Staff File Checklist- Center

Name of Employee:_____Date of Employment: _____

The following items must be present in each staff member's personnel file

	Documentation	Due Date	Date Received/ Completed
❑	Employment Application (includes DOB, education, training, and experience)	Day 1	
❑	Medical Report	Prior to employment	
❑	TB Test or Screening	Day 1	
❑	Health Questionnaire	Day 1 & annually	
❑	Emergency Information Form	Day 1 & as changes occur & annually	
❑	CBC Qualification Letter	Day 1 & every 3 years	
❑	Documentation of Orientation	Within 2 weeks/ 6 weeks of employment	
❑	Documentation of Health and Safety Training	Within 1year & every 5 years thereafter	
❑	Documentation of On-Going Training	After the first year of employment & annually thereafter	
❑	Documentation of CPR/First Aid Certification	Within 90 days of employment Renew before expiration date	
❑	Documentation of Playground Safety Training (if applicable)	Within 6 months of employment	
❑	Documentation of BSAC training (if applicable)	Within 3 months of employment	
❑	Documentation of ITS-SIDS Safe Sleep Training (if applicable) *Administrators must complete within 90 days*	Within 2 months of infant room work & every 3 years	
❑	Documentation of Emergency Medical Care Plan (EMC) review	Review annually & whenever plan is revised	
❑	Documentation of EPR Plan Review	Orientation & annually	
❑	Documentation of EPR in Child Care Training (if applicable)	Within 1 year of licensure & within 4 months of trained staff's departure date	
❑	Documentation of Recognizing and Responding to Suspicions of Child Maltreatment training	Within 90 days	
❑	Documentation of receipt of prevention of shaken baby syndrome and abusive head trauma policy	Day 1 & 14 days prior to new policy implementation	
	WORKS Qualification Information:	Within 6 months of assuming duties	
❑	Notification from the DCDEE WORKS regarding submitted education/training for position qualification information		
❑	Documentation of Enrollment in Coursework (if applicable)		
❑	Professional Development Plan	Within 1 year & annually	
❑	Documentation of Staff Evaluation	Annually	
❑	Documentation of Job Description Receipt	When applicable	
❑	Documentation of Operational and Personnel Policy Receipt	Day 1 & when changes occur	
❑	Documentation of receipt of Aquatic Activities Policy, guidelines provided by the pool operator or off-site aquatic facility/aquatic rules (if applicable)	Day 1 & annually	

Application for Employment

Date of Application _____

Please Print (Fully complete both pages)

Last four digits of SSN	Last Name	First Name	Middle Name
Address (street number and name)		City	County
State	Zip Code	Phone (home or where you can be reached)	Business Phone

Position Applied For: _____

Date of Birth: _____ N. C. Driver's License Number _____
(month) (day) (year)

Have you ever been convicted of breaking a law other than a minor traffic violation? YES____ NO____ If yes, give the date and explain fully. Use an additional piece of paper if more space is needed: _____

_____

Have you ever had an abuse or neglect or child maltreatment substantiation? YES____ NO____ If yes, list county/State and give the date and explain fully. Use an additional piece of paper if more space is needed: _____

_____

(The offense(s) and how recently you were convicted will be evaluated in relation to the job for which you are applying.)

Education

Circle the highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 GED College 1 2 3 4

Schools	Name and Location	Dates Attended	Coursed of Study	Degree/Diploma
High School		to		
College or University		to		
		to		
		to		
		to		
Graduate or Professional				
Educational, Vocational Schools, etc.				

Child care training completed in the last three years (such as First Aid, CPR, Health and Safety Training, ITS-SIDS, CDA etc.):

_____

References

List the names, addresses, and phone numbers of people we may contact as references:

_____

_____

_____

Work History

(List child care/early childhood experience first.)

Current or Last Employer			Address		
Job Title			Supervisor's Name		No. Supervised by you
Date Employed (mo/yr)	Starting Salary $ Per		Ending Salary $ Per	Reason for leaving	May we contact employer? yes ☐ no ☐
Date Separated (mo/yr)			Duties:		
Full Time	Years	Months			
Part Time	Years	Months			
If part time, number of hours per week					

Current or Last Employer			Address		
Job Title			Supervisor's Name		No. Supervised by you
Date Employed (mo/yr)	Starting Salary $ Per		Ending Salary $ Per	Reason for leaving	May we contact employer? yes no
Date Separated (mo/yr)			Duties:		
Full Time	Years	Months			
Part Time	Years	Months			
If part time, number of hours per week					

I certify that I have given true, accurate, and complete information on this form to the best of my knowledge. In the event confirmation is needed in connection with my work, I authorize educational institutions, associations, registration, and licensing boards, and others to furnish whatever detail is available concerning my qualifications. I authorize investigations of all statements made in this application and understand that false information of documentation, or a failure to disclose relevant information may be grounds for rejection of my application, disciplinary action, or dismissal if I am employed, and (or) criminal action. I further understand that dismissal on unemployment shall be mandatory if fraudulent disclosures are given to meet position qualifications.

Signature of Applicant_____ Date_____

Updated 5/19

Staff Health Assessment/Medical Report

10A NCAC 09 .0701 (Child Care Centers)

This document, completed by a health care professional prior to employment, indicates that the individual listed is emotionally and physically fit to care for children. This form must have been completed within the last twelve months.

Full name of individual:	
Home address:	
Phone number:	Email:

To be completed by a health care professional

Date of assessment:
Does this applicant have any physical condition that would limit their ability to work with children? ☐ Yes ☐ No If yes, please describe:
Is this applicant currently under treatment that would limit their ability to work with children? ☐ Yes ☐ No If yes, please describe:
Is this applicant currently taking any medication that would affect his/her work with children? ☐ Yes ☐ No If yes, please describe:
In your opinion, is this applicant emotionally and physically capable to care for children on a daily basis? ☐ Yes ☐ No

Name of health care professional:	Date:
Signature of health care professional:	
Address:	
Phone number:	

*This information must be included in the staff member's medical file, which must be maintained separately from the staff member's individual personnel file in the center. Child Care Rule 10A NCAC 09 .0701(d).

North Carolina Child Care Health and Safety Resource Center
800.367.2229
healthychildcare.unc.edu

Tuberculosis Screening Form

10A NCAC 09 .0701 (a) (Centers); .1702 (b)(4) and .1729 (a)(5) & (b) (Family Child Care Homes)

This questionnaire must be administered to all child care providers, by a licensed health care professional, before coming into contact with children. Directors, operators, additional caregivers, substitutes, and individuals who volunteer more than once a week must be screened. Testing should only be performed if the individual answers "yes" to one of the screening questions. Both screening and testing are available at the local health department.

Note to health care professionals: A negative risk and symptom screen should be considered a negative tuberculosis test in such individuals, and no further testing is required. An Interferon Gamma Release Assay is preferred over a tuberculin skin test for otherwise low-risk individuals with a positive response to the risk or symptom screening questionnaires. (See page 2.)

