# 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: _____

Address of Licensee/Applicant: _____Emergency Phone No. _____

Location Address: _____ Town: _____ Zip Code: _____

Location Phone No. _____ Location Fax No. _____

Location Mailing Address (if different): _____

State License No. _____ (for re-licensures only) Expiration Date: _____ (for re-licensures only) Licensed capacity _____ No. 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)**

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

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

Certificate No. _____ 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)

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**Office Use Only:**
Fee Paid: ☐ Yes ☐ No Receipt No. _____ Check No. _____ Cash _____

Date Application Received:_____

11/23/22

submit applications to: applications@ncdhd.org