EXAMPLE

GUAM POLICE DEPARTMENT
DIPÅTTAMENTON POLISIAN GUAHAN
Government of Guam

LOURDES A. LEON GUERRERO
Governor

JOSHUA F. TENORIO
Lieutenant Governor

Bldg. 13-16A Mariner Avenue, Tiyan
Barrigada, Guam 96913
P.O. Box 23909 Barrigada, Guam 96921
Telephone: (671) 475-8473 (Switchboard); (671) 475-8508 / 8509 / 8512
Fax: (671) 475-3222

STEPHEN C. IGNACIO
Chief of Police

AUTHORIZATION

I,_____, (D.O.B._____) do hereby authorize

_____to request and obtain on my behalf a Police

Clearance . A copy of my driver's license is attached.

Signed on this_____day of _____,20___.

_____ _____
Print Name Signature

Submitted by:

_____
Print Name
Agency/Department's Representative

_____
Signature

Parent/Legal Guardian Information

Department of Youth Affairs

Today's Date

Parent/Legal Guardian Name and Signature

Leave Blank

EXAMPLE

AUTHORIZATION FOR CERTIFICATE OF SEARCH
(aka Court Clearance)

Date: _____

To the Records Section, Superior Court of Guam:

I, _____, hereby authorized the _____

_____, specifically _____,

to obtain a Certificate of Search, or what is more commonly referred to as a Court Clearance on my behalf.

Required Information:

Date of Birth: _____

Alias (es): _____

Social Security Number (optional): _____

Mailing Address: _____

Physical Address: _____

Contact Telephone Number(s): _____

*A clear, valid, and legible photocopy of my proof of identity (driver's license, passport, or state ID) is attached.

_____ _____
(Print) (Signature)

Attachment

Parent/Legal Guardian Name

Department of Youth Affairs

Ashley N. Bato (DYA Personnel)

Applicant's Information

Parent/Legal Guardian Name and Signature

EXAMPLE

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES (DPHSS)
DIVISION OF CHILDREN'S WELLNESS
BUREAU OF CHILD CARE SERVICES (BCCS)
Child Care Assistance Program
www.guamchildcare.com
671-735-7344 / 7256

CONSENT FOR DISCLOSURE OF CLIENT INFORMATION

As stipulated in Guam Public Law 31-73 and as required by Federal law, 45 C.F.R. § 98.43, all adults (18 years and older) residing in the location where child care services are being provided, those employed by a child care provider for compensation, contracted employees and self-employed child care providers, and those who care for, supervise, or have unsupervised access to children are subject to a comprehensive background check. This consent shall be effective immediately and shall remain in effect for a duration not to exceed ninety days. A separate **CONSENT FOR DISCLOSURE OF CLIENT INFORMATION** form shall be submitted for every adult present where child care services are conducted.

PURPOSE OR NEED FOR DISCLOSURE

- National Sex Offender Registry
- Local Sex Offender Registry
- Guam Child Abuse and Neglect Registry
- National FBI Criminal History Check (Fingerprint)
- Virtual Computerized Criminal History
- General (Internet) Google Search
- Other: _____
- Other: _____

INFORMATION REQUIRED TO PROCESS A COMPREHENSIVE BACKGROUND CHECK

First Name		Middle Name	Last Name
Other Known Alias	Date of Birth	Race/Ethnicity	Military Service Member? ☐Yes ☐No

Current Address on Guam: ☐ check box if currently residing outside of Guam

Current Address	Village	State	Zip Code

Previous Address Within the Last Five Years:

Previous Address

Previous Address Outside of Guam Within the Last Five Years:

Previous Address

NAME OF PROGRAM OR ORGANIZATION TO RECEIVE INFORMATION

Requesting Organization:	Department of Public Health and Social Services, Bureau of Child Care Services
Email Address:	childcare@dphss.guam.gov
Mailing Address:	130 University Drive Unit 15, Mangilao Guam 96913
Contact Number:	(671) 735-7344; (671) 735-7256

By signing this authorization form, I give my permission and consent to the Bureau of Child Care Services (BCCS) to obtain and review records of criminal history to prove the eligibility requirements are satisfied as required by law.

