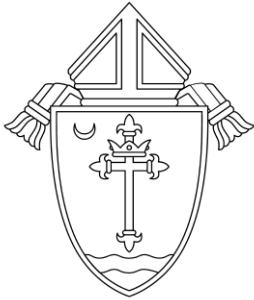


Archdiocese of St. Louis

**DIRECTOR/COORDINATOR OF RELIGIOUS EDUCATION  
PASTOR (CLERGY) REFERENCE FORM**



Name of Applicant: \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Name of Reference: \_\_\_\_\_

Parish \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

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With reference to the **Family Education Rights & Privacy Act of 1974:**

\_\_\_\_\_ I waive my option to view my recommendations.

\_\_\_\_\_ I claim my option to view my recommendations.

Applicant's Signature \_\_\_\_\_

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The applicant named above is applying for a DRE/CRE position in a Catholic school and has given your name as a reference. Please answer the following questions to the best of your ability.

1. How long have you known the applicant and in what pastoral relationship?

\_\_\_\_\_

2. Does the applicant demonstrate commitment to the Catholic Church and is he/she an active member of your parish? \_\_\_\_\_ Yes \_\_\_\_\_ No

If no, please explain: \_\_\_\_\_

\_\_\_\_\_

3. The Witness Statement for those who serve in Catholic Education States: "All who serve in Catholic Education in the parish and school programs of the Archdiocese of St. Louis will witness by their public behavior, actions, and words a life consistent with the teachings of the Church."

Is there any reason you are aware of why the candidate would not be able to abide by this Witness Statement?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. What particular strengths do you think the applicant would bring to the position of Catholic school DRE/CRE?

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5. Describe how you perceive the applicant as providing spiritual leadership to a Catholic School community.

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6. What weaknesses does the applicant have that you think would interfere with his/her effectiveness as a Catholic school DRE/CRE?

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7. Would you employ this applicant as a DRE/CRE in a Catholic school/parish?

\_\_\_\_\_ Yes \_\_\_\_\_ No

Signed: \_\_\_\_\_

Position: \_\_\_\_\_

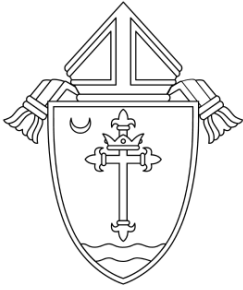
Date: \_\_\_\_\_

**After completing this form, please return to:**

Education HR  
Office of Catholic Education and Formation  
20 Archbishop May Dr.  
St. Louis, MO 63119  
Fax: 314-792-7309

Archdiocese of St. Louis

**DIRECTOR/COORDINATOR OF RELIGIOUS EDUCATION  
REFERENCE FORM**



Name of Applicant: \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Name of Reference: \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

With reference to the **Family Education Rights & Privacy Act of 1974:**

\_\_\_\_\_ I waive my option to view my recommendations.

\_\_\_\_\_ I claim my option to view my recommendations.

Applicant's Signature \_\_\_\_\_

The applicant named and whose signature appears above has given your name as a reference. You will confer a favor by giving your estimate of the applicant's qualifications as Director/Coordinator of Religious Education.

**To what extent does the applicant exhibit the following qualities or traits in connection with the work situation?**

	<b>Outstanding</b>	<b>Satisfactory</b>	<b>Limited</b>	<b>No Opportunity to Observe</b>
Knowledge of Catholic faith	_____	_____	_____	_____
Practice of Catholic faith	_____	_____	_____	_____
Understanding of Catholic philosophy of education	_____	_____	_____	_____
Commitment to the mission of lifelong Catholic education	_____	_____	_____	_____
Administrative ability/potential	_____	_____	_____	_____
Leadership ability	_____	_____	_____	_____
Collaborative skills	_____	_____	_____	_____
Knowledge of religion curriculum/ instruction/assessment	_____	_____	_____	_____
Interpersonal relationships:				
a. faculty	_____	_____	_____	_____
b. students	_____	_____	_____	_____
c. parents	_____	_____	_____	_____
d. parish leadership	_____	_____	_____	_____
Cooperation	_____	_____	_____	_____
Responsibility	_____	_____	_____	_____

