

CFS 689
6/2001

State of Illinois
Illinois Department of Children and Family Services

AUTHORIZATION FOR BACKGROUND CHECK
Child Abuse and Neglect Tracking System (CANTS)

Madden MHC
Facility

For Programs NOT Licensed by DCFS

NOTE: Do not use this form if you are an applicant for licensure or an employee/volunteer of a licensed child care facility. Please contact your licensing representative.

Name: _____
Last First Middle

Date of Birth: _____ Gender (circle): Male Female Race: _____

Current Address: _____
Street/Apt #

City State Zip Code

List all addresses at which you have resided in the past five years:

List maiden name and/or 'all other names by which you have been known: (last, first, middle)

I hereby authorize the Illinois Department of Children and Family Services to conduct a search of the Child Abuse and Neglect Tracking system (CANTS) to determine whether I have been a perpetrator of an indicated incident of child abuse and/or neglect or involved in a pending investigation. I further consent to the release of this information to the agency listed below.

Signed Date

Please type, use bold letters or label:

Department of Human Services (Agency Name)

Attn: Peggy Wilham (Contact Person)

222 S College--Ground Floor (Address)

Springfiled, IL 62704 (City !State/Zip)



John J. Madden MHC
Annual Employee Tuberculosis Screening Questionnaire

*Questionnaire is completed annually by all employees.

*If you are uncertain about how you are to screen contact Employee Health Services at ext. 7318.

Directions: Please circle answer which applies. Write in additional information in space provided. On item #12, print your name, provide signature and date. ~

- | Yes | No | |
|------------|-----------|--|
| 1. Y | N | History of suspected or confirmed [diagnosed TB) |
| 2. Y | N | Has a physician requested that you use isoniazide [INH) or rifampin for preventive or prophylactic purposes? _____ |
| 3. Y | N | Productive cough for 3 weeks or longer _____ |
| 4. Y | N | Persistent low grade fever _____ |
| 5. Y | N | Night Sweats _____ |
| 6. Y | N | Loss of Appetite _____ |
| 7. Y | N | Swollen glands [usually in the neck) _____ |
| 8. Y | N | Recurrent bladder or kidney infections _____ |
| 9. Y | N | Coughing up blood _____ |
| 10. Y | N | Shortness of breath _____ |
| 11. Y | N | Has a member of your household been diagnosed and treated for TB? |

12. I _____ acknowledge that I have been provided with access to the Madden MHC PPD
Print Name IC-20, Management of Tuberculosis. I also understand the need for, and, importance
of, employee screening as it relates to the general welfare of myself, patients &
family members served at this facility, co-workers, &, the community.

Signature Date

Employee Health Services Notes

*Documentation of follow up, and/or, action taken in response to "yes" answers by employee.

Signature/Title Person Recording _____ Date _____

*When either of the following is suspected consult with Health Services Physician:

- 1. The employee needs Mantoux screening.
- 2. The employee may have a latent TB infection, and, May not have had medical consultation or treatment,

Employee Health Services Physician Notes

Physician Signature _____ Date _____



ILLINOIS

Rod R. Blagojevich, Governor

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

REQUEST FOR :RELEASE OF INFORMATION

TO: Director Illinois State Police

FACILITY: JOHN J. MADDEN M. H. C.

I, _____, do hereby authorize the Illinois State Police to release information relative to the existence or nonexistence of any criminal record which it might have concerning me to any Department of the State of Illinois solely to determine my suitability for employment or continued employment with the State of Illinois. I further authorize any agency, which maintains records relating to me to provide same on request to the Illinois State Police for the purpose of this investigation.

I certify that the Illinois State Police, and its officers or employees who furnish this information concerning me, and any agency and its officers and employees which provides these records to the Illinois State police, shall not be held accountable for giving this information. I do hereby release and save harmless the Illinois State Police, its officers and employees, and any other agency and its officers and employees which provides records concerning me for the purpose of this investigation, from any and all liability which may be incurred as a result of releasing such information.

A photocopy of this release form will be valid as an original thereof, even though the said photocopy does not contain an original writing of my signature •.

I have read and understand the contents of this Request for Release of information.

Witness Signature (include maiden name) Address City, State Zip Code Date of Birth Social Security Number Drivers License Number Gender (circle) Male Female

COMPLETE AND SIGN BOTH SIDES OF THIS FORM

APPLICANT BACKGROUND INFORMATION

Please complete the following question:

Have you ever been convicted of a criminal offense other than a minor traffic violation?

YES

NO

If your answer to the foregoing question is "yes," please provide a detailed statement for each such occurrence.

Signature

Date

COMPLETE AND SIGN BOTH SIDES OF THIS FORM