NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Mary T. Bassett, MD, MPH
Commissioner

Health

Frank Cresciullo
Assistant Commissioner

Bureau of Child Care
125 Worth Street
Suite 315 – Box CN68
New York, NY 10013

+1 646 632-6100 tel.
+1 347 396-8064 fax

January 11, 2017

Dear Camp Operators:

The Department of Health and Mental Hygiene (DOHMH) welcomes all summer camp operators to the 2017 camp year. Renewing and prospective camp operators should apply now for a summer camp permit to provide care during the summer months, using the DOHMH Online Licensing System.

The online system allows applicants to submit their applications and pay applicable fees. You can access the system at www.nyc.gov/mylicense. New applicants will need to create an account in order to submit the required camp application documents, fees, or proof of 501c (3) tax exemption status. Once accounts have been created, you may go online to submit new applications, request amendments, check on the status of your applications, and make payments.

Applicants should contact 311 for assistance with the online system or contact your respective borough office with any questions you may have. We hope you find these improvements beneficial and that these changes provide efficiencies in the associated processes and your interaction with the DOHMH as you continue to provide for the health and safety of children in your care.

Sincerely,

Frank Cresciullo
Assistant Commissioner

This page is intentionally left blank.

SUMMER CAMP **NEW** PERMIT APPLICATION PROCEDURES AT A GLANCE
BUREAU OF CHILD CARE

SUBMIT YOUR APPLICATION AT LEAST 90 DAYS PRIOR TO THE START DATE OF YOUR CAMP.
Summer Camp Applicants must use the Citywide Licensing System to renew or apply for a new permit, pay a permit fee, and pay outstanding violations. New camps will need to create an online account to apply.

Step 1: **New Permit Applicants**

- Go online to www.nyc.gov/mylicense
- Create an account by clicking on "New User?" in the login box
- Login using your new "User Name" and password
- Click "Select An Online Service"
- Accept Terms and Agreements, click "Continue"
- Choose "Child Care – Summer Camps Fee Exempt Permit Process" or
  "Child Care – Summer Camps Permit Process"
- Complete the online application

- UPLOAD DOCUMENTS INDIVIDUALLY

After attaching each document below, choose the "type" from the drop down list and provide a description.

- ❒ Initial Site Survey Form (Initial Site Inspection Request Form)
- ❒ Affidavit
- ❒ Government Issued Photo Identification
- ❒ If you are Fee Exempt, submit proof of fee exemption – (Proof of ACS Contract or 501(c)(3) Status) and a letter of "current and good-standing" with the U.S. Treasury Department, otherwise you must process the non-refundable $200 permit fee. **Retain a copy of the e-mail confirmation as proof of payment.**

-The BCC will schedule and conduct a site viability inspection upon receipt of your Site Inspection Request.

-Subsequently the following forms and documents must also be uploaded INDIVIDUALLY:

- ❒ Children's Camp Facility and Staff Description
- ❒ Camp Director SCR Database Check Form
- ❒ Camp Director Certified Statement on Criminal History
- ❒ Trip Itinerary and Parental Consent Form
- ❒ Workers' Compensation Insurance
- ❒ Proof of Current Disability Insurance Coverage
- ❒ Proof of Current Comprehensive Liability Coverage
- ❒ Motor Vehicle Insurance (Camp)
- ❒ Certificate of Occupancy (C of O), or Temporary Certificate of Occupancy (TCO) or Letter of No Objection (LNO). Either of these may be obtained from the NYC Department of Buildings and shall not be expired prior to camp's start date. (Please note: TCO or LNO may take up to 90 days to obtain.)

Step 2: Submit a Summer Camp Safety Plan for review to your respective borough Office. The Safety Plan template can be downloaded from our website at www.nyc.gov/health/camps, click on "NYC Summer Camp Safety Plan - For New Camps or New Camp Directors (PDF)". A copy of the safety plan must be retained on site.

Step 3: ***New*** Camp Directors and Aquatics Directors must attend an Orientation Session. You must register by visiting www.nyc.gov/health/camps, click "Camp Director's Information", then click "Online Service Registration."
After attendance, you will be given a certificate with a number starting with "CLD" which will be required before you receive your permit.

SUBMIT YOUR APPLICATION EVEN IF YOU HAVE NOT YET ATTENDED AN ORIENTATION.

The following documents should be reviewed before hiring staff and shall be provided to the department upon request:

1. Health Director Certifications (e.g. Current CPR and Advance First Aid Certifications)
2. Aquatic Director Certifications (e.g. Current CPR and Lifeguard Management Certifications)
3. Sex Offender Registry Check by NYS Division of Criminal Justice Services for all staff
4. Letters of Reference from most recent employers
5. Staff Physical Examinations

Review Article 48 of the New York City Health Code and Subpart 7-2 of the State Sanitary Code for all permit requirements at www.nyc.gov/health/camps.

NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Mary T. Bassett, MD, MPH
Commissioner

SUMMER CAMP SITE INSPECTION REQUEST FORM

(Pursuant to Article 48 of the Health Code of the City of New York)

PLEASE PRINT ALL RESPONSES WHERE REQUIRED

1) NAME OF APPLICANT/OWNER/SPONSOR:

_____

2) NAME OF SUMMER CAMP (DBA):

_____

3) NAME OF DIRECTOR WHO ATTENDED THE DIRECTOR'S ORIENTATION:

_____

4) SITE ADDRESS AND APPLICANT CONTACT INFORMATION:

Building No.: _____ Street: _____

Borough/Town: _____ Zip: _____

Tel No.: (_____)_____ Fax No. (_____)_____
(Where you may be reached at all times)

E-Mail Address: _____ Website:_____

5) MAILING ADDRESS (If different from site address):

Building No.: _____ Street: _____

Borough/Town: _____ Zip: _____

6) PERMIT FOR WHICH YOU ARE APPLYING – Check only one:

- ❑ Summer Day Camp
- ❑ Municipal Summer Day Camp
- ❑ Children's Overnight Camp
- ❑ Traveling Summer Day Camp
- ❑ Developmentally Disabled Summer Day Camp

Are 20 percent or more of campers enrolled developmentally disabled?

