IdentoGO
By MorphoTrust USA

New Jersey Universal Fingerprint Form

www.bioapplicant.com/nj

(1) Originating Agency Number (ORI #)	(2) Category	(3) Statute Number	
NJ920690Z	CFK	30:5B-6.13	
(4) Reason for Fingerprinting		(5) Document Type	(6) Payment Information
DAY CARE EMPLOYMENT		RB2	BILL STATE AGENCY
(7) Contributor's Case # (Unique Identifier)		(8) Miscellaneous	
DC0932180500086			

(9) First Name	(10) MI	(11) Last Name		
(12) Daytime Phone Number	(13) Social Security Number (Optional)	(14) Date of Birth	(15) Height	(16) Weight
( ) -				
(17) Maiden or Alias Last Name	(18) Place of Birth (US State if US Citizen; Country for all others)		(19) Country of Citizenship	

(20) Home Address

Address City State Zip

(21) Gender (Select one)	(22) Hair Color	(23) Eye Color	(24) Race (Select One)
[ ] Female [ ] Male [ ] Both			[A] Asian/ Pacific Islander (Includes Asian Indian) [B] Black [I] American Indian / Alaska Native [W] White (Includes Hispanic/ Spanish Origin) [U] Unknown

(25) Occupation / Position (with respect to Requirement)	(26) Employer / Organization Name (with respect to Requirement) **Watch Me Grow "N" After Care and Summer Camp** Employer Address **3 MARSHALL ST STORE 7** City **IRVINGTON** State **NJ** Zip **07111**

Identification Requirement - *Identification must be presented at the time of printing.* Identification presented MUST be one (1) document that is current (not expired). A combination of documents will not be accepted. The single document must include the following criteria; Photo, Name, Address (home/employer), Date of Birth and is issued by a Federal, State, County or Municipal entity for identification purposes. Examples of acceptable ID are: 1) Valid U.S. State Photo Driver's License/ Non Driver's License, 2) U.S. Passport, 3) USCIS Permanent Resident ID Card (issued after 5/10/2010), and 4) USCIS Employment Authorization Card (issued after 10/31/2010).

Please READ this form carefully

and follow all of the instructions provided by your agency/employer to complete the fingerprint process. You must have this form (Blocks 1 through 26) completed prior to scheduling your fingerprint appointment via the website or call center. PLEASE PRINT LEGIBLY. It is required you present this completed Universal Fingerprint Form, IDG_NJAPP_020115_V2, at your scheduled appointment.

Appointment Scheduling:

Scheduling is available anytime at www.bioapplicant.com/nj. Appointments may also be scheduled through our Call Center. English and Spanish speaking agents are available at **1-877-503-5981**, Monday through Friday, 8:00AM to 5:00PM EST and Saturday, 8:00AM to 12 Noon EST.

Payment:

When an Applicant is responsible for payment, Payment is Required at the time of scheduling. The following forms of payment are accepted: Visa, MasterCard, or electronic debit (ACH) from a checking account; accounts will be debited immediately.

Cancel/ Reschedule:

Appointments may be canceled or rescheduled via the website or the call center before the deadline of 5PM EST the business day prior to the scheduled appointment (Saturday Noon for Monday appointments). An appointment fee of $10.00 will be incurred by applicants who do not cancel/reschedule their appointment prior to the deadline. MorphoTrust will refund the remainder of the fee paid (state/federal search fees) to the original payment method.

Unable to be Fingerprinted:

An applicant is considered "Unable to be Fingerprinted" for any of the following reasons: Failure to appear for scheduled appointment; Inability to present proper Identification; Inability to present this completed Universal Fingerprint Form IDG_NJAPP_020115_V2; Information on this form does not exactly match the information provided during the scheduling process. Applicants unable to be fingerprinted will incur a $10.00 appointment fee; MorphoTrust will refund the remainder of the fee paid (state/federal search fees) to the original payment method.

PCN and Receipts:

Upon the completion of fingerprinting you will be assigned a PCN number. The PCN will be recorded on this form and on your receipt. MorphoTrust will not provide *duplicate receipts, PCN Numbers or any appointment/printing information after the time of printing.*

Applicant ID Number:	Payment Authorization:	PCN:
Scheduled Day & Date:	Scheduled Time:	Scheduled Site:
Agency Information: STATE AND FBI BACKGROUND CHECK		

You **MUST** retain a copy of this form and the receipt of printing for your personal records.

APPLICANTS MUST NOT ALTER, SHARE, OR REUSE THIS FORM

Date Printed: 5/16/2018

For OOL Use Only: Log #_____

CHILD ABUSE RECORD INFORMATION (CARI) CONSENT FORM
STATE OF NEW JERSEY
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF LICENSING

CHILD CARE CENTER

Indicate Reason for CARI by Checking Appropriate Box:

☐ New Center
☐ Renewing Center
☐ New Staff Member Hired at a Licensed Center (Not Renewing)
Date of Hire _____

Please Check Only If You Are:

☐ Sponsor (Owner) or Sponsor Representative

DO NOT SUBMIT PHOTOCOPY OR FAX A COMPLETED FORM.

