



**STATE OF DELAWARE**  
**Department of Safety & Homeland Security**  
**DIVISION OF ALCOHOL & TOBACCO ENFORCEMENT**  
600 S. BAY ROAD, SUITE 3  
DOVER, DE 19901

TELEPHONE: (302) 741-2721  
FAX: (302) 739-4770

Thank you for your interest in the 2023 Cooperating Underage Witness (CUW) program!

The CUW program was designed by the Division of Alcohol and Tobacco Enforcement (DATE) to ensure all alcohol and tobacco retailers are in compliance with state and federal laws prohibiting the sale of alcohol, tobacco products and tobacco substitutes to those underage.

CUW's are compensated while assisting officers with alcohol and tobacco compliance checks year-round throughout the state. There is no minimum or maximum number of hours that a CUW will work. The amount of work hours will depend on the availability of the CUW, number of locations or complaints assigned to officers and the availability of our officers. Officers with the Division are certified police officers in the state of Delaware. Every CUW will be accompanied by an officer at all times.

For more information about our agency and the CUW program, visit us online at [www.date.delaware.gov](http://www.date.delaware.gov), visit us on Facebook or call (302) 741-2715 if you have any questions.

**2023 PROGRAM QUALIFICATIONS:**

- Must be 17 years old of age and no older than 20 years and 6 months.
- Must be mature, honest, and demonstrate responsible behavior at all times.
- Successfully pass a background screening.
- Attend a mandatory in-person training upon acceptance into the program. Training will be held in the evening at our office in Dover, the first or second week of May. More information to follow.

**APPLICATION DEADLINE: APRIL 25, 2023**

**HOW TO APPLY:**

The following must be completed and returned by the deadline. Incomplete applications will hinder our process and may disqualify your participation in the program. All paperwork and copies should be clear, legible and printed in blue or black ink.

- Application for Participation and Pre-Employment Criminal Background Release
- Copy of Birth Certificate
- Copy of Social Security Card
- Copy of School ID, State-Issued ID or Military ID

Application and documents may be mailed to the address above or emailed to [tiffany.lacy@delaware.gov](mailto:tiffany.lacy@delaware.gov). Please put ATTN: CUW Program on the envelope or the email subject line.

STATE OF DELAWARE  
DIVISION OF ALCOHOL AND TOBACCO ENFORCEMENT  
**COOPERATING UNDERAGE WITNESS PROGRAM**

***Application for Participation***

---

---

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

School: \_\_\_\_\_ Gender:  Male  Female

How did you hear about the CUW Program? \_\_\_\_\_

Why do you want to join the CUW Program? \_\_\_\_\_

---

Do you or your parent/guardian have significant financial interest such as owning stock in, serving as an employee, trustee, officer, or Director of **a company that is licensed to sell tobacco and/or alcohol** in the State of Delaware?

YES  NO

*If you answered yes, please provide the person's name, their relationship to you, the name and location of the company they are affiliated with:* \_\_\_\_\_

**Employment History**

Are you currently employed?  YES  NO

1. Employment Date(s): \_\_\_\_\_ Job Title: \_\_\_\_\_

Employer: \_\_\_\_\_ Location: \_\_\_\_\_

Name & Title of Supervisor: \_\_\_\_\_ Supervisor Phone #: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_ Duties: \_\_\_\_\_

The following information will be used for Affirmative Action/EEOC purposes only:

- Have you been involuntarily discharged or forced to resign from state employment in the last 3 years?

YES  NO

- Are you lawfully permitted to work in the United States?  YES  NO

- Are you a U.S. Citizen?  YES  NO

- Persons with Disabilities?  YES  NO

**Permission To Participate – MINORS ONLY**

I give my child permission to participate in the Division of Alcohol and Tobacco Enforcement’s Cooperating Underage Witness (CUW) Program conducted by Delaware’s Division of Alcohol and Tobacco Enforcement. My child may attend the training session and participate in the compliance check activities. I understand that my child may be required to offer testimony against violators in any court of law and/or in an administrative proceeding, that may result from their cooperation with the Division of Alcohol and Tobacco Enforcement. I agree to fully comply with any requirement and/or subpoena that I or my child may receive.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship to Minor: \_\_\_\_\_

**Parent/Guardian Contact Information – MINORS ONLY**

Parent/Guardian Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Applicant Release of Employment Information - Please read carefully and sign below**

Information provided on this application may be verified, including, but not limited to, contacting former employers. Any false or substantive omission of information may be cause for rejection or dismissal if employed by the State. I authorize the release of any information from previous employers or references. If I am a current or former employee of the State of Delaware, I acknowledge that my personnel records shall be subject to review by the hiring agency. By signing this application, I certify agreement with the terms given above for Applicant Release of Employment Information. I certify that I have read and understand the conditions of employment as stated below. I also certify that this application was completed by me, that all entries on it are true, and that I seek employment under these conditions:

- **Direct Deposit:** As a condition of employment, direct deposit of paychecks is required for all new employees.
- **Immigration Law:** At the time of hire, state employees must meet the documentation requirements of the Immigration Reform and Control Act of 1986.
- **Accommodations:** Accommodations are available for applicants with disabilities in all phases of the application and employment process. To request an auxiliary aid or service please call Human Resource Management (302) 739-5458. TDD users should call the Delaware Relay Service Number 1-800-232-5460 for assistance.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

STATE OF DELAWARE  
DIVISION OF ALCOHOL AND TOBACCO ENFORCEMENT  
**COOPERATING UNDERAGE WITNESS PROGRAM**  
*Pre-Employment Criminal Background Release*

---

---

**This form must be completed by the applicant. If the applicant is under the age of 18, a parent/guardian must acknowledge and sign.**

**NAME OF APPLICANT:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

I, the above-named applicant, understand the purpose of this pre-employment background check and that I am required to undergo a criminal background check conducted by the Division of Alcohol and Tobacco Enforcement to participant in the CUW program. **I hereby provide consent for the background check and I understand that the Division may disqualify me from participating in the program if negative police contact or criminal history information is discovered.** This authorization, or a reproduction thereof, shall be valid for the duration of my assignment to the CUW Program and shall not exceed four (4) years from the date of execution of this document.

**Applicant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PARENT/GUARDIAN (UNDER 18 YEARS OLD)**

As a parent of the above-referenced applicant, I understand the purpose of this pre-employment background check and that my child, named herein, is required to undergo a criminal background check conducted by the Division of Alcohol and Tobacco Enforcement to participant in the CUW program. **I hereby provide consent for the background check and I understand that the Division may disqualify my child, named herein, if negative police contact or criminal history information is discovered.** This authorization, or a reproduction thereof, shall be valid for the duration of my child's assignment to the CUW Program, not to exceed four (4) years from the date of execution of this document.

**Parent Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Relationship to Minor:** \_\_\_\_\_ **Date:** \_\_\_\_\_

---

---

*Division use only:*

Date of check:	Performed by:	Result:	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail
Date of check:	Performed by:	Result:	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail
Date of check:	Performed by:	Result:	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail
Date of check:	Performed by:	Result:	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail