



# Certification for Youth Camps 2015

**Department of Health and Mental Hygiene  
Environmental Health Bureau**

**Center for Healthy Homes and Community Services  
6 Saint Paul St, Suite 1301  
Baltimore, MD 21202-1608**

**Phone 410-767-8417**

**Fax 410-333-8926**



# CHHCS Staff

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Cecil              Frederick      Garrett  
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Caroline      Dorchester      Somerset      Talbot      Wicomico      Worcester



# Mission Statement

## **MISSION**

- The mission of the Prevention and Health Promotion Administration is to protect, promote and improve the health and well-being of all Marylanders and their families through provision of public health leadership and through community-based public health efforts in partnership with local health departments, providers, community based organizations, and public and private sector agencies, giving special attention to at-risk and vulnerable populations.

## **VISION**

- The Prevention and Health Promotion Administration envisions a future in which all Marylanders and their families enjoy optimal health and well-being.



# Legal Authority/Regulation

- Law: Youth Camp Act:  
Health General Title 14 Subtitle 4
- Regulation: COMAR 10.16.06
  - Updated in 2014
- Regulation: COMAR 10.01.17
  - Update in 2014

# Is My Program a “Youth Camp”?



# Is My Program a “Youth Camp”?



# What Is **NOT** a Youth Camp?

- A licensed child care center
- A family day care home
- A program operating before or after a daily school session
- A competitive activity sponsored by a sports league
- A summer school program taught by certified teacher and offering credit

# New Application

- New Youth Camp Application
  - Print from Youth Camp website  
<http://phpa.dhmh.maryland.gov/OEHFP/CHS/Shared%20Documents/Application%20for%20New%20Youth%20Camp%202014.pdf>  
Fill out completely, accurately, attach all required supporting documents, & fee
- Renewal Applications
  - Renewal packages are sent to operator
  - “Good Standing”- Pay reduced fee
- Applications not signed, submitted without fee, or with incorrect fee will not be reviewed and will be returned.

# Renewal Application

- Renewal Applications
  - Renewal packages are sent to operator
  - “Good Standing”- Pay reduced fee
    - Application submitted on time
    - Annual Report submitted on time
    - All fees paid
    - No Critical Violations for 2 years
    - Self-Assessment submitted on time
- Applications not signed, submitted without fee, or with incorrect fee will not be reviewed and will be returned.

# Procedures

## Health Program

- Regulations 10.16.06.22, through .33

## Emergency Procedures

- Regulation 10.16.06.34

## Trip and Transportation

- Regulations 10.16.06.52, and .53

## Supervision during routine activities

- Regulation 10.16.06.54

## Specialized Activities

- Regulations 10.16.06.47, through .52

## Child Abuse Prevention and Reporting

- Regulation 10.16.06.35



# Health Program

## Health Supervisor

COMAR 10.16.06.23

- Doctor
- Nurse
- Certified Nurse Practitioner
- **Duties**
  - Review & Approve Health Program Annually
  - Oversee or Delegate Medication Administration
  - Oversee Health Treatment Area
  - Review Camper Health Forms



# Health Program

## CPR/First Aid

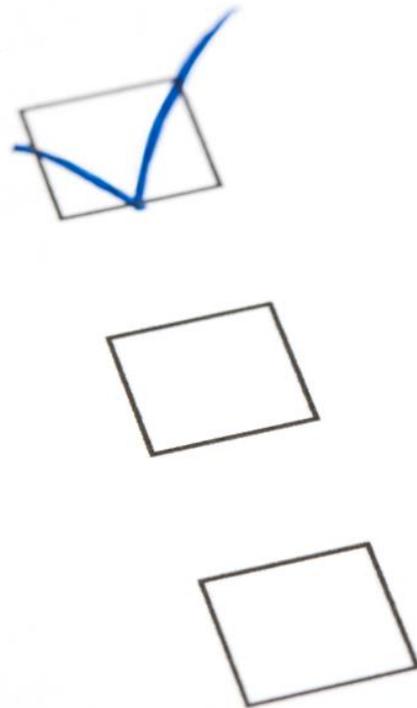
COMAR 10.16.06.23

- Minimum of 2 Adults
  - Certification Issued by National Organization
- On Duty at All Times
  - From 1<sup>st</sup> camper arrival to last camper pick up
- Field Trips
  - One with trip and one at camp if campers stay behind

# Health Program

## Written Health Program

**COMAR 10.16.06.22**



Refer to list of questions  
provided in your packet.



