BON SECOURS CHARITY HEALTH SYSTEM
A member of the
Westchester Medical Center Health Network

Cover Sheet for Medical Staff Clinical Rotations

This form is designed to assist in expediting the clinical placement of medical staff, clinical rotation students. In accordance with Bon Secours Charity Health System's policies, we are asking that the faculty/student submits all requested documentation in one complete packet.

Name of Student: _____ Date:_____

Student Email: _____ Phone:_____

Preceptor/Department: _____Rotation Start Date: _____

School/Educational Institution: _____

School Contact/Coordinator: _____Email:_____

Last four digits Social Security Number: _____ Sizing for scrubs (unisex): _____

I have reviewed the following information:

☐ Code of Conduct_____ (Initials) ☐ Catholic and Religious Directives_____ (Initials) ☐ Orientation Verification Attestation_____ (Initials)

I have attached the following documentation:

☐ Request for Observations, Internship or Clinical Rotation Privileges Form

☐ Confidentiality Agreement

☐ Health Assessment and physical examination report

☐ EMR / IT Security Access Form

☐ Code of Conduct for Custodians of People with Special Needs

☐ PPD Results (within one year) If PPD positive, a chest x-ray report must be included within the past 2 years.

☐ Rubella Titre

☐ Rubeola (Measles) Titre, if born after 1/1/1957

☐ Flu Vaccine for current season.

Submit this Cover Sheet with ALL required paperwork via Email

A representative from Bon Secours Charity Health System will contact the student for an in-person meeting prior to start of their Rotation. EMR (ConnectCare) training will also be required.

Submit all forms to:

Good Samaritan Hospital
Medical Student Education Coordinator
Charity_MedStudent@wmchealth.org
845.368.5585 (office) 845.368-5938 (fax)

Medical Staff Services
Bon Secours Community Hospital • Good Samaritan Hospital
St. Anthony Community Hospital

BON SECOURS CHARITY HEALTH SYSTEM
A member of the
Westchester Medical Center Health Network

Request for Observation or Clinical Rotation Privileges

Date: _____

In the interest of furthering my education regarding _____, I

_____ request to ☐ observe or ☐ perform a clinical rotation with _____.

If performing a clinical rotation, please indicate the school name: _____.

** A current executed agreement with Bon Secours Charity Health System, WMC Health Network must be on file.*

Requested time period from: _____/_____/_____ to _____/_____/_____.

Specialty: _____

The following terms and conditions of my hospital experience and status apply:

1. Observers – Absolutely **no hands-on patient care is to be provided by me at any time**.
2. Patients under the care of the physician are to be notified of my status.
3. Patient confidentiality must be maintained at all times as stipulated by the rules and regulations established by the Confidentiality Agreement regarding patient privacy as outlined in Federal Law.
4. I release, discharge and relieve Bon Secours Charity Health System and its' employees from any and all claims whatsoever of any nature arising out of / as a result of his / her participation with Bon Secours Charity Health System and all related activities.

Student attestation:
I agree to the terms as outlined above.

_____ _____
Student Signature Date

_____ _____
Email Mobile Phone

_____ _____
Emergency Contact Name Phone

Licensed Independent Practitioner (LIP), Site Director or Preceptor attestation:
I understand the above named observer / student has been granted permission as set by the terms and conditions described above. I understand that Observers will provide no hands-on patient care at any time.

_____ _____
LIP, Site Director or Preceptor Print Name Date

_____
LIP, Site Director or Preceptor Signature

****

Authorized by:

_____ _____
System Director, Medical Staff Services or Designee, Print Name Date

_____
System Director, Medical Staff Services or Designee, Signature

BON SECOURS CHARITY HEALTH SYSTEM
A member of the
Westchester Medical Center Health Network

Observer/Intern/Student Confidentiality Agreement

This Agreement (the "Agreement") is effective _____ day of _____, 20____,

Between_____facility") and _____ (Observer, Intern, Student),

to participate in clinical learning activities at facility. Observer agrees as follows:

