



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Community Based Regulation Section

TO: Child Care Operator Applicants

FROM: Child Day Care Licensing Unit

The **Initial Application** for licensure was designed to meet the requirements of the Public Health Code Regulations for Child Day Care Centers and Group Day Care Homes, Sections 19a-79-1a to 19a-79-12, inclusive, which became effective **January 1, 1994**.

The Initial Application for the licensure packet consists of:

1. Fee Invoice Form
2. Coordinating Check List
3. Affidavit (Original and Notarized)
4. Proof of Worker's Compensation Insurance
5. Initial Application for Licensure Including Supplementary Application for Infant/Toddlers
6. Fingerprinting Packet Including Instructions. **(to be returned to the Legal Department @ The Department of Public Health, Legal Office, 410 Capitol Ave., MS#12LEG, P.O. B0x 340308, Htfd., CT 06134-0308)**

If you have obtained this application over the Internet, please call the Department of Public Health, Legal Office @ (860) 509-7600 to obtain background check/fingerprint cards.

A **Complete Application** shall be submitted to the Department at least 60 days prior to the anticipated date of opening.

Please retain one copy for your own records and submit one copy to the Local Health Department.

EACH ATTACHMENT MUST HAVE THE ATTACHMENT NUMBER ON THE UPPER RIGHT HAND CORNER OF EACH PAGE.

Please note that your application will **not** be accepted without the following:

1. Fire Marshall (Attachment #5a)
2. Building Approval (Attachment #5b)
3. **FINAL** Zoning Approval (Attachment #5c)
4. Staff Work Schedule (Attachment 10a)
5. Completed Verification of Experience for Head Teacher (Attachment #10c)
6. Consultant/Head Teacher Data Sheet (Attachment 11f)
7. Water Supply (Attachment #13b)
8. All Required Attachments

If you have any concerns or questions related to your Initial Application contact the Day Care Application Unit at 1-800-282-6063 or (860) 509-8045.



Phone: (860) 509-8045, Fax: (860) 509-7541
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12CBR
P.O. Box 340308, Hartford, CT 06134
An Equal Opportunity Employer
T:\Grp&Ctr\Application\G_C_InitialAppLtr.doc 3/6/08

COORDINATING CHECK LIST FOR APPLICATION
(PLEASE CHECK EACH BOX OR CHECK N/A IF NOT APPLICABLE)