# Health Program

## Medications

### COMAR 10.16.06.33

- Covers Prescription and Nonprescription Medicine
- Delegation ability varies depending on credentials of Health Supervisor
- Self-administration vs. Staff Administration
- Prescriptive Order for All Medication – DHMH form
- Parental Consent Documented
- Standing Orders
- Sunscreen, see July 2, 2011 memo

# Health Program

Treatment Area

COMAR 10.16.06.32

Day  
Camp



# Health Program

Treatment Area

COMAR 10.16.06.32

# Residential Camp

Hot/Cold  
Running  
Water

Bathroom  
with Flush  
Toilets

Hand Sink,  
Shower, and  
Isolation &  
Convalescent  
Area

External  
Lighting



# Health Program

## Health Records

COMAR 10.16.06.27-.30

CAMPER HEALTH HISTORY

Child's Name: \_\_\_\_\_

The following information is required:

Parent or Legal Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Child's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

HEALTH INFORMATION:

1. Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware?  YES  NO

YES, Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Are there any medications, dietary restrictions, allergies, or special needs that we need to be aware of to ensure that your child's camp experience is positive?  YES  NO

YES, Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

IMMUNIZATION INFORMATION:

|  |                    |  |
|--|--------------------|--|
| <p>For campers who reside within the United States, a United States territory, or the District of Columbia:</p> <p>1. State/territory in which child resides: _____</p> <p>2. Is this child exempt from any immunizations? <input type="checkbox"/> YES <input type="checkbox"/> NO<br/> <input type="checkbox"/> YES, List them: _____</p> <p>_____</p> | <p>OR</p> <p>↔</p> | <p>For campers who reside outside the United States, a United States territory, or the District of Columbia:</p> <p>1. Country in which child resides: _____</p> <p>2. Attach Department form DHMH-896 (record of vaccination or immunity)</p> |
|--|--------------------|--|

Parent or Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Health Program

## Health Records

COMAR 10.16.06.27-.30

STAFF/VOLUNTEER HEALTH HISTORY

Staff Member's/Volunteer's Name: \_\_\_\_\_

The following information is required:

Emergency Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

HEALTH INFORMATION:

1. Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware?  YES  NO

YES, Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Are there any medications, dietary restrictions, allergies, or special needs of which we need to be aware?  YES  NO

YES, Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

IMMUNIZATION INFORMATION:

|  |                    |  |
|--|--------------------|--|
| <p>For staff members/volunteers who reside within the United States, a United States territory, or the District of Columbia:</p> <p>1. State/territory in which person resides: _____</p> <p>2. Is this person exempt from any immunizations? <input type="checkbox"/> YES, List them: _____</p> <p>_____</p> <p>_____</p> | <p>OR</p> <p>↔</p> | <p>For staff members/volunteers who reside outside the United States, a United States territory, or the District of Columbia:</p> <p>1. Country in which person resides: _____</p> <p>2. Attach Department form DHMH-896 (record of vaccination or immunity)</p> |
|--|--------------------|--|

\_\_\_\_\_  
Staff Member/Volunteer Signature or  
Parent or Legal Guardian's Signature (If Staff Member is Under 18 Years)

\_\_\_\_\_  
Date

# Health Program

## Health Log

COMAR 10.16.06.24



See Sample Health Log

Must Be:

1. On Lined Paper
2. Kept Confidential
3. In Locked Compartment
4. Available to Department
5. Retained for 3 years
6. Recorded in Ink
7. No Skipped Lines
8. Spiral Book Must Have Sequentially Numbered Pages



Must Include:

1. Date
2. Name of Camper
3. Ailment
4. Treatment Prescribed
5. Name or Initials of Person Administering Care



# Health Program

## Injury/Illness Report

COMAR 10.16.06.25 & .26

**MARYLAND YOUTH CAMP**  
**INJURY OR ILLNESS REPORT FORM**

Department of Health and Mental Hygiene (DHMH)  
 Center for Healthy Homes and Community Services (CHHCS)  
 5 St. Paul Street, Suite 1301, Baltimore MD 21202-1059  
 Phone 410-767-8417 Toll Free 1-877-4MD-DHMH, ext.5417 Fax 410-333-8926

Before forwarding this report to DHMH, remove name from Items 1 and 6.

