



# Certification for Youth Camps 2012

**Department of Health and Mental Hygiene  
Center for Environmental Health and Community Services**

**Division of Community Services**

**6 Saint Paul St, Suite 1301**

**Baltimore, MD 21202-1608**

**Phone 410-767-8417**

**Fax 410-333-8926**



# Mission Statement

We work to improve the health of Marylanders by reducing the transmission of infectious diseases, helping impacted persons live longer, healthier lives, and protecting individuals and communities from environmental health hazards.

We work in partnership with local health departments, providers, and community based organizations to provide public health leadership in the prevention, control, monitoring, and treatment of infectious diseases and environmental health hazards.



# Legal Authority/Regulation

- Law: Youth Camp Act
- Regulation: COMAR 10.16.06
  - Updated in 2011
- Regulation: COMAR 10.01.17
  - Update in 2011

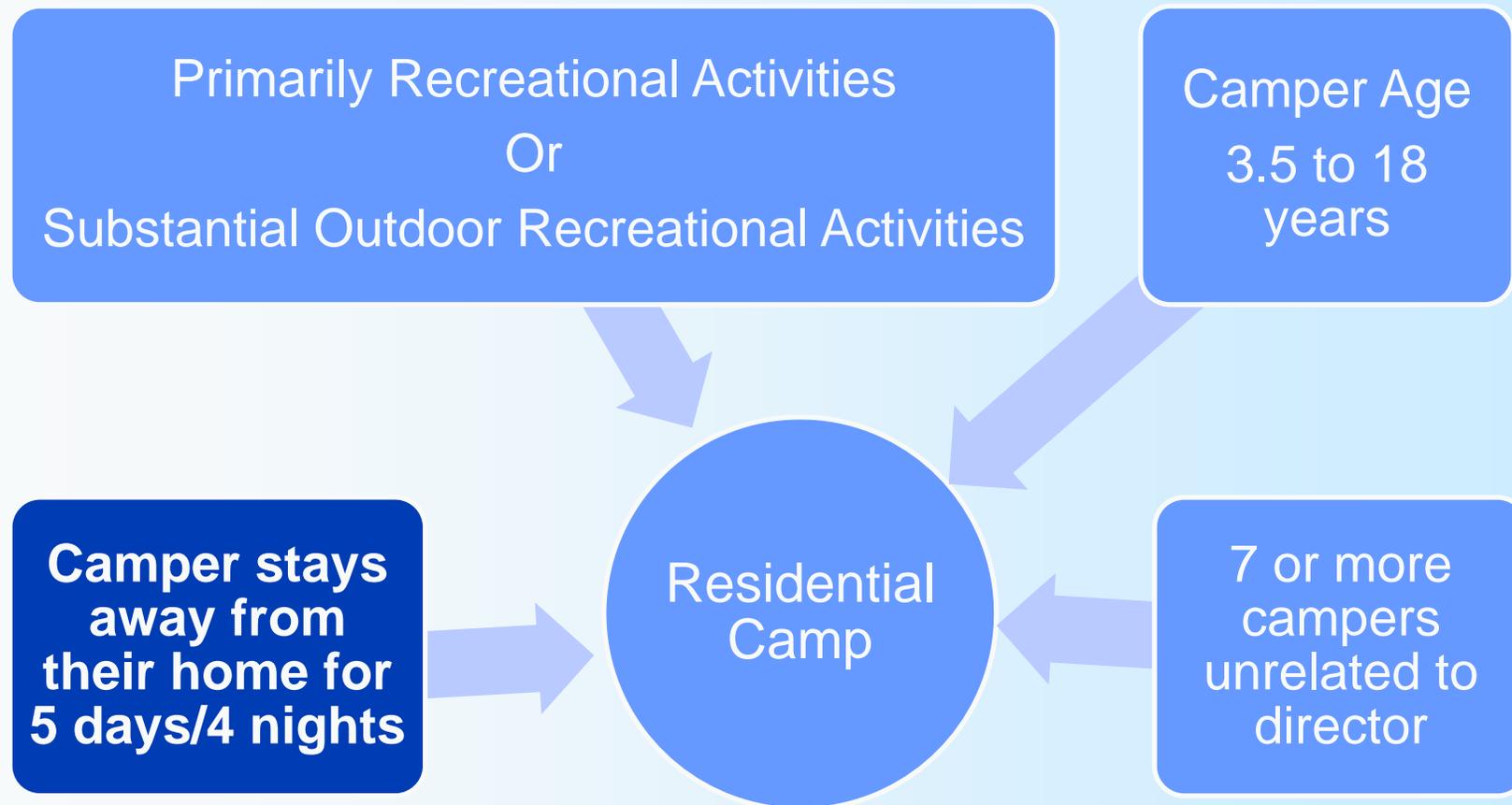


# Is My Program a “Youth Camp”?





# 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



# Application

- New Youth Camp Application
  - Print from Youth Camp website  
<http://ideha.dhmf.maryland.gov/OEHFP/CHS/SitePages/youth-camp-certifications.aspx>
  - Fill Out completely, accurately, attach all required supporting documents, & fee
- Renewal Applications
  - Renewal packages are sent to operator
- Applications not signed or submitted without fee will not be reviewed



# 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 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

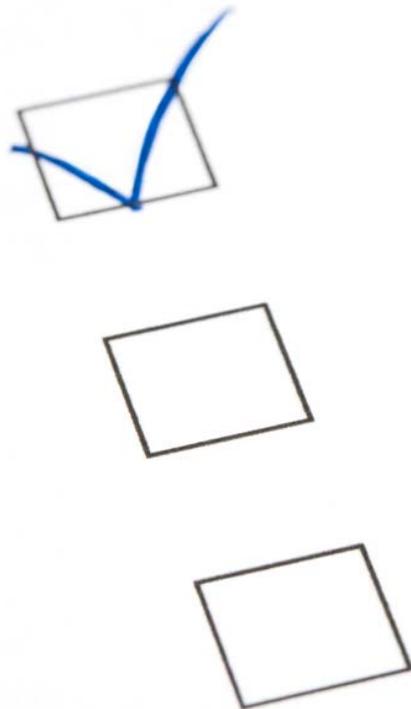
- Minimum of 2 Adults
- Certification Issued by National Organization
- On Duty at All Times
  - From 1<sup>st</sup> camper arrival to last camper pick up



# 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
- Parental Consent Documented
- Sunscreen, see July 2, 2011 memo



# Health Program

Treatment Area