Center Name:	**Watch Me Grow "N" After Care and Summer Camp**		
Site Address:	**3 MARSHALL ST STORE 7**		
	IRVINGTON NJ 07111	**County: Essex**	**Fee: $10.00**
Mailing Address:	**8 GREAT HORNED OWL CT**		
	Hackettstown NJ 07840		
Phone:	**9733731160**	**Director: Kameelah Phillips**	
Renewal Date:	**Pending**	**ID #: 180500086**	

DO NOT WRITE IN OR USE WHITE-OUT OR CROSS-OUTS IN THIS BOX. DOING SO WILL MAKE THE FORM INVALID.

PLEASE PRINT CLEARLY IN INK; DO NOT USE PENCIL. PLEASE GIVE YOUR FULL NAME; DO NOT USE INITIALS. COMPLETE THIS FORM ON BOTH PAGES. SIGN, DATE, AND RETURN IT TO THE CHILD CARE CENTER. ATTACH ADDITIONAL SHEETS IF MORE SPACE IS NEEDED.

Print your full name (first, middle, last): _____

Previous name, maiden name or nicknames: _____

Date of name change or date of marriage: _____

Home address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____ Race: _____

Social Security number: _____ Sex: _____

NOTE: Pursuant to the Federal Privacy Act of 1974 (P.L. 93-579), the disclosure of your Social Security number is voluntary. Your Social Security number, race, date of birth, and sex will only be used for the purpose of conducting a Child Abuse Record Information background check as authorized by the State Child Care Center Licensing Law (N.J.S.A. 30:5B-1 to 15).

12/13/12

Name: _____
(Please clearly print applicant's name.)

Full names and birth dates of your children, if any, whether living with you or not: **NOTE: If none, check this box ☐**

Child's First Name	Middle Name	Last Name	Date of Birth

Your previous addresses since 1990 and the dates you lived at each address: **NOTE: If none, check this box ☐**

1) _____

Resided from: _____ (month) _____ (year) To: _____ (month) _____ (year)

2) _____

Resided from: _____ (month) _____ (year) To: _____ (month) _____ (year)

3) _____

Resided from: _____ (month) _____ (year) To: _____ (month) _____ (year)

4) _____

Resided from: _____ (month) _____ (year) To: _____ (month) _____ (year)

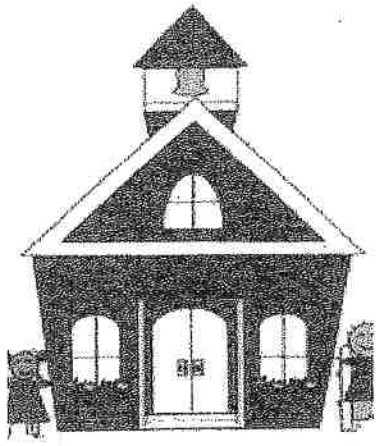
All persons completing this form **must** read the following and sign below:
I consent to have the Department of Children and Families conduct a Child Abuse Record Information check to determine whether an allegation of child abuse or neglect has been substantiated against me. I certify that I am not currently being investigated for any allegation of child abuse or neglect. I understand that if a record of substantiated child abuse or neglect is found, or if I refuse to sign this consent form, I will not be permitted to sponsor or work at this or any other licensed child care center in New Jersey. I certify that all information I have given on this form is accurate and complete to the best of my knowledge.

Signature: _____ **Date:** _____

FOR OFFICE OF LICENSING USE ONLY

OOL staff initials_____

Watch Me Grow Academy
928 Clinton Ave.
Irvington, NJ 07111
973-373-1160 (Fax) 973-373-1170



Employment Application Form

Please fill out this application to the best of your ability. We are an equal opportunity employer. We do not discriminate on the basis of race, religion, color, sex, national origin, disability, veteran status or any other status or condition protected by applicable federal or state laws.

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone #: _____ Cell #: _____

Is there any additional information relative to a change of name, maiden name or nickname necessary to enable a check on your work record? If so please explain:

_____

_____

Position Applied for: Teacher Full Time | Teacher Assistant Part Time | Volunteer

Employment History:
Please begin with your current or last Job. Include military service assignments. If you include volunteer activities, please exclude organizations that might indicate race, color, religion, national origin, disability or other protected status.

(1.) Employer: _____

Address: _____ Phone#: _____

Job Title: _____ Supervisor: _____

Duties/ Responsibilities: _____

_____

From ___/___/___ To ___/___/___ Salary: $_____

Reason for leaving:_____

_____

May we contact your previous supervisor? **Yes** **No**

Employer:_____

Address:_____ Phone#:_____

Job Title:_____ Supervisor: _____

Duties/ Responsibilities: _____

_____

From ___/___/___ To ___/___/___ Salary: $_____

Reason for leaving:_____

_____

May we contact your previous supervisor? **Yes** **No**

Employer:_____

Address:_____ Phone#:_____

Job Title:_____ Supervisor: _____

Duties/ Responsibilities: _____

_____

From ___/___/___ To ___/___/___ Salary: $_____

Reason for leaving:_____

_____

May we contact your previous supervisor? **Yes** **No**

Education: Please include the school name, location, diploma, degree or certification received and what your studies were.

