ALABAMA DEPARTMENT OF HUMAN RESOURCES
CHILD CARE PERFORMANCE STANDARDS DEFICIENCY REPORT

SECTION A- IDENTIFYING INFORMATION

Facility Name: PURE WORD ACADEMY	Type of Facility : Center [X] Day [X] OST [ ] Night [ ] Family [ ] University [ ] Group [ ]	Date of Visit: 11/24/2025
Facility Address: 2530 S. SHELTON BEACH RD., EIGHT MILE, AL 36613, Mobile	Licensee: JANNIE JACKSON C/O PURE WORD DEL. H.O.P.	Telephone #: (251) 456-1234
Ages: 6 Weeks to 12 Years	Director (if applicable): JANNIE JACKSON	Capacity: 75 / NA Day Night

SECTION B - DEFICIENCY INFORMATION

Performance Standard Deficiency ***HAZARDS MUST BE CORRECTED IMMEDIATELY****	**Date Corrected by Licensee**
Deficiency Summary	
Failed - Ongoing Training, Staff Checklist Comments: needs 10 hours	12/15/2025
Failed - CA/N Clearance Form (Every Five Years), Staff Checklist Comments: expired	11/24/2025
Failed - Health and Safety Training, Staff Checklist Comments: need all 11 hours	12/18/2025
Failed - Ongoing Training, Staff Checklist Comments: need 10 hours	12/15/2025
Failed - Ongoing Training, Staff Checklist Comments: needs 10 hours	12/15/2025

INSTRUCTIONS TO LICENSEE: Column 2, Date Corrected by Licensee, is to be completed by the facility representative after each deficiency is corrected. The facility representative must put the date of correction and his/her initials in Column 2. This form must be returned to the Department of Human Resources on or before _____, as verification that deficiencies have been corrected.

NOTICE: Any misleading or any false statements or reports made to the Department and/or failure to correct the listed deficiencies can be the basis for adverse action. None of these requirements are to be interpreted to allow anyone to operate in violation of Performance Standards. A facility licensed by the Department must always meet Performance Standards applicable to that facility. It is the responsibility of the licensee to operate in compliance with Performance Standards.

_____ _____

Signature of Facility Representative Date

LESLIE WILLIAMS

_____ _____

Signature of DHR Licensing Representative Date

COPIES TO: _____