CCL-205
(05/21)

Staff/Non-Staff Record Summary

STATE OF WYOMING
Department of Family Services

DIRECTOR NAME:	FACILITY NAME:	CERTIFICATE NUMBER:

INSTRUCTIONS:

- ***List all individuals working at the facility including: staff, substitutes, volunteers, janitors, cooks, bus drivers, secretaries, speech therapist, occupational therapist, social/family aides, etc. (Section 1 and Section 2)***
- ***For FCCHs and FCCCs that are in a residence, all household members example*** **Spouse, Adult Child, Relative, Friend, etc.** ***age 18 years and older must also be listed, even if not present when children are in care (Section 1)***

Section 1: Required for all							Section 2: Required for all individuals providing direct care to children					
1. Name and 2. Date of Birth 3. Position or Job Title; examples Assistant director, Infant director	Start Date or Date moved into the home	Central Registry Check Date and Results	Out-of-state Child Abuse Neglect Check Date and Result	Sex Offender Check Date and Results	DCI/FBI Fingerprint Check Date and Results	Risk Assessment or TB Test Results Date	Used to meet Staff: Child Ratios or direct care of children	Used 24 hours or more per month in direct care of children	1. CCL Rules 2. Facility Orientation 3. Pre-service 4. ELG and ELF	Infant CPR and First Aid Expires Date	Works with Infants	Transports Children Driver's License (DL) expiration date
1. 2. 3. PROVIDER/DIRECTOR	Date:	Date: Results Passed ☐Yes ☐No	Date: Results Passed ☐Yes ☐No	Date: Results Passed ☐Yes ☐No	Date: Results Passed ☐Yes ☐No	Date: Assessment ☐Yes ☐No TB Test Positive ☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	Date: Date: Date: Date:	Date: Date:	☐Yes ☐No	☐Yes ☐No DL Expires:
1. 2. 3.	Date:	Date: Results Passed ☐Yes ☐No	Date: Results Passed ☐Yes ☐No	Date: Results Passed ☐Yes ☐No	Date: Results Passed ☐Yes ☐No	Date: Assessment ☐Yes ☐No TB Test Positive ☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	Date: Date: Date: Date:	Date: Date:	☐Yes ☐No	☐Yes ☐No DL Expires:
1. 2. 3.	Date:	Date: Results Passed ☐Yes ☐No	Date: Results Passed ☐Yes ☐No	Date: Results Passed ☐Yes ☐No	Date: Results Passed ☐Yes ☐No	Date: Assessment ☐Yes ☐No TB Test Positive ☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	Date: Date: Date: Date:	Date: Date:	☐Yes ☐No	☐Yes ☐No DL Expires:
1. 2. 3.	Date:	Date: Results Passed ☐Yes ☐No	Date: Results Passed ☐Yes ☐No	Date: Results Passed ☐Yes ☐No	Date: Results Passed ☐Yes ☐No	Date: Assessment ☐Yes ☐No TB Test Positive ☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	Date: Date: Date: Date:	Date: Date:	☐Yes ☐No	☐Yes ☐No DL Expires:

To the best of my knowledge, the information I have provided is correct ______________________________ ____________

Provider/Director Signature Date

CCL-205
(05/21)

Staff/Non-Staff and Facility Record Summary

STATE OF WYOMING
Department of Family Services

Section 1: Required for all							Section 2: Required for all individuals providing direct care to children					
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1. 2. 3.	Date:	Date: Results Passed ☐Yes ☐No	Date: Results Passed ☐Yes ☐No	Date: Results Passed ☐Yes ☐No	Date: Results Passed ☐Yes ☐No	Date: Assessment ☐Yes ☐No TB Test Positive ☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	Date: Date: Date: Date:	Date: Date:	☐Yes ☐No	☐Yes ☐No DL Expires:

To the best of my knowledge, the information I have provided is correct _____ _____

Provider/Director Signature **Date**