❑Yes ❑No

7) OPERATIONAL INFORMATION – Please complete the following:

EXPECTED DATE OF OPERATION (MM/DD/YYYY): _____TO_____,

Days Open: ❑ SUN ❑ MON ❑ TUES ❑ WED ❑ THURS ❑ FRI ❑ SAT Hours:

Open from: ____:_____❑ AM ❑ PM Close at: ____:____❑ AM ❑ PM

Number of Camp Sessions: _____

A. SESSION DATES:

FIRST SESSION: FROM: _____ TO: _____

SECOND SESSION: FROM: _____ TO: _____

THIRD SESSION: FROM: _____ TO: _____

FORTH SESSION: FROM: _____ TO: _____

8) ORGANIZATION TYPE – If known, check whether applicant is an:

❑ Individual
❑ Incorporated Organization
❑ Partnership
❑ Non-Profit 501(c)(3) (**Note**: Must submit Proof of Current Non-Profit Status)

9) EMPLOYMENT IDENTIFICATION NUMBER (EIN): _____

10) ORGANIZATION NAME– If known:

NAME OF INDIVIDUAL, PARTNERSHIP OR INCORPORATED OR UNINCORPORATED ORGANIZATION:			
WHERE INCORPORATED:	**DATE INCORPORATED:**	**FILED IN COUNTY OF:**	**DATE FILED**

Please attach a copy of charter or certificate of incorporation, or document showing organization as a partnership and/or Non-Profit 501 (c) 3 status.

OWNER/ BOARD MEMBERS – If applicable:

OWNER/OPERATOR/BOARD MEMBERS		
PRINT NAME:	**TITLE:**	**HOME ADDRESS:**

Please use another piece of paper for additional board members.

11) STAFFING – If known:

	NAME:	**HOME ADDRESS:**	**TELEPHONE:**
CAMP OPERATOR			( )
CAMP DIRECTOR			( )

12) OTHER PROGRAMS:

Do you or anyone associated with this application currently operate any other residential or commercial child care service?

❑ Yes ❑ No

If yes please identify. Select all that apply

❑ Group Child Care ❑ School Based Child Care

❑School-Age Child Care ❑Family and/or Group Family Day Care

❑Other_____

If so, what is the Permit/License/Certificate or Registration number?

Permit/License/Certificate/Registration #:

_____

_____

If yes, please identify name (s) and address (es):

_____

_____

_____

_____

Have you or anyone associated with this application ever operated a residential or commercial child care service?

❑ Yes ❑ No

If yes please identify. Select all that apply

❑ Group Child Care ❑ School Based Child Care

❑School-Age Child Care ❑Family and/or Group Family Day Care

❑Other_____

If so, what is the Permit/License/Certificate or Registration number?

Permit/License/Certificate/Registration #:

_____

_____

If yes, please identify name (s) and address (es):

_____

_____

_____

_____

Have you or anyone associated with this application ever owned, operated, or worked at a residential or commercial child care service that was suspended and / or revoked?

❑ Yes ❑ No

If yes, please identify name (s) and address (es):

_____

_____

_____

_____

_____

13) FLOORS AND ROOMS TO BE USED FOR CARE OF CHILDREN – (Please identify the floor, room number or name and the room's anticipated use):

FLOOR(S):	**ROOM NUMBERS PER FLOOR:**

Please attach an additional sheet of paper to add more rooms.

14) **Past History**

Have you or anyone associated with this application <u>ever</u> operated a Summer Camp other than the one related to this application?

❑ Yes ❑ No

If yes please identify. Select all that apply

❑ Summer Day Camp
❑ Municipal Summer Day Camp
❑ Children's Overnight Camp
❑ Traveling Summer Day Camp
❑ Developmentally Disabled Summer Day Camp

If so, what is the Permit/License/Certificate or Registration number?

Permit/License/Certificate/Registration #:

_____

If yes, please identify name (s), address (es) and position held:

_____

_____

_____

_____

Have you or anyone associated with this application ever owned, operated, or worked at a summer camp whose permit was suspended and /or revoked?

❑ Yes ❑ No

If yes, please identify name (s) and address (es):

_____

_____

_____

_____

_____

15) SIGNATURE OF SUBMITTER:

_____	_____
SIGNATURE	DATE (MONTH/ DAY/ YEAR)
_____	_____
PRINT NAME	TITLE
_____	
RELATION TO APPLICANT	

NYC DEPARTMENT OF HELATH AND MENTAL HYGIENE- BUREAU OF CHILD CARE

AFFIDAVIT FOR PERMIT APPLICATION

I have read the New York City Health Code regulations pertaining to child care and will comply with all regulations pertaining to child care and will comply with all requirements if issued a permit.

A) I understand that my child care service will be subject to inspection. I shall comply with the terms of the permit of the New York City Health Code and other applicable laws and regulations.

B) I hereby certify that any statement made on this form or information given later on in the course of an investigation of my application will be true and correct to the best of my knowledge.

If the permittee or his/her employees or agents refuse to answer questions related to this permit application after being granted testimonial or use immunity, this permit may be revoked or other appropriate action may be taken.

_____ _____

PRINT NAME OF OWNER/OPERATOR/BOARD MEMBER TITLE

_____ _____

SIGNATURE DATE

_____

BUILDING NO. STREET

_____

BOROUGH/CITY STATE ZIP CODE

Sworn to before me

This ____ day of _____

_____

Notary Public

This page is intentionally left blank.

Bureau of Child Care

Children's Camp Facility and Staff Description

❒New Camp Permit
❒Renewing Camp Permit CAMIS/RECORD ID#:_____

Section A - Camp Information

Camp Organization/Sponsor: _____

DBA Name:_____

Camp Site Address: _____
Street Borough Zip code

Operator/Director E-mail:_____

Camp Website:_____ Contact Tel. #:_____

Camp Type: ❒Day Camp ❒Traveling Camp ❒Overnight Camp ❒Developmentally Disable

Section B - Facility

Camp Tel #:_____ Camp Fax #:_____

Days Open: ❒Su ❒M ❒Tu ❒W ❒Th ❒F ❒Sa Hours: From _____:_____ To _____:_____

Section C- Sessions

If your program has more than 1 session, provide the open and close dates for each.

Session 1	Open Date_____	Close Date_____	❒No Trips	❒Itinerary submitted
Session 2	Open Date_____	Close Date_____	❒No Trips	❒Itinerary submitted
Session 3	Open Date_____	Close Date_____	❒No Trips	❒Itinerary submitted
Session 4	Open Date_____	Close Date_____	❒No Trips	❒Itinerary submitted

Use a separate sheet of paper for additional sessions.

Section D- Services/Activities

❒ Amusement Parks
❒ Aquatics Theme Parks
❒ Archery
❒ Arts & Crafts
❒ Aquatics Off-Site Swim
❒ Aquatics On-Site Swim
❒ Aquatics Wilderness Swim
❒ Bicycling
❒ Boating/Canoeing/Rafting
❒ Bowling
❒ Classroom Instruction
❒ Cooking
❒ Court Sports
❒ Dance
❒ Field Sports
❒ Fishing
❒ Go Carts
❒ Gymnastics
❒ Hiking
❒ Horseback Riding
❒ Ice Skating
❒ Martial Arts
❒ Nature Study/Walks
❒ Off-Site Trips
❒ Organized Games
❒ Overnight Trips
❒ Petting Zoo
❒ Rock Climbing
❒ Ropes/Challenge
❒ Skating/Skate boarding
❒ Sprinklers
❒ Theatre/Performance
❒ Wood Working/Carving
❒ Zip Lining
❒ Other_____
❒ Other_____
❒ Other_____

CAMIS/RECORD ID#:_____

Section E - CAPACITY

Facility Capacity:_____
Maximum capacity shall not exceed Certificate of Occupancy/Letter of No Objection.