Signature of Client/Parent/Guardian: _____ **Date**: _____

**********FOR OFFICAL USE ONLY **********

Authorized BCCS Personnel	Signature	Date

The client may revoke this Consent for Disclosure of Client Information at any time by completing the following:
I HEREBY REVOKE CONSENT FOR DISCLOSURE OF THE INFORMATION TO THE DPHSS-BCCS AS OF: _____

Signature of Client/Parent/Guardian: _____ Date:_____

Applicant Information

Parent/Legal Guardian AND Applicant Signature

GUAM POLICE DEPARTMENT

DIPÅTTAMENTON POLISIAN GUAHAN

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Signed on this_____day of _____,20__24__.

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Submitted by:

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Print Name
Agency/Department's Representative

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_____ _____
(Print) (Signature)

Attachment

GOVERNMENT OF GUAM
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES

Division of Environmental Health, Health Certificate Program
Division of Public Health, Communicable Disease Control Program

HEALTH CERTIFICATE CLEARANCE APPLICATION

PLEASE COMPLETE BOX BELOW BEFORE PRESENTING THIS FORM TO YOUR HEALTHCARE PROVIDER

Applicant's Name: _____ **Citizenship:** _____
Last First Middle

Birth Date: ____/____/____ **Social Security #** _____ - _____ - _____ **Sex:** ☐ **Male** ☐ **Female**
(Mo.) (Day) (Year)

Marital Status: ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed** **Ethnicity/Nationality:** _____

Contact Number: **(Work)** _____ **(Home)** _____ **(Cell)** _____

Mailing Address: _____

Residential Address: _____

Place of Employment: _____ **Location (Village):** _____

Job Title: _____

I certify that the information provided above is true and accurate to the best of my knowledge:

SIGNATURE: _____ **Date:** _____

NOTE TO APPLICANT: A valid photo I.D. (i.e. passport, driver's license, authorization to work for alien workers, or other valid photo I.D.) must be presented when submitting this form to the department.

TYPE OF APPLICATION

NOTE TO HEALTHCARE PRACTITIONER: The above-named person is applying for DPH&SS Health Certificate in the occupation category checked below.

☐ NEW APPLICANT

☐ **FOOD FACILITY (GFC):**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.

☐ **COSMETOLOGY:**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.
- Certification of Examination
- Professional License

☐ **COSMETOLOGY STUDENT:**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.
- Certification of Examination
- Letter of enrollment from certified cosmetology school

☐ **COSMETOLOGY HELPER ONLY:**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.

☐ **TATTOO:**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.
- Certification of Examination

☑ **INSTITUTIONAL (Nursing Home, Adult Care, Child Care, Correctional Facility):**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.
- Physician's Certification of Examination

☐ **LAUNDRY/DRY CLEANING:**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.
- Physician's Certification of Examination

☐ **THERAPEUTIC MASSAGE:**
- Two current passport sized photographs
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.
- Certification of Examination
- Professional License

☐ **THERAPEUTIC MASSAGE HELPER ONLY:**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.

☐ RENEWAL APPLICANT

☐ **FOOD FACILITY (GFC):**
- Do not use this form, please use the *RENEWAL of Eating & Drinking and/or Food Establishments* form

☐ **COSMETOLOGY:**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.
- Certification of Examination
- Professional License

☐ **COSMETOLOGY STUDENT:**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.
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- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.
- Certification of Examination

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- Physician's Certification of Examination

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- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.
- Certification of Examination
- Professional License

☐ **THERAPEUTIC MASSAGE HELPER ONLY:**
- PPD skin test for TB within 6 months of applying – if ***POSITIVE***, perform chest x-ray and obtain clearance from CDC office, Room 118.

HEALTHCARE PROVIDER CERTIFICATION ON REVERSE SIDE

HEALTHCARE PROVIDER CERTIFICATION

NOTE TO ALL HEALTHCARE PROVIDERS: Please review the following instructions before completing this form.

PPD TEST RESULTS: Report the result of PPD skin test by giving the date the PPD was given, the date read, and the measurement in millimeters (mm).

Section A: This section is to be completed only if the applicant is free of communicable diseases, including those for which screening is specified.

Section B: This section is to be completed only if the applicant is not free of communicable diseases, including those for which screening is specifically indicated. Applicants with positive PPD skin tests must be referred by their physician to their reference x-ray facility to have a routine chest x-ray performed to screen for active tuberculosis. This x-ray must be read and interpreted by a licensed radiologist and a written report prepared for the physician.