Confidentiality Observer/Intern/Student acknowledges that as a result of the clinical learning activities, Observer/Intern/Student will have access to confidential information of the Facility, including patient health information. Observer/Intern/Student will hold confidential all patients and Facility information obtained as a participant in these activities and will not to disclose any personal, medical, related information, or any other confidential information to third parties, family members, or other Observers/Interns/Students and teachers, except as permitted in this Agreement or as required by law. Observer/Intern/Student is committed to protecting and safeguarding from any oral and written disclosure all confidential patient and Facility information that Observer/Intern/Students comes in contact with. Observer/Intern/Student shall not copy surgery schedules, patient medical records, or other Facility information. Except as permitted or required by this Agreement or by law, Observer/Intern/Student will not use or disclose patient information in a manner that would violate the laws of New York State or the requirements of any federal law, including, for example, the Privacy and Security Standards contained in the Health Insurance Portability and Accountability Act of 1996 (45 CFR §§ l60 through 164). Observer/Intern/Student expressly agrees to comply with state and federal law in all respects, and to implement of all necessary safeguards to prevent such disclosure. Observer/Intern/Student acknowledges that any breach of confidentiality or misuse of information will result in termination of Observer's clinical activities at Facility, as well as the potential termination of the Facility's relationship with Observer's/Intern/Students school or legal action. Unauthorized disclosure may give rise to irreparable injury to the patient or the owner of the confidential information and accordingly, the patient or owner of such information may seek legal remedies against the Observer/Intern/Student.

Compliance with Policies and Rules While participating in clinical activities at Facility, Observer/Intern/Student will abide by all applicable Facility rules, policies, procedures and instructions, whether verbal or written, including the Bon Secours Health System Code of Conduct. Observer/Intern/Student shall review the Facility's Administrative Policy Manual which includes information regarding bloodborne pathogens, hazardous chemicals, TB prevention, fire safety, electrical safety, and emergency preparedness. Observer/Intern/Student will wear appropriate attire, including an identification badge identifying him/her as an Observer/Intern/Student, as requested by Facility.

Release and Professional Liability Insurance Observer/Intern/Student will hold harmless the Facility, its parents, officers, directors, employees, members, and any and all of their affiliates, subsidiaries, employees, agents and insurers (collectively "Facility"), from any and all liability of whatsoever nature and from injuries, sickness or other damages, physical as well as emotional, suffered by Observer/Intern/Student during participation in the clinical activities. Observer/Intern/Student acknowledges that Observer/Intern/Student is covered by Observer's/Intern/Student own (or school's) professional liability insurance coverage and agrees to furnish proof of such coverage to Facility.

Limitation Observer/Intern/Student understands that by signing this Agreement, Observer/Intern/Student is not guaranteed participation in any clinical activities at Facility. Eligibility of participation shall be determined exclusively by Facility, in its sole discretion.

Withdrawal of Observer/Intern/Student Facility may require the Observer/Intern/Student to immediately withdraw from the clinical activities in the event Facility determines, in it sole discretion, that Observer/Intern/Student conduct, demeanor or cooperation is unsatisfactory or that Observer has violated Facility policies or rules, including, but not limited to, breach of confidentiality.

Observer/Intern/Student Status Observer/Intern/Student understands that Observer/Intern/Student is not and will not be considered an employee of Facility or any of its subsidiaries or affiliates by virtue of Observer's/Intern's/Student's participation in the clinical learning activities and shall not as a result of Observer's/Intern's/Student's participation in the clinical activities, be entitled to compensation, remuneration or benefits of any kind.

Observer/Intern/Student Signature:	Date
Facility Representative:	Date

Confidentiality Agreement

The Westchester Medical Center Health Network (WMCHealth) has a legal and ethical responsibility to safeguard the privacy of all patients, residents, and clients and to protect the confidentiality of their personal health information. Additionally, WMCHealth must protect the confidentiality of organizational information that may include, but is not limited to, human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, information systems, and management information from any source or in any form including, without limitation, paper, magnetic or optical media, conversations, electronic, and film. For the purpose of this Agreement, all such information is referred to as "Private" or "Non-Public" Data.

I UNDERSTAND AND HEREBY AGREE THAT:

1. In the course of my employment / association / affiliation with WMCHealth, I may have access to Non-Public Data. I will only access and use WMCHealth Non-Public Data only as necessary to perform my duties as a workforce member, and in accordance with all policies and procedures of WMCHealth.
2. My WMCHealth information technology (IT) account is denoted by identified credentials including my WMCHealth user-ID and password. Such credentials are for my use only; I will not disclose my WMCHealth user-ID and password to anyone.
3. I understand that I am responsible and accountable for all system access, entries made, and information accessed, attributed to my system account, as logged by WMCHealth. Likewise, WMCHealth physical identification and access credentials, such as my facility workforce identification badge, are strictly for my use, and may not be used by or given to any other non-authorized individual for any purpose.
4. Violation of this Agreement may result in disciplinary action, up to and including civil or criminal action, termination of employment / affiliation / association with WMCHealth, and suspension and / or loss of medical staff privileges in accordance with WMCHealth policies.
5. I will not copy, release, sell, lend, alter, or destroy any Non-Public Data except as properly authorized by law or by WMCHealth policy.
6. I will not discuss Non-Public Data so that it can be overheard by unauthorized persons. I will not discuss any information that can be used to identify a patient in a public area even if the patient's name is not used.
7. I will not access or use systems or devices that I am not specifically authorized to access or use, and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.
8. I will not disclose WMCHealth Non-Public Data to any unauthorized individuals. I will verify the authority, credentials, and business need to know of individuals with whom I may share or transmit to WMCHealth Confidential and PHI Data.
9. I have no expectation of privacy when using WMCHealth information systems. WMCHealth has the right to log, access, review, and otherwise use information stored on or passing through its systems, including e-mail.
10. I will not connect to unauthorized networks through WMCHealth systems or devices.
11. I will comply with WMCHealth policies intended to safeguard the privacy of all electronic communications, including the use of encryption protection for all data transmissions containing patients' protected health information (PHI).
12. I will promptly notify my manager and WMCHealth Information Systems of any lost or stolen computing or telecommunications devices issued to me by WMCHealth or lost/stolen devices under my care and supported by WMCHealth for work purposes.
13. I will promptly notify my manager and WMCHealth Information Systems if I know or believe that my WMCHealth system user or facility credentials have been stolen or used by someone other than me, without appropriate authorization.
14. Upon termination of my employment / affiliation / association with WMCHealth, I will immediately return or destroy, as appropriate, any Non-Public Data in my possession.

By signing this document, I acknowledge that I have read this Agreement, and I agree to comply with all the terms and conditions stated above.

My typed name shall serve as my electronic signature.

Signature _____ Date _____

Printed Name _____ Employee No. _____

Entity _____

Department _____

OBSERVER and CLINICAL ROTATION ORIENTATION VERIFICATION

Please review the orientation documents by visiting our non-employee portal at:

Medical Staff Services Orientation and Reorientation:
http://bschs.bonsecours.com/nonemporient

Prepping for the OR*:
https://www.youtube.com/playlist?list=PLcRU-gvOmxE2mwMWkowouBkxGXkLZ8Uis

I have reviewed and understand the following provided to me through the non-employee portal:

_____ Medical Staff Services Orientation Module

_____ Code of Conduct

_____ Ethical and Religious Directives

_____ Sterile Technique

_____ Prepping for the OR – Sterile Technique Training (7 Videos)

Student Attestation:

_____ _____

Student Name – Printed **Student Name - Signature**

_____

Date:

*Surgical Infection Society, Filmed at the University of Alberta

STUDENT AGREEMENT

This Student Agreement (the "**Agreement**") is effective the _____ day of _____, 20___, between _____ ("**Facility**") and _____ ("**Student**"), a student currently enrolled at _____ (the "**School**") to participate in clinical learning activities at Facility. Student agrees as follows:

Confidentiality. Student acknowledges that as a result of the clinical learning activities, Student will have access to confidential information of the Facility, including patient health information. Student will hold confidential all patient and Facility information obtained as a participant in these activities and will not to disclose any personal, medical, related information, or any other confidential information to third parties, family members, or other students and teachers, except as permitted in this Agreement or as required by law. Student is committed to protecting and safeguarding from any oral and written disclosure all confidential patient and Facility information that Student comes in contact with. Student shall not copy surgery schedules, patient medical records, or other Facility information. Except as permitted or required by this Agreement or by law, Student will not use or disclose patient information in a manner that would violate the laws of the State of New York or the requirements of any federal law, including, for example, the Privacy and Security Standards contained in the Health Insurance Portability and Accountability Act of 1996 (45 CFR §§ l60 through 164). Student expressly agrees to comply with state and federal law in all respects, and to implement of all necessary safeguards to prevent such disclosure. Student acknowledges that any breach of confidentiality or misuse of information will result in termination of Student's clinical activities at Facility, as well as the potential termination of the Facility's relationship with Student's school or legal action. Unauthorized disclosure may give rise to irreparable injury to the patient or the owner of the confidential information and accordingly, the patient or owner of such information may seek legal remedies against the Student. Student shall agree to comply with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule") issued under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which govern the use and/or disclosure of individually identifiable health information.