(over)

How long have you known the applicant and in what official relationship? \_\_\_\_\_

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If this individual was employed as a DRE/CRE in your system, please specify dates:

**FROM:** \_\_\_\_\_ **TO:** \_\_\_\_\_

The Witness Statement for those who serve in Catholic Education states: "All who serve in Catholic Education in the parish and school programs of the Archdiocese of St. Louis will witness by their public behavior, actions, and words a life consistent with the teachings of the Church."

Is there any reason you are aware of why the candidate would not be able to abide by this Witness Statement?

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What particular strengths do you think the applicant would bring to the position of Catholic parish/school Director/Coordinator of Religious Education?

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What weaknesses does the applicant have that you think might interfere with his/her effectiveness as a Catholic school Director/Coordinator of Religious Education?

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Would you employ this applicant as Director/Coordinator of Religious Education? \_\_\_\_\_

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Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Position: \_\_\_\_\_

**After completing this form, please return to:**

Education HR  
Office of Catholic Education and Formation  
20 Archbishop May Dr.  
St. Louis, MO 63119

**Missouri Family Care Safety Registry**

Family Care Safety Registry and the Worker Registration Form: Applicants should register through the Missouri Family Care Safety Registry website: <http://health.mo.gov/safety/fcsr/>.

Please return a copy of the Worker Registration form to Education HR at The Office of Catholic Education and Formation (address below) with your application and other documents requested.

Please contact Sharon Giesecking in Education HR if you have any questions at:

314-792-7308 or [SharonGiesecking@archstl.org](mailto:SharonGiesecking@archstl.org)

The Office of Catholic Education and Formation

20 Archbishop May Dr.

St. Louis, MO 63119



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
 FAMILY CARE SAFETY REGISTRY  
**WORKER REGISTRATION**

FCSR USE ONLY

Register online at [www.health.mo.gov/safety/fcsr](http://www.health.mo.gov/safety/fcsr) OR mail this form, copy of Social Security card, and payment to Missouri Dept. of Health and Senior Services, Fee Receipts, PO Box 570, Jefferson City, MO 65102.

**REGISTRATION TYPE (Check all that apply. Complete column on right only if Long Term Care/Personal Care selected from left.)**

Adoptive Parent  
 Agency Name: \_\_\_\_\_

Child Care

Foster Parent/Family Member of Foster Parent  
 County Office: \_\_\_\_\_

Hospital

Long Term Care/Personal Care (Please choose subcategory at right ▶.)

Mental Health/Psychiatric Hospital

Voluntary (Select voluntary if no other registration type applies.)

**Long Term Care / Personal Care Subcategories (Complete if LTC/PC selected at left.)**

Adult Day Care

Assisted Living Facility

Hospice

Hospital LTAC/Swing Bed

Mental Health – Residential Facility/ICF

Nursing Facility/Skilled Nursing

Personal Care – Home Health

Personal Care – In-Home Services

Personal Care – Consumer Directed Services/Center for Independent Living

Personal Care – HCY/PDW/DDD/Other

A one-time registration fee of \$14.00 applies to all categories except Foster Parents. Foster Parents must list the Children's Division county office.

Register only once. If you believe you have already registered, check our website at [www.health.mo.gov/safety/fcsr](http://www.health.mo.gov/safety/fcsr) or call, toll free, 866-422-6872.