COMMUNICABLE DISEASE CONTROL (CDC) CERTIFICATION: CDC certification is to be signed ONLY by the CDC Tuberculosis Program Coordinator of the department upon completion of all the reporting requirements and after the CDC physician's medical evaluation certifies that the applicant has completed/or is currently under treatment and has been certified as non-contagious.

WARNING: THIS CLEARANCE IS NOT VALID UNLESS THE PRINTED NAME AND SIGNATURE OF THE PHYSICIAN/AUTHORIZED PERSON (INCLUDING TITLE) ARE PRESENT IN SECTION "A" OR "B" ALONG WITH THE PHYSICIAN'S/AUTHORIZED PERSON'S STAMP AND THE REQUIRED MEDICAL INFORMATION.

Applicant's Name: _____

PPD TEST RESULT: Date Given: _____, Date Read: _____, Reading: _____ (mm)

PLEASE CHECK AND COMPLETE EITHER SECTION "A" OR "B" AS APPROPRIATE

I have performed the health screen tests indicated on the front of this form and find the applicant:

A

☐ is free of the communicable diseases for which screening is indicated above for the occupation in which the applicant desires employment.

_____
Physician's or other Authorized Name (Print and Stamp)

_____
If not Physician, Title (Print and Stamp)

_____
Signature Date

This Applicant should go directly to the DIVISION OF ENVIRONMENTAL HEALTH at the Department of Public Health and Social Services in Mangilao to continue processing.

COMMUNICABLE DISEASE CONTROL CERTIFICATION

FOR COLUMN "B" TO THE RIGHT:

The applicant ☐ may ☐ may not

Be employed in the occupation indicated above as of this

Date: _____

_____
Signature: DPH&SS, CDC Certifying Officer

B

☐ is **NOT** free of the communicable disease for which screening is indicated above for the occupation in which the application desires employment.

Attached are the copies of the following indicated documents:

☐ Physical Examination (Health Screen) Form
☐ A written report of laboratory test results.
☐ A copy of the official Radiological Report.
☐ Other (Specify) _____

_____
Physician's or Other AUTHORIZED Name (Print and Stamp)

_____
If not Physician, Title (Print and Stamp)

_____
Signature Date

This Applicant should go directly to the COMMUNICABLE DISEASE CONTROL PROGRAM, ROOM 118, at the Dept. of Public Health and Social Services in Mangilao to continue Processing.

FOR DEH USE ONLY:

Received by: _____

Date: _____

TUBERCULOSIS (TB) EVALUATION FORM

PLEASE SUBMIT FOR CLEARANCE REQUEST FOR PATIENTS HAVING POSITIVE TB INFECTION

NAME	_____	**DOB:**	_____
HOME ADDRESS:	_____	**ETHNICITY:**	_____
MAILING ADDRESS:	_____	**PHONE NUMBERS:** (Home/Work/Mobile)	_____

PPD SKIN TEST	Date given:_____ Date read: _____ Result:_____ Reading: _____mm
IGRA TEST	Date given:_____ Test Type: _____ Result: _____

Has the patient been exposed to active TB in the last (2) years? ☐ *Yes* ☐ *No*

SYMPTOMS ≥ 2 WEEKS	**YES**	**NO**
Cough		
Fever		
Weight loss		
Night sweats		
Fatigue		
Chest pain		
Shortness of breath		
Hoarseness		

DOES THE PATIENT HAVE A HISTORY OF:

Cancer ☐ Yes ☐ No Type: _____

Hepatitis ☐ Yes ☐ No

Kidney Disease ☐ Yes ☐ No On dialysis? ☐ Yes ☐ No

Rheumatoid Arthritis (Joint Pain) ☐ Yes ☐ No

HIV/AIDS ☐ Yes ☐ No On medications? ☐ Yes ☐ No

Other/Note: _____

If response is "yes" to any of the symptoms or CXR is abnormal, patient will need a repeat (2) view CXR or follow the Radiologist' recommendations before referral to Public Health for clearance*

Chest X-ray

(copy of report **MUST** be attached)

Date of CXR: _____ ☐ Normal ☐ Abnormal

Comments: _____

REPEAT CXR

(if applicable, copy of report **MUST** be attached)

Date of CXR: _____ ☐ Normal ☐ Abnormal

Comments: _____

NOTE: If active TB is suspected, refer by call or email to the Tuberculosis/Hansen's Disease Control Program

LTBI TREATMENT: ☐ 3HP ☐ INH ☐ RIF Other: _____

Date Started:_____Date Completed:_____

☐ Refused Date Refused _____Reason for refusing:_____

Adverse reactions to LTBI therapy? ☐ ***Yes*** ☐ ***No***

By signing this form, I,_____(Name of licensed provider (MD/NP/PA)), am certifying that I have ruled out active TB and the patient is cleared for work/school.