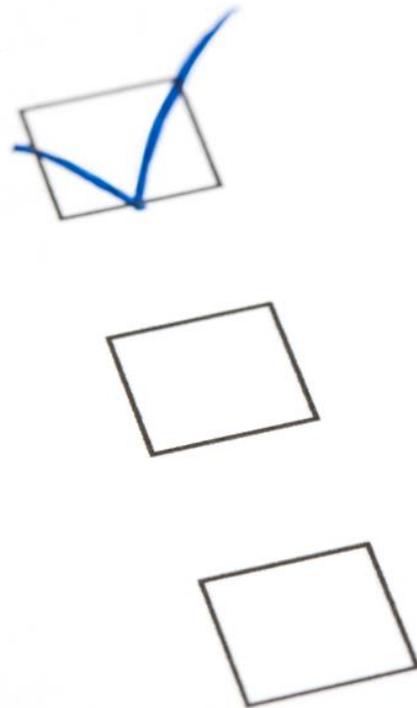
|   |  |   |  |
|---|--|---|--|
| <b>A. PERSONAL INFORMATION</b>  |  |   |  |
| 1. Name (print)   | 2. Age   | 3. Gender<br><input type="checkbox"/> Male <input type="checkbox"/> Female  | 4. Check One <input type="checkbox"/> Day Camper <input type="checkbox"/> Residential Camper<br><input type="checkbox"/> Camp Employee <input type="checkbox"/> Other: |
| <b>B. INCIDENT INFORMATION</b> Complete items 5 through 14 for an injury, illness or medication error.  |  |   |  |
| 5. Report Type (check one)<br><input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Medication Error  |  | 6. Date of incident/illness Onset   |  |
|   |  | 7. Time of incident/illness Onset<br>: : AM <input type="checkbox"/> PM <input type="checkbox"/>  |  |
| 8. For injuries, specify how the injury occurred and what the injured person was doing at the time of the incident. For illnesses, specify the symptoms and/or relevant medical conditions. For medication errors, specify medication and dose given and symptoms, if any.  |  |   |  |
| <b>C. Additional information attached</b>   |  |   |  |
| 9. Did the incident require any of the following:<br>CPR - <input type="checkbox"/> No <input type="checkbox"/> Yes    Epinephrine - <input type="checkbox"/> No <input type="checkbox"/> Yes<br>AED - <input type="checkbox"/> No <input type="checkbox"/> Yes    Inhaler - <input type="checkbox"/> No <input type="checkbox"/> Yes   |  |   |  |
| 10. Did incident result in death? <input type="checkbox"/> No <input type="checkbox"/> Yes<br>Yes (at Date of death: / / )<br>No (at Date of death: / / ) am <input type="checkbox"/> pm <input type="checkbox"/>   |  |   |  |
| 11. Was the person transported off-site for medical care?<br><input type="checkbox"/> No <input type="checkbox"/> Yes, complete A, and B.<br>A. Transported by:<br><input type="checkbox"/> Camp or personal vehicle<br><input type="checkbox"/> Ambulance<br><input type="checkbox"/> Helicopter<br>B. Treated or evaluated at (check all that apply, specify the name of facility):<br><input type="checkbox"/> Urgent Care Facility<br><input type="checkbox"/> Hospital<br><input type="checkbox"/> Doctor's Office<br><input type="checkbox"/> Other (specify) _____   |  |   |  |
| 12. After off-site or on-site medical evaluation, the person (check all that apply):<br><input type="checkbox"/> Was admitted to the hospital<br><input type="checkbox"/> Went home Date _____<br><input type="checkbox"/> Returned to camp with medical restrictions<br><input type="checkbox"/> Returned to camp with no restrictions   |  |   |  |
| 13. Did the incident involve physical abuse, neglect, sexual abuse, or mental injury?<br><input type="checkbox"/> No <input type="checkbox"/> Yes   |  |   |  |
| 14. Did the incident prompt a report or investigation by government authorities or officials?<br><input type="checkbox"/> No <input type="checkbox"/> Yes (specify) _____<br>Government Agency _____<br>Report/Investigation Date _____<br>Report/Investigation Number _____  |  |   |  |
| <b>C. Complete Items 15 through 22 only for an injury. See Item 23 for an illness.</b>  |  | <b>20. Continued</b>  |  |
| 15. What was the cause of injury:<br><input type="checkbox"/> Slip (by what) _____<br><input type="checkbox"/> Burn (by what) _____<br><input type="checkbox"/> Contact/Collision with Person<br><input type="checkbox"/> Contact/Collision with Object (specify) _____<br><input type="checkbox"/> Drowning or Near-Drowning<br><input type="checkbox"/> Fall (from what) _____<br><input type="checkbox"/> Hazardous Material Exposure (specify) _____<br><input type="checkbox"/> Poisoning (by what) _____<br><input type="checkbox"/> Trip/Slip (on what) _____<br><input type="checkbox"/> Weapon (by what) _____<br><input type="checkbox"/> Other (specify) _____ |  | <input type="checkbox"/> Groundslazing/Maintenance (staff only)<br><input type="checkbox"/> Gunwound/Choke/Chokewound<br><input type="checkbox"/> Horseback Riding<br><input type="checkbox"/> Motorized Vehicle (specify) _____<br><input type="checkbox"/> Playground<br><input type="checkbox"/> Primitive Camping<br><input type="checkbox"/> Rifle/y<br><input type="checkbox"/> Rock Climbing/Rappelling<br><input type="checkbox"/> Rafting Course/Challenge Course/Zip-line<br><input type="checkbox"/> Swimming<br><input type="checkbox"/> Walking/Running/Hiking<br><input type="checkbox"/> Other (specify) _____   |  |
