MARYLAND STATE DEPARTMENT OF EDUCATION Office of Child Care

SUBSTITUTE FORM
(For Provider or Additional Adult)

Name of Substitute: _____
(First, Middle, Last) (Maiden or other names used)

Address: _____

City: _____ State: _____ Zip Code: _____ Phone #: _____

Social Security #: _____ Date of Birth: _____ Gender: ☐ Female ☐ Male ☐ Non-binary

Race (check all that apply): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Pacific Islander ☐ White ☐ other (specify):

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Primary Spoken Language: _____

Relationship to the Provider (i.e. spouse, parent, child, sibling, etc.): _____

I have agreed to serve as a substitute for: ☐ The Provider: ☐ Provider's Additional Adult:

Provider's Name: _____

Provider's address: _____

I agree to apply for Federal and State criminal background checks. If I reside or have resided, in a state outside of Maryland in the past 5 years, I agree to complete a background check within that state as required by the Office of Child Care (OCC).	YES ☐	NO ☐
I am at least 18 years of age and, physically and mentally capable of providing care for children.	YES ☐	NO ☐
I have read the family childcare regulations and agree to follow them. COMAR 13A.15 Family Child Care	YES ☐	NO ☐
I agree to be ready to substitute at the provider's address during the childcare hours.	YES ☐	NO ☐
I agree to submit to the OCC, a medical evaluation that has been completed within the past 12 months.	YES ☐	NO ☐

I understand that a substitute cannot be used as a substitute for more than 20 days in any 12-month period. A day counts only when the substitute gives care for more than 2 hours. The Office of Child Care (OCC) must approve, in advance, the use of more than 20 substitute days in a 12-month period.

I understand that OCC will complete a child and adult abuse and neglect check on me, which requires the completion of a notarized release of information form. I understand that I cannot be used as a substitute until OCC completes the required clearances for my approval.

I understand that the provider shall inform me about matters pertinent to the health and safety or welfare of children in care.

I certify that the information on this form is correct and true.

Substitute Signature:_____ Date:_____

Provider Signature:_____ Date:_____