COMAR 10.16.06.32

Day  
Camp

Temporary  
Isolation

Private  
and  
Quiet

First Aid  
Supplies  
and Hand  
Washing

Continual  
Supervision



# 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 for a camper to be admitted to day camp:

CAMPER IMMUNIZATION INFORMATION

All campers must be current on all immunizations, see www.EDCP.org (Immunization).

1. Provide date (month and year) of camper's last tetanus (or DTP) shot: \_\_\_\_\_
2. Is the camper currently enrolled in a Maryland school, public or private?
  - YES, provide name of Maryland school: \_\_\_\_\_
  - NO, provide a copy of immunizations confirming that the child has received all immunizations as required by the Maryland DHMH Recommended Childhood Immunization Schedule. See www.EDCP.org (Immunization) for information.
3. Is the camper exempt from any immunization on medical or religious grounds?
  - YES, provide a signed copy of Maryland Department of Health and Mental Hygiene Immunization Certificate from either a licensed physician indicating that the immunization is medically contraindicated, or the parent or guardian indicating that they object to immunizations for religious reasons.
  - NO

CONTACT INFORMATION:

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

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

Camper's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

HEALTH INFORMATION: Provide information on any medical conditions, psychological conditions, behavioral conditions, medications, dietary restrictions, allergies, or special needs that we need to be aware of to ensure that your child's camp experience is positive:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

CAMPER HEALTH HISTORY

Child's name \_\_\_\_\_

The following information is required for a camper to be admitted to residential camp:

CAMPER IMMUNIZATION INFORMATION

All campers must be current on all immunizations, see www.EDCP.org (Immunization).