ATTACHMENT

- | | | | | | | |
|--------------------------|---|--|--|--------------------------|-----------------------------------|--|
| <input type="checkbox"/> | <u>Fee Enclosed</u> | <input type="checkbox"/> | <u>Fee Invoice Form</u> | <input type="checkbox"/> | <u>Application</u> | |
| <input type="checkbox"/> | <u>Affidavit</u> | | | | | <u>COMMENTS</u> |
| <input type="checkbox"/> | <u>Worker's Compensation Insurance Certificate</u> | <input type="checkbox"/> | <u>Proof of Worker's Compensation Insurance</u> | | | |
| <input type="checkbox"/> | Directions | | | | | |
| <input type="checkbox"/> | 5a Fire | | | | | |
| <input type="checkbox"/> | 5b Building | | | | | |
| <input type="checkbox"/> | 5c Zoning | | | | | |
| <input type="checkbox"/> | 5d Local Health - Date Application Sent: | _____ | | | | |
| <input type="checkbox"/> | 5e Building structure constructed prior 1978 | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No | If yes, a full comprehensive lead inspection is required |
| | Lead inspection to be conducted by the local health department or a private licensed lead inspector | | | | | |
| <input type="checkbox"/> | 7 Schedule | | | | | |
| <input type="checkbox"/> | 8a Discipline Policy: | <input type="checkbox"/> | Positive Guide | <input type="checkbox"/> | Redirection | |
| | | <input type="checkbox"/> | Limits | <input type="checkbox"/> | Supervision | <input type="checkbox"/> |
| | | | | <input type="checkbox"/> | Abuse/Neglect Policy | |
| <input type="checkbox"/> | 8b Closing Time Plan: | <input type="checkbox"/> | 2 People | <input type="checkbox"/> | Time Frame | <input type="checkbox"/> |
| | | <input type="checkbox"/> | Alternate Pick Up | <input type="checkbox"/> | Notification | |
| <input type="checkbox"/> | 8c Emergency Plans: | <input type="checkbox"/> | Medical | <input type="checkbox"/> | Fire | <input type="checkbox"/> |
| | | <input type="checkbox"/> | Weather | <input type="checkbox"/> | Evacuation | |
| <input type="checkbox"/> | 8d Supervision Plan: | <input type="checkbox"/> | In\Out | <input type="checkbox"/> | Group Size | <input type="checkbox"/> |
| | | <input type="checkbox"/> | Ratio | <input type="checkbox"/> | Nap | <input type="checkbox"/> |
| | | <input type="checkbox"/> | Bathroom Supervision Plan (Correlates with Floor Plan) | | | |
| <input type="checkbox"/> | 8e Operating Policies: | <input type="checkbox"/> | Admission w/Health Record | | <input type="checkbox"/> | Parents Involvement/Access |
| | | <input type="checkbox"/> | Agreements with Parents | | <input type="checkbox"/> | Menus/Times |
| | | <input type="checkbox"/> | W/D of Child | | <input type="checkbox"/> | Days/Hours-Operation (including sick, vacation, holiday) |
| | | <input type="checkbox"/> | Medication Policies, if applicable | | | |
| <input type="checkbox"/> | 8f Personnel Policies: | <input type="checkbox"/> | Job Description | <input type="checkbox"/> | Benefits | <input type="checkbox"/> |
| | | <input type="checkbox"/> | Probation Period | <input type="checkbox"/> | Supervision of Staff | |
| | | <input type="checkbox"/> | Parent Communication | | | |
| <input type="checkbox"/> | 8g Administration of Medications: | <input type="checkbox"/> | Types of Medications | <input type="checkbox"/> | Storage of Medications | |
| | | <input type="checkbox"/> | Record Keeping | <input type="checkbox"/> | Parental Responsibilities | <input type="checkbox"/> |
| | | <input type="checkbox"/> | Staff Responsibilities | <input type="checkbox"/> | Medication Training Certificates | |
| <input type="checkbox"/> | 10a Staff Work Schedule Form | | | | | |
| <input type="checkbox"/> | 10b Fingerprint/Background Checks (Submit to the Legal Department) | | | | | |
| <input type="checkbox"/> | 10c Head Teacher Form or Certificate of Approval | | | | | |