**SOCIAL SECURITY NUMBER (Mail copy of card with form.)**

\_\_\_\_\_

**PERSONAL INFORMATION (Provide all names you have used, starting with most recent. Include legal names and nicknames.)**

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX (JR., SR., II, III)
MAIDEN NAME (IF APPLICABLE)	PRIOR NAMES USED (IF APPLICABLE LIST FIRST AND LAST NAMES.)	DATE OF BIRTH (MM-DD-YYYY)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F

**CONTACT INFORMATION**

MAILING ADDRESS (ENTER YOUR STREET ADDRESS OR POST OFFICE BOX. THIS ADDRESS MUST BE DIFFERENT FROM EMPLOYER ADDRESS.)

\_\_\_\_\_

CITY	STATE	ZIP CODE	COUNTY
TELEPHONE	EMAIL ADDRESS (REQUIRED)	COUNTRY (COMPLETE ONLY IF OUTSIDE U.S.)	

**EMPLOYER ASSOCIATED WITH THIS REGISTRATION (Complete either left or right column, not both.)**

<input type="checkbox"/> My current/potential child care, long term care or mental health care employer is:	<input type="checkbox"/> No Employer, because I am a(n):	
EMPLOYER NAME	<input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Foster Parent/Family Member <input type="checkbox"/> Home Child Care Provider <input type="checkbox"/> Private Pay/Private Duty <input type="checkbox"/> Student <input type="checkbox"/> Volunteer <input type="checkbox"/> Other (Explain: _____)	
EMPLOYER ADDRESS		
EMPLOYER CITY		
STATE		
ZIP		
EMPLOYER TELEPHONE	EMPLOYER CONTACT NAME	EMPLOYER CONTACT TITLE

**REGISTRATION AGREEMENT**

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Furthermore, I authorize the DHSS to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) and any related background information to the requester of the FCSR for employment purposes only, as provided in §210.921, subsection 1, subdivisions (1) and (2), RSMo. For purposes of the FCSR, "employment purposes" includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy of the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening.

**NOTICE:** The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to my designated bank account. I understand that my signature below authorizes my financial institution to deduct this payment from my account. In the event that DHSS or its subcontractor is unable to secure funds from my account or I provide insufficient or inaccurate information regarding my account, my obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

SIGNATURE OF APPLICANT	DATE OF SIGNATURE (MUST BE WITHIN SIX MONTHS OF SUBMISSION.)
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### **WHAT IS THE FAMILY CARE SAFETY REGISTRY?**

The Family Care Safety Registry (FCSR), administered by the Missouri Department of Health and Senior Services (DHSS), provides families and employers with a method to obtain background screening information. The Registry, through various state agencies, offers several resources to screen child care, long term care and mental health workers:

- State criminal history and sex offender registry records maintained by the Missouri State Highway Patrol
- Child abuse/neglect records maintained by the Missouri Department of Social Services
- The Employee Disqualification List maintained by the Missouri Department of Health and Senior Services
- The Employee Disqualification Registry maintained by the Missouri Department of Mental Health
- Child care facility licensing records maintained by the Missouri Department of Health and Senior Services
- Foster parent records maintained by the Missouri Department of Social Services

### **WHO HAS TO REGISTER?**

Any person hired on or after January 1, 2001, as a child care worker or elder care worker, hired on or after January 1, 2002, as a personal care worker, or hired on or after January 1, 2009, as a mental health worker, as provided in §210.906, RSMo, is required to make application for registration in the Family Care Safety Registry within fifteen (15) days of the beginning of employment. Such person who fails to submit a completed registration form to the DHSS without good cause, as determined by the department, is guilty of a class B misdemeanor. Employees and volunteers from non-state and/or federally regulated entities are NOT REQUIRED to register with the FCSR.

### **HOW DO I COMPLETE THE REGISTRATION FORM?**

**Registration Type** – Check at least one box from the left column for type of registration that best describes your worker category. If no other type applies, select "Voluntary." (A "voluntary registrant" is a person who is not mandated to register with the Family Care Safety Registry pursuant to §210.900 et seq., RSMo.) If you checked Long Term Care / Personal Care, please also make one or more selections from the column on the right for subcategory.