1. Provide a copy of immunizations confirming that the camper has received all immunizations as required by the Maryland DHMH Recommended Childhood Immunization Schedule. See www.EDCP.org (Immunization) for information.
2. Is the camper exempt from any immunization on medical or religious grounds?
  - YES, provide a signed copy of Maryland Department of Health and Mental Hygiene Immunization Certificate from either a licensed physician indicating that the immunization is medically contraindicated, or the parent or guardian indicating that they object to immunizations for religious reasons.
  - NO

CONTACT INFORMATION:

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

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

Camper's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

HEALTH INFORMATION: Provide information on any medical conditions, psychological conditions, behavioral conditions, medications, dietary restrictions, allergies, or special needs that we need to be aware of to ensure that your child's camp experience is positive:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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



# Health Program

## Health Records

COMAR 10.16.06.27-.30

STAFF OR VOLUNTEER HEALTH HISTORY

NAME \_\_\_\_\_

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

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

HEALTH INFORMATION: Provide information on any medical conditions, psychological conditions, behavioral conditions, medications, dietary restrictions, allergies, or special needs:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Staff or Volunteer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

STAFF OR VOLUNTEER UNDER 18

All staff or volunteers under 18 years old must be current on all immunizations.

1. Was staff/volunteer enrolled in a Maryland school, public or private, within the past year?
  - YES, provide name of Maryland school: \_\_\_\_\_
  - NO, provide a copy of immunizations confirming that the child has received all immunizations as required by the Maryland DHMH Recommended Childhood Immunization Schedule. See [www.EDCP.org](http://www.EDCP.org) (Immunization) for information.
2. Is staff/volunteer exempt from any immunization on medical or religious grounds?
  - YES, provide a signed copy of Maryland Department of Health and Mental Hygiene Immunization Certificate from either a licensed physician indicating that the immunization is medically contraindicated, or the parent or guardian indicating that they object to immunizations for religious reasons
  - NO

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



# Health Program

## Immunizations

COMAR 10.16.06.28 & .30



Vaccine Requirements For Children  
 Enrolled in Preschool Programs and in Schools — Per DHMH COMAR 10.06.04.03  
 Maryland School Year 2011 - 2012 (Valid 9/1/11 - 8/31/12)

Required cumulative number of doses for each vaccine for PRESCHOOL aged children enrolled in educational programs									
Vaccine	DTaP/DTP/ DT	Polio <sup>2</sup>	Hib <sup>3</sup>	Measles <sup>2,4</sup>	Mumps <sup>2,4</sup>	Rubella <sup>2,4</sup>	Varicella <sup>2,4,5</sup> (Chickenpox)	Hepatitis B	PCV <sup>3</sup> (Prenar <sup>TM</sup> )
Current Age of Child									
Less than 2 months	0	0	0	0	0	0	0	1	0
2 - 3 months	1	1	1	0	0	0	0	1	1
4 - 5 months	2	2	2	0	0	0	0	2	2
6 - 11 months	3	3	2	0	0	0	0	3	2
12 - 14 months	3	3	At least 1 dose given after 12 months of age	1	1	1	1	3	2
15 - 23 months	4	3	At least 1 dose given after 12 months of age	1	1	1	1	3	2
24—59 months	4	3	At least 1 dose given after 12 months of age	1	1	1	1	3	1
60 - 71 months	4	3	0	2	2	2	1	3	0

Required cumulative number of doses for each vaccine for children enrolled in KINDERGARTEN - 12 <sup>th</sup> grade								
Grade Level Grade	DTaP/DTP/ Tdap/DI/Td <sup>1</sup>	Polio <sup>2,7</sup>	Measles <sup>2,4</sup>	Mumps <sup>2,4</sup>	Rubella <sup>2,4</sup>	Varicella <sup>2,4</sup> (Chickenpox)	Hepatitis B <sup>3</sup>	
Kindergarten (5 yrs)	4	3	2	1	1	1	3	
Grades 1 - 12 (6 - 18+ yrs)	4 or 3 <sup>8</sup>	3	2	1	1	1 or 2 <sup>5</sup>	3	

\* See footnotes on back

Maryland Department of Health & Mental Hygiene  
 Center for Immunization

www.EDCP.org (Immunization)  
 410-767-6679

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, Secretary



# Health Program

## Health Log

COMAR 10.16.06.24





# Health Program

## Injury/Illness Report

COMAR 10.16.06.25 & .26

**MARYLAND YOUTH CAMP** Department of Health and Mental Hygiene (DHMH)/Center for Consumer Health Services (CHS)  
 6 St. Paul Street, Suite 1301, Baltimore MD 21202-1608  
 Phone: 410-767-8417 Toll Free: 1-877-AMC-DRINK, ext.8417 Fax: 410-333-8525

**INJURY OR ILLNESS REPORT FORM**

Before forwarding this report to DHMH, remove confidential information such as the person's name or other personal identifiers.

**A. PERSONAL INFORMATION**

1. Name (print) \_\_\_\_\_ 2. Age \_\_\_\_\_ 3. Gender  Male  Female 4. Check One  Day Camper  Residential Camper  
 Camp Employee  Other

**B. INCIDENT INFORMATION** Complete items 5 through 14 for an injury, illness or medication error.

5. Report Type (check one)  Injury  Illness  Medication Error 6. Date of Incident/Illness Onset: \_\_\_\_\_ 7. Time of Incident/Illness Onset: \_\_\_\_\_  
 AM  PM

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.

Additional information attached

9. Did the incident require any of the following:  
 CPR  No  Yes Epinephrine  No  Yes  
 AED  No  Yes Inhaler  No  Yes

10. Did incident result in death?  No  Yes  
 Yes List Date of death: / / List Time of death: : am/pm

11. Was the person transported off-site for medical care?  
 No  Yes, complete A. and B.

A. Transported by:  
 Camp or personal vehicle  
 Ambulance  
 Helicopter  
 Other (specify): \_\_\_\_\_

B. Treated or evaluated at (check all that apply), specify the name of facility:  
 Urgent Care Facility  
 Doctor's Office  
 Hospital  
 Other (specify): \_\_\_\_\_

12. After off-site or on-site medical evaluation, the person (check all that apply):  
 Was admitted to the hospital  
 Went home, Date: \_\_\_\_\_  
 Returned to camp with medical restrictions  
 Returned to camp with no restrictions

13. Did the incident involve physical abuse, neglect, sexual abuse, or mental injury?  No  Yes

14. Did the incident prompt a report or investigation by government authorities or officials?  
 No  Yes (specify) \_\_\_\_\_  
 Government Agency \_\_\_\_\_  
 Report/Investigation Date \_\_\_\_\_  
 Report/Investigation Number \_\_\_\_\_

**C. Complete Items 15 through 22 only for an injury. See Item 23 for an illness.**

15. What was the cause of injury:  
 Slip (on what) \_\_\_\_\_  
 Burn (by what) \_\_\_\_\_  
 Contact/Collision with Person  
 Contact/Collision with Object (specify) \_\_\_\_\_  
 Drowning or Near-Drowning  
 Fall (from what) \_\_\_\_\_  
 Hazardous Material Exposure (specify) \_\_\_\_\_  
 Poisoning (by what) \_\_\_\_\_  
 Trip/Slip (on what) \_\_\_\_\_  
 Weapon (by what) \_\_\_\_\_  
 Other (specify) \_\_\_\_\_

16. Was the injury:  
 Unintentional (accidental)  
 Intentional (self-inflicted)  
 Intentional (inflicted by another): \_\_\_\_\_  
 Other (specify) \_\_\_\_\_

17. Did the individual sustain a (check all that apply):  
 Contusion  Other Head Injury  
 Spinal Cord Injury  Loss of Consciousness  
 Severe Laceration  Fracture  
 None of above

18. Specify the body part(s) injured:  
 On Site  
 Off Site

19. Describe where the injury occurred:  
 On Site (specify location) \_\_\_\_\_  
 Off Site (specify location) \_\_\_\_\_

