North Central District Health Department

□ Enfield—31 North Main Street, Enfield, CT 06082 * (860) 745-0383 Fax (860) 745-3188
□ Vernon—375 Hartford Turnpike, Room 120, Vernon, CT 06066 * (860) 872-1501 Fax (860) 872 1531
□ Windham—Town Hall, 979 Main Street, Willimantic, CT 06226 * (860) 465-3033 Fax (860) 465-3034
□ Stafford—Town Hall, 1 Main Street, Stafford Springs, CT 06076 * (860) 684-5609 Fax (860) 684-1768

Patrice A. Sulik, MPH, R.S.
Director of Health

APPLICATION FOR DAY CARE CENTER
LICENSING AND RE-LICENSING INSPECTIONS
(with or without food service facilities)

Date: _____

Business Name: _____

Name of Licensee/Applicant: _____ Emergency Phone #: _____

Address of Licensee/Applicant: _____

Location Address: _____ Town: _____ Zip Code: _____

Location Phone #: _____ Location Fax #: _____

Location Mailing Address (if different): _____

State License #: _____ Exp. Date: _____ Licensed Capacity: _____ # of Employees: _____

Licensed for: □Under 3 Years □Pre-School (3-5 Years) □School Age □Night Care

Water Supply: □Public Water □Private Well □State Health Dept. Water Supply Notification

Sewage Disposal: □Public Sewer □Private Septic System □Interior Grease Trap □Exterior Grease Tank

Age of Building: _____ **Exterior Playground Equipment:** Yes No **Equipment Age:** _____

Lead Paint Present: Yes No **(If Yes – An *updated* Lead Management Plan is required on-site)**

Food Service License (only for on-site meal preparation): Yes No

If yes, please list the Qualified Food Operator for your facility: _____

Certificate #: _____ Approved Test: _____ Date Granted: _____

A $200.00 fee is due with this completed application to request an inspection. **Payment and application must be received at least two weeks prior to the anticipated inspection. This fee is non-refundable and shall be made payable to: North Central District Health Department.** I have read this form and certify that the information given on this form is true and complete to the best of my knowledge.

_____ _____
Licensee/Applicant Signature Date

_____
Contact Email Address

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Office Use Only:

Fee Paid: Yes No Receipt #: _____ Check #: _____ Cash: _____ Credit Card: _____

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