Check one:
❒ Certificate of Occupancy (CO) attached/previously submitted
❒ Temporary Certificate of Occupancy (TCO) attached, Expiration Date:____/____/_____
❒ Letter of No Objection (LNO) attached/previously submitted
❒ Place of Assembly attached/ previously submitted

Section F - STAFF

Name of Camp Operator(Required)**:**_____

Name of Camp Director(Required)**:**_____, _____/_____/_____
Date of Birth

Orientation Attendance: _____/_____/_____
Date Attended or Will Attend

Experience/Qualification: _____

Provide the following with this application:
❒Resume showing supervisory camp experience (for New Directors)

Name of Co-Director(Optional): _____ , _____/_____/_____
(or Assistant Director) Date of Birth

Orientation Attendance: _____/_____/_____
Date Attended or Will Attend

Experience/Qualification: _____

Provide the following with this application:
❒Resume showing supervisory camp experience

Name of Health Director(Required): _____

Qualifications: ❒Physician ❒Physician Assistant ❒Nurse Practitioner ❒Registered Nurse
❒Licensed Practical Nurse ❒Emergency Medical Technician
❒Other (CPR Pro and Advance First Aid)

NYS Certificate/License# (if applicable):_____

Check only one:
❒ Health Director will be ON site.
❒ Health Director will be OFF site, Name of On-site Designee: _____
(or Assistant Health Director)

CAMIS/RECORD ID#:_____

The following certifications must be made available up time of inspection:

Certifications	*Course Provider	*Course Title	Issue Date
CPR PRO			
Advance First Aid			

*Refer to the "Guidelines for Aquatic, CPR and First Aid Certifications" for accepted courses.

You may skip this section if your program does not provide Swimming, Boating, or Aquatics Theme Park services.

Name of Aquatics Director:_____, _____/_____/_____
Date of Birth

Orientation Attendance: _____/_____/_____
Date Attended or Will Attend

Experience/Qualification: _____

Provide the following:
❒Resume showing qualifying experience (for New Aquatic Directors)

The following certifications must be made available up time of inspection:

Certifications	*Course Provider	*Course Title	Issue Date
CPR PRO			
Lifeguard Management			

*Refer to the "Guidelines for Aquatic, CPR and First Aid Certifications" for accepted courses.

Section G – Rooms – Do Not Leave This Section Blank

Room Type (e.g. Bathroom, Classroom, Play Area, Pool etc.)	**Floor #** (e.g. 1st, basement, cellar)	**Room #**

Pool CAMIS/RECORD ID #:_____
(for on-site pools only)

Section H - INSURANCE

Worker's Compensation

Certificate Attached: ❒C-105.2 Issued by Insurance Carrier ❒U26.3 NYS Insurance Fund ❒SI-12 Self-Insured ❒GSI-105.2 Group Self-Insured ❒CE-200 Exempt

❒ "NYC DOHMH, 125 Worth Street, New York, NY 10013" is listed as the certificate holder.

CAMIS/RECORD ID#:_____

Disability

Certificate Attached: ❒DB120.1 (Issued by Insurance Carrier) ❒DB-155 (Self-Insured) ❒CE-200 (Exempt)

❒ "NYC DOHMH, 125 Worth Street, New York, NY 10013" is listed as the certificate holder.

General Liability

❒Proof Attached (showing policy number, expiration date, coverage amount)

Vehicular Liability
Does your program own, rent, or charter vehicles for Trips or Pick Up/Drop Off Service?

❒Not Applicable ❒Yes - Proof Attached (showing policy number, expiration date, coverage amount)

Section I - SAFETY PLAN

Check one:
❒ New Safety Plan Submitted
❒ Safety Plan previously submitted, updated pages attached
❒ Safety Plan previously submitted, no updates needed

Section J - PARENT INFORMATION STATEMENT

Section 48.29 of the NYC Health Code requires a written statement be provided by each camp to all parents or guardians describing that

1) the camp is licensed by the New York City Department of Health and Mental Hygiene
2) is inspected twice yearly and includes the address where inspection reports are filed

❒ The above information will be provided to parents/guardians with the enrollment application forms and/or enrollment contract forms.

SIGNATURE

I CERTIFY THAT ALL THE INFORMATION GIVEN ON THIS FORM IS TRUE:

Signature of Camp Operator/Director: _____, ____/____/_____ (Date)

Print Name:_____

PENALTY FOR FALSE OR MISLEADING STATEMENTS - MADE ORALLY OR IN WRITING - MAY RESULT IN A MONETARY VIOLATION AND/OR IN A DENIAL OR REVOCATION OF YOUR SUMMER CAMP PERMIT.

Health
Bureau of Child Care

Instructions for Completing the State Central Register Database Check Form

Please note that all applicants must provide their complete addresses which they have resided for the last 28 YEARS.

It is extremely important that all information on the form can be easily read, so that data entry and results are accurate. Each SCR Database Check submitted should be reviewed for completeness and legibility by the camp program. If the form is incomplete or illegible, it will be returned to you for corrections.

APPLICANT/HOUSEHOLD MEMBER AREA:

- First line: Indicate your name. Last name first.
- Second line: Any maiden names, previous married names, or aliases by which you have been known. Circle whether it's maiden or alias. Use additional lines if there is more than one maiden/married/alias name to be listed. **Indicate "NONE" if there are no maiden or alias names.**
- If there are no other household members, check off box ☐ if you live alone below the "Maiden/Alias" line.
- Remaining lines: Indicate the names of all household members. **All household members that live with you are to be listed in this area of the form, regardless if they are related or not. Include all adults, children and roommates.** (Attach an additional page if needed.)
    - First column: indicate the **relationship** to the applicant, of each person listed as spouse, child, family member, or other.
    - Third column: indicate the **sex**. Fill in either M (Male) or F (Female) for each person listed.
    - Last column: fill in **date of birth** (mm/dd/yy) for each person listed.