High School: _____

_____

Trade School: _____

_____

College: _____

_____

Specialized Training or any specific job related skills: _____

_____

Please indicate if you speak, read and write any languages other than English and skill level: _____ **Fluent** **Good** **Fair**

Military History (Job related training): _____

Current Status: _____

Personal:

Childcare requires you to perform essential job functions, such as the ability to change diapers and lift children (lifting weights up to approximately 35lbs). Can you perform these and other essential job to which you are applying? Yes No

Have you ever been convicted of a crime or disorderly person's offense? Yes No
If yes, please explain.

_____

_____

If position requires driving, do you have the appropriate license? Yes No

If applying for a position that requires driving, have you been ticketed for a moving violation in the last three years? Yes No

If yes, please explain. _____

_____

Can you provide proof of identification and proof of eligibility to work in this country (Examples: green card, social security card, passport, working papers, etc.)?
Yes No

When can you start employment with us? _____

What are your hours of availability? Monday: _____ Tuesday _____
Wednesday_____ Thursday _____ Friday _____

How long can I keep your application on file as active? _____

Are you willing to attended training programs which will enhance your ability to perform your job? Yes No

References other than previous employers and relatives whom I can contact:

Name:_____ Phone:_____

Name:_____ Phone:_____

Applicant's Acknowledgement (Please read before signing.)

I certify that the answers given in this application are true and complete to the best of my knowledge. I authorize investigation into all statements I have made on this application as may be necessary for reaching an employment decision.
As a condition of my employment I accept the principle that the welfare of the organization and the children of Watch Me Grow Academy cares for depends upon my conduct and honesty of its employees and trust and confidence of our customers and the public in general. Watch Me Grow Academy expects honesty, security and confidentiality.
The applicant understands that neither this document nor any offer of employment from this employer constitutes an employment contract unless the employer and the employee execute a specific document in writing. Any oral or written statement to the contrary a re hereby expressly disavowed and should not be relied upon unless the employer and employee execute a specific document in writing.

IF HIRED, I AGREE TO CONFORM TO THE RULES AND REGULATIONS OF THE COMPANY, AND I UNDERSTAND THAT THE COMPANY HAS COMPLETE DISCRETION TO MODIFY SUCH RULES AND REGULATIONS AT ANY TIME, EXCEPT THAT IT WILL NOT MODIFY ITS POLICY OF EMPLOYMENT AT-WILL.

_____ _____

Signature of applicant Date

STAFF HEALTH EXAMINATION FORM

TO BE COMPLETED BY APPLICANT			
PATIENT'S NAME:		BIRTHDATE:	

I authorize (health care provider's name) _____ to release my medical information to (center) _____ in connection with my job application.

I understand that the center will keep this information confidential.

PATIENT'S SIGNATURE:		DATE:	

TO BE COMPLETED BY HEALTH CARE PROVIDER

The above-named patient is applying for employment at our child care center. New Jersey State regulations require a health care provider's statement indicating that he or she is in good health and poses no health risk to persons at the center. Such statement shall be based on a medical examination within the six months immediately preceding such person's working at the center.

A Mantoux tuberculin skin test with five TU (tuberculin units) of PPD tuberculin, except that the staff member shall have a chest x-ray taken if he or she has had a previous positive Mantoux tuberculin test. The staff member shall submit to the center written documentation of the results of the test and x-ray.

If the Mantoux tuberculin test result is insignificant (zero to nine millimeters (mm) of induration), no further testing shall be required.

If the Mantoux tuberculin skin test result is significant (10 or more mm of induration), the individual shall have a chest x-ray taken. If the chest x-ray shows significant results, the staff member shall not come in contact with the children unless he or she submits to the center a written statement from a health care provider certifying that he or she poses no threat of tuberculosis contagion

DATE OF MANTOUX TEST:		RESULTS:	
DATE OF CHEST X-RAY (IF APPLICABLE):		RESULTS:	
DATE OF PHYSICAL EXAMINATION: (must be within 6 months immediately preceding hire date)		RESULTS:	

Is there any reason to preclude this patient from working with children?

☐ NO

☐ YES (please explain):

REMARKS:

I have examined the above-named patient and found him/her to be in good health and to pose no health risk to others at the child care center.

HEALTH CARE PROVIDER'S SIGNATURE:		DATE:	
HEALTH CARE PROVIDER'S NAME:			
HEALTH CARE PROVIDER'S OFFICE ADDRESS (PRINT OR STAMP):			