20. Specify the activity the individual was engaged in at the time of injury (select most applicable activity):  
 Archery  
 Arts & Crafts  
 Biking  
 Boating (specify) \_\_\_\_\_  
 Competitive Sport/Game (specify) \_\_\_\_\_  
 Cooking/Food Preparation  
 Fishing  
 General Camp Life (specify) \_\_\_\_\_

21. Was the activity supervised?  
 Not Applicable  No  
 Yes (specify) \_\_\_\_\_  
 Number of campers in activity: \_\_\_\_\_  
 Number of staff in activity: \_\_\_\_\_

22. Was the individual using safety equipment?  
 Not Applicable  No  
 Yes (specify) \_\_\_\_\_

23. DHMH requires certain diseases, conditions, outbreaks and unusual manifestations reported to the local health department.  
 A. Was the illness a suspected reportable disease, condition or outbreak?  No  Yes  
 For the required DHMH reportable diseases list and outbreak information go to: <http://dshhs.dhmh.maryland.gov/reportable-diseases.aspx>  
 B. Was the illness reported to a local health department?  
 No  Yes  
 If Yes (specify department): \_\_\_\_\_  
 The camp health supervisor or responding health care provider completes Provider Report Form # 1140 when reporting to the local agency go to: <http://dshhs.dhmh.maryland.gov/1140.pdf>

**E. GENERAL REPORT INFORMATION** Complete Items 24 through 27 for an injury, illness or medication error.

24. Report Completed By-Employee Name (print) \_\_\_\_\_ Title \_\_\_\_\_

25. Camp Name \_\_\_\_\_ Address \_\_\_\_\_ DHMH CAMP ID # \_\_\_\_\_

26. Notification:  
 Parent, Guardian, or Emergency Contact was notified  No  Yes Date \_\_\_\_\_ Method \_\_\_\_\_  
 Camp Health Supervisor was notified  No  Yes Health Supervisor Name \_\_\_\_\_ Date \_\_\_\_\_ Method \_\_\_\_\_  
 DHMH/CHS was notified within 24 hours  No  Yes DHMH Contact Name \_\_\_\_\_ Date \_\_\_\_\_ Method \_\_\_\_\_  
 27. Employee Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone Number \_\_\_\_\_

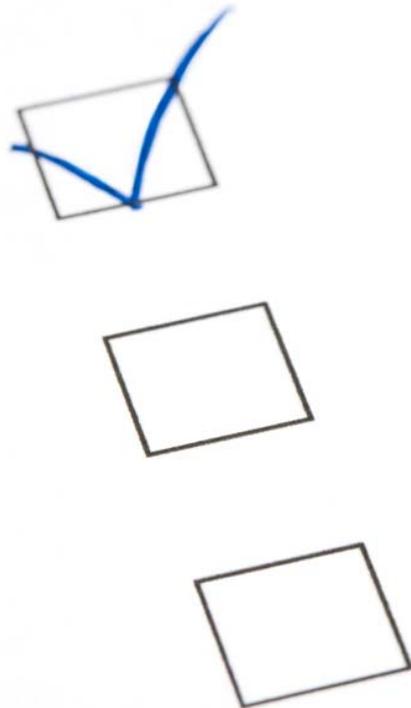
DHMH 042011 Maintain this report for at least 3 years.



# 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
  - Evacuation plan
  - Missing campers
  - 911
  - Transportation
  - Notify parents
  - Ensure camper safety



# Trip and Transportation

- Regulations 10.16.06.52, and .53
- Written Safety Plans for
  - Field trips
  - Specialized activities
- Written parental authorization
- Rules
- Supervision



# Specialized Activities

- Regulations 10.16.06.47, through .52
- Swimming
  - Written Swim Safety Plan
    - Director present
    - Swim ability test
    - Safety system to quickly account for campers
    - WATCHERS, WATCHERS, WATCHERS
- Marksmanship
- Horseback Riding
- Other Specialized Activities



# Supervision and Reporting

- Supervision during routine activities
  - Regulation 10.16.06.54
- Child Abuse Reporting
  - Regulation 10.16.06.35