ADDRESS AREA:

- Indicate all addresses that you have resided for the last 28 years or since birth in date order.
- Complete addresses are required. Include building number, street name/number, city/town/village and zip code. **Post Office box numbers are not acceptable.**
- If the applicant has lived abroad, indicate country and dates of residence. If the applicant has spent time in the military, list base names and locations along with dates. **Be sure that there are no periods of time unaccounted for.**
- The top line is for the current address. The previous address should be listed on the second line downward, and so on going back 28 years or since birth. (**Attach an additional page if needed.)**

SIGNATURE AREA:

- Only the applicant's signature is required.
- The signatures should match the applicant's name. For example, William Smith should not sign Will Smith.
- All signatures must be dated (mm/dd/yyyy). **The SCR will not accept a form with a signature date more than 6 months old.**

LDSS-3370 FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STATEWIDE CENTRAL REGISTER DATABASE CHECK

Agency Use Only

SCR USE ONLY
REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY USE ALPHA CODE:	PHONE NUMBER (Area Code):
DOHMH			M	

PRINT BELOW THE ADDRESS TO WHICH YOU WANT THE RESPONSE RETURNED:

AGENCY NAME: New York City Department of Health & Mental Hygiene

AGENCY LIAISON: Bureau of Child Care

STREET ADDRESS:

CITY: **STATE:** **ZIP CODE:**

The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box are also on the reverse side of this form.

FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS SECTIONS THAT APPLY. IF NONE, STATE "NONE" IN APPELLATIONSHIP in the fields below

(see reverse side for instructions) Attach additional page if necessary.

SAMPLE

The purpose of collecting the demographic data on other persons in your household who are not screened pursuant to Section 424-a of the Social Services Law is to enable the N.Y.S. Office of Children and Family Services to identify with the greatest degree of certainty, whether the person(s) being screened is the subject of an indicted child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA ***PLEASE TYPE OR PRINT CLEARLY**

Relationship to Applicant	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH mm	dd	yy
APPLICANT	DOE	JANE	F	5	9	63
~~MAIDEN~~/ALIAS	SMITH					
	☐ ← Check this box if you live alone.					
SPOUSE	DOE	JOHN	M	2	1	54
SON	DOE	JOHNNY	M	7	7	83
DAUGHTER	DOE	JANICE	F	3	20	02

Please provide your current address and any other addresses at which you have resided for the last 28 YEARS, including street, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 and older. Attach additional pages if necessary.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
10 STRAWBERRY STREET	1 FL	APPLETON	NY	10599	8/01	**PRESENT**
PREVIOUS STREET ADDRESS: 2 LAKE PLACE	APT # PH	CITY GREENTOWN	STATE NY	ZIP 10799	FROM 5/93	TO 7/01
PREVIOUS STREET ADDRESS: 378 BROAD AVENUE	APT # 12H	CITY LONGWOOD	STATE NY	ZIP 10999	FROM 1/89	TO 5/93
PREVIOUS STREET ADDRESS: 123 ORANGE ROAD	APT # 6F	CITY LEMONTOWN	STATE NY	ZIP 10699	FROM 1/87	TO 12/88
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO

I affirm that all the information provided on this form is true. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE	DATE	APPLICANT'S SIGNATURE	DATE
Jane Doe	1/15/2015		

Camp Name: Johnny B Good Day Camp CAMIS/RECORD ID#: 42322125

Camp Address: 75 South Camp Road, Down Town, NY 10699

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STATEWIDE CENTRAL REGISTER DATABASE CHECK

Agency Use Only

SCR USE ONLY
REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY USE ALPHA CODE:	PHONE NUMBER (Area Code):
DOHMH			M	(646) 632-6100

PRINT BELOW THE ADDRESS TO WHICH YOU WANT THE RESPONSE RETURNED:

AGENCY NAME: New York City Department of Health & Mental Hygiene

AGENCY LIAISON: Bureau of Child Care

STREET ADDRESS:

CITY: **STATE:** **ZIP CODE:**

The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box above are also on the reverse side of this form

FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS SECTIONS THAT APPLY. IF NONE, STATE "NONE" List RELATIONSHIP in the fields below

(see reverse side for instructions) Attach additional page if necessary.

The purpose of collecting the demographic data on other persons in your household who are not screened pursuant to Section 424-a of the Social Services Law is to enable the N.Y.S. Office of Children and Family Services to identify with the greatest degree of certainty, whether the person(s) being screened is the subject of an indicted child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA ***PLEASE TYPE OR PRINT CLEARLY**

Relationship to Applicant	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH mm	dd	yy
APPLICANT						
MAIDEN/ALIAS						
	☐ ← Check this box if you live alone.					

Please provide your current address and any other addresses at which you have resided for the last 28 YEARS, including street, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 and older.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM / MONTH YEAR	TO **PRESENT**
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM / MONTH YEAR	TO / MONTH YEAR
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM / MONTH YEAR	TO / MONTH YEAR
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM / MONTH YEAR	TO / MONTH YEAR
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM / MONTH YEAR	TO / MONTH YEAR

I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE	DATE	APPLICANT'S SIGNATURE	DATE

Camp Name: _____ RECORD ID#: _____

Camp Address: _____

This page is intentionally left blank.

STAPLE TO LDSS-3370 (IF NEEDED)

STATE CENTRAL REGISTER DATABASE CHECK FORM ADDITIONAL PAGE

(Use only if the space on the LDSS-3370 form is not sufficient)

APPLICANT NAME: _____

Print clearly. All dates must be consecutive. Be sure to associate address histories with particular individuals

Previous Street Address	Apt #	City	State	Zip	From	To
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR

STAPLE TO LDSS-3370 (IF NEEDED)

STATE CENTRAL REGISTER DATABASE CHECK FORM ADDITIONAL PAGE

(Use only if the space on the LDSS-3370 form is not sufficient)

APPLICANT NAME: _____

Other Household Members are (please print clearly):

SCR Use Only	Relationship to Applicant	Last Name	First Name	Sex	Date of Birth		
				M/F	MM	DD	YY

Bureau of Child Care

Prospective Children's Camp Director Certified Statement

Relative to Conviction of a Crime or the Existence of a Pending Criminal Action

CAMIS/RECORD ID#:_____

Director's Name: _____ **Date of Birth:** ____/____/_____

Home Address: _____,_____ _,_____ ,_____
Building Address City State Zip code

Have you ever been convicted of a crime (i.e. misdemeanor felony) or do you presently have a criminal action pending against you?

Yes ❒ No ❒ If "Yes", submit a copy of the disposition and provide the following information:

1. The date of the incident which resulted in the criminal conviction or charge:____/____/_____
2. The date of the conviction or charge:____/____/_____
3. The crime you were convicted of or are presently charged with:
   _____
   _____
4. The nature of the incident which resulted in the criminal conviction or charge:
   _____
   _____
5. The city, county and state you were convicted in or are presently charged in:
   _____
6. The name of the court you were convicted in or are presently charged in:
   _____
7. The penalties imposed as a result of the conviction (i.e., fine, jail term, restitution, etc.):
   _____
8. For each of the penalties imposed, list on the other side or a separate sheet of paper, the date the penalty was complied with (i.e. date fine or restitution was paid in full, date jail term was completed, etc.)