| <input type="checkbox"/> | 10d Organization Chart | | | | | |
| <input type="checkbox"/> | 10e First Aid Training Certificates | <input type="checkbox"/> | CPR Training Certificate | | | |
| <input type="checkbox"/> | 10f Plan for Continuing Education | <input type="checkbox"/> | 1% of Total Annual Hours Worked | | | |
| | | <input type="checkbox"/> | Attendance at Classes, Seminars, Conferences, etc. | | | |
| | | <input type="checkbox"/> | ECE Child Development Licensing, etc. | | | |
| <input type="checkbox"/> | 11 Plan for Consultation | <input type="checkbox"/> | Annual Policy Review | <input type="checkbox"/> | Availability in Person | |
| | | <input type="checkbox"/> | Annual In-service Ed Program Review | <input type="checkbox"/> | Availability by Telecommunication | |
| <input type="checkbox"/> | 11a Education Consultant Form / Copy of Agreement | | | | | |
| <input type="checkbox"/> | 11b Copy of Agreement/Contract for Physician/Public Health RN | | | | | |
| <input type="checkbox"/> | 11c Copy of Agreement/Contract for Dentist | | | | | |
| <input type="checkbox"/> | 11d Copy of Agreement/Contract for Registered Dietitian | | | | | |
| <input type="checkbox"/> | 11e Copy of Agreement/Contract for Social Service Consultant | | | | | |
| <input type="checkbox"/> | 11f Consultant/Head Teacher Data Sheet | | | | | |
| <input type="checkbox"/> | 13a Floor Plan - Indoor | | | | | |
| <input type="checkbox"/> | 13b Water Supply Attachment: | | | | | |
| | <input type="checkbox"/> | Lead Water Test Results/Date | _____ | | | |
| | <input type="checkbox"/> | Within Limits (<0.15 ppb) | <input type="checkbox"/> | Exceeds Limits | | |
| | <input type="checkbox"/> | Public Water Supply | <input type="checkbox"/> | Copy of Bill | | |
| | <input type="checkbox"/> | Bacterial and Chemical Water Test Results/Date | _____ | | | |
| | <input type="checkbox"/> | On Site Well (In compliance with CT Public Health Code Sections 19-13-B51 and 19-13-B102) | | | | |
| | <input type="checkbox"/> | Local Health verified with DPH Water /Supplies Section for facilities licensed to serve 25 or more adults and children over 60 days per year | | | | |
| | <input type="checkbox"/> | Private Well – Facilities serve less than 25 children & adults | | | | |
| | <input type="checkbox"/> | Other (Please Specify) | _____ | | | |
| <input type="checkbox"/> | 13c Number of Toilets | <input type="checkbox"/> | Children _____ | <input type="checkbox"/> | Adults _____ | |
| | | <input type="checkbox"/> | Sinks | <input type="checkbox"/> | Children _____ | <input type="checkbox"/> |
| | | <input type="checkbox"/> | | <input type="checkbox"/> | Adults _____ | |
| <input type="checkbox"/> | 13d Pet Care Plan | <input type="checkbox"/> | Procedures for Care & Maintenance | <input type="checkbox"/> | Access to Children | |
| <input type="checkbox"/> | 13e Radon Test Results | | | | | |
| <input type="checkbox"/> | 14a Sketch - Outdoor Play Space | | | | | |
| <input type="checkbox"/> | 14b Pool Approval | | | | | |
| <input type="checkbox"/> | 15 Educational Program Plan | <input type="checkbox"/> | Infant/Toddler | <input type="checkbox"/> | Preschool | <input type="checkbox"/> |
| | | <input type="checkbox"/> | School Age | | | |
| <input type="checkbox"/> | S3 Indoor Floor Plan for Infant Toddler | | | | | |
| <input type="checkbox"/> | S4 Nurse's License and Resume | | | | | |
| <input type="checkbox"/> | S5a Diapering Plan | <input type="checkbox"/> | Diapering Procedure | <input type="checkbox"/> | Disposal of Diapers | |
| | | <input type="checkbox"/> | Hand washing | <input type="checkbox"/> | Sanitizing Process | |
| <input type="checkbox"/> | S5b Cloth Diaper Plan | <input type="checkbox"/> | Place in Sealed Container | <input type="checkbox"/> | Removing Daily | |
| | | <input type="checkbox"/> | Cleaning & Sanitizing Container Daily | | | |