| 16. Was the injury:<br><input type="checkbox"/> Unintentional (accidental)<br><input type="checkbox"/> Intentional (self-inflicted)<br><input type="checkbox"/> Intentional (inflicted by another)<br><input type="checkbox"/> None of above  |  | 21. Was the activity supervised?<br><input type="checkbox"/> Not Applicable <input type="checkbox"/> No<br><input type="checkbox"/> Yes (specify) _____<br>Number of campers in activity _____<br>Number of staff in activity _____   |  |
| 17. Did the individual sustain a (check all that apply):<br><input type="checkbox"/> Concussion <input type="checkbox"/> Other Head Injury<br><input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Loss of Consciousness<br><input type="checkbox"/> Severe Laceration <input type="checkbox"/> Fracture<br><input type="checkbox"/> None of above  |  | 22. Was the individual using safety equipment?<br><input type="checkbox"/> Not Applicable <input type="checkbox"/> No<br><input type="checkbox"/> Yes (specify) _____   |  |
| 18. Specify the body part(s) injured:<br>Describe where the injury occurred:<br><input type="checkbox"/> On Site <input type="checkbox"/> Off Site<br>(specify location) _____  |  | <b>D. Complete Item 23 for an illness, not for an injury.</b>   |  |
| 19. Describe where the injury occurred:<br><input type="checkbox"/> On Site <input type="checkbox"/> Off Site<br>(specify location) _____   |  | 23. DHMH requires certain diseases, conditions, outbreaks and unusual circumstances reported to the local health department.<br>A. Was the illness a suspected reportable disease, condition or outbreak? <input type="checkbox"/> No <input type="checkbox"/> Yes<br>For the required DHMH reportable diseases list and outbreak information go to:<br><a href="http://dhsa.dhmh.maryland.gov/DEHA/Share/Document/What-to-report%20reportable-disease-ILCP.pdf">http://dhsa.dhmh.maryland.gov/DEHA/Share/Document/What-to-report%20reportable-disease-ILCP.pdf</a><br>B. Was the illness reported to a local health department?<br><input type="checkbox"/> No <input type="checkbox"/> Yes<br>If Yes (specify department):<br>The camp health supervisor or responsible health care provider completes Provider Report Form # 1140 when reporting to the local agency - go to:<br><a href="http://dhsa.dhmh.maryland.gov/DEHA/Share/Document/What-to-prepare-DHMH1140.pdf">http://dhsa.dhmh.maryland.gov/DEHA/Share/Document/What-to-prepare-DHMH1140.pdf</a> |  |
| <b>E. GENERAL REPORT INFORMATION</b> Complete items 24 through 27 for an injury, illness or medication error.   |  |   |  |
| 24. Report Completed By-Employee Name (print)   |  | Title   |  |
| 25. Camp Name   |  | Address   |  |
| Parent, Guardian, or Emergency Contact was notified   |  | DHMH CAMP ID #  |  |
| <input type="checkbox"/> No <input type="checkbox"/> Yes  |  | Date  |  |
| Method  |  |   |  |
| 26. Significant   | Camp Health Supervisor was notified                      |   | Date   |
|   | <input type="checkbox"/> No <input type="checkbox"/> Yes |   | Method   |
|   | Date   |   |  |
| 26. Significant   | DHMH/CHCS was notified within 24 hours                   |   | Date   |
|   | <input type="checkbox"/> No <input type="checkbox"/> Yes |   | Method   |
| 27. Employee Signature  |  | Date  |  |
|   |  | Phone Number  |  |