I, _____, certify under penalty or perjury that the above information is complete and accurate.

Signature: _____ **Date:** ____/____/_____

Sponsor/Camp Name: _____

Camp Address: _____,_____ _,_____ ,_____
Building Address City State Zip code

This page is intentionally left blank.

Health
Bureau of Child Care

Trip Itinerary & Parental Consent Form

For Off-Site and Swim Trips

Camp Name: _____ Session #: _____ CAMIS/RECORD ID#:_____

Camp Address:_____,_____,_____
(Building Address) (Borough) (Zip code)

*If swim trip is not an all-day event, provide hours **If camp uses "public transportation", indicate

Trip Date & (Swim Hours)*	Trip Destination & Complete Address	Mode of Transportation**	Activities	Parental Consent
				Yes❒ No❒
				Yes❒ No❒
				Yes❒ No❒
				Yes❒ No❒
				Yes❒ No❒
				Yes❒ No❒

Parental Consent:

I, _____, the parent/legal guardian of _____,
(Parent Name) (Camper Name)

_____ hereby give permission for him/her to participate in the trips and activities as indicated on the above itinerary.
(Camper Age)

Signature: _____ Date: _____

Use additional pages as needed.

Rev. 12/18/2013

This page is intentionally left blank.

BUREAU OF CHILD CARE
RESOURCE LIST FOR SUMMER CAMP PERMIT APPLICANTS

Bureau of Child Care (BCC) Administrative Office

For more information, visit: www.nyc.gov/health/childcare. Please direct questions to the office in which you plan to operate your Summer Camp. Walk-in hours at all offices are Tuesday through Thursday, from 9 a.m. to 4 p.m., or by appointment.

Fee Processing Unit

125 Worth Street, 3rd Fl, Room 315, Box 68
New York, NY 10013
Tel: (646) 632-6100
Fax: (347) 396-8054

Bureau of Child Care (BCC) Borough Offices

Manhattan/Staten Island Office

125 Worth Street, 9th floor, Room 916, Box 40
New York, NY 10013
Tel: (646) 632-6305
Fax: (347) 396-8953

Bronx Office

1309 Fulton Avenue, 4th floor
Bronx, NY 10456
Tel: (718) 579-7775 Fax: (347)396-8959

Brooklyn Office

195 Montague Street, 4th floor
Brooklyn, NY 11201
Tel: (718) 222-6323
Fax: (347) 396-8957

Queens Office

90-27 Parsons Boulevard, Suite 300
Jamaica, NY 11432
Tel: (718) 480-2263/2265
Fax: (347) 396-8955

Other New York City Agencies

Call **311**, or (212) NEW-YORK from outside NYC, for information about government services or visit 311 online at: www.nyc.gov/311.

How to Search for a Certificate of Occupancy

To search for an existing Certificate of Occupancy, visit **NYC Department of Buildings** website: www.nyc.gov/buildings
For information and application **forms to amend** or apply for a Certificate of Occupancy (CO) or Letter of No Objection (LNO) visit: http://www1.nyc.gov/site/buildings/about/forms.page

How to Obtain a Certificate of Fitness

NYC Fire Department: http://www.nyc.gov/fdny
The Fire Department issues Certificates of Fitness by providing written examinations to applicants. A valid Certificate of Fitness is required by laws and regulations to conduct child care within New York City. One employee at the child care service must hold a **Certificate of Fitness for Fire Alarm Systems and other Related Systems** called,"**S-95**." This Certificate is valid for three years, and must be renewed by the expiration date through payment of the renewal fee to the Fire Department. For more information, visit: http://www1.nyc.gov/site/fdny/business/all-certifications/certificates-of-fitness.page or contact: **(718)999-1988** or (**718)999-2504**.

NYS Sex Offender Registry

Article 13-B of Public Health Law requires children's camp operators to determine whether an employee or volunteer is listed on the NYS Division of Criminal Justice Services (DCJS) Sex Offender Registry. Checks of the Registry must be completed prior to the day the employee or volunteer starts work at the camp and annually thereafter prior to their arrival at camp. The law applies to all children's camps (day, traveling day and overnight) and to all prospective employees and volunteers at the camp regardless of their job title/responsibilities or employment status (full or part-time). For more information regarding the Division of Criminal Justice Services Sex Offender Registry, call **(518) 457-3167** or visit their website http://www.criminaljustice.ny.gov/nsor/800info_cdsubmit.htm

How to Submit a Child Abuse Clearance Form

State Central Register for Child Abuse and Maltreatment (SCR)

As part of the initial permit application process, Camp Directors proposing to operate a summer camp must complete and submit a hard copy of the child abuse clearance form (LDSS-3370), along with the application to their respective BCC borough office. This form and instructions may be downloaded from our webpage at **www.nyc.gov/health/camps** **(click on "Camp Directors' Information" , then "Obtain a Permit to Operate a Summer Camp").**

NYC Child Care Connect is an online portal that includes a group child care center directory and a free messaging service that parents and caregivers can sign up for to receive notifications about specific child care centers. Profiles include the program's approved age range, capacity, years in operation and a three-year performance summary. Visit **www.nyc.gov** and search for "NYC Child Care Connect"

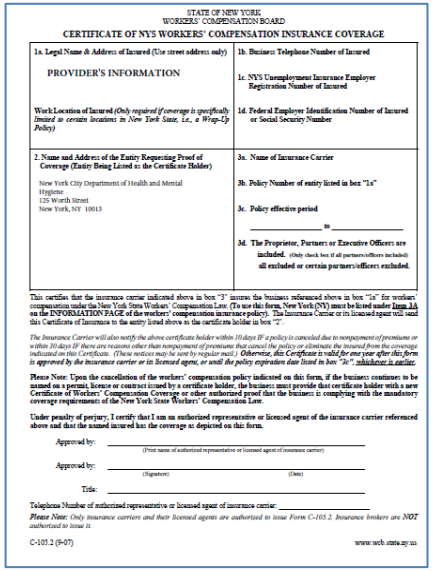
REMINDER:

As a mandated reporter, you are legally required to report suspected child abuse or maltreatment. Mandated reporters include school staff, medical professionals, child care providers and others.

Call **1-800-635-1522** or **311** to report suspicions of child abuse or neglect.
If a child is in immediate danger, call **911**.

Examples of ACCEPTABLE Proof of Insurance for Summer Camps

C-105.2 - Certificate of **Worker's Compensation** (issued by applicant's insurance carrier)



STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (Use street address only) PROVIDER'S INFORMATION Work Location of Insured (Only required if coverage is specifically limited in certain locations in New York State, i.e., a Wrap-Up Policy)	1b. Business Telephone Number of Insured 1c. NYS Unemployment Insurance Employer Registration Number of Insured 1d. Federal Employer Identification Number of Insured or Social Security Number
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) New York City Department of Health and Mental Hygiene 125 Worth Street New York, NY 10013	3a. Name of Insurance Carrier 3b. Policy Number of entity listed in box "1a" 3c. Policy effective period _____ to _____ 3d. The Proprietor, Partners or Executive Officers are included. (Only check box if all partners/officers included) all excluded or certain partners/officers excluded.

This certifies that the insurance carrier indicated above in box "3" insures the business referenced above in box "1a" for workers' compensation under the New York State Workers' Compensation Law. (To use this form, New York (NY) must be listed under Item 3A on the INFORMATION PAGE of the workers' compensation insurance policy). The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed above as the certificate holder in box "2".

The Insurance Carrier will also notify the above certificate holder within 10 days IF a policy is canceled due to nonpayment of premiums or within 30 days IF there are reasons other than nonpayment of premiums that cancel the policy or eliminate the insured from the coverage indicated on this Certificate. (These notices may be sent by regular mail.) Otherwise, this Certificate is valid for one year after this form is approved by the insurance carrier or its licensed agent, or until the policy expiration date listed in box "3c", whichever is earlier.

Please Note: Upon the cancellation of the workers' compensation policy indicated on this form, if the business continues to be named on a permit, licence or contract issued by a certificate holder, the business must provide that certificate holder with a new Certificate of Workers' Compensation Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Workers' Compensation Law.

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has the coverage as depicted on this form.

Approved by: _____
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: _____
(Signature) (Date)

Title: _____

Telephone Number of authorized representative or licensed agent of insurance carrier: _____

***Please Note:** Only insurance carriers and their licensed agents are authorized to issue Form C-105.2. Insurance brokers are **NOT** authorized to issue it.*

C-105.2 (9-07) www.wcb.state.ny.us

U-26.3 - Certificate of **Worker's Compensation** Insurance (issued by the State Insurance Fund)

NYSIF New York State Insurance Fund
Workers' Compensation & Disability Benefits Specialists Since 1914
199 CHURCH STREET, NEW YORK, N.Y. 10007-1100
Phone: (800) 87-NYSIF

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

POLICYHOLDER	CERTIFICATE HOLDER
PROVIDER INFORMATION	New York City Department of Health and Mental Hygiene 125 Worth Street New York, NY 10013

POLICY NUMBER	CERTIFICATE NUMBER	PERIOD COVERED BY THIS CERTIFICATE: COVERAGE TO (MM/DD/CC)	DATE 1/8/2009

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. [illegible] WHICH CERTIFIES COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION LAW UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW.

IF SAID POLICY IS CANCELLED, OR CHANGED PRIOR TO MAILING IN SUCH MANNER AS TO AFFECT THIS CERTIFICATE, 10 DAYS WRITTEN NOTICE OF SUCH CANCELLATION WILL BE GIVEN TO THE CERTIFICATE HOLDER ABOVE. NOTICE BY REGULAR MAIL SO ADDRESSED SHALL BE SUFFICIENT COMPLIANCE WITH THIS PROVISION. THE NEW YORK STATE INSURANCE FUND DOES NOT ASSUME ANY LIABILITY IN THE EVENT OF FAILURE TO GIVE SUCH NOTICE.

THIS CERTIFICATE DOES NOT APPLY TO ALL FIRE DEMOLITION.

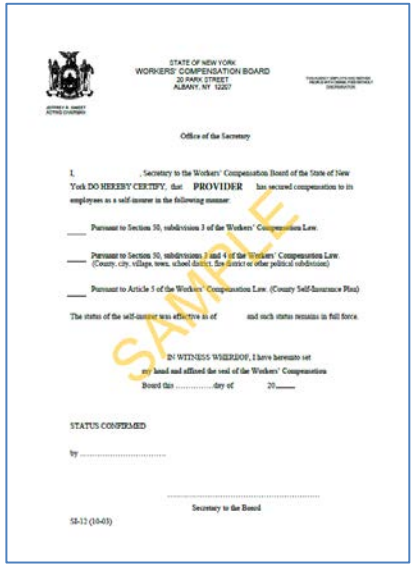
THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

NEW YORK STATE INSURANCE FUND
John Mamelli
DIRECTOR, INSURANCE FUND UNDERWRITING

This certificate can be validated on our web site at https://www.nysif.com/certificate/ or by calling (888) 875-9700
VALIDATION NUMBER: 107013-1606

U-26.3 0/2010/080-21/54

SI-12 - Certificate of **Worker's Compensation** Self-Insurance



STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
20 PARK STREET
ALBANY, NY 12207

Office of the Secretary

I, _____, Secretary to the Workers' Compensation Board of the State of New York DO HEREBY CERTIFY, that PROVIDER has secured compensation to its employees as a self-insurer in the following manner:

____ Pursuant to Section 50, subdivision 3 of the Workers' Compensation Law.

____ Pursuant to Section 50, subdivisions 3 and 4 of the Workers' Compensation Law. (County, city, village, town, school district, fire district or other political subdivision)

____ Pursuant to Article 5 of the Workers' Compensation Law. (County Self-Insurance Plan)

The status of the self-insurer was effective as of _____ and such status remains in full force.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of the Workers' Compensation Board this _____day of _____ 20____

STATUS CONFIRMED

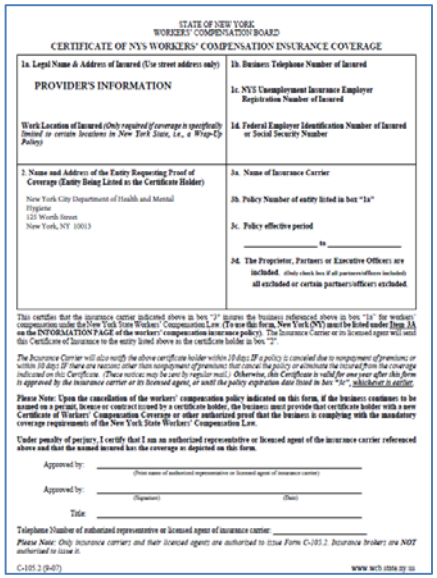
by _____

_____
Secretary to the Board

SI-12 (10-03)

SAMPLE

GSI-105.2 - Certificate of Participation in **Worker's Compensation** Group Self-Insurance



STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (Use street address only) PROVIDER'S INFORMATION Work Location of Insured (Only required if coverage is specifically limited in certain locations in New York State, i.e., a Wrap-Up Policy)	1b. Business Telephone Number of Insured 1c. NYS Unemployment Insurance Employer Registration Number of Insured 1d. Federal Employer Identification Number of Insured or Social Security Number
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) New York City Department of Health and Mental Hygiene 125 Worth Street New York, NY 10013	3a. Name of Insurance Carrier 3b. Policy Number of entity listed in box "1a" 3c. Policy effective period _____ to _____ 3d. The Proprietor, Partners or Executive Officers are included. (Only check box if all partners/officers included) all excluded or certain partners/officers excluded.

