**ALL FACILITIES:** Please list **all** facility personnel, whether paid or unpaid, including volunteers. (\*see position titles below)

**If you are reporting a staff change, complete and return page 1 for new staff or page 2 for position changes and/or deletions.**

Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE PRINT OR TYPE SHADED AREA FOR OCC USE ONLY**

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| Name of Staff Member | Position \* | Hire Date at this Site | CBC√ | Date of Medical Report | Date ofRelease of Information | Date of Medication Admin | Expiration Date of First Aid and CPR | Date of Basic Health and Safety | Continued Training Complete√ | Approved for Position√ | FBI received by OCC√ | MD CBC received by OCC√ | Privacy Rights form√ | MD Release Received√ | Out of State NeededY/N |
| # of hours worked |
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\* Position Title: Operator, Director, Teacher, Assistant Teacher, Aide, Food Service Worker, Clerical Worker, Driver, Custodian, Substitute, Resident and/or Volunteer.

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**Signature of Operator or Director** **Date** **E-mail**

Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STAFF MEMBER CHANGE INFORMATION**

Complete this section if change or deletion information is being reported.

|  |  |  |
| --- | --- | --- |
| Name of Staff Member  | Type of Change | Transferring from another facility in Maryland? |
| Delete Date | Change Date  | Please explain(i.e. hours, position, age of group)  | No  | Yes  | Name and County of previous facility  | Date left  |
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**Signature of Operator or Director** **Date** **E-mail**