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH Community Based Regulation Section

Child Day Care Licensing – Initial Application Fee Invoice Form

The licensing fee along with this Initial Application Fee Invoice Form is due with your application to obtain a child day care license. **THE FEE IS NON-REFUNDABLE.**

Please complete items 1 through 9 of this form. If you have questions, call the licensing office at 1-800-282-6063 or (860) 509-8045. Make your payment by check or money order payable to: **TREASURER-STATE OF CONNECTICUT.** Mail this form along with your payment and application to the *Department of Public Health* at the address on the bottom of this form.

1. Name of Applicant: _____
(Legal Operator)

2. Program Name: _____
(Applicable For Group/Center Only)

3. Program Location Address:
_____, CT _____
Street Address City/Town Zip Code

4. Program Phone Number: (____) _____ - _____ Program Fax Number: (____) _____ - _____

5. Mailing Address (if different):
_____, CT _____
Street Address City/Town Zip Code

6. Program E-mail Address: _____

7. Enclosed Check/Money Order: \$ _____ Check #: _____ Check Date: ____/____/____

8. Federal Employer ID #: _____ - _____
(2 digits) (7 digits)

9. Payment is for the following type of license: (check one box below)

Child Day Care Center (Account #42431)	Group Day Care Home (Account #42431)	Family Day Care Home (Account #42431)
<input type="checkbox"/> 4-year license (new program) \$400.00	<input type="checkbox"/> 4-year license (new program) \$200.00	<input type="checkbox"/> 4-year license (new provider) \$40.00





STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
Community Based Regulation Section

ALL FAMILY DAY CARE HOMES, GROUP DAY CARE HOMES, AND CHILD DAY CARE CENTERS PROOF OF WORKERS' COMPENSATION INSURANCE

IF YOU HIRE EMPLOYEES TO WORK IN YOUR PROGRAM State Law (CGS Section 31-286a(b)) **requires** that no state department, board or agency may issue or renew a license, or permit to operate a business in this state unless the applicant first presents sufficient evidence of current compliance with the workers' compensation insurance coverage requirements of Section 31-284.

This means that if you hire employees to work in your family day care home, group day care home or child day care center on a part time or full time basis, you must submit to the Department of Public Health as part of your initial license application or relicensure application, sufficient evidence of compliance with this law.

For More Information Contact:

Your Insurance Agent or The Workers' Compensation Commission: 1-800-223-9675 or 1-860-493-1534

**THIS FORM MUST BE COMPLETED AND RETURNED WITH YOUR APPLICATION
FOR A CHILD DAY CARE LICENSE (EVEN IF YOU DO NOT EMPLOY STAFF)**

Program/Provider Name: _____ New Application
Address: _____ Relicensure Application
Town/State/Zip: _____ Telephone: _____ License #: _____

Do you hire employees in your program that requires you to obtain Workers' Compensation Insurance?
 Yes No

If "Yes", please check off which of the required certificates you have, as indicated below, and mail a copy of the certificate to the Department of Public Health, Day Care Licensing Program.

Sufficient evidence means: (Check off and enclose a copy)

- (1) a certificate of self-insurance issued by a workers' compensation commissioner pursuant to section 31-284; or
- (2) a certificate of compliance issued by the insurance commissioner pursuant to section 31-286; or
- (3) a certificate of insurance issued by any stock or mutual insurance company or mutual association authorized to write workers' compensation insurance in this state or its agent.

(Signature Operator/Provider)

(Date)

(Printed Name)

T:\Fam&Ctr\Application\CDC_WCInsForm.doc 2/24/06



Phone: (860) 509-8045, Fax (860) 509-7541
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12CBR
P.O. Box 340308 Hartford, CT 06134
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**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH**

**APPLICATION FOR INITIAL LICENSE
CHILD DAY CARE CENTER OR
GROUP DAY CARE HOME**

Complete **original** application, answering all items as they apply to your program.

Please submit: **original** application to your **Day Care Licensing Specialist**
Please keep: **one** complete copy **on file at licensed premise**

1. **Name of Program:** _____

Program Location Address _____ **Phone:** (____) _____
(Number & Street)

Town/City/State: _____ **Zip Code:** _____

Mailing Address: (if different, i.e., RFD or P.O. Box, or central office)

Directions for reaching program from Hartford (include street names, landmarks and entrance to program space.) (**Attachment #1**)

- **Was the building/structure in which you will be providing child care constructed prior to 1978?** Yes No (if yes, please refer to question #5e)

2. **OPERATOR:** _____

Operator's Mailing Address: _____ Business Phone: (____) _____

Town/City/State: _____ Zip Code: _____

3. **DIRECTOR:** _____

Home Address: _____ Home Phone: (____) _____

Town/City/State: _____ Zip Code: _____

4. **HEAD TEACHER:** _____

(designated for site)