This certifies that the insurance carrier indicated above in box "3" insures the business referenced above in box "1a" for workers' compensation under the New York State Workers' Compensation Law. (To use this form, New York (NY) must be listed under Item 3A on the INFORMATION PAGE of the workers' compensation insurance policy). The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed above as the certificate holder in box "2".

The Insurance Carrier will also notify the above certificate holder within 10 days IF a policy is canceled due to nonpayment of premiums or within 30 days IF there are reasons other than nonpayment of premiums that cancel the policy or eliminate the insured from the coverage indicated on this Certificate. (These notices may be sent by regular mail.) Otherwise, this Certificate is valid for one year after this form is approved by the insurance carrier or its licensed agent, or until the policy expiration date listed in box "3c", whichever is earlier.

Please Note: Upon the cancellation of the workers' compensation policy indicated on this form, if the business continues to be named on a permit, licence or contract issued by a certificate holder, the business must provide that certificate holder with a new Certificate of Workers' Compensation Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Workers' Compensation Law.

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has the coverage as depicted on this form.

Approved by: _____
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: _____
(Signature) (Date)

Title: _____

Telephone Number of authorized representative or licensed agent of insurance carrier: _____

***Please Note:** Only insurance carriers and their licensed agents are authorized to issue Form C-105.2. Insurance brokers are **NOT** authorized to issue it.*

C-105.2 (9-07) www.wcb.state.ny.us

DB-120.1 - Certificate of **Disability** Benefits (issued by applicant's insurance carrier)

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
CERTIFICATE OF INSURANCE COVERAGE UNDER THE NYS DISABILITY BENEFITS LAW

PART 1. To be completed by Disability Benefits Carrier or Licensed Insurance Agent of that Carrier

1a. Legal Name and Address of Insured (Use street address only) PROVIDER'S INFORMATION	1b. Business Telephone Number of Insured 1c. NYS Unemployment Insurance Employer Registration Number of Insured 1d. Federal Employer Identification Number of Insured or Social Security Number
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) New York City Department of Health and Mental Hygiene 125 Worth Street New York, NY 10013	3a. Name of Insurance Carrier 3b. Policy Number of entity listed in box "1a" 3c. Policy effective period _____ to _____

4. Policy covers:
a. ☐ All of the employer's employees eligible under the New York Disability Benefits Law
b. ☐ Only the following class or classes of the employer's employees:

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has NYS Disability Benefits Insurance coverage as described above

Date Signed _____ By _____
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number _____ Title _____

IMPORTANT: If box "NO" is checked, or this form is signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent of that carrier, this certificate is COMPLETE. Mail it directly to the certificate holder.
If box "NO" is checked, this certificate is NOT COMPLETE for purposes of Section 220, Part 4 of the Disability Benefits Law. It must be mailed for signature to the Workers' Compensation Board, 20 Park Street, Albany, New York 12207.

PART 2. To be completed by NYS Workers' Compensation Board (Only if box "NO" of Part 1 has been checked)

State Of New York
Workers' Compensation Board

According to information maintained by the NYS Workers' Compensation Board, the above named employer has complied with the NYS Disability Benefits Law with respect to all of his/her employees.

Date Signed _____ By _____
(Signature of NYS Workers' Compensation Board Employee)

Telephone Number _____ Title _____

Please Note: Only insurance carriers licensed to write NYS disability benefits insurance policies and NYS licensed insurance agents of those insurance carriers are authorized to issue Form DB-120.1. Insurance brokers are NOT authorized to issue this form.

DB-120.1 (3-06)

DB-155 - Certificate of **Disability** Benefits Self-Insurance

FORM DB-155

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD - SELF-INSURANCE OFFICE
20 PARK STREET - ROOM 206
ALBANY, NY 12207
(518) 402-0247
FAX (518) 402-0199

COMPLIANCE WITH DISABILITY BENEFITS LAW
(Pursuant to Section 220, subd. 4 of the Disability Benefits Law)

EMPLOYER PROVIDER INFORMATION	FEDERAL EMPLOYER IDENTIFICATION NUMBER LOCATION OF OPERATION
ADDRESS (HOME OR MAIN OFFICE) PROVIDER INFORMATION	OWNER OR PERSON WHO IS THE OWNER OR ABOUT:

There are on file with the Workers' Compensation Board, Self-Insurance Office, certificates indicating that the above-named employer has complied with the Disability Benefits Law with respect to all of his or her employees in the following manner:

☐ By approved self-insurance under Section 211, subdivision 3 of the Disability Benefits Law
☐ By a certificate of approved insurance issued pursuant to Section 211, subdivision 5 of the Disability Benefits Law and in accordance with authorized insurance carrier(s):

Date: _____

By: _____
Chris Wagner
WC Examiner

DB-155 (3/99)

THE AGENCY EMPLOYS & SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

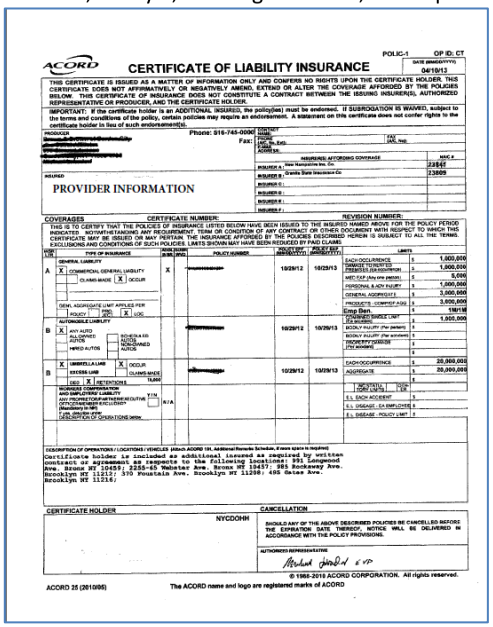
New York State Workers' Compensation Board 39

SAMPLE

Examples of ACCEPTABLE Proof of Insurance for Summer Camps

Comprehensive Liability or Auto Insurance

Comprehensive and Auto Insurance certificates must show, Policy #, Coverage Amount, and Expiration