Last name (print clearly)	First name	Middle	Date of Birth

Tuberculosis Risk Questionnaire

1) Were you born outside the USA in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe?	☐ YES	☐ NO
2) Have you traveled outside the USA and lived for more than one month in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe?	☐ YES	☐ NO
3) Do you have a compromised immune system such as from any of the following conditions: HIV/AIDS, organ or bone marrow transplantation, diabetes, immunosuppressive medicines (e.g. prednisone, Remicade), leukemia, lymphoma, cancer of the head or neck, gastrectomy or jejeunal bypass, end-stage renal disease (on dialysis), or silicosis?	☐ YES	☐ NO
4) Have you ever done one of the following: used crack cocaine, injected illegal drugs, worked or resided in jail or prison, worked or resided at a homeless shelter, or worked as a healthcare worker in direct contact with patients?	☐ YES	☐ NO
5) Have you ever been exposed to anyone with infectious tuberculosis?	☐ YES	☐ NO

Tuberculosis Symptom Questionnaire

Do you currently have any of the following symptoms?		
1) Unexplained cough lasting more than 3 weeks?	☐ YES	☐ NO
2) Unexplained fever lasting more than 3 weeks?	☐ YES	☐ NO
3) Night sweats (sweating that leaves the bedclothes and sheets wet)?	☐ YES	☐ NO
4) Shortness of breath?	☐ YES	☐ NO
5) Chest pain?	☐ YES	☐ NO
6) Unintentional weight loss?	☐ YES	☐ NO
7) Unexplained fatigue (very tired for no reason)?	☐ YES	☐ NO

The above health statement is accurate to the best of my knowledge. I will contact my health care professional and/or the health department if my health status changes.

Signature:	Date:

Screening administered by licensed health care professional:

Printed name and location:	
Signature:	Date:

*This information must be included in the operator or staff member's medical file, which must be maintained separately from the operator or staff member's individual personnel file that is kept on site.

Tuberculosis Testing Form

10A NCAC 09 .0701 (a) (Centers); .1702 (b)(4) and .1729 (a)(5) & (b) (Family Child Care Homes)

Record of Tuberculosis Test

Last name (print clearly)	First name	Middle	Date of birth

Type of test:

☐ Tuberculin

Date given	
Date read	
Results	MM reading: _____ ☐ Negative ☐ Positive

☐ Interferon Gamma Release Assay

Date	
Results	

Comments:

Signature of Authorized Health Professional	Date	Location

*This information must be included in the operator or staff member's medical file, which must be maintained separately from the operator or staff member's individual personnel file that is kept on site.

Health Questionnaire – Child Care Centers

10A NCAC 09 .0701(a)

All staff, including the director, must complete a health questionnaire annually following the initial medical report. Substitute providers and volunteers must complete a health questionnaire on or before the first day of work and annually thereafter.

Full name of individual:	
Home address:	
Phone number:	Email:

I certify that I am emotionally and physically fit to care for children.

Signature:
Date:

This portion of the form to be completed by the Child Care Center Director

As the director, I understand that I may request another evaluation of a staff member's emotional and physical fitness to care for children when there is reason to believe that there has been deterioration in the staff member's emotional or physical fitness to care for children. This request may be made based upon factors such as observations of myself or other staff members, reports of concern from family, reports from law enforcement, or reports from medical personal. Child Care Rule 10A NCAC 09 .0701(b).

Director's Signature:
Date:

*This information must be included in the staff member's medical file, which must be maintained separately from the staff member's individual personnel file in the center. Child Care Rule 10A NCAC 09 .0701(d)

Emergency Information – Staff

10A NCAC 09 .0701(a)

Child care providers, including the director, uncompensated providers, substitute providers, and volunteers must provide this information on or before the first day of work. Emergency information must be updated as changes occur and at least annually.

Date completed:	
Full name of individual:	
Home address:	
Phone number:	Email:

Person(s) to be contacted in case of an emergency:

Primary contact
Name:
Address:
Phone number:
Secondary contact
Name:
Address:
Phone number:

Choice of health care professional:
Address:
Telephone number:

NOTICE
CHILD CARE PROVIDER MANDATORY CRIMINAL HISTORY CHECK

NORTH CAROLINA LAW REQUIRES THAT A CRIMINAL HISTORY CHECK BE CONDUCTED ON ALL PERSONS WHO PROVIDE CHILD CARE IN A LICENSED OR REGULATED CHILD CARE FACILITY, AND ALL PERSONS PROVIDING CHILD CARE IN NONLICENSED CHILD CARE HOMES, OR FACILITIES THAT RECEIVE STATE OR FEDERAL FUNDS.

"Criminal history" means a county, state, or federal criminal history of conviction, pending indictment of a crime, or criminal charge, whether a misdemeanor or a felony, that bears on an individual's fitness to have responsibility for the safety and well-being of children. Such crimes include, but are not limited to, the following North Carolina crimes contained in any of the following Articles of Chapter 14 of the General Statutes: Article 6, Homicide; Article 7A, Rape and Kindred Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary; Article 16, Larceny; Article 17, Robbery; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19C, Identity Theft; Article 26, Offenses Against Public Morality and Decency; Article 27, Prostitution; Article 29, Bribery; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; and Article 59, Public Intoxication. Such crimes also include cruelty to animals in violation of Article 3 of Chapter 19A of the General Statutes, violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. In addition to the North Carolina crimes listed in this notice, such crimes also include similar crimes under federal law or under the laws of other states. Your fingerprints will be used to check the criminal history records of the State Bureau of Investigation (SBI) and the Federal Bureau of Investigation (FBI).

If it is determined, based on your criminal history, that you are unfit to have responsibility for the safety and well-being of children, you shall have the opportunity to complete, or challenge the accuracy of, the information contained in the SBI or FBI identification records.

If you disagree with the determination of the North Carolina Department of Health and Human Services on your fitness to provide child care, you may file a civil lawsuit within 60 days after receiving written notification of disqualification in the district court in the county where you live.

Any child care provider who intentionally falsifies any information required to be furnished to conduct the criminal history record check shall be guilty of a Class 2 misdemeanor.

Signature	Printed Name	Date

Maintain Copy with Qualification Letter

FINGERPRINT SUBMISSION RELEASE OF INFORMATION

I authorize the submission or transmission of my fingerprints to the State Bureau of Investigation (SBI). I authorize the North Carolina Department of Public Safety through the State Bureau of Investigation to perform a national criminal history record check in connection with my fitness to be a child care provider/employee, or other household member of a child care program regulated by the Department of Health and Human Services, Division of Child Development and Early Education pursuant to N.C.G.S. §§NCGS 114-19.5, 110-90.1 to 110-91.

I understand that the North Carolina State Bureau of Investigation, Criminal Information and Identification Section, the Federal Bureau of Investigation, and its officials and employees shall not be held legally accountable in any way for providing this information to the above named agency, and I hereby release said agency and persons from any and all liability which may be incurred as a result of furnishing such information.