5. **LOCAL APPROVALS:**

- a. LOCAL FIRE approval (**Attachment #5a**)
- b. LOCAL BUILDING approval (**Attachment #5b**)
- c. ZONING approval (**Attachment #5c**)
- d. DATE you sent copy of application to LOCAL HEALTH DEPARTMENT _____
- e. LOCAL HEALTH Approval (Environmental Inspection Report)

A lead inspection is required for buildings constructed prior to 1978. If a lead inspection is required the local health department/private licensed lead inspector's Lead Inspection Report must be submitted. If lead-based paint or lead hazards are not identified, no additional documents are required to be submitted. If lead-based paint or lead hazards are identified, any of the following documents that are generated based upon the inspection results must be submitted: (a) **Plan of Abatement/Correction**, (b) **Letter of Compliance from local health department**, (c) **the Management Plan**.

6. **ENROLLMENT:**

Requested licensed capacity: _____

Ages of children you will accept: _____

SERVICES PROVIDED:

- | | |
|--|---|
| <input type="checkbox"/> Infant/Toddler 6 weeks-3 years | <input type="checkbox"/> Preschool 3-5 years |
| <input type="checkbox"/> Kindergarten 5-6 years
(Attending Kindergarten at your facility) | <input type="checkbox"/> School Age 5 years & over
(Attending Elementary School) |
| <input type="checkbox"/> Night Care | |

7. **OPERATIONS OF CENTER/HOME:** (Indicate time open each day)

Monday _____ Tuesday _____ Wednesday _____

Thursday _____ Friday _____ Saturday _____

Sunday _____ (i.e., Mon. 9 AM-12 PM; Tues. 10 AM-12 PM; Wed. 2-4 PM)

Months Center/Home Operates: _____ (i.e., September to June)

Days/Weeks program is scheduled to be CLOSED : _____
(i.e., holidays, in-service, vacations). (**Attachment #7**)

8. **ADMINISTRATION:**

Attach copies of the following policies, procedures and forms:

- a. Discipline policy including accepted and prohibited discipline methods.
(**Attachment #8a**)
- b. Plan for the care of the child not picked up at closing time.
(**Attachment #8b**)

- c. Emergency plans which include medical, fire, weather and evacuation policies and procedures. These plans should include detailed information explaining how each type of emergency would be handled by the program. **(Attachment #8c)**
- d. Supervision of children: This plan shall include information on how the program will maintain ratios, group size, supervision of all areas inside and outside throughout the day including naptime and bathroom areas. **(Attachment #8d)**
- e. Operating policies which include information on agreements with parents, parental involvement, medication policies, food service, enrollment/disenrollment, operating schedule and access to facility. **(Attachment #8e)**
- f. Personnel policies which include information on job descriptions for each staff position, employee benefits, staff supervision, probationary period, parent communication. **(Attachment #8f)**
- g. Administration of medications: (Required only if program administers medication.) Develop a written plan that includes the types of medications to be administered, parental and staff responsibilities, proper storage of medications and record keeping. **(Attachment #8g)**
9. **RECORD KEEPING:** The operator is responsible for maintaining records for each child enrolled in the program. **Please be sure the forms you use contain ALL of the required information outlined in the regulations:**
- Enrollment form
 - Emergency Medical permission
 - Permission for responsible adult (other than parent) to remove child from program
 - Permission for field trips - any activity away from premise (i.e., walks)
 - Permission for use of transportation services (if provided)
- Is transportation provided? Yes No

10. **STAFF - (paid or volunteer):**

Attach copies of the following:

- a. List name, date of birth, position, work schedule, date of employment for each employee, including substitutes (use enclosed staff work schedule form.) **(Attachment #10a)**
- b. **Important:** Background Check Fingerprint Cards (To be returned to the Legal Department @ the Department of Public Health, Legal Office, 410 Capital Avenue. MS#12 LEG, P. O. Box 340308, Hartford, CT 06134-0308.)
- c. Head Teacher: (Use enclosed required experience form.) Supply evidence of required supervised experience and education or attach a copy of Head Teacher Approval. **(Attachment #10c)**

