _____
3. When was the last time you had contact with the applicant? _____

Respond to all questions by checking which response best describes your experience with this applicant.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
4. Applicant gets along well with others.					
5. Applicant handles stressful situations well.					
6. I have trust the applicant would keep private information confidential.					
7. I believe the applicant is honest and trustworthy.					
8. I have not witnessed any displays of prejudice.					
9. The applicant loses his/her temper easily.					
10. I do not have any knowledge of the applicant's use or involvement with illegal drugs or narcotics.					
11. I believe the applicant is reliable.					
12. I would recommend the applicant as a caregiver.					

Comments:

Signature: _____ **Date:** _____

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Comments:

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GOVERNMENT OF BERMUDA
Ministry of Health

MEDICAL CLEARANCE FORM FOR CARE PROVIDERS

This certificate is to establish that the patient named below is in good physical and mental condition as to not adversely affect the health or safety of those persons they care for.

PATIENT INFORMATION and AUTHORIZATION (To be completed by the PATIENT)

Name:	**Date of Birth:**
I authorize the release of this medical information to my potential employer and Ministry of Health appointed inspectors to ensure compliance with: ☐ the Residential Care Home and Nursing Home Act 1999, Regulations 2001 and Code of Practice and/or Ageing and Disability Services home care provider registration requirements or, ☐ the Day Care Centre Regulations 1999 and/or Child Care Regulation Programmes' requirements. **Signature:** **Date:**	

MEDICAL INFORMATION (To be completed by PHYSICIAN)

1. Check to indicate general health status of patient: *If any are unchecked provide an explanation in comments section*	☐ Free from active infections of communicable diseases ☐ Free from substance abuse ☐ Mentally fit and capable of caring for vulnerable persons
2. Check to indicate if your patient has the physical capacity to perform the functions of their post: *Must have physical ability (i.e. mobile and able to lift, squat, assist their care recipients, in and out of a building, car, up/down steps etc).*	☐ **Yes** ☐ **No** Specify: ☐ Drive a car, if necessary.
3. Check to indicate patient's current vaccine status (As known. No testing required): *This to prompt discussion of identifying who may be at risk and advise if vaccines are recommended due to care giver or care recipient(s) risk factors. Additionally it documents history in event of outbreak.*	☐ Influenza vaccine Date:_____ ☐ Measles, Mumps, Rubella Date:_____ ☐ Varicella (chickenpox): Date:_____ ☐ Polio: Date_____ ☐ Hepatitis B: Date_____ ☐ Tetanus, Diphtheria, Pertussis Date:_____ ☐ Other (see Adult Immunization Schedule)_____
Comments:	
Date:	**Physician Signature:**
Contact Number:	**Print Name:**

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