Applicant's Name: _____ DOB: _____
(Please print name clearly – as it appears on your photo Identification Card you will present to Agent)

Date: _____ Applicant's Signature: _____

Parent/Legal Guardian's Signature *(if applicant is under age 18)* _____

Please check appropriate box for type of submission:

☐ **ELECTRONIC SUBMISSION**
The Division of Child Development & Early Education (DCDEE) authorizes the above named subject to be fingerprinted and have the fingerprints submitted to the SBI electronically.

Law Enforcement Agent
I certify that I have taken the fingerprints of the above named subject and forwarded them electronically to the SBI/Criminal Information and Identification Section.

Date: _____ Signature of Official Taking Fingerprints: _____

☐ **MANUAL submission** *(Prints Were Not Transmitted Electronically)*
Card must be mailed to DCDEE by applicant*

The completed fingerprint card is attached. _____ (initials of Law Enforcement Agent)

This completed form is to be mailed **with other CBC items to:**
DCDEE CBC, 2201 Mail Service Center, Raleigh, NC 27699.
*Include manual card if received from LEA. Do **NOT** send this form to the SBI.
THE NAME ON YOUR FINGERPRINT CARD MUST MATCH WITH THE OTHER ITEMS SUBMITTED TO THE DIVISION.

☐ By checking this box, I understand my rights to complete or challenge the accuracy of the information contained in the FBI identification record. The procedure for obtaining a change, correction, or updating an FBI identification record are set forth in Title 28, CFR, 16.34.

APPLICANT INFORMATION for CHILD CARE

Please print name as shown on photo Identification Card you will take to Law Enforcement Agency.

Name: Last: _____ ***Date of Birth:*** _____

First: _____ ***Place of Birth:*** _____

Middle: _____ ***Residence:*** _____

Maiden Name: _____ _____

Aliases: _____

_____

Employer and Address:
DOCD
2201 Mail Service Center
Raleigh, NC 27699

Sex: Male___Female_____

Race: _____
(Write the appropriate letter in the space provided)

W =White B =Black I =American Indian

A =Asian or Pacific Islander U =Unknown

Reason Fingerprinted:
State and Federal Check
NC Day Care Provider
NCGS 114-9.5, 110-90.1 to 110.91

Height: _____ ***Social Security Number:*** _____

Weight: _____

Eye Color: _____
(Write the appropriate letters in the space provided)

BLK =Black GRY =Gray MAR =Maroon

BLU =Blue BRO =Brown GRN =Green

HAZ =Hazel PNK =Pink XXX -Unknown

Your Case NO. (OCA): DOCD000000

Type of Transaction: **Non-Federal User Fee**

NCFP Card Type: **Child Care Provider**

Hair Color: _____
(Write the appropriate letters in the space provided)

BAL =Bald BLK =Black BLN =Blond or strawberry

BRO =Brown GRY =Gray or partially

RED =Red or Auburn SDY =Sandy

This form is to be taken to the Law Enforcement Agency when you visit to be fingerprinted.
Do NOT send this form to the SBI.

YOUR NAME MUST MATCH ON ALL FORMS

DOCUMENTATION OF STAFF ORIENTATION
CHILD CARE CENTERS

Name of Employee_____Date of Employment_____

Rule 10A NCAC 09 .1101: Each center shall ensure that each new employee who is expected to have contact with children receives a **minimum of 16 clock hours of on-site orientation within the first six weeks of employment.** As part of this orientation, each new employee shall **complete six clock hours of orientation within the first two weeks of employment as listed in the top section of this chart.** The orientation pursuant to this Rule shall not be counted toward annual on-going training requirements.

Orientation Topics (Within the first 2 weeks of employment)	Date	Hours	Provider
Recognizing, responding to, and reporting child abuse, neglect, or maltreatment pursuant to G.S. 110-105.4 and G.S. 7B-301.			
Review of the center's operational policies, including the center's safe sleep policy for infants, policy for transportation, the center's identification of building and premises safety issues, the Emergency Preparedness and Response Plan, and the emergency medical care plan.			
Adequate supervision of children in accordance with 10A NCAC 09 .1801.			
Information regarding prevention of shaken baby syndrome and abusive head trauma and child maltreatment.			
Prevention and control of infectious diseases, including immunizations.			
Orientation Topics (Within the first 6 weeks of employment)	**Date**	**Hours**	**Provider**
Firsthand observation of the center's daily operations.			
Instruction in the employee's assigned duties.			
Instruction in the maintenance of a safe and healthy environment.			
Instruction in the administration of medication to children in accordance with 10A NCAC 09. 0803.			
Review of the center's purposes and goals.			
Review of G.S.110, Article 7 and 10A NCAC 09 (Child Care Law and Rules)			
An explanation of the role of State and local government agencies in the regulation of child care, their impact on the operation of the center, and their availability as a resource.			
An explanation of the employee's obligation to cooperate with representatives of State and local government agencies during visits and investigations.			
Prevention of and response to emergencies due to food and allergic reactions.			
Review of the center's handling and storage of hazardous materials and the appropriate disposal of biocontaminants.			
Information about criminal history mandatory reporting.			
Information concerning the enhanced standards (Required for staff in programs earning two stars or higher).			
Additional Orientation Topics	**Date**	**Hours**	**Provider**

I attest that orientation was provided on the topics listed above.

Signature of Administrator _____Date _____

I have received orientation in the topics listed above.

Signature of Employee_____Date_____

SAMPLE
FORM

On-Going Training Documentation

Name of Employee_____Date of Employment_____Record for training year beginning_____

Training Hours Required_____Training Hours Brought Forward _____

Training Date	Number of Training Hours Received	Topic	Instructor	Sponsor

(attach documentation of attendance, agendas, etc. for each training event)

Acknowledgement of Policies

Please initial acknowledging you are aware of the policies listed below.

_____ The Emergency Medical Care Plan is located in each classroom and the kitchen. It explains who is to make various decisions in case of an emergency.

_____ Emergency Preparedness & Response (EPR) Plan There are two (2) of these notebooks. One is located on the information table and the other is in the financial office. Both books are available for viewing. The EPR explains what is to occur in a natural disaster and how we should respond.

_____ Operational & Personnel Policies
This document is available at www.futureleadersacademycharlotte.com/staff/handbook.pdf

_____ _____

Signature Date

Lead Teacher

Position Description

Please note: This job description has not been adopted by the State Board of Education. It is a general description created using guidelines established by the owner of Future Leaders Academy. Future Leaders Academy can and often do modify the job descriptions to meet their individual needs

Role

A lead teacher typically works in a preschool, often with an assistant teacher to share duties. These professionals instruct students in concepts like the alphabet, colors, and shapes, often through play or encouraging imaginative thinking. Preschool education involves language, motor, and social skills, so lead teachers often work those into their curriculum alongside the alphabet and other concepts.

Aside from instructing, lead teachers are also responsible for maintaining the state of the classroom, planning lessons around a curriculum, and keeping progress reports and other information for parents and the school. Lead teachers train assistant teachers, who may go on to be lead teachers themselves. Some schools will require a lead teacher to oversee multiple classrooms. Because teachers in a preschool setting spend so much time around children, many are also well versed in responding to children's needs and recognizing behavioral or emotional problems, which are reported to parents.