- d. Written organizational chart that establishes the line of authority and responsibility in all matters relating to the management and maintenance of the center or group home and care of children. Attach copy of the organizational chart. **(Attachment #10d)**
- e. Copies of staff certificates from approved first aid courses and approved CPR course. **(Attachment #10e)**
- f. Written plan for the continuing education for program staff. **(Attachment #10f)**

11. **CONSULTANTS:**

Describe your plan for consultation services for each consultant, including a review of policies and availability of the consultants. Please attach written agreements for each consultant. **(Attachment #11)**

- a. Early Childhood/School Age Education Consultant (submit enclosed application) **(Attachment #11a)**
- b. Health Consultant **(Attachment #11b)**
- c. Dental Consultant **(Attachment #11c)**
- d. Registered Dietitian Consultant (required if meals are served) **(Attachment #11d)**
- e. Social Service Consultant **(Attachment #11e)**

12. **FOOD SERVICE:**

- a. Meals and snacks served: (check **All** that apply):

_____ Breakfast meal	_____ A.M. snack
_____ Midday meal	_____ P.M. snack
_____ Evening meal	_____ Snack brought by children
_____ Meals brought by children	

- **If meals are served, please submit a copy of your Food Service Certificate**

- b. Who plans food service? _____
Where is food prepared? _____

- c. Eating, serving and drinking utensils (check **All** that apply):

Disposable Reusable

Dishwashing facilities:

Machine Hand

13. **PHYSICAL PLANT - INDOORS:** (attach copies of the following)

- a. **PROGRAM SPACE:** Submit a floor plan for the entire day care center/home. Show the dimensions in **FEET** of each program area/classroom. Indicate the functions of each room. Indicate on the floor plan, entrances and exits, doors, windows, corridors, storage areas, child bathrooms, sinks, kitchens/food prep areas, office, staff bathrooms, isolation area. **(Attachment #13a)**

b. **WATER SUPPLY:** (check one) (**Attachment #13b**)

City/Municipal Well Other

1. **If water source is City/Municipal**, submit copy of most recent bill or other documentation for verification purposes - with program's location address on it. (**Attachment #13b**)
2. Submit copy of Lead Water Test completed every 2 years for **All** water supplies. (**Attachment #13b**)
3. **If water source is a well**, submit a copy of the Bacterial and Chemical Test every two years. (**Attachment #13b**)
4. **If water source is a well and facility will serve 25 or more adults and children for over 60 days per year**, the facility must be in compliance for required water quality testing and well construction for non community public water systems per CT Public Health Code Sections 19-13-B102 and 19-13-B51, respectively. Information must be verified with DPH Drinking Water Section at (860) 509-7333.

- Water Supply Engineer Contact Person: _____
Print Name

c. Number of toilets for children: _____ Number of toilets for staff/adults: _____
Number of sinks for children: _____ Number of sinks for staff/adults: _____

d. **PETS** - If pets are present in the, program submit a written plan for their care and access to children. (**Attachment #13d**)

e. **RADON TESTING:** If the program is located in a basement level or ground floor submit copy of radon test. Results must be posted. **Testing must be done between the months of November and April.** (**Attachment #13e**)

14. **OUTDOOR PLAY SPACE:** (attach copies of the following)

- a. Sketch showing dimensions in **FEET**. Include information on location of facility, major play equipment, type of surface(s), fencing and storage areas. (**Attachment #14a**)
- b. Copy of official swimming pool approval to indicate compliance with Public Health Code, if applicable.

15. **EDUCATION PROGRAM:**

Child Day Care Centers/Group Day Care Homes shall have policies, procedures and activities that meet and enhance the needs of children served. **Attach the following information for age groups served:**

- **Educational Program Plan:** Describe the educational program plan, which meets and enhances the individual needs of the diverse population of children serviced, including how the program will provide indoor/outdoor physical activities, problem solving experiences, creative arts activities, language learning experiences, self-reliance/self esteem experiences and health education activities. (**Attachment #15**)

The licensing authority (Department of Public Health) must be notified of any change in plan of operation involving facility, staff, children served at any one time from that indicated on this application. Additional approval is required for continued licensure if there are any changes in the conditions on which any earlier licensure is granted. The official license to operate a child day care center/home must be posted on the premises of the center/home in a conspicuous manner.