ACORD — CERTIFICATE OF LIABILITY INSURANCE

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PROVIDER INFORMATION

COVERAGES — CERTIFICATE NUMBER: — REVISION NUMBER:

INSR LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	GENERAL LIABILITY — COMMERCIAL GENERAL LIABILITY — CLAIMS-MADE / OCCUR		10/25/12	10/25/13	EACH OCCURRENCE $ 1,000,000; DAMAGE TO RENTED PREMISES (Ea occurrence) $ 1,000,000; MED EXP (Any one person) $ 5,000; PERSONAL & ADV INJURY $ 1,000,000; GENERAL AGGREGATE $ 3,000,000; PRODUCTS - COMP/OP AGG $ 3,000,000
B	AUTOMOBILE LIABILITY — ANY AUTO / ALL OWNED AUTOS / SCHEDULED AUTOS / HIRED AUTOS / NON-OWNED AUTOS		10/25/12	10/25/13	COMBINED SINGLE LIMIT (Ea accident) $ 1,000,000; BODILY INJURY (Per person) $; BODILY INJURY (Per accident) $; PROPERTY DAMAGE (Per accident) $
B	UMBRELLA LIAB — OCCUR / CLAIMS-MADE; EXCESS LIAB; DED / RETENTION		10/25/12	10/25/13	EACH OCCURRENCE $ 20,000,000; AGGREGATE $ 20,000,000
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY — ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)				WC STATUTORY LIMITS / OTH-ER; E.L. EACH ACCIDENT $; E.L. DISEASE - EA EMPLOYEE $; E.L. DISEASE - POLICY LIMIT $

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

Certificate holder is included as additional insured as required by written contract or agreement as respects to the following locations: 991 Longwood Ave. Bronx NY 10459; 2255-65 Webster Ave. Bronx NY 10457; 385 Rockaway Ave. Brooklyn NY 11212; 370 Fountain Ave. Brooklyn NY 11208; 485 Gates Ave. Brooklyn NY 11216;

CERTIFICATE HOLDER: NYCDOHMH

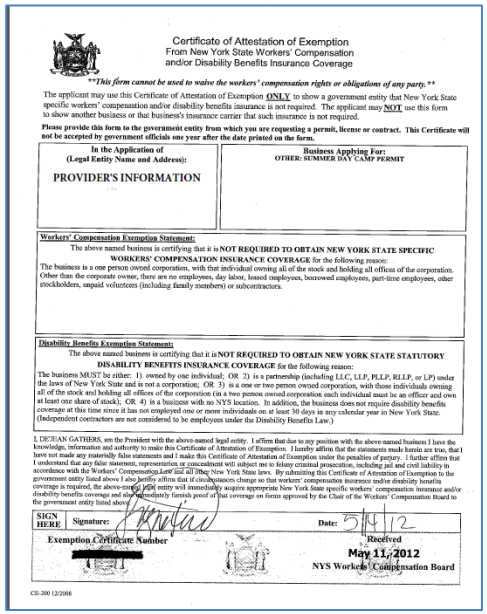
CANCELLATION: SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

© 1988-2010 ACORD CORPORATION. All rights reserved.

ACORD 25 (2010/05) — The ACORD name and logo are registered marks of ACORD

CE-200 - **Exemption** of Worker's Compensation and/or Disability Insurance



Certificate of Attestation of Exemption
From New York State Workers' Compensation
and/or Disability Benefits Insurance Coverage

This form cannot be used to waive the workers' compensation rights or obligations of any party.

The applicant may use this Certificate of Attestation of Exemption **ONLY** to show a government entity that New York State specific workers' compensation and/or disability benefits insurance is not required. The applicant may **NOT** use this form to show another business or that business's insurance carrier that such insurance is not required.

Please provide this form to the government entity from which you are requesting a permit, license or contract. This Certificate will not be accepted by government officials one year after the date printed on the form.

In the Application of (Legal Entity Name and Address):	Business Applying For: OTHER: SUMMER DAY CAMP PERMIT
PROVIDER'S INFORMATION	

Workers' Compensation Exemption Statement:

The above named business is certifying that it is **NOT REQUIRED TO OBTAIN NEW YORK STATE SPECIFIC WORKERS' COMPENSATION INSURANCE COVERAGE** for the following reason:

The business is a one person owned corporation, with that individual owning all of the stock and holding all offices of the corporation. Other than the corporate owner, there are no employees, day labor, leased employees, borrowed employees, part-time employees, other stockholders, unpaid volunteers (including family members) or subcontractors.

Disability Benefits Exemption Statement:

The above named business is certifying that it is **NOT REQUIRED TO OBTAIN NEW YORK STATE STATUTORY DISABILITY BENEFITS INSURANCE COVERAGE** for the following reason:

The business MUST be either: 1) owned by one individual; OR 2) is a partnership (including LLC, LLP, PLLP, RLLP, or LP) under the laws of New York State and is not a corporation; OR 3) is a one or two person owned corporation, with those individuals owning all of the stock and holding all offices of the corporation (in a two person owned corporation each individual must be an officer and own at least one share of stock); OR 4) is a business with no NYS location. In addition, the business does not require disability benefits coverage at this time since it has not employed one or more individuals on at least 30 days in any calendar year in New York State. (Independent contractors are not considered to be employees under the Disability Benefits Law.)

I, DEBAN GATHERS, am the President with the above-named legal entity. I affirm that due to my position with the above-named business I have the knowledge, information and authority to make this Certificate of Attestation of Exemption. I hereby affirm that the statements made herein are true, that I have not made any materially false statements and I make this Certificate of Attestation of Exemption under the penalties of perjury. I further affirm that I understand that any false statement, representation or concealment will subject me to felony criminal prosecution, including jail and civil liability in accordance with the Workers' Compensation Law and all other New York State laws. By submitting this Certificate of Attestation of Exemption to the government entity listed above I also hereby affirm that if circumstances change so that workers' compensation insurance and/or disability benefits coverage is required, the above-named legal entity will immediately acquire appropriate New York State specific workers' compensation insurance and/or disability benefits coverage and shall immediately furnish proof of that coverage on forms approved by the Chair of the Workers' Compensation Board to the government entity listed above.

SIGN HERE — Signature: — Date: 5/4/12

Exemption Certificate Number: [redacted]

Received May 11, 2012 NYS Workers' Compensation Board

CE-200 12/2008

Workers' Compensation and **Disability** policy must name the Department of Health and Mental Hygiene, located at 125 Worth Street, CN17A, New York, NY 10013 as the Certificate Holder.

If a transportation service has provided their **Vehicle insurance** certificate, the certificate should indicate that the camp program is an "additional insured."