Essential Job Functions

1. ***Professional Development:***
    a. Training early Associate and Professional Teachers, other Lead Teachers and Mentor Teachers
    b. Observing and providing peer assistance for colleagues.
    c. Leading early Associate and Professional Teachers.
    d. Participating in professional development activities.
    e. Participating in a formalized peer review process as a formative evaluator.
    f. Assisting in the coordination of all school based professional development opportunities linked to individual professional development plans and job competencies.
    g. Assisting in the coordination of the program for preservice teachers by communicating with Human Resources Department and college/university personnel.
2. ***Curriculum:***
    a. Collaborating with colleagues to construct benchmark lessons.
    b. Serving as the official liaison between the school site and the Department of Curriculum and Instructional Services.
    c. Assisting with identifying the curriculum needs of the faculty.
    d. Planning and managing the development of standards-based curriculum, instruction, and assessment plans and strategies.
    e. Assisting in the adoption of curriculum resources that are consistent with the district's curriculum. Overseeing the textbook ordering and inventory for the school site.

f. Ensuring that all textbooks are used effectively as a resource to meet curriculum goals g. Updating themes/units and supervising theme/unit writing.
g. Ensuring that all substitutes have lesson plans.
h. Coordinating communication and planning among all learning communities.

Education and Experience

- All child care center lead teachers must have earned the North Carolina Early Childhood Credential (NCECC) or its equivalent. Individuals must enroll within six months of being hired and will have 18 months from their date of hire to satisfy the NCECC or equivalency requirements.
- All individuals requesting to be assessed for lead teacher status must submit an education and equivalency form and original transcripts, if applicable. See Guidelines to Education Evaluations for full instructions to the application process located on the ncchildcare.nc.gov website.
- Professional development in the area(s) of:
    a. communication and conferencing skills
    b. leadership development
    c. classroom management
    d. standards-based curriculum development
    e. peer observation, coaching, mentoring, and conferencing skills
    f. student and parent conferencing skills
    g. knowledge of subject matter
    h. planning for instruction
    i. delivery of instruction
    j. assessment of student performance
    k. grant writing
- In-field certification

Lead Teacher

Position Description

Employment Standards

- Ability to establish and maintain effective relationships with adults and students
- Communicate effectively orally and in writing
- Work independently exercising sound judgment and initiative in implementing tasks and recognizing problems
- Ability to lead and utilize motivational techniques and strategies in the development curriculum and assessment
- Develop, coordinate, promote and evaluate curriculum
- Ability to meet physical requirements necessary to safely and effectively perform required duties
- Ability to get along with co-workers and deal with the general public tactfully, courteously and professionally

Physical Functions

- Sit and stand for extended periods of time
- Must be able to bend and stoop to interact on child's level. Must be able to play and communicate with children (run, jump, demonstrate physical exercise)
- Accurate perceiving of sound, near and far vision, and depth perception
- Reach in all directions
- Ability to lift 50 lbs. maximum or carry any object weighing up to 15 lbs.
- Bend, twist, kneel and stoop
- Write legible reports
- Read notes, memos and printed material
- Speak clearly and communicate effectively
- Ability to physically respond quickly in an emergency
- Understand the risk of exposure to blood and bodily fluids and use universal precautions in such instances
- Ability to travel to various locations for field trips or outings. On these occasions, public transportation or other acceptable modes of transportation may be employed
- Valid North Carolina driver's license and clean driving record for past three (3) years

Signature: _____ Date: _____

Prevention of Shaken Baby Syndrome and Abusive Head Trauma
SAMPLE Policy

Belief Statement

We, _____ (name of facility), believe that preventing, recognizing, responding to, and reporting shaken baby syndrome and abusive head trauma (SBS/AHT) is an important function of keeping children safe, protecting their healthy development, providing quality child care, and educating families.

Background

SBS/AHT is the name given to a form of physical child abuse that occurs when an infant or small child is violently shaken and/or there is trauma to the head. Shaking may last only a few seconds but can result in severe injury or even death[1]. According to North Carolina Child Care Rule (child care centers, 10A NCAC 09 .0608, family child care homes, 10A NCAC 09 .1726), each child care facility licensed to care for children up to five years of age shall develop and adopt a policy to prevent SBS/AHT[2].

Procedure/Practice

Recognizing:

- Children are observed for signs of abusive head trauma including irritability and/or high pitched crying, difficulty staying awake/lethargy or loss of consciousness, difficulty breathing, inability to lift the head, seizures, lack of appetite, vomiting, bruises, poor feeding/sucking, no smiling or vocalization, inability of the eyes to track and/or decreased muscle tone. Bruises may be found on the upper arms, rib cage, or head resulting from gripping or from hitting the head.

Responding to:

- If SBS/ABT is suspected, staff will[3]:
  - Call 911 immediately upon suspecting SBS/AHT and inform the director.
  - Call the parents/guardians.
  - If the child has stopped breathing, trained staff will begin pediatric CPR[4].

Reporting:

- Instances of suspected child maltreatment in child care are reported to Division of Child Development and Early Education (DCDEE) by calling 1-800-859-0829 or by emailing webmasterdcd@dhhs.nc.gov.
- Instances of suspected child maltreatment in the home are reported to the county Department of Social Services. Phone number: _____

Prevention strategies to assist staff* in coping with a crying, fussing, or distraught child

Staff first determine if the child has any physical needs such as being hungry, tired, sick, or in need of a diaper change. If no physical need is identified, staff will attempt one or more of the following strategies[5]:

- Rock the child, hold the child close, or walk with the child.
- Stand up, hold the child close, and repeatedly bend knees.
- Sing or talk to the child in a soothing voice.
- Gently rub or stroke the child's back, chest, or tummy.
- Offer a pacifier or try to distract the child with a rattle or toy.
- Take the child for a ride in a stroller.
- Turn on music or white noise.
- Other _____
- Other _____

In addition, the facility:

- Allows for staff who feel they may lose control to have a short, but relatively immediate break away from the children[6].
- Provides support when parents/guardians are trying to calm a crying child and encourage parents to take a calming break if needed.
- Other _____

Prevention of Shaken Baby Syndrome and Abusive Head Trauma
SAMPLE Policy

Prohibited behaviors
Behaviors that are prohibited include (but are not limited to):

- shaking or jerking a child
- tossing a child into the air or into a crib, chair, or car seat
- pushing a child into walls, doors, or furniture

Strategies to assist staff members understand how to care for infants
Staff reviews and discusses:

- The five goals and developmental indicators in the 2013 North Carolina Foundations for Early Learning and Development, ncchildcare.nc.gov/PDF_forms/NC_Foundations.pdf
- How to Care for Infants and Toddlers in Groups, the National Center for Infants, Toddlers and Families, www.zerotothree.org/resources/77-how-to-care-for-infants-and-toddlers-in-groups
- Including Relationship-Based Care Practices in Infant-Toddler Care: Implications for Practice and Policy, the Network of Infant/Toddler Researchers, pages 7-9, www.acf.hhs.gov/sites/default/files/opre/nitr_inquire_may_2016_070616_b508compliant.pdf