The facts as stated in completion of this application are true

Signature of Operator or Legal Representative

Date

**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH**

**SUPPLEMENTARY INFORMATION OF INFANT/TODDLER DAY CARE
PROGRAM IN DAY CARE CENTERS AND GROUP DAY CARE HOMES**

PUBLIC HEALTH CODE SECTION 19A-79-10 UNDER THREE ENDORSEMENT

“The operator of a program caring for children under three (3) years of age shall comply with sections 19a-79-1a through 19a-79-8a and section 19a-79-10 of the Regulations of Connecticut State Agencies.

Complete **original application**, answering all items as they apply to your Child Care Center/Group Day Care Home:

Please send: **original** application to your **Day Care Licensing Specialist**

Please keep: **one** complete copy **on file at licensed premise**

S1. Name of Center/Home: _____

Location Address: _____
(Number & Street/Road)

Town/City/State: _____ **Zip Code:** _____

Telephone on Premises: _____

S2. LICENSED CAPACITY AND ENROLLMENT:

Requested licensed capacity for children under three years of age: _____

S3. GROUPING OF INFANTS/TODDLERS:

Sketch indoor program space and specify the following: (**Attachment #S3**)

- a. Dimensions + total square footage (in **FEET**) of each room/program area.
- b. Relationship of this space to any other program space.
- c. How groups of eight are divided with physical barriers.
- d. Where sinks and changing tables are located.

S4. NURSE CONSULTATION:

Attach a copy of the following: **(Attachment #S4)**

S4 Name, resume and copy of current registered nurse's license.

S5. HEALTH AND HYGIENE:

Develop the following written policies and procedures and attach copies:

S5a. Diapering and toileting, including a description of the diapering procedure, the disposal of soiled diapers, hand washing procedures and sanitizing procedures. **(Attachment #S5a)**

Cloth diapers used: Yes No

S5b. If cloth diapers are used, submit a plan describing the procedures used to handle soiled non-disposable diapers and clothing. **(Attachment #S5b)**

The licensing authority (Department of Public Health) must be notified of any change in plan of operation involving facility, staff, children served at any one time from that indicated on this application. Additional approval is required for continued licensure if there are any changes in the conditions on which any earlier licensure is granted. The official license to operate a child day care center/home must be posted on the premises of the center/home in a conspicuous manner.

The facts as stated in completion of this application are true

Signature of Operator or Legal Representative

Date

**CT Department of Public Health
Division of Community Based Regulation
Consultant/ Head Teacher Data Sheet**

(Attachment 11f)

**PLEASE PRINT - Please enter complete information for each Consultant and Head Teacher.
Enter N/A (not applicable) for questions that do not apply**

CURRENT AGREEMENTS FOR ALL CONSULTANTS MUST BE SUBMITTED WITH THIS FORM

Name of Person completing this form: _____

Position: _____ Date form completed: _____

Program Name: _____ License # _____

Street Address: _____ Town: _____ CT Zip: _____

Telephone #: (____)____-____ Fax #: (____)____-____ E-mail _____

Health Consultant (Required)

Last name: _____ First: _____ Middle initial: _____

Resident Street Address: _____ Town: _____ State: _____ Zip: _____

Telephone #: (____)____-____ Fax #: (____)____-____ E-mail: _____

Work Address: _____ Town: _____ State: _____ Zip: _____

Telephone #: (____)____-____ Fax #: (____)____-____ E-mail: _____

Professional license held: Physician Physician Assistant AP Registered Nurse Registered Nurse

Professional License #: _____ License Expiration Date: _____

Early Childhood Education Consultant (Required)