DHMH 02/2014 Maintain this report for at least 3 years.

# Health Program

## Acute Illness & Communicable Disease

**COMAR 10.16.06.31**



Refer to list provided in  
your packet.

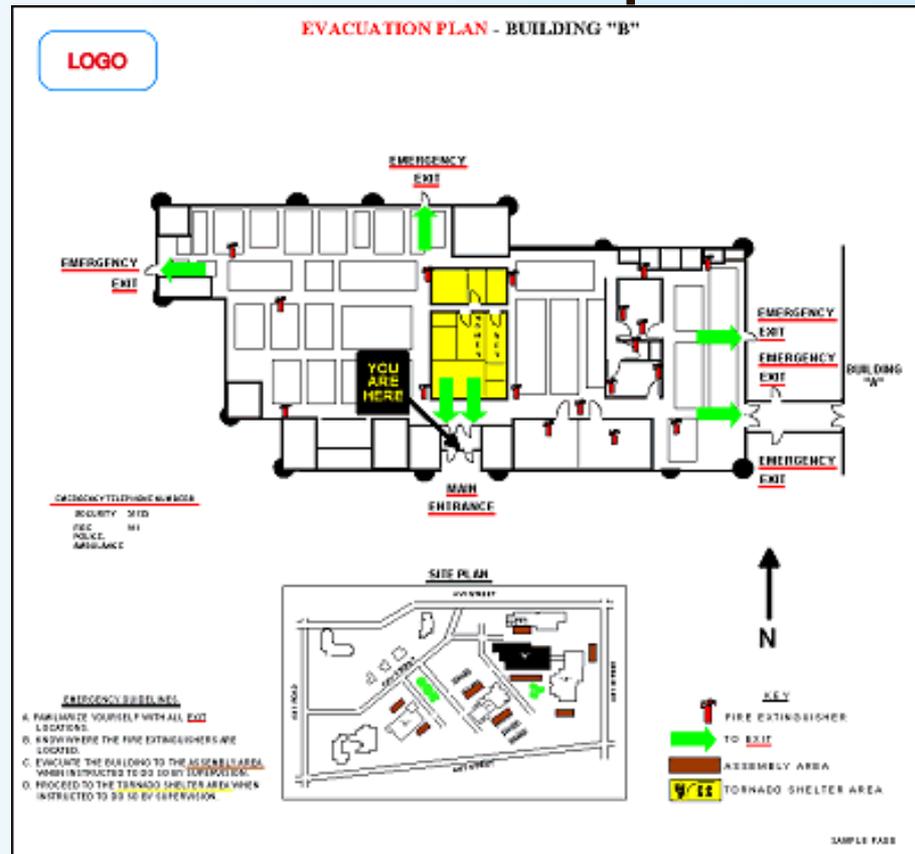
# Emergency Procedures

- Regulation 10.16.06.34
  - Natural disasters and severe weather



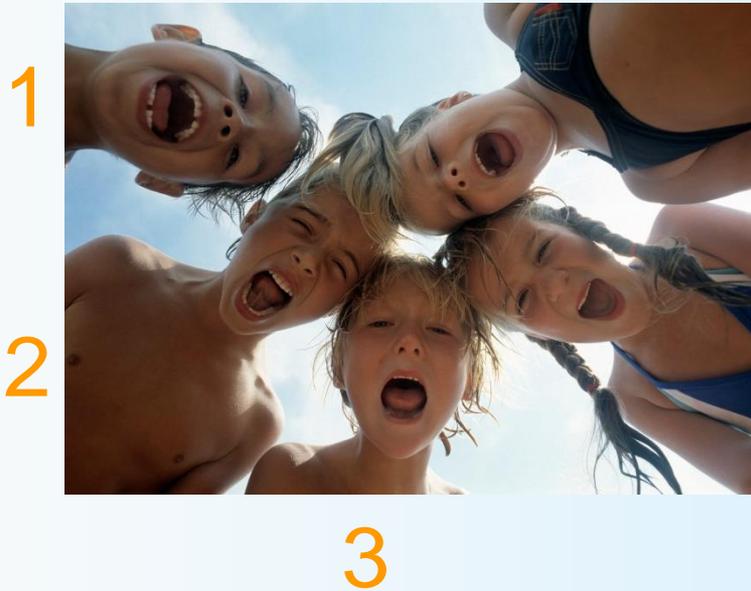
# Emergency Procedures

## –Evacuation plan



# Emergency Procedures

–Missing campers



6 ?

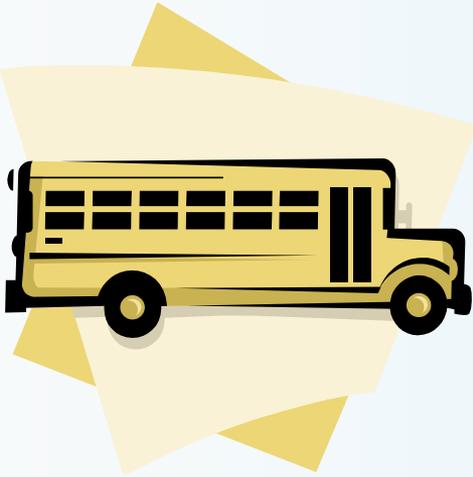
# Emergency Procedures

-911



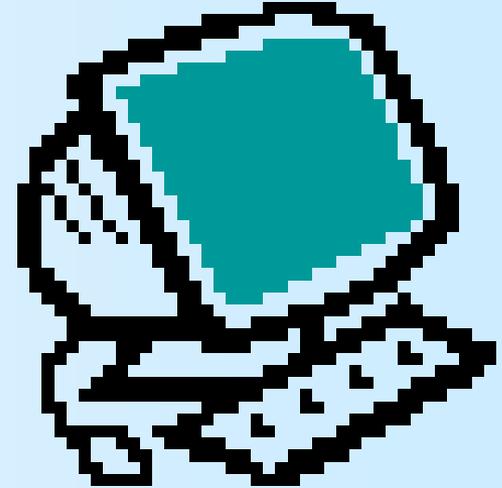
# Emergency Procedures

## –Transportation for Evacuation



# Emergency Procedures

–Notify parents



# Emergency Procedures

–Ensure camper safety



# Trip and Transportation

- Regulations 10.16.06.52 and .53
- Written Safety Plans for:
  - Field trips (See Handout)
  - Transportation (See Handout)
    - Safety Seats for Younger Children
- Written parental authorization
- Rules
- Supervision



# Specialized Activities Regulation .47 - .52

- All Specialized Activities
  - Director Present
  - Safety Plan Developed and Implemented
  - Staff Training
  - Staff Ratio (1 staff to 10 campers)
- Swimming
  - Swim ability test
  - Safety system to quickly account for campers
  - WATCHERS, WATCHERS, WATCHERS
- Marksmanship
- Horseback Riding

# Supervision

| Campers               | Required Number of Adults and Assistant Counselors |                                |
|-----------------------|--|--------------------------------|
|                       | Adults   | Assistant Counselors or Adults |
| 3 ½ to 5 years old    |  |                                |
| 1 to 8                | 1  | 0                              |
| 9 to 16               | 1  | 1                              |
| 17 to 24              | 1  | 2                              |
| 6 to 10 years old     |  |                                |
| 1 to 15               | 1  | 0                              |
| 16 to 30              | 1  | 2                              |
|                       | Or<br>2  | 0                              |
| 11 years old or older |  |                                |
| 1 to 15               | 1  | 0                              |
| 16 to 30              | 1  | 2                              |
|                       | Or<br>2  | 0                              |
| 31 to 40              | 2  | 2                              |
|                       | Or<br>3  | 0                              |



# Child Abuse Prevention and Reporting

Regulation 10.16.06.35

- Develop and implement child abuse prevention and reporting plan *\*\*see handout\*\**
- Provide training to staff members on the prevention and reporting plan annually
- Keep sign-in sheet for training on file
- Keep a copy of the local DSS numbers on file