**Social Security Number** – You must provide your Social Security number pursuant to 19CSR 30-80.030(1). This identifying information, including Social Security number, will be used for internal identification purposes and to conduct background screenings for the resource information listed in paragraph one above.

**Personal Information** – List your current Last Name, First Name, Middle Name, and any suffix associated with your last name. List any other names by which you may have been known, including maiden names, past married names, and nicknames (attach additional sheets if needed). For identification purposes, list your gender and date of birth.

**Contact Information** – List your address, city, state, ZIP code, and county. Include your telephone number and email address. We will use this information to notify you of registration results and any background screenings conducted. Email notifications will be encrypted for improved security. To reduce postage costs, the Registry may contact you to request a personal email address if one is not provided.

**Employer Associated with this Registration** - If you are currently employed by or are seeking employment with a child care or long term care provider, please list the facility name, address, telephone number, and contact person. If registration is not for employment purposes, make a selection from column on right. The employer entered in this section will not receive a copy of the registration notification. Employers eligible to use the Registry for caregiver screenings must make a separate request for your background information.

**Registration Agreement** – Sign and date the registration form. Your signature will authorize the Family Care Safety Registry to conduct the background screening outlined in §210.903.2, RSMo and to provide the information to requesters for employment purposes, as provided in §210.921.1, RSMo.

### **WHERE DO I SEND MY REGISTRATION FORM?**

Send your completed registration form and photocopy of Social Security card and required fee to the **Missouri Department of Health and Senior Services, ATTN: Fee Receipts, P.O. Box 570, Jefferson City, MO 65102**. If you have questions, please call the Registry using the toll-free telephone number, **866-422-6872**.

### **WHEN WILL I KNOW THE RESULTS OF MY BACKGROUND SCREENING?**

After the background screening has been completed, you will be notified in writing of the results that will be recorded in the Family Care Safety Registry. You will also be notified in writing each time background screening information is provided. The notification will contain the name and address of the person who made the request and the background information disclosed. The person making the request will be informed that information will be released for employment purposes only, pursuant to §210.921.1, RSMo. Any person using Registry information for any other purpose is guilty of a class B misdemeanor. In addition, state agencies can request information for licensure or regulatory purposes. Prior to disclosing information, the Registry obtains the name and address of the requester, and determines that the request is for employment or regulatory purposes. To ensure you receive these notifications, it will be important for you to notify the Family Care Safety Registry when you have a change in your contact information. Notify the Family Care Safety Registry of changes in personal or contact information using the toll-free telephone number, 866-422-6872, by email to [fcsr@health.mo.gov](mailto:fcsr@health.mo.gov), or by mail to FCSR, PO Box 570, Jefferson City, MO 65102.

### **WHAT IF I DON'T AGREE WITH THE RESULTS OF MY BACKGROUND SCREENING?**

As provided in §210.912, RSMo, you have the right to appeal the information transferred to the Family Care Safety Registry. Your right to appeal is limited to the accuracy of the transfer of information from the state agency that maintains the background information and does not include a right to appeal the accuracy of the substance of the information transferred. An appeal must be filed in writing to the Office of the Director, Missouri Department of Health and Senior Services, P.O. Box 570, Jefferson City, MO, 65102, within 30 days of receiving the results of the background screening determination. An administrative appeal shall be set within 30 days of the filing of the appeal and a decision shall be made within 60 days. This right to appeal is in addition to any other appeal rights granted by state law.

### **WHAT INFORMATION WILL BE DISCLOSED BY THE FAMILY CARE SAFETY REGISTRY?**

Disclosure of background information on a person registered in the Family Care Safety Registry will be limited. If the person is registered, the Registry worker will disclose whether the person's name is listed in any of the background checks pursuant to §210.903, subsection 2, RSMo, and if so, which one(s). Specific information will be disclosed by the Registry pursuant to §210.921, subsection 1, subdivision (2).