Compliance with Policies and Rules. While participating in clinical activities at Facility, Student will abide by all applicable Facility rules, policies, procedures and instructions, whether verbal or written, including the Bon Secours Health System Code of Conduct. Student shall review the Facility's Administrative Policy Manual which includes information regarding bloodborne pathogens, hazardous chemicals, TB prevention, fire safety, electrical safety, and emergency preparedness. Student will wear appropriate attire, including an identification badge identifying him/her as a student, as requested by Facility.

Release and Professional Liability Insurance. Student will hold harmless the Facility, its parents, officers, directors, employees, members, and any and all of their affiliates, subsidiaries, employees, agents and insurers (collectively "Facility"), from any and all liability of whatsoever nature and from injuries, sickness or other damages, physical as well as emotional, suffered by Student during participation in the clinical activities. Student acknowledges that Student is covered by School's professional liability insurance coverage and agrees to furnish proof of such coverage to Facility.

Limitation. Student understands that by signing this Agreement, Student is not guaranteed participation in any clinical activities at Facility. Eligibility of participation shall be determined exclusively by Facility, in its sole discretion.

Withdrawal of Student. Facility may require the Student to immediately withdraw from the clinical activities in the event Facility determines, in it sole discretion, that Student's conduct, demeanor or cooperation is unsatisfactory or that Student has violated Facility policies or rules, including, but not limited to, breach of confidentiality.

Student Status. Student understands that Student is not and will not be considered an employee of Facility or any of its subsidiaries or affiliates by virtue of Student's participation in the clinical learning activities and shall not as a result of Student's participation in the clinical activities, be entitled to compensation, remuneration or benefits of any kind.

Ownership of Intellectual Property. All reports and other data (including without limitation, written, printed, graphic, video and audio material contained in any computer data base or computer readable form, but excluding

any academic or scholarly publications) (hereinafter "Works of Authorship") developed during the term of this Agreement and while on Facility's premises or using Facility resources or information are the property of the Facility. Works of Authorship created during the term of this Agreement are "Works for Hire", as that term is defined in copyright law. Facility shall own all rights to any inventions, discoveries, new uses, advances on the state of art, protocols, ideas, products or other protectable rights arising from the Student's participation in the clinical learning activities at Facility pursuant to this Agreement (hereinafter "Inventions"). Student shall execute all documents, provide all information, and otherwise take all actions requested by Facility, including, without limitation, assignments of rights, if any, Student may have in such works, to secure for Facility the ownership rights and available legal protections for all Works of Authorship or Inventions.

_____	_____
Student	Facility
Date: _____	Date: _____

CODE OF CONDUCT FOR CUSTODIANS OF PEOPLE WITH SPECIAL NEEDS

Revised January 21, 2016

Introduction

The Code of Conduct, as set forth in the Code of Conduct itself, sets forth a framework intended to assist impacted employees to help people with special needs "live self-directed, meaningful lives in their communities, free from abuse and neglect, and protected from harm," in addition to the specific guidance provided by the agency's policies and training.

Similarly, the Notice to Mandated Reporters contains guidance designed to assist mandated reporters, and is intended to provide a summary of reporting obligations for mandated reporters. It is not intended to supplement or in any way add to the reporting obligations provided by law, rule, or regulation.

As provided by law, rule, or regulation, only custodians who have or will have regular and direct contact with vulnerable persons receiving services or support from facilities or providers covered by the *Justice Center Act* must sign that they have read and understand the Code of Conduct.

The framework provides:

1. **Person-Centered Approach**

   My primary duty is to the people who receive supports and services from this organization. I acknowledge that each person of suitable age must have the opportunity to direct his or her own life, honoring, where consistent with agency policy, their right to assume risk in a safe manner, and recognizing each person's potential for lifelong learning and growth. I understand that my job will require flexibility, creativity and commitment. Whenever consistent with agency policy, I will work to support the individual's preferences and interests.

2. **Physical, Emotional and Personal Well-being**

   I will promote the physical, emotional and personal well-being of any person who receives services and supports from this organization, including their protection from abuse and neglect and reducing their risk of harm to others and themselves.

3. **Respect, Dignity and Choice**

   I will respect the dignity and individuality of any person who receives services and supports from this organization and honor their choices and preferences whenever possible and consistent with agency policy. I will help people receiving supports and services use the opportunities and resources available to all in the community, whenever possible and consistent with agency policy.

4. **Self-Determination**

I will help people receiving supports and services realize their rights and responsibilities, and, as consistent with agency policy, make informed decisions and understand their options related to their physical health and emotional well-being.

