

MARYLAND STATE DEPARTMENT OF EDUCATION  
Office of Child Care

**SUBSTITUTE FORM**  
**(For Provider or Additional Adult)**

Name of Substitute: \_\_\_\_\_  
(First, Middle, Maiden, and Last)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to the Provider (i.e. spouse, parent, child, sibling, etc.): \_\_\_\_\_

I have agreed to serve as a substitute for  the Provider  Provider's Additional Adult:

Provider's Name: \_\_\_\_\_

Provider's address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

	YES	NO
I agree to apply for Federal and State criminal background checks. If I reside, or have resided, in a state outside of Maryland in the past 5 years, I agree to complete a background check within that state as required by the Office of Child Care (OCC).		
I am at least 18 years of age and, physically and mentally capable of providing care for children.		
I have read the family child care regulations and agree to follow them. <u>COMAR 13A.15 Family Child Care</u>		
I agree to be ready to substitute at the provider's address during the child care hours.		
I agree to submit a medical evaluation to the OCC that has been completed within the past 12 months.		

I understand that a substitute cannot be used as a substitute for more than 20 days in any 12-month period. A day counts only when the substitute gives care for more than 2 hours. The Office of Child Care (OCC) must approve, in advance, the use of more than 20 substitute days in a 12-month period.

I understand that OCC will complete a child and adult abuse and neglect check on me, which requires the completion of a notarized release of information form. I understand that I cannot be used as a substitute until OCC completes the required clearances for my approval.

I understand that the provider shall inform me about matters pertinent to the health and safety or welfare of children in care.

I certify that the information on this form is correct and true.

Substitute Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_