# Staff

- Training
  - Document staff training for the following:
    - Health Program
    - Emergency Plan
    - Trip and Transportation Plans
    - Specialized Activities Safety Plans
- 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

NAME _____		CLASS _____		
ALIAS 0-459219		BLACK	MALE	
No. _____		COLOR _____	SEX _____	
REF 03/09/95		Loc: 32		
RIGHT HAND				
1. THUMB	2. INDEX FINGER	3. MIDDLE FINGER	4. RING FINGER	5. LITTLE FINGER
LEFT HAND				
6. THUMB	7. INDEX FINGER	8. MIDDLE FINGER	9. RING FINGER	10. LITTLE FINGER
TAKEN BY: <u>SIXLV</u>	NOTE AMPUTATIONS		SIGNATURE OF PERSON FINGERPRINTED	
CLASSIFIED BY: _____				
VERIFIED BY: _____				
FOUR FINGERS TAKEN SIMULTANEOUSLY LEFT HAND		L. THUMB R. THUMB	FOUR FINGERS TAKEN SIMULTANEOUSLY RIGHT HAND	

- 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

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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\_CIS Fax: 410-663-6320

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  
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Post Office Box 32708 - Pikesville, Maryland - 21282-2708  
Main No: 410-764-4501 - Toll Free: 1-888-795-0011

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 Fax: 410-663-6320



# 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)  
 Adult Dependent Care  
 Attorney/Client  
 Child care  
 Criminal Justice  
 Gold Seal/ Adoption  
 Gold Seal/Letter/VISA  
 Government Employment  
 Government Licensing or Certification  
 Immigration/VISA  
 Individual Challenge  
 Individual Review  
 MSP Licensing  
 Private Party Petition  
 Public Housing

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



**Maryland CJIS will no longer accept inked fingerprints as of April 15, 2012.**  
**Use LIVESCAN PRE-REGISTRATION APPLICATION**



# Camp Owner/Director

- DHMH must have the camp owner's or camp director's criminal background results from CJIS
- Use DHMH Authorization Number: 9400019171
- ***DO NOT USE THIS AUTHORIZATION NUMBER FOR OTHER STAFF***



# 180 Day Request

STATE OF MARYLAND  
DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONAL SERVICES  
CENTRAL REPOSITORY  
P.O. BOX 2768  
PIKESVILLE, MD. 21822-2768

**180 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 \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Mandatory, Required under MD Code Art. 27 712-713 and MD Regs. 18.16.01 to verify and preserve security of the record.)

REFERENCE NUMBER FROM MOST RECENT CHILD CARE APPLICATION FOR CRIMINAL HISTORY RECORD CHECK (THAT INCLUDED FINGERPRINTS) MUST BE WITHIN THE PAST 180 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: \_\_\_\_\_

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 22769, PIKESVILLE, MD. 21822-2769 Customer Assistant Desk (410) 764-4501

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 before the effective date of October 1, 1996  
 \_\_\_\_\_ the application associated with this reference number was received more than 180 days before receipt of this request.  
 \_\_\_\_\_ requested information is not completed

- Use for individuals who were fingerprinted for child care within last 6 months
- Does not require fingerprints
- No charge





# Facilities

- Required toilet ratio, COMAR 10.16.06.38
- Hand washing, COMAR 10.16.06.39
- Garbage removal, COMAR 10.16.06.43
- Insect and rodent control, COMAR 10.16.06.44
- Sleeping facilities, COMAR 10.16.06.40



# Documentation

- Building
- Water and sewage
- Plumbing
- Electrical
- Fire safety inspection
- Food Service



# Submitting Required Reports

- Annual Report must be sent to CHS within 2 weeks of camp ending.
- Submit injury/illness reports within 2 weeks of camp ending.