5. **Relationships**

I will help people who receive services and supports from this organization maintain or develop healthy relationships with family and friends. I will support them in making informed choices about safely expressing their sexuality and other preferences, whenever possible and consistent with agency policy.

6. **Advocacy**

I will advocate for justice, inclusion and community participation with, or on behalf of, any person who receives services and supports from this organization, as consistent with agency policy. I will promote justice, fairness and equality, and respect their human, civil and legal rights.

7. **Personal Health Information and Confidentiality**

I understand that persons served by my organization have the right to privacy and confidentiality with respect to their personal health information and I will protect this information from unauthorized use or disclosure, except as required or permitted by law, rule, or regulation.

8. **Non-Discrimination**

I will not discriminate against people receiving services and supports or colleagues based on race, religion, national origin, sex, age, sexual orientation, economic condition or disability.

9. **Integrity, Responsibility and Professional Competency**

I will reinforce the values of this organization when it does not compromise the well-being of any person who receives services and supports. I will maintain my skills and competency through continued learning, including all training provided by this organization. I will actively seek advice and guidance of others whenever I am uncertain about an appropriate course of action. I will not misrepresent my professional qualifications or affiliations. I will demonstrate model behavior to all, including persons receiving services and supports.

10. **Reporting Requirement**

As a mandated reporter, I acknowledge my legal obligation under *Social Services Law* § 491, as may be amended from time to time or superseded, to report all allegations of reportable incidents immediately upon discovery to the Justice Center's Vulnerable Persons' Central Register by calling 1-855-373-2122.

_____

CODE OF CONDUCT[1] ACKNOWLEDGMENT FOR CUSTODIANS OF PEOPLE WITH SPECIAL NEEDS

I pledge to prevent abuse, neglect, or harm toward any person with special needs, consistent with agency policy. In addition, to the extent I am required to report abuse, neglect, or harm of any person with special needs by law, rule, or regulation, I agree to abide by the law, rule, or regulation. If I learn of, or witness, any incident of abuse, neglect or harm toward any person with special needs, I will offer immediate assistance, notify emergency personnel, including 9-1-1, and inform the management of this organization, consistent with agency policy.

I acknowledge that I have read and that I understand the Code of Conduct.

_____	_____	_____
Signature	Print Name	Date

Program:

Department:

Facility/Provider Organization:

[1] No aspect of this Code of Conduct is in any way intended to interfere, abridge, or infringe upon the rights provided by the *Taylor Law*.

Observer/Intern/Clinical Rotation
Health Assessment Evaluation

BON SECOURS CHARITY HEALTH SYSTEM
A member of the
Westchester Medical Center Health Network

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

Required Health Documentations:

- PPD Results (within one year), If PPD positive, a Chest X-Ray report must be included
- Rubella Titre
- Rubeola(Measles) Titre, if born after 1/1/57,
- Flu Vaccine administered after November 1st

Do you have a physical, mental, or emotional condition or substance abuse problem that could affect your ability to observe safely?
☐ Yes ☐ No

Do you consider yourself to be in good health? ☐ Yes ☐ No

	Yes	No
Have you ever had a positive PPD (TB skin test)?		
Were you ever placed on medication for having a reaction to the PPD (TB skin test)?		
Have you ever received a BCG vaccine?		

TB AND IMMUNIZATIONS

FOR PPD NEGATIVE REACTORS – Complete the PPD (Mantoux) test information below or submit equivalent form. New York State regulation 405.3 requires PPD (Mantoux) skin test within the last twelve (12) months..

Date administered: _____ Lot #: _____ Left or Right Forearm

Date read: _____ Results: _____mm Induration (Indicate Zero if No Reaction)

Rubella Titer _____
Rubeola(Measles)Titer _____
(if born after 1/1/57)

Signature of Medical Professional (other than yourself):

Signature: _____ Date: _____

Print Name: _____ Office Phone Number:_____

Email:_____

SIGNATURE REQUIRED

I hereby state that the information provided on this form is complete, true and accurate.

Signature: _____ Date: _____

Print Name: _____

Office Use Only – Reviewed By

Signature: _____ Date: _____

Print Name: _____ Employee Health Consult Needed: ☐ Yes ☐ No

Bon Secours Charity Health System

TUBERCULOSIS SCREENING: PPD+ REACTOR QUESTIONNAIRE

CONFIDENTIAL

Name (Print) _____

School: _____

Annual Screening ☐ Post exposure baseline ☐

Post Offer Screening ☐ Post exposure 8-10 wks ☐

During the past 12 months:	YES	NO	IF YES, PLEASE EXPLAIN
Have you been in contact with someone with TB this year?			
If yes, were you wearing a TB mask?			
Has your physician told you that your immune system is weak?			
Have you had a persistent cough this year?			
Have you had a cough lasting greater than 4 weeks?			
Have you had chest pain with the cough?			
Have you had a cough productive of phlegm?			
Have you coughed up blood?			
Has your voice been hoarse most of the year?			
Are you currently a cigarette smoker?			
If not, did you smoke in the past?			
Have you had night sweats?			
Have you had excessive weight loss?			
Have you had a loss of appetite?			
Have you had a persistent fever?			

