

CROMWELL HEALTH DEPARTMENT

41 West Street, Cromwell, CT 06416

Tel.: (860) 632-3426

Fax: (860) 632-3477

CHILD DAY CARE CENTER APPLICATION

FEE: \$50.00

Licensed for:

☐ Under 3 years ☐ School Age ☐ Preschool (3-5 Years) ☐ Kindergarten

Days of Operation: _____

Hours of Operation: _____

Meals prepared on-site and provided daily: ☐ Yes ☐ No

(If yes, additional Food Service License Required)

Name of Establishment: _____

Mailing Address: _____

Phone #: _____ Email: _____

Owner's Name: _____

Home Address: _____

Phone #: _____ Email: _____

Director: _____ Phone #: _____

Assistant Director: _____ Phone #: _____

Rubbish/Trash Hauler:

Name: _____

Phone #: _____

I hereon attest that the above is the truth and agree that the permit to which this application is made will at all times be operated in compliance with the terms of the General Statutes of the State of Connecticut, the Connecticut State Health Codes, local Ordinances, and orders of the Director of Health or his authorized Agent regarding all matters concerned with public health.

Signature: _____

Name Printed: _____

Date: _____