Strategies to ensure staff members understand the brain development of children up to five years of age
All staff take training on SBS/AHT within first two weeks of employment. Training includes recognizing, responding to, and reporting child abuse, neglect, or maltreatment as well as the brain development of children up to five years of age. Staff review and discuss:

- Brain Development from Birth video, the National Center for Infants, Toddlers and Families, www.zerotothree.org/resources/156-brain-wonders-nurturing-healthy-brain-development-from-birth
- The Science of Early Childhood Development, Center on the Developing Child, developingchild.harvard.edu/resources/inbrief-science-of-ecd/

Resources
List resources such as a staff person designated to provide support or a local county/community resource:

_____

_____

Parent web resources

- The American Academy of Pediatrics: www.healthychildren.org/English/safety-prevention/at-home/Pages/Abusive-Head-Trauma-Shaken-Baby-Syndrome.aspx
- The National Center on Shaken Baby Syndrome: http://dontshake.org/family-resources
- The Period of Purple Crying: http://purplecrying.info/
- Other _____

Facility web resources

- Caring for Our Children, Standard 3.4.4.3 Preventing and Identifying Shaken Baby Syndrome/Abusive Head Trauma, http://cfoc.nrckids.org/StandardView.cfm?StdNum=3.4.4.3&=+
- Preventing Shaken Baby Syndrome, the Centers for Disease Control and Prevention, http://centerforchildwelfare.fmhi.usf.edu/kb/trprev/Preventing_SBS_508-a.pdf
- Early Development & Well-Being, Zero to Three, www.zerotothree.org/early-development
- Other _____

Prevention of Shaken Baby Syndrome and Abusive Head Trauma
SAMPLE Policy

References

1. The National Center on Shaken Baby Syndrome, www.dontshake.org
2. NC DCDEE, ncchildcare.dhhs.state.nc.us/general/mb_ccrulespublic.asp
3. Shaken baby syndrome, the Mayo Clinic, www.mayoclinic.org/diseases-conditions/shaken-baby-syndrome/basics/symptoms/con-20034461
4. Pediatric First Aid/CPR/AED, American Red Cross, www.redcross.org/images/MEDIA_CustomProductCatalog/m4240175_Pediatric_ready_reference.pdf
5. Calming Techniques for a Crying Baby, Children's Hospital Colorado, www.childrenscolorado.org/conditions-and-advice/calm-a-crying-baby/calming-techniques
6. Caring for Our Children, Standard 1.7.0.5: Stress http://cfoc.nrckids.org/StandardView/1.7.0.5

Application

This policy applies to children up to five years of age and their families, operators, early educators, substitute providers, and uncompensated providers.

Communication

Staff*

- Within 30 days of adopting this policy, the child care facility shall review the policy with all staff who provide care for children up to five years of age.
- All current staff members and newly hired staff will be trained in SBS/AHT before providing care for children up to five years of age.
- Staff will sign an acknowledgement form that includes the individual's name, the date the center's policy was given and explained to the individual, the individual's signature, and the date the individual signed the acknowledgment
- The child care facility shall keep the **SBS/AHT staff acknowledgement form** in the staff member's file.

Parents/Guardians

- Within 30 days of adopting this policy, the child care facility shall review the policy with parents/guardians of currently enrolled children up to five years of age.
- A copy of the policy will be given and explained to the parents/guardians of newly enrolled children up to five years of age on or before the first day the child receives care at the facility.
- Parents/guardians will sign an acknowledgement form that includes the child's name, date the child first attended the facility, date the operator's policy was given and explained to the parent, parent's name, parent's signature, and the date the parent signed the acknowledgement
- The child care facility shall keep the **SBS/AHT parent acknowledgement form** in the child's file.

* For purposes of this policy, "staff" includes the operator and other administration staff who may be counted in ratio, additional caregivers, substitute providers, and uncompensated providers.

Effective Date

This policy was reviewed and approved by:

Owner/Director (recommended) **Date**

DCDEE Child Care Consultant (recommended) **Date** **Child Care Health Consultant (recommended)** **Date**

Annual Review Dates

Prevention of Shaken Baby Syndrome and Abusive Head Trauma
SAMPLE Policy

Staff acknowledgement form:

I _____ (name) acknowledge that I have read and received a copy of the facility's Shaken Baby Syndrome/Abusive Head Trauma Policy.

_____
Date policy given/explained to staff person

_____ _____
Staff signature **Date**

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

► **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
► **Give Form W-4 to your employer.**
► **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		► **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly** (or Qualifying widow(er))
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the online estimator, and privacy.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ► ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependents

If your income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 ► $ _____

Multiply the number of other dependents by $500 . . . . . ► $ _____

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.

► _____ **Employee's signature** (This form is not valid unless you sign it.) ► _____ **Date**

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $ _____

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $ _____

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $ _____

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $ _____

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . 3 _____

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . 4 $ _____

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 10% of your income . . . . . 1 $ _____

2 Enter:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . . 2 $ _____

3 If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-" . . 3 $ _____

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information . . . 4 $ _____

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $ _____

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

PAYCHEX

Direct Deposit Enrollment/Change Form*

Company Name and/or Client Number _____

Employee/Worker Name_____ **Employee/Worker Number** _____

EMPLOYEE/WORKER: Retain a copy of this form for your records. Return the original to your employer/company.

EMPLOYER/COMPANY: Return this form to your local Paychex office. For clients using on-line services, please retain a copy of this document for your records.

COMPLETE TO ENROLL / ADD / CHANGE BANK ACCOUNTS - *PLEASE PRINT CLEARLY IN BLACK/BLUE INK ONLY*

Type of Account ☐ Checking ☐ Savings | Accountholder's Name: _____

Routing/Transit Number ☐☐☐☐☐☐☐☐☐

Checking/Savings Account Number** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Financial Institution ("Bank") Name _____

I wish to deposit (check one): ☐ _____% of Net ☐ Specific Dollar Amount $ _____.00 ☐ Remainder of Net Pay

Type of Account: ☐ Checking ☐ Savings | Accountholder's Name: _____

Routing/Transit Number ☐☐☐☐☐☐☐☐☐

Checking/Savings Account Number** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Financial Institution ("Bank") Name _____

I wish to deposit (check one): ☐ _____% of Net ☐ Specific Dollar Amount $ _____.00 ☐ Remainder of Net Pay

COMPLETE IF CHANGING EXISTING DEPOSIT AMOUNTS – *PLEASE PRINT CLEARLY IN BLACK/BLUE INK ONLY*

Type of Account ☐ Checking ☐ Savings | Accountholder's Name: _____

Routing/Transit Number ☐☐☐☐☐☐☐☐☐

Checking/Savings Account Number** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Financial Institution ("Bank") Name _____

I wish to change my deposit amount to (check one): ☐ From _____% to____% of Net ☐ From $_____.00 To $_____.00
☐ Remainder of Net Pay

EMPLOYEE/WORKER CONFIRMATION STATEMENT

PLEASE SIGN IN BLACK/BLUE INK ONLY

I authorize my employer/company to deposit my earnings into the bank account(s) specified above and, if necessary, to electronically debit my account to correct erroneous entries. I certify my account(s) allow these transactions. Furthermore, I certify that the above listed account number accurately reflects my intended receiving account. I agree that direct deposit transactions I authorize comply with all applicable laws. My signature below indicates that I am agreeing that I am either the accountholder or have the authority of the accountholder to authorize my employer/company to make direct deposits into the named account.