Last name: _____ First: _____ Middle initial: _____

Resident Street Address: _____ Town: _____ State: _____ Zip: _____

Telephone #: (____)____-____ Fax #: (____)____-____ E-mail: _____

Work Address: _____ Town: _____ State: _____ Zip: _____

Telephone #: (____)____-____ Fax #: (____)____-____ E-mail: _____

DPH approval on file: Yes No

Name at time of approval if different: _____

PLEASE BE SURE TO COMPLETE THE REVERSE SIDE OF THIS FORM

Dental Consultant (Required)

Last name: _____ First : _____ Middle initial : _____
Resident Street Address: _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Work Address: _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Professional license held: Licensed Dentist Dental hygienist
Professional License #: _____ Expiration Date: _____

Social Service Consultant (Required)

Last name: _____ First: _____ Middle initial: _____
Resident Street Address: _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Work Address: _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Professional degrees held: BSW BA/ BS - Field of study: _____
 MSW MA/MS - Field of study: _____
Professional License # (if applicable): _____ Expiration Date: _____

Registered Dietitian Consultant (Required for programs that serve meals)

Last name : _____ First: _____ Middle initial: _____
Resident Street Address: _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Work Address _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Professional license held: RD License/ID #: _____ Expiration Date: _____

CURRENT AGREEMENTS FOR ALL CONSULTANTS MUST BE SUBMITTED WITH THIS FORM

Head Teacher(s) (Required)

Please complete this section for each Department Approved Head Teacher at this program. If your program has more than (1) Head Teacher, please submit this information as an attachment.

Last name: _____ First: _____ Middle initial: _____
Resident Street Address _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Work Address: _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Dept. of Public Health approval on file: Yes No Under 3 Years Preschool School Age

Name at time of approval if different: _____

**Please return this form to: Department of Public Health, Division of Community Based Regulation,
410 Capital Avenue MS#12 DAC, P.O. Box340308, Hartford, CT 06134-0308 or Fax (860) 509-7541**

Water Supply

(Attachment# 13b)

Program Name: _____

License #: _____

Location Address: _____

Capacity: _____

City or Town: _____

(If **New** program, indicate “**New**” next to license #.)

PLEASE BE SPECIFIC:

- Months of Operation (i.e. September-June): _____
- Days/Hours of Operation: Monday _____ Tuesday _____ Wednesday _____
Thursday _____ Friday _____

Name of Property Owner: _____

Address: _____

City or Town: _____

Phone #: _____

Section 1

Are you or your landlord a Customer of a Water Company? Yes No

If Yes, complete Section 2 and provide the name of the Water Company: _____

If No, complete section 3

Section 2

Lead Water Test – Required for all programs every two years and when there are changes in water supply

Along with this form you **YOU MUST ATTACH** the following:

- *A copy of the program’s most **recent water bill or other documentation**, for verification purposes, with the program location address on it;
- * A copy of the program’s first draw **lead water test**;

If you answered yes to Section 1 and completed Section 2, DO NOT continue on to Sections 3 and 4

Section 3

Facility has an on site well and serves less than 25 adults and children Yes No

If **YES**, you are required to submit both a first draw **lead water test** and **bacterial & chemical test**

If **NO**, complete **Section 4**

Lead Water Test – (Required for all programs every two years and when there are changes in water supply)

Bacterial & Chemical Test (Required every 2 years for all programs with on site wells serving less than 25 adults and children)

Along with this form, **YOU MUST ATTACH** the following:

- *A copy of the program’s first draw **lead water test**
- *A copy of the program’s **bacterial and chemical test**

CONTINUED ON BACK PAGE

Section 4 (Facility has on site well and serves 25 or more adults and children *at least 60 days of the year*)

Please Note: Your facility meets the classification of a Public Water Supply System and will be Referred to the Department of Public Health, Drinking Water Section.

Lead Water Test – (Required for all programs every two years and when there are changes in water supply)

Along with this form, **YOU MUST ATTACH** the following:

*A copy of the program's first draw **lead water test and bacterial and chemical test.**