# Staff Training and Certification

- Training
  - Document staff training for the following:
    - Health Program
      - Including Medication Administration
    - Emergency Plan
    - Trip Safety Plan
    - Transportation Safety Plan
    - Specialized Activities Safety Plans
    - Child Abuse Prevention and Reporting
- CPR and First Aid certification
  - Document current CPR/first aid
  - Ensure that at least 2 adults with CPR/FA are on duty during camp

# Criminal Background Checks

COMAR 10.16.06.21



© Viviane Moos





# Authorization Number

For CJIS use Only  
Authorization #:

STATE OF MARYLAND  
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES (ITCD)  
CRIMINAL JUSTICE INFORMATION SYSTEM (CJIS) - CENTRAL REPOSITORY (CR)

GENERAL REGISTRATION FORM

I. COMPANY OR AGENCY NAME: \_\_\_\_\_  
CONTACT PERSON: \_\_\_\_\_  
(This is the person to whom all correspondence will be addressed)  
CONTACT PERSON'S POSITION TITLE: \_\_\_\_\_  
CONTACT PERSON'S TELEPHONE NUMBER: \_\_\_\_\_ EXT: \_\_\_\_\_  
MAILING ADDRESS: \_\_\_\_\_  
FAX NUMBER: \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

II. REASON FOR REQUEST:

ADULT DEPENDENT CARE (For Maryland Adult Dependent Program ONLY)  
 ATTORNEY/CLIENT  
 CHILD CARE (For Maryland Child Care Facilities ONLY)  
 CRIMINAL JUSTICE (For Criminal Justice Agencies ONLY)  
 GOVERNMENT EMPLOYMENT (select one only)  Federal  State  Local  
 GOVERNMENT LICENSING/CERTIFICATION  
 PUBLIC HOUSING AUTHORITY  
IF AUTHORIZED BY STATUTE, ENTER STATUTORY CITATION: \_\_\_\_\_

III. CERTIFY THAT UNDER THE SPIRIT AND INTENT OF THE LAWS OF MARYLAND, I UNDERSTAND THAT DATA RETURNED TO ME CAN ONLY BE USED AS REQUESTED AND THAT I AM NOT AUTHORIZED FOR FURTHER DISSEMINATION.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Title \_\_\_\_\_

MAIL SIGNED AND COMPLETED FORM TO:  
CJIS AUTHORIZATION ADMINISTRATOR  
POST OFFICE BOX 32708  
PIKESVILLE, MARYLAND 21282-2708  
410 653 5690

OR FAX SIGNED AND COMPLETED FORM TO: 410 653 5690

Revised 3/4/03

- Camp applies for Authorization Number through CJIS
- Results are sent to contact person
- Email notification
- View/print results from secure web site



# Criminal Background Checks

Maryland

And

FBI

- Must have completed MD & FBI check for all required employees
- Copy of results must be addressed to employer, not the employee



# Criminal Background Checks

State of Maryland  
Department of Public Safety and Correctional Services



Martin O'Malley  
Governor

Anthony G. Brown  
Lt. Governor

Gary D. Maynard  
Secretary



G. Lawrence Franklin  
Deputy Secretary

Ronald C. Brothers  
Chief Info. Officer

C. Kevin Combs  
Deputy Chief Info. Officer

Carole Shelton  
Director

**Information Technology and Communications Division**

Criminal Justice Information System - Central Repository  
Post Office Box 32708 - Pikesville, Maryland - 21282-2708  
Main No: 410-764-4501 - Toll Free: 1-888-795-0011

[www.dpscs.state.md.us](http://www.dpscs.state.md.us)

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MARYLAND DEPARTMENT OF HEALTH & MENTAL HYGIENE/ OFPCHS  
LINDA RUDIE  
6 ST. PAUL STREET, SUITE 1301, DIVISION OF COMMUNITY SERVICES  
BALTIMORE, MD 212021608

Received: 02/02/2011  
Reference: 1 [REDACTED]

February 02, 2011

Your request for a criminal history record check of Maryland's Criminal Justice Information System has been completed. This record check was based upon the identification information provided as follows:

---

NAME: [REDACTED]  
Sex: [REDACTED] Race: [REDACTED] Date of Birth: [REDACTED]

---

 No criminal history was found under the Maryland statute or regulation authorizing you to receive the information.

 A fingerprint supported national criminal history record check has been initiated. The results of that investigation will be sent to the requesting agency only.

---

The Maryland Criminal Justice Information System is operated under the authority of the Secretary of the Department of Public Safety and Correctional Services and may not contain data prior to 1978.

*Carole Shelton*

Carole Shelton, Director  
Criminal Justice Information Systems  
Central Repository

February 02, 2011 - 1 [REDACTED] - RL\_CJIS Fac410-683-8320

State of Maryland  
Department of Public Safety and Correctional Services



Martin O'Malley  
Governor

Anthony G. Brown  
Lt. Governor

Gary D. Maynard  
Secretary



G. Lawrence Franklin  
Deputy Secretary

Ronald C. Brothers  
Chief Info. Officer

C. Kevin Combs  
Deputy Chief Info. Officer

Carole Shelton  
Director

**Information Technology and Communications Division**

Criminal Justice Information System - Central Repository  
Post Office Box 32708 - Pikesville, Maryland - 21282-2708  
Main No: 410-764-4501 - Toll Free: 1-888-795-0011

[www.dpscs.state.md.us](http://www.dpscs.state.md.us)

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MARYLAND DEPARTMENT OF HEALTH & MENTAL HYGIENE/ OFPCHS  
LINDA RUDIE  
6 ST. PAUL STREET, SUITE 1301, DIVISION OF COMMUNITY SERVICES  
BALTIMORE, MD 212021608

Received: 02/02/2011  
Reference: 1 [REDACTED]

Originally printed: 2011-02-02

February 02, 2011

Your request for a criminal history record check has been conducted. Information from the Federal Bureau of Investigation (FBI), based upon the fingerprint supported identification information indicated below, has been reviewed.

---

Name: [REDACTED]  
Sex: [REDACTED] Race: [REDACTED] Date of Birth: [REDACTED]

---

 The FBI criminal history investigation has been completed. The covered individual is not the subject of any criminal charge/charges.

---

The Maryland Criminal Justice Information System is operated under the authority of the Secretary of the Department of Public Safety and Correctional Services and does not contain data prior to 1978.

*Carole Shelton*

Carole Shelton, Director  
Criminal Justice Information Systems  
Central Repository

February 02, 2011 - 1 [REDACTED] - RL\_FBI Fac410-683-8320

# Fingerprints

  
**STATE OF MARYLAND**  
**DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES**  
**CRIMINAL JUSTICE INFORMATION SYSTEMS – CENTRAL REPOSITORY**

**LIVESCAN PRE-REGISTRATION APPLICATION**

**APPLICANT INFORMATION (PLEASE TYPE OR PRINT CLEARLY)**

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Gender:  Male  Female *(Please check)*

Height: ft. \_\_\_\_\_ inches \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. \_\_\_\_\_ Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Race:  Black  White  Asian/Pacific Islander  Native American  Other *(Please check)*

Place of Birth: \_\_\_\_\_ Citizenship: \_\_\_\_\_

Current address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

**AGENCY INFORMATION**

Agency Authorization #: \_\_\_\_\_

ORI # (if required): MD004455Y Reason fingerprinted? CHILD CARE

Position Applied for: \_\_\_\_\_

Request Type: *(Choose one ONLY)*

|  |  |
|--|--|
| <input type="checkbox"/> Adult Dependent Care  | <input type="checkbox"/> Government Licensing or Certification |
| <input type="checkbox"/> Attorney/Client       | <input type="checkbox"/> Immigration/VISA                      |
| <input checked="" type="checkbox"/> Child care | <input type="checkbox"/> Individual Challenge                  |
| <input type="checkbox"/> Criminal Justice      | <input type="checkbox"/> Individual Review                     |
| <input type="checkbox"/> Gold Seal/ Adoption   | <input type="checkbox"/> MSP Licensing                         |
| <input type="checkbox"/> Gold Seal/Letter/VISA | <input type="checkbox"/> Private Party Petition                |
| <input type="checkbox"/> Government Employment | <input type="checkbox"/> Public Housing                        |

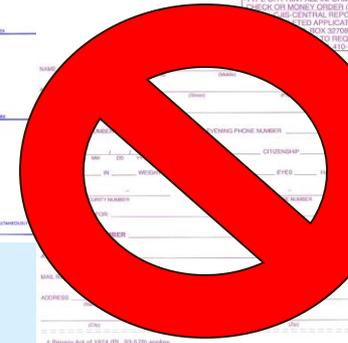
**Mail Response to:**  
(Mailing option only available for Visa Gold Seal and/or Individual Review)

  
**APPLICATION FOR CRIMINAL HISTORY RECORD CHECK**

READ INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION  
 ONLY ORIGINAL APPLICATION WILL BE PROCESSED  
 TYPE OR PRINT ALL INFORMATION CLEARLY  
 TYPE OR MONEY ORDER (NO CASH) MADE PAYABLE TO:  
 STATE OF MARYLAND  
 CRIMINAL JUSTICE INFORMATION SYSTEMS – CENTRAL REPOSITORY  
 100 SOUTH STONE BRIDGE DRIVE, P.O. BOX 3708  
 ANNE ARUNDEL COUNTY, MARYLAND 21038-0708  
 REQUESTING AGENCY (DO NOT WRITE)

08 3038 03184 5

State Only  
 State and FBI  
 State and FBI Volunteer  
 (MAY REQUEST TYPE)  
 Check Only One  
 Adult Dependent Care  
 Attorney/Client  
 Criminal Case #  
 Child Care  
 Criminal Justice  
 Gold Seal Letter/Adoption  
 Gold Seal Letter/Visa  
 Government Employment  
 Government  
 Licensing or Certification  
 Immigration/Visa  
 Individual Challenge  
 Individual Review  
 MSP Licensing  
 Private Employer Petition  
 Public Housing Authority  
 Payment Enclosed  
 Amount \$ \_\_\_\_\_  
 Check or M.O. # \_\_\_\_\_  
 Bill Authorization Account  
 (Must have approved billing agreement)  
 Judgment (Form must be attached with verification)  
 One FBI Fingerprint card enclosed for FBI