Student's Signature: _____ Date: _____

Reviewed by: _____ Date: _____

BEHAVIORAL HEALTH
and PSYCHIATRY
ROTATIONS

The following four pages are for Behavioral Health/Psychiatry rotations only.

FOR BEHAVIORAL HEALTH ROTATIONS ONLY

LDSS-3370 (Rev. 03/2019)

Instructions for Completing the Statewide Central Register Database Check Form LDSS-3370

- **ALL** information on the form must be easily read so that data entry and results are accurate. Each SCR Database Check submitted should be reviewed for completeness and legibility by the program/agency liaison. If the form is incomplete or illegible, it will be returned to the agency for corrections.

THE PROPER WAY TO COMPLETE THE FORM:

AGENCY INFORMATION

TOP LINE OF FORM:

- The three-digit agency code must be placed in the top left-hand box, followed by the Resource I.D. (RID) in the next box to the right. (Contact the licensing agency if there are any questions about these.)
- Daycare providers must place their Child Care Facility System (CCFS) Number in the box next to Resource ID (RID), in lieu of Resource ID number. (Contact your licensing agency/Regional Office if you have any questions).
- Clearance Category letter code (see back of Form LDSS-3370) must be placed in the middle box.
- Phone number (with area code) enables the SCR to contact the agency liaison if this becomes necessary.
- The Request ID Box is for SCR use only.

AGENCY ADDRESS AREA:

- **Agency Name:** Please use full name, no abbreviations
- Agency Liaison is the contact person at the inquiring agency. (*The SCR response will be addressed to the liaison.) **The liaison cannot be the applicant or a relative of the applicant.**
- **Agency Address:** Must include street, city

APPLICANT INFORMATION

APPLICANT/HOUSEHOLD MEMBER AREA:

- **ALL** HOUSEHOLD MEMBERS, ADULTS AND CHILDREN, WHETHER RELATED TO THE APPLICANT OR NOT, ARE TO BE LISTED IN THIS AREA OF THE FORM.
- Remember to **write clearly** or **type** all information in order to assist in obtaining an accurate response. Record all names with the last name first, then the first name, and middle name.
- **First line:** Applicant's name. If there is more than one applicant place the additional name(s) on the lines below the maiden name line.
- **Second line:** Any maiden names, previous married names, or aliases by which the applicant is or has been known.
  Use additional lines if there is more than one maiden/married/alias name to be listed.
- **Remaining lines:** Names of all other household members. (Attach an additional page if needed.)
  IF THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK BOX FOR NO OTHER HOUSEHOLD MEMBERS.
- **First column**: indicate the relationship to the applicant of each person listed. *(Spouse, son, daughter, mother, father, friend, etc.)*
- **Sex M/F column:** fill in either M (Male) or F (Female) for every person listed.
- **Date of Birth column:** fill in complete date of birth (mm/dd/yy) for everyone listed on the form.

ADDRESS AREA:

The information required varies depending on the particular category:

- For Adoption, Foster Care and Family and Group Family Day Care (see back of form for categories), provide addresses for the applicant and any household member who is 18 and older. **We need this information for the last 28 years.** Attach supplemental pages if necessary, but **do not use** another **LDSS-3370** form to list this additional information. Be sure to associate address histories with particular individuals *(i.e., indicate which addresses are for which household members).*
- For all other categories, only the applicant's address history is required – **for the last 28 years**.
- Complete addresses are required. Include street name and city/town/village. Also include street number and apartment number. **Post Office Box numbers are not acceptable.** If the applicant has lived abroad, indicate country and dates *(mo/yr)* of residence. If the applicant has spent time in the military, list base names and locations along with dates *(mo/yr)*. **Be sure that there are no periods of time unaccounted for.**
- The top line is for the current address. The previous address should be listed on the second line downward, and so on to the back of the form for the last 28 years. Staple the attached supplemental page to the form if more space is needed, but do not use another copy of the **LDSS-3370** for this additional information.

