GOVERNMENT OF BERMUDA
Ministry of Health
Department of Health

DAY CARE PROVIDER APPLICATION FORM

INCOMPLETE APPLICATIONS WILL NOT BE REVIEWED

Section A: *Application Submission and Document Requirements*

A person wishing to care for up to three children in their home must be registered with the Child Care Regulation Programme, Department of Health.

☐ **NEW APPLICATION** ☐ **RENEWAL OF REGISTRATION**

(No photos of the following forms will be accepted. We will accept hard copies or scans to childcare@gov.bm)
Registration requires the following items:

- ☐ A completed application form (signed and dated)
- ☐ Copy of a valid photo I.D (e.g. Drivers Licence, Passport)
- ☐ CPR/First Aid Certification (issued within the last 2 years)
- ☐ Criminal Background Check with Bermuda Police or Magistrate Court (issued within the last 2 years)
- ☐ Department of Child and Family Services Background Check (issued within the last 2 years)
- ☐ A completed Medical Clearance Form dated and signed by yourself and your doctor (issued within the last 5 years)
- ☐ SCARS Certificate (issued in the last 3 years)
- ☐ Two Reference Questionnaires (see application form)

Section B: *Applicant Information*

Business Name:		
Name:		
Last name	**First Name**	**Middle Name (s)**
Date of Birth (dd/m/year):		
Physical Address (House name, House/Apt #, Street name, Parish Postal Code):		
Mailing Address (if different from above):		
Telephone:	Cell:	
E-mail:		
Emergency Contact Name and relationship: Telephone:	Cell:	

Household Members – list all household members and their ages*
***Anyone 18-years-old or over, must provide a Criminal Background Check issued in the last 2 years**

Names	Ages
1.	
2.	
3.	

Section C: *Screening Questions*: Circle Yes or No for all questions. If you answer yes to any of the following questions provide an explanation on a separate sheet of paper and submit with this application.

1. Have you been convicted of, pled guilty or no contest to a crime in Bermuda or any other country?	Yes	No
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
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
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

Section D: *Continuing Professional Development:* Please document training hours issued in the last 2 years.

1. Name of Activity:
Topic Covered:
Number of Hours:
Date Completed:
Instructional Method:
Name of organization giving the training:
2. Name of Activity:
Topic Covered:
Number of Hours:
Date Completed:
Instructional Method:
Name of organization giving the training:
3. Name of Activity:
Topic Covered:
Number of Hours:
Date Completed:
Instructional Method:
Name of organization giving the training:
4. Name of Activity:
Topic Covered:
Number of Hours:
Date Completed:
Instructional Method:
Name of organization giving the training:
5. Name of Activity:
Topic Covered:

	Number of Hours:
	Date Completed:
	Instructional Method:
	Name of organization giving the training:
6.	Name of Activity:
	Topic Covered:
	Number of Hours:
	Date Completed:
	Instructional Method:
	Name of organization giving the training:

Section E: ***Declaration Statement:*** check each box after reading and signing 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 denial or removal of my registration.
- ☐ I understand my application for registration as a day care provider in the community, if approved, may be suspended or revoked at any time there is significant concern, evidence, or allegation regarding fraudulent activities, abuse or neglect.
- ☐ I understand this registration is valid for 2 years.
- ☐ 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.
- ☐ I agree that I will adhere to the Children Act 1998, Day Care Centre Regulations 1999, and Childcare Standards 2018.

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**
Email: childcare@gov.bm

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)

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DAY CARE PROVIDER PERSONAL REFERENCE QUESTIONAIRE #1

This reference is required by the Child Care Regulation Programme for Day Care Provider 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: ***childcare@gov.bm*** ***or***
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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DAY CARE PROVIDER PERSONAL REFERENCE QUESTIONAIRE #2

This reference is required by the Child Care Regulation Programme for Day Care Provider 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: childcare@gov.bm or ***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):

_____

4. How do you know the applicant? _____
5. How long have you known the applicant? _____
6. 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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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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DAY CARE PROVIDER EMERGENCY/RELIEF PERSON REGISTRATION FORM

Personal Information – **PLEASE PRINT IN BLUE INK**			
Emergency/Relief Name:			
First Name	***Middle Name***	***Last Name***	
Physical Address:			
House No.	***Street Address***	***Parish and Postal Code***	
Home Phone:	Cellular:	Other:	
E-mail Address:			
First Aid Training:		Yes ☐	No ☐
DCFS Child Abuse Clearance Form:		Yes ☐	No ☐
Valid Photo I.D:		Yes ☐	No ☐
SCARS Certification:		Yes ☐	No ☐
CPR Certification:		Yes ☐	No ☐
Magistrates Court Criminal Background Check:		Yes ☐	No ☐
Government Medical Clearance Form:		Yes ☐	No ☐
Required Continuing Professional Development (CPD) Hours 6			

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**

Completed Continuing Professional Development **forms** are mailed/delivered to:

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

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The Child Care Regulation Programme recommends that all Day Care Provider Emergency/Relief Personnel engage in a minimum of 6 hours of Continuing Professional Development annually.

Name of Course	Date	Number of Hours	Presenter/Event

Calendar year (e.g. 2019-2020): _____

Date Submitted to CCRP Office: _____

TOTAL CPD Hours for the year:

I hereby declare that this is an accurate record of the training and professional development I have completed for the period stated and I submit these hours to fulfill my annual requirement.

DCP Emergency/Relief Name: _____

DCP Emergency/Relief Signature: _____

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