**Maryland CJIS no longer accepts inked fingerprints as of April 15, 2012, except for out of state. Use LIVESCAN PRE-REGISTRATION APPLICATION**



# Personnel Administrator

- DHMH must have the personnel administrator's criminal background results from CJIS
- Use DHMH Authorization Number: 9400019171
- ***DO NOT USE THIS AUTHORIZATION NUMBER FOR OTHER STAFF MEMBERS***



# 365 Day Request

 STATE OF MARYLAND  
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES  
CENTRAL REPOSITORY  
P.O. BOX 32350  
PIKESVILLE, MD. 21202-2700

**365 DAY REQUEST FOR CHILD CARE CRIMINAL HISTORY RECORD CHECK**

NAME \_\_\_\_\_  
(Last) (First) (MI)

ADDRESS \_\_\_\_\_  
(Number) (Street) (P.O. Box)

\_\_\_\_\_  
(City) (State) (Zip Code)

SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_  
(This information is required under Article 27, § 742.255, Maryland Annotated Code and under COMAR 12.15.01 in order verify and preserve security of the record)

THE REFERENCE NUMBER FROM YOUR MOST RECENT CHILD CARE APPLICATION FOR A FINGERPRINT SUPPORTED CRIMINAL HISTORY RECORD CHECK (the check must have occurred within the past 365 days).

\_\_\_\_\_ (12 DIGIT NUMBER)

I hereby give my consent for requested Child Care Criminal History Information to be forwarded to the employer listed below.

SIGNATURE OF EMPLOYEE \_\_\_\_\_ DATE \_\_\_\_\_

.....

TO BE COMPLETED BY NEW EMPLOYER: Please list complete mailing address.

\_\_\_\_\_  
(EMPLOYER NAME)

\_\_\_\_\_  
(ADDRESS)

\_\_\_\_\_  
(CITY) (STATE) (ZIP CODE)

AUTHORIZATION NUMBER: \_\_\_\_\_

AUTHORIZED SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

.....

MAIL TO: CJIS CENTRAL REPOSITORY, P.O. BOX 32780, PIKESVILLE, MD. 21202-2780  
Customer Assistance Desk: (410) 764-4501 Fax/F: 410-455-5600 Alt. Fax/F: 410-453-4320

.....

FOR CJIS CENTRAL REPOSITORY USE ONLY

This request can not be processed because:

\_\_\_\_\_ this is not a valid reference number

\_\_\_\_\_ this is not a valid authorization number

\_\_\_\_\_ this reference number has not been received at the Central Repository

\_\_\_\_\_ this authorization number is not approved for this request.

\_\_\_\_\_ the application associated with this reference number was received more than 365 days before receipt of this request.

\_\_\_\_\_ requested information is not completed

- Use for individuals who were fingerprinted for child care within last year
- Does not require fingerprints
- No charge



# Background Clearance from Child Protective Services

- All employees must complete CPS Release of Information Form (DHR/SSA 1279).
- Personnel Administrator should use the sample form provided which includes the contact information for DHMH-CHHCS.



# Reviewing Background Checks and Clearances

- Personnel Administrator must review MD and FBI background checks and CPS background clearance information.
- No hits for something in Regulation .21E.
- If hit for something in Regulation .21F must review accordingly.



# Facilities

| Type of Facility        | Day        | Residential |
|-------------------------|------------|-------------|
| 1 Toilet per            | 35 campers | 15 campers  |
| 1 Hand Washing Unit per | 35 campers | 25 campers  |
| 1 Showerhead per        | N/A        | 15 campers  |
| 1 Bed, Cot or Bunk per  | N/A        | 1 camper    |

# Facilities

- Garbage removal, COMAR 10.16.06.43
  - Durable containers in good repair
  - Collected as necessary to prevent overflow
  - Disposed of legally
  - Outside containers have:
    - Tight-fitting Lids
    - Are leak-proof, fly-proof, and rodent-proof



# Facilities

- Insect and rodent control, COMAR 10.16.06.44
  - Minimize entry
  - Eliminate harborage





# Documentation for Private Building

- Building
  - Use and Occupancy Permit
  - Or
  - Master Plumber and Master Electrician Letters
- Water and Sewage
  - Public Water and Sewer
  - Or
  - Local Health Approval Form
- Fire Marshal Inspection
- Food Service Facility Permit from LHD
- Swimming Pool Permit from LHD



# Documentation for School/Government Building

- Building Safety Form
  - Covers:
    - Water
    - Sewage Disposal
    - Plumbing
    - Electrical
    - Fire
    - Building/Zoning
- Food Service Facility Permit from LHD
- Swimming Pool Permit from LHD



# Submitting Required Reports

- COMAR 10.16.06.06
- Annual Report must be sent to Center for Healthy Homes and Community Services within 4 weeks of camp ending along with any required injury/illness reports.
- Camps will be able to submit AR and IIR online in 2015.

# Questions