SIGNATURE AREA:

Signatures required depend upon the particular category:

- For Adoption, Foster Care and Family and Group Family Day Care *(see back of form for category)*, signatures are needed from the applicant and any household member who is 18 or older.
- For all other categories, only the applicant's signature is required.
- All signatures must correspond to the names recorded in the Applicant/Household Member Area-for example; Mary Smith should not sign Mary Ann Smith. Victoria Smith should not sign Vicki.
- Applicants must sign in the boxes marked "Applicant's Signature", household members over 18 who are not applicants must sign in the boxes at the extreme bottom of the page marked "Signature".
- All signatures must be dated *(mm/dd/yy)*. The SCR **will not accept** a form with a signature date more than 6-months old.

If you have questions regarding proper completion of this form, **please call the SCR at 518-474-5297.**

MAIL YOUR COMPLETED LDSS-3370 FORM TO: **STATEWIDE CENTRAL REGISTER**
P.O. BOX 4480
ALBANY, N.Y. 12204-0480

TO ORDER A SUPPLY OF LDSS-3370 FORMS:

Please access the (**OCFS-4627**) *Request for Forms and Publications*, from the Intranet:http://ocfs.state.nyenet/admin/forms/SCR/ Internet: http://ocfs.ny.gov/main/forms/cps/ and mail the completed **OCFS-4627** *Request for Forms and Publications*, to: **THE OFFICE OF CHILDREN AND FAMILY SERVICES, FORMS AND PUBLICATIONS UNIT, 52 WASHINGTON ST. ROOM 134 NORTH, RENSSELAER, NY 12144-2834.**

FOR BEHAVIORAL HEALTH ROTATIONS ONLY

LDSS-3370 (Rev. 03/2019) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STATEWIDE CENTRAL REGISTER DATABASE CHECK

Agency Use Only

SCR USE ONLY
REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE:	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY USE ALPHA CODE:	PHONE NUMBER (Area Code):
				( ) -

PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER:

AGENCY NAME:

AGENCY LIAISON:

STREET ADDRESS

CITY:	STATE:	ZIP CODE:

The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box above are also on the reverse side of this form

FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS/MARRIAGE SECTIONS THAT APPLY. IF NONE, STATE "NONE" *List RELATIONSHIP in the fields below*

(see reverse side for instructions) Attach additional page if necessary

The purpose of collecting the demographic data on *other persons in your household* who are not screened pursuant to Section 424-a of the Social Services Law is to enable the N.Y.S. Office of Children and Family Services to identify with the greatest degree of certainty whether the person(s) being screened is the subject of an indicated child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA

*PLEASE TYPE OR PRINT CLEARLY

☐ **IF THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK THIS BOX.**

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH
APPLICANT				
APPLICANT MAIDEN/ALIAS/MARRIED NAME				

Please provide your current address and any other addresses at which you have resided for the last 28 years, including street, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 of age and older.

	APT #	CITY	STATE	ZIP	FROM (Mo/Yr)	TO (Mo/Yr)
CURRENT STREET ADDRESS					/	/
PREVIOUS STREET ADDRESS					/	/
PREVIOUS STREET ADDRESS					/	/
PREVIOUS STREET ADDRESS					/	/
PREVIOUS STREET ADDRESS					/	/

I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE	DATE / /

APPLICANT'S SIGNATURE	DATE / /

EIGHTEEN YEARS OLD OR OVER:

I understand that as a person eighteen-years of age or over in a home of an applicant to become an Adoptive or a Foster Parent or a Family or Group Family Day Care provider, the information I have provided will be used to inquire of the Statewide Central Register to determine if I am the subject of an indicated report of child abuse or maltreatment.

SIGNATURE	DATE / /

SIGNATURE	DATE / /

FOR BEHAVIORAL HEALTH ROTATIONS ONLY

LDSS-3370 (Rev. 03/2019) REVERSE

AGENCY LIAISON INSTRUCTIONS

Please verify that each form is completed. Incomplete forms will be returned to the sender. For ADOPTION, FOSTER CARE, and FAMILY and GROUP FAMILY DAY CARE, if both spouses are applicants, both are to sign. Persons eighteen years old and over residing in the home of applicants for ADOPTION, FOSTER CARE and FAMILY AND GROUP FAMILY DAY CARE also must sign the form.

AGENCY CODE - **Record your 3-digit agency code. NOTE:** Day Care, Family and Group Family Day Care and Camps must provide the agency code of the agency or office which issues your license or certificate. Verify your Alpha or Alpha/Numeric 3-digit code with your licensing agency.