NAME OF CLINIC	**PHYSICIAN SIGNATURE/STAMP**	***Date (valid 90 days)***

DEPARTMENT OF PUBLIC HEALTH & SOCIAL SERVICES
BUREAU OF COMMUNICABLE DISEASE CONTROL
TUBERCULOSIS/HANSEN'S DISEASE CONTROL PROGRAM
520 West Santa Monica Avenue, Dededo, Guam 96929
Phone: (671) 687-4388 / Email: tb.program@dphss.guam.gov

Revised and effective: August 01, 2020

CLEAR FORM

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIVISION OF ENVIRONMENTAL HEALTH

INSTITUTIONAL FACILITY
PHYSICIAN'S CERTIFICATION OF EXAMINATION

APPLICANT: ***Please complete and submit this form if applying for Health Certificate to work at a Childcare facility, Nursing Home, Adult Care, Correctional Facility and other institutional facility (Title 10 GCA, Chapters 22 and 25). NOTE: Only forms with the original signature of the physician will be accepted. Stamped or digital signatures will NOT be accepted.***

Name: _____ Sex: _____ Citizenship: _____
Last, First MI

Date of Birth: ____/____/_____ Place of Birth: _____ Ethnicity/Nationality: _____

Place of Employment: _____ Location: _____

Healthcare Provider: ***Please complete the portion below and return to above applicant for submission to the Department of Public Health and Social Services.***

Based on my examination of the above person, I certify that the individual:

1. Has been tested for tuberculosis within the past 6 months of this date and the result was negative, OR result was positive but further test(s) revealed that the individual is not infectious.

2. Is currently free of any communicable disease that can be easily transmitted to another individual at the above person's workplace during his/her usual course of activities.

_____
NAME OF PHYSICIAN

_____
SIGNATURE

_____
CLINIC OR HOSPITAL

Date: _____

For Official Use Only

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES (DPHSS)
DIVISION OF CHILDREN'S WELLNESS
BUREAU OF CHILD CARE SERVICES (BCCS)
Child Care Assistance Program
www.guamchildcare.com
671-735-7344 / 7256

CONSENT FOR DISCLOSURE OF CLIENT INFORMATION

As stipulated in Guam Public Law 31-73 and as required by Federal law, 45 C.F.R. § 98.43, all adults (18 years and older) residing in the location where child care services are being provided, those employed by a child care provider for compensation, contracted employees and self-employed child care providers, and those who care for, supervise, or have unsupervised access to children are subject to a comprehensive background check. This consent shall be effective immediately and shall remain in effect for a duration not to exceed ninety days. A separate **CONSENT FOR DISCLOSURE OF CLIENT INFORMATION** form shall be submitted for every adult present where child care services are conducted.

PURPOSE OR NEED FOR DISCLOSURE

- National Sex Offender Registry
- Local Sex Offender Registry
- Guam Child Abuse and Neglect Registry
- National FBI Criminal History Check (Fingerprint)
- Virtual Computerized Criminal History
- General (Internet) Google Search
- Other: 2024 GSYEP
- Other: _____

INFORMATION REQUIRED TO PROCESS A COMPREHENSIVE BACKGROUND CHECK

First Name	Middle Name	Last Name

Other Known Alias	Date of Birth	Race/Ethnicity	Military Service Member?
			☐Yes ☐No

Current Address on Guam: ☐check box if currently residing outside of Guam

Current Address	Village	State	Zip Code

Previous Address Within the Last Five Years:

Previous Address

Previous Address Outside of Guam Within the Last Five Years:

Previous Address

NAME OF PROGRAM OR ORGANIZATION TO RECEIVE INFORMATION

Requesting Organization:	Department of Public Health and Social Services, Bureau of Child Care Services
Email Address:	childcare@dphss.guam.gov
Mailing Address:	130 University Drive Unit 15, Mangilao Guam 96913
Contact Number:	(671) 735-7344; (671) 735-7256

By signing this authorization form, I give my permission and consent to the Bureau of Child Care Services (BCCS) to obtain and review records of criminal history to prove the eligibility requirements are satisfied as required by law.