Employee/Worker Signature _____ **Date** _____

Note: Digital or Electronic Signatures are **not** acceptable.

I confirm that the above named employee/worker has added or changed a bank account for direct deposit transactions processed by Paychex, Inc. I have reviewed the information provided and it is accurate to the best of my knowledge. My signature below indicates that I have the authority to execute this document on behalf of the Client.

Employer/Company Representative Printed Name: _____

Employer/Company Representative Signature: _____ **Date:** _____

*** All fields are required except Employee/Worker Number.**

**** Certain accounts may have restrictions on deposits and withdrawals. Check with your bank for more information specific to your account.**

Teacher Profile (For Website Use)

1. Name
2. DOB (month & day)
3. Your position?
4. Where are you from?
5. Credentials held
6. How many years of experience do you have in childcare/education?
7. What college/university did you attend?
8. How long have you worked for FLA?
9. What's your favorite thing about coming to work at FLA?
10. What's your favorite color?
11. What's your favorite vacation place?

Center Sanitation/Cleanliness Policy

Classrooms

All teachers must take part in keeping rooms clean. Below are some of the items that need to be done on a daily basis unless otherwise noted. There may be other items requested of you or posted in your rooms that will need to be done as well.

- Floors need to be swept and mopped
- Trash taken out to dumpster. New trash bags must be placed in can.
- Sanitizer & Disinfectant bottles should be emptied & placed in kitchen at the end of the day for daily preparation.
- Soapy water bottles should be placed in kitchen as needed for preparation. Every Friday, bottles must be emptied & placed in kitchen for Monday preparation
- Rooms must be tidied at the end of each day. Toys should be placed in their respective bins/shelves. Tables cleaned and sanitized. Chairs should be wiped down, etc.
- Anything that must be laundered should be placed in a green mesh bag and placed in front area on Fridays.

Kitchen

- Cook will ensure floors are swept and mopped daily
- Spills are cleaned up immediately
- Refrigerator, freezer, stove, countertops & cabinets are wiped down daily
- Open but unused items, expired items, etc., should be cleaned out of refrigerator, freezer and pantry every Friday.
- Pantry closet is as organized as possible

Common areas

Common areas will take team effort to keep clean. Below are assignments for those areas:

- Adult bathroom: Staff working in Senators & Congressmen rooms are responsible for cleaning the adult restroom. Suggested schedule: Weeks 1 & 3 – Senators clean M/W/F; Congressmen clean T/TH. Weeks 2 & 4 – Senators clean T/Th; Congressmen clean M/W/F.
- Front Childrens' Bathroom: Staff members assigned to the Governors & Vice Presidents Room. Typically there are 2 staff members assigned to this room and they may want to alternate based on suggested schedule above.
- Back Childrens' Bathroom: Staff members assigned to the Presidents & Afterschool/Summer Camp Room. Again, staff members may want to utilize suggested schedule above.
- Administrative Staff will maintain offices, entry area, and areas not frequently used

There are task lists posted in every room as well. These items should be done daily and as needed where applicable.

When classes have finished on the playground, teacher should ensure any trash has been picked up.

If cleaning supplies are getting low, please let a member of the administrative staff know PRIOR to it running out.

Staff Signature:_____ Date:_____

North Carolina Division of Child Development and Early Education
Criminal Background Check Change of Information Form

This form is to be completed by the Owner/Administrator and submitted to the Criminal Background Check Unit when you hire a new employee and/or a household member moves into your home.

Child Care Centers: Complete this form when you hire a new employee.

Centers in a Residence and Family Child Care Homes: Complete this form when you hire a new employee or a new household member moves into your home. IF YOU HAVE MADE APPLICATION IN THE CBC PORTAL, PLEASE ENTER YOUR FACILITY INFORMATION IN THE PORTAL.

Please print or type.

Required Fields (Complete all fields in this section)	**SSN (Last 4 Digits Only):**	**Email Address:**		
Date of Birth (mm/dd/yy): / /	**Current Legal Name (First, Middle Initial, Last):**			
Current Home Mailing Address:		**City:**	**State:**	**Zip Code:**
Telephone #: ( )	**County of Residence:**			

Facility Information (Complete all fields in this section)		**Date Employed at this Facility:** / /	
Name of Current Facility:	**Facility ID # (on license):**	**Facility Telephone #:** ( )	
Address of Current Facility:	**City:**	**State:**	**Zip Code:**

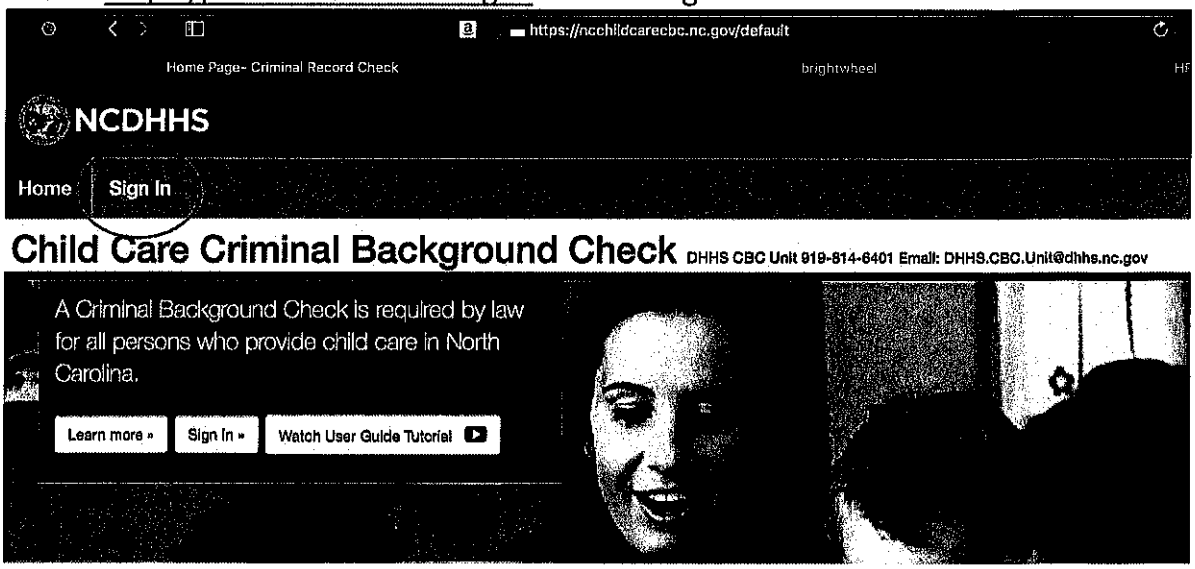
Comments:

Mail to: NC DCDEE
Attn: Criminal Background Check Unit
2201 Mail Service Center
Raleigh, NC 27699-2201

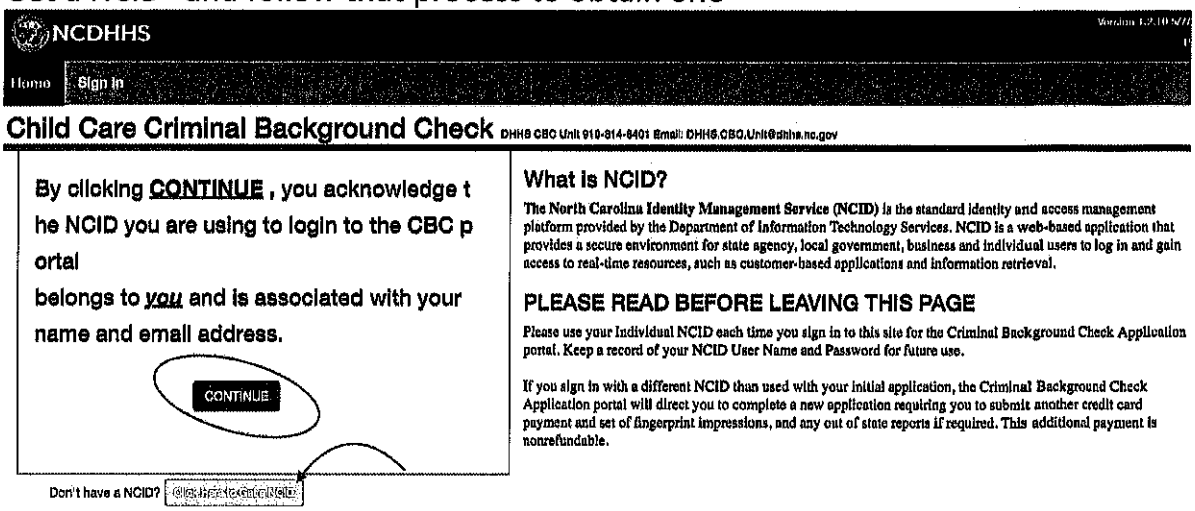
Questions: Criminal Background Check Unit
919-814-6401
DCDEE: 1-800-859-0829

Website: https://ncchildcare.ncdhhs.gov/

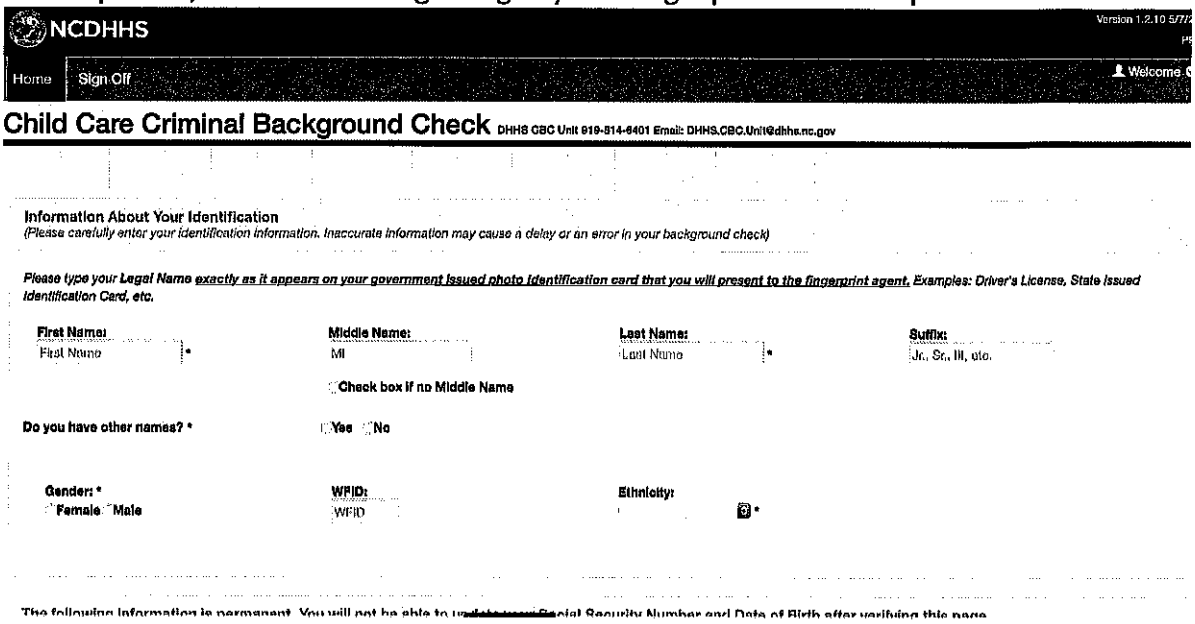
1. Go to: https://ncchildcarecbc.nc.gov & click "Sign In"



2. If you already have an NCID, select "Continue". If not select "Click Here to Get a NCID" and follow that process to obtain one



3. Follow the prompts for your information & pay the fee. Once that process is completed, You'll need to go to get your fingerprints down uptown



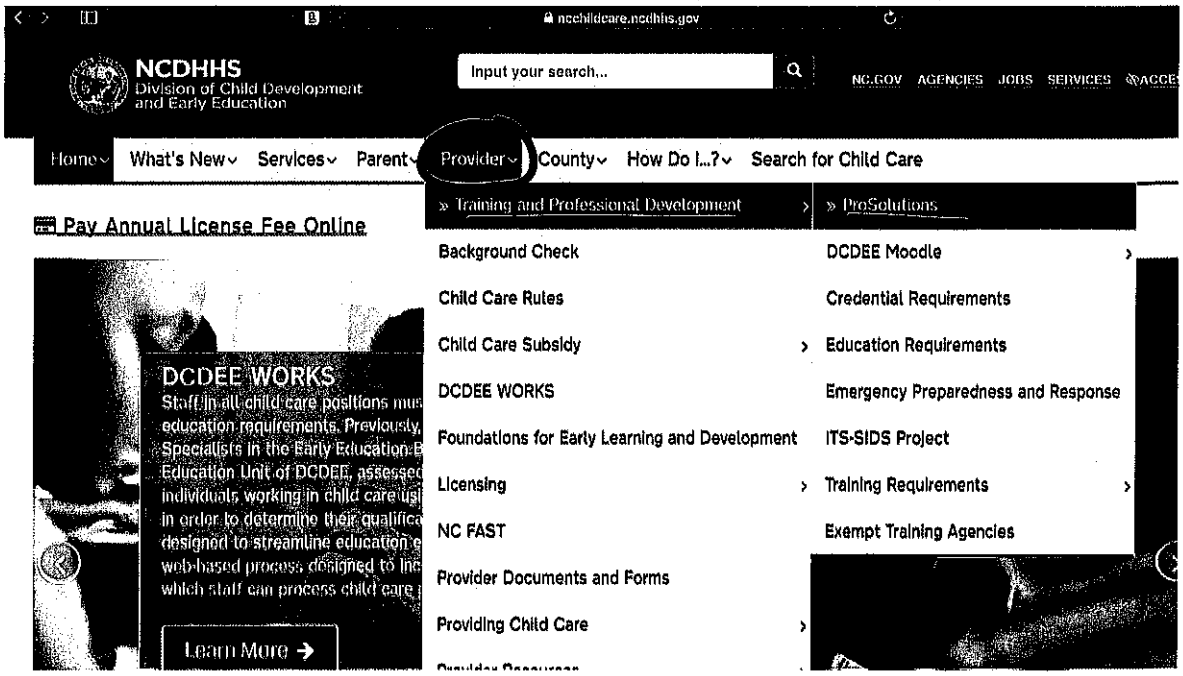
4. Mecklenburg Sheriff's office info
   Information Line: 704-336-8100
   Mailing Address: 700 E. 4th St. Charlotte, NC 28202
   Office Hours: Monday - Friday 8 a.m. - 5 p.m.
   Hours of Operation: 24 hours, 7 days/wk
   http://www.mecksheriff.com/fingerprinting.asp