DAYCARE PROVIDERS - Must place their Child Care Facility System (CCFS) Number in the box next to Resource ID (RID), in lieu of Resource ID (RID) number. *(Contact your licensing agency/Regional Office if you have any questions).*

RESOURCE I.D. (RID) - Record your RESOURCE I.D. (RID) in this field. OCFS, OMH, OMRDD, DOH, OASAS and SED licensed agencies and programs, and Local Departments of Social Services, have RID'S as of 9/01. Verify your RID number with your licensing agency. If you need assistance, email: ocfs.sm.conn_app@ocfs.ny.gov

CLEARANCE CATEGORIES - Record the appropriate category.

A – Adult Services/Family Type Home for Adults	**Q** - Applying to be group family day care provider. *(fee required - see below)* Provide address history for all household members 18 and over.*
D - Prospective employee *(Local DSS district - bill against reimbursement)***	**R** - Applying to be kinship foster parents.
E - Current employee.	**S** - Provider of goods/services
F - Prospective/new employee other than day care employees. (fee required - see below)*	**U** – Universal Pre-K Teacher *(fee required - see below)**
M - Director of a summer camp, overnight camp, day camp or traveling day camp.	**W** - Applying to be foster parents or family care home providers.
N - Applying for a license to operate a day care center. (To be submitted by authorized licensing agency only.) (fee required - see below)*	**X** - Applying to be adoptive parents pursuant to an application pending before the inquiring agency.
P - Applying to be family day care provider. *(fee required - see below)* Provide address history for all household members 18 and over.*	**Y** - Prospective Day Care employee *(fee required - see below)**
	Z - Prospective volunteer/consultant.

AGENCY LIAISON - Record the name of the person to whom the response should be sent *(cannot be the same as applicant or related to the applicant).*

APPLICANT/HOUSEHOLD MEMBER AREA INSTRUCTIONS - This information is to be provided by the applicant/ employee/provider. *See front of form.*

APPLICANT(S) (at least one person must be so designated)-USE FIRST LINE

MAIDEN NAME/ALTERNATIVE/AKA: must be completed for every applicant. Record **ALL** previous names used. Start with second line. Use as many lines as needed *(One last name per line)*

OTHER HOUSEHOLD MEMBERS: describe relationship to applicant, e.g., son, daughter, father, mother, friend, etc. on remaining lines *(ATTACH ADDITIONAL PAGE IF NECESSARY)*

IF THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK BOX FOR NO OTHER HOUSEHOLD MEMBERS.

*Social Service Law 424a requires the collection of a $25.00 fee for certain categories. A certified check, postal or bank money order, teller's check, cashier's check or agency check made payable to "New York State Office of Children and Family Services" in the amount of twenty-five dollars, is to accompany the form. The check also is to include the applicant's name and the agency code. **N.B.: a separate check must accompany each form.**

**Social Service Law 424a, allows local DSS to bill against their reimbursement the charge collected for screening prospective employees.

If you have questions, please call the SCR at 518-474-5297.

MAIL YOUR COMPLETED LDSS-3370 FORM TO:

STATEWIDE CENTRAL REGISTER
P.O. BOX 4480, Attention: Service Center Unit
ALBANY, N.Y. 12204-0480

TO ORDER A SUPPLY OF LDSS-3370 FORMS:

Please access the ***OCFS-4627***, *Request for Forms and Publications*, from the Intranet: http://ocfs.state.nyenet/admin/forms/SCR/ Internet: http://ocfs.ny.gov/main/forms/cps/ and mail the completed **OCFS-4627**, *Request for Forms and Publications* to: **THE OFFICE OF CHILDREN AND FAMILY SERVICES, FORMS AND PUBLICATIONS UNIT, 52 WASHINGTON ST. ROOM 134 NORTH, RENSSELAER, NY 12144-2834**. If you have difficulty accessing a form on either site, you can call the automated Forms Request Line at **518-473-0971**.

FOR BEHAVIORAL HEALTH ROTATIONS ONLY

LDSS-3370 (Rev. 03/2019)

STAPLE TO LDSS-3370 *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM
ADDITIONAL PAGE

(Use only if the space on the LDSS-3370 form is not sufficient)

APPLICANT NAME: _____

Print clearly, all dates must be consecutive *(mo/yr)*. Be sure to associate address histories with particular individuals.

Previous Street Address	City	State	Zip	From (Mo/Yr)	To (Mo/Yr)
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