# Annual Report

- COMAR 10.16.06.06
- Must be filed with DHMH within 2 weeks of camp ending
- Report includes number of campers as well as other important information
- Ensure Injury/Illness Reports are also on file

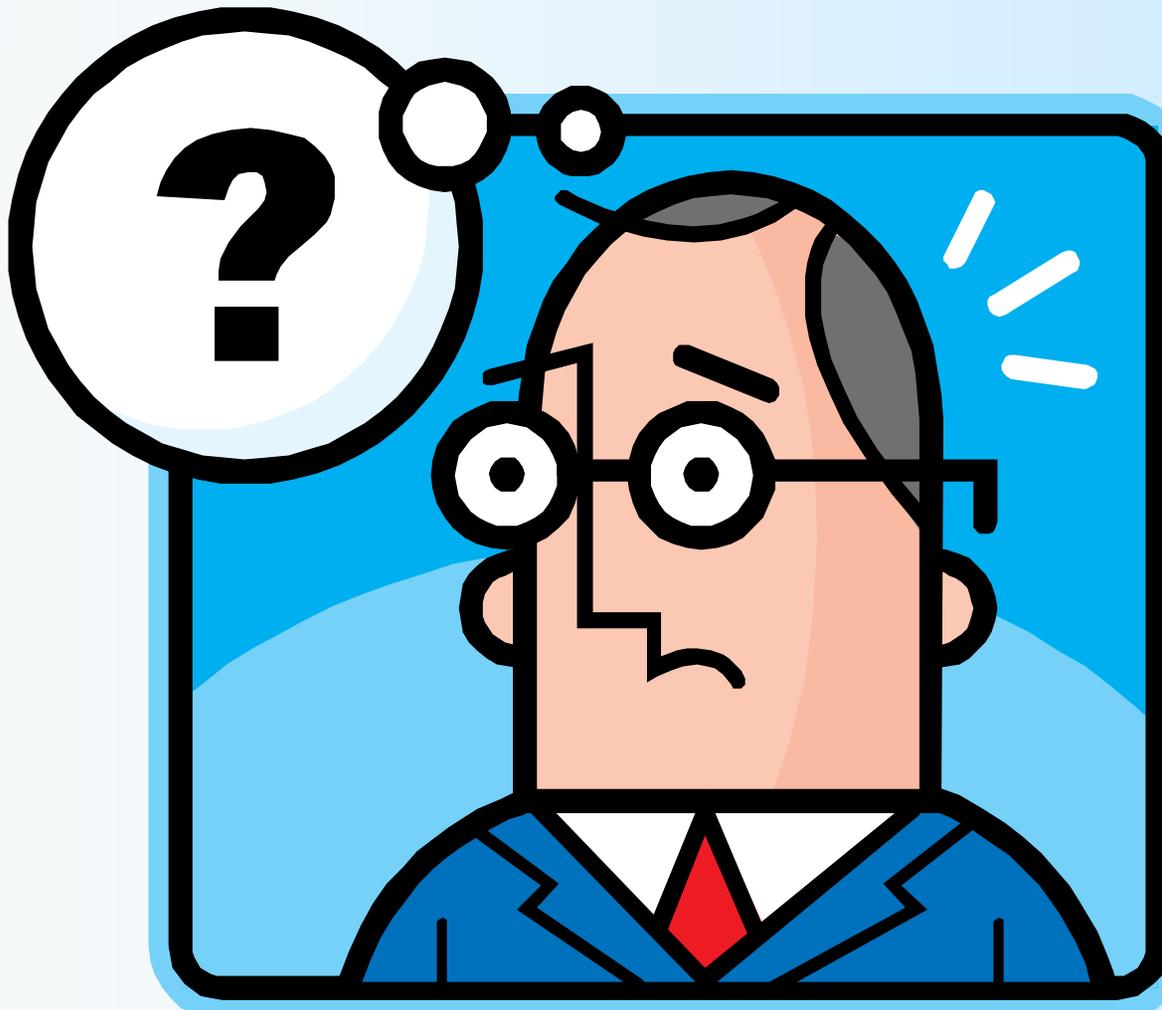


# Provisional Certification

- After all documents are approved provisional certificate is issued
- Valid for first operational period **ONLY**



# Questions





# Post Test & Evaluation





# Post Test Review