Pro-Solutions Registration

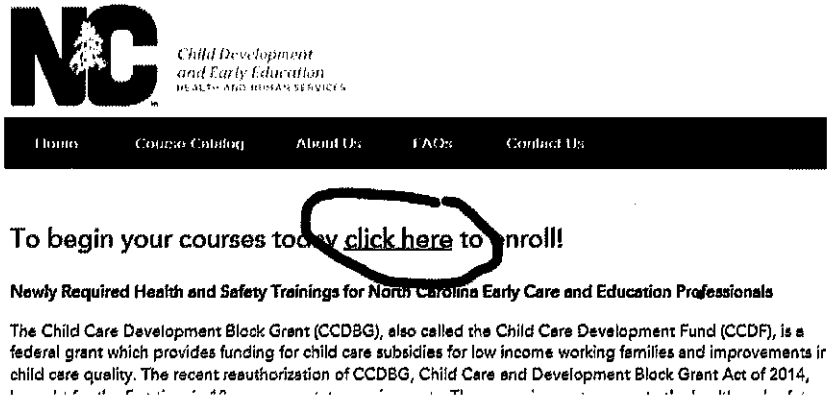
1. Go to www.ncchildcare.nc.gov. Hover over "Providers"

2. Hover over "Training and Professional Development" from the sub-menu

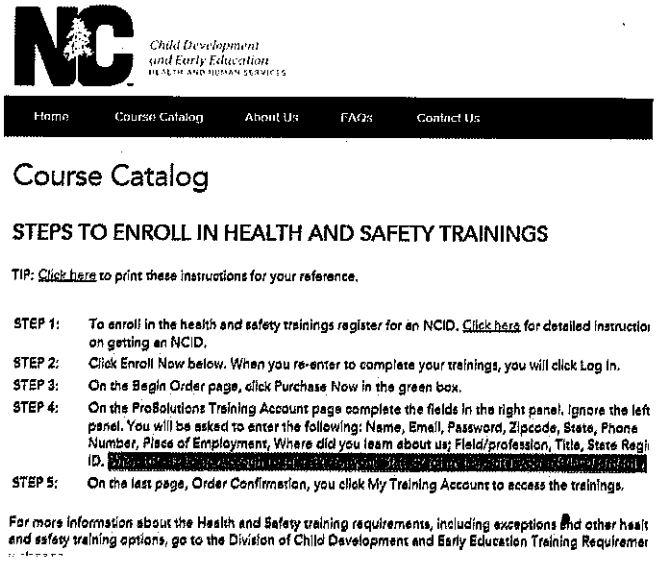
3. Select "ProSolutions"



4. You should be taken to the ProSolutions website. Select "click here" where it says "To begin your courses today click here to enroll"



5. Follow the steps to enroll in Health and Safety Trainings. Or select "Log In" under "Already Enrolled?"



Child Development and Early Education
HEALTH AND HUMAN SERVICES

Home | Course Catalog | About Us | FAQs | Contact Us

Course Catalog

STEPS TO ENROLL IN HEALTH AND SAFETY TRAININGS

TIP: Click here to print these instructions for your reference.

STEP 1: To enroll in the health and safety trainings register for an NCID. Click here for detailed instructio on getting an NCID.

STEP 2: Click Enroll Now below. When you re-enter to complete your trainings, you will click Log In.

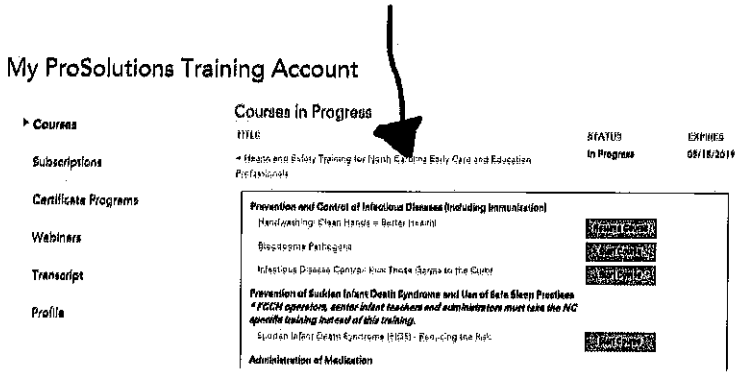
STEP 3: On the Begin Order page, click Purchase Now in the green box.

STEP 4: On the ProSolutions Training Account page complete the fields in the right panel. Ignore the left panel. You will be asked to enter the following: Name, Email, Password, Zipcode, State, Phone Number, Place of Employment, Where did you learn about us; Field/profession, Title, State Regi ID.

STEP 5: On the last page, Order Confirmation, you click My Training Account to access the trainings.

For more information about the Health and Safety training requirements, including exceptions and other healt and safety training options, go to the Division of Child Development and Early Education Training Requireme

6. Once enrolled, you should see the list of courses in your account



My ProSolutions Training Account

- Courses
- Subscriptions
- Certificate Programs
- Webinars
- Transcript
- Profile

Courses in Progress

TITLE	STATUS	EXPIRES
Health and Safety Training for North Carolina Early Care and Education Professionals	In Progress	08/15/2019

Prevention and Control of Infectious Diseases (Including Immunization)
Handwashing: Clean Hands = Better Health
Bloodborne Pathogens
Infectious Disease Control: Knock Those Germs to the Curb

Prevention of Sudden Infant Death Syndrome and Use of Safe Sleep Practices
* FCCH operators, center infant teachers and administrators must take the NC specific training instead of this training.
Sudden Infant Death Syndrome (SIDS) - Reducing the Risk

Administration of Medication