Signature of Client/Parent/Guardian: _____ **Date**: _____

**********FOR OFFICAL USE ONLY **********

Authorized BCCS Personnel	Signature	Date

The client may revoke this Consent for Disclosure of Client Information at any time by completing the following:

I HEREBY REVOKE CONSENT FOR DISCLOSURE OF THE INFORMATION TO THE DPHSS-BCCS AS OF: _____

Signature of Client/Parent/Guardian: _____ Date:_____

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES (DPHSS)
DIVISION OF CHILDREN'S WELLNESS
BUREAU OF CHILD CARE SERVICES (BCCS)
Child Care Assistance Program
www.guamchildcare.com
671-735-7344 / 7256

Background check requirements are applicable to licensed, regulated, and registered child care providers, and current & prospective child care staff members. Refusal to submit to the background check requirements will result in ineligibility to be employed as a child care provider and receive CCDF payments. Child care facilities or child placement agents shall not employ or certify any individual who has been found guilty of any disqualifying crime. Applicants may appeal the results of a background check to challenge the accuracy or completeness of the information contained in the report.

HOW TO APPEAL AGAINST FINDINGS

Request to appeal should be directed to the agency of jurisdiction. Contact the Child Care Licensing section for information regarding the appeals process.

Guam Criminal History Report and/or **Office of the Attorney General Clearance**	Guam Police Department or Office of Attorney General
Guam Sex Offender Registry	Judiciary of Guam
Guam Child Abuse and Neglect Registry	DPHSS-BOSSA, Child Protective Services
General Internet Search	DPHSS-BCCS
National Criminal History Check (FBI Finger Print Check) and **NCIC National Sex Offender Registry Check**	FBI at https://www.edo.cjis.govx
Appeals related to **Interstate Background Checks** and/or Child Abuse and Neglect Registry Checks	Filed subject to the providing state's requirements.
Navy Criminal Investigation Section	Navy-Marine Corps Court of Criminal Appeals

DISQUALIFYING CRIMES
[45 CFR 98.43(c)(1)]
List of disqualifying crimes that may make a person unsuitable to own, conduct, maintain, operate, or be employed by a child care center, group child care home, family child care home, or by any license or license-exempt CCDF certified child care provider.

Misdemeanors	**Felonies**	
Child abuse	Murder	Child Abuse or Neglect
Child endangerment	Spousal Abuse	Arson
Sexual assault	Kidnapping	Physical Assault or Battery
Misdemeanor involving child pornography	Crime against children, including pornography	Drug-related offense
	Rape or sexual assault	

BCCS shall notify the applicant about their eligibility to be CCDF certified

FAQ

How do I receive a copy of any records found?
Any individual subject to a background check may receive a copy of any records found on any of the registries or databases by submitting a written request. If the results of any information found on any registry is incorrect, the individual(s) subject to the background checks shall contact the registry to appeal such errors.

What if there was a charge that has been dismissed or expunged?
Please send the court documents that show the charge information, including the date of the charge and the charge status being dismissed or expunged to our office email: childcare@dphss.guam.gov, and BCCS shall validate this information.

What happens if a new charge or conviction occurs after being qualified?
All child care providers and household members who have incurred any pending charges, indictments, or convictions must notify BCCS within 10 business days or before returning to work, whichever comes first. An individual will be disqualified to work in providing child care if any of the disqualifying crimes are committed.

What is required for applicants who lived outside of Guam within the last 5 years?
Applicants who have lived out of Guam within the last 5 years is subject to undergo a criminal history report and a child abuse and neglect registry check from the states they have lived in.

When will the applicant be issued the CCDF Provider Certification?
A CCDF Provider Certification will be issued upon validation of documentation and successful completion of the preliminary requirements to include but not limited to: undergo a preliminary facility inspection, criminal history background check, and pre-service orientation of health and safety standards.