



APPLICATION TO OPERATE A CHILD CARE FACILITY

CHILD CARE FACILITIES BOARD
FLORIDA DEPARTMENT OF HEALTH - PALM BEACH COUNTY
 800 Clematis Street, West Palm Beach, FL 33401

FOR OFFICE USE ONLY Offender Search Date _____ By _____ Result: Exact match, Yes or No
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PLEASE TYPE OR PRINT LEGIBLY

Instructions: All information on this application must be truthful and correct. This three-page application must be completed in its entirety. Incomplete applications will not be accepted. Please contact this office if there are any questions relating to completing this application.

Check applicable boxes below			
<input type="checkbox"/> New Facility	<input type="checkbox"/> Drop-In Child Care Facility	<input type="checkbox"/> Certificate of Compliance Facility	
<input type="checkbox"/> Child Care Facility	<input type="checkbox"/> School Age Child Care Facility	<input type="checkbox"/> Change in Capacity/Use	
<input type="checkbox"/> Indoor Recreation Facility	<input type="checkbox"/> Specialized Child Care/Mildly Ill	<input type="checkbox"/> Change Ownership	<input type="checkbox"/> Change Director

I. FACILITY INFORMATION

Name of facility as it is to appear on the license					Telephone Number ()	
Street Address of Facility (do not enter a P.O.Box)				City	Zip Code	
Mailing address of Facility, if different (include city and zip code)				Email address		
<input type="checkbox"/> Full Day	<input type="checkbox"/> Before School	<input type="checkbox"/> Night Care	<input type="checkbox"/> Transportation	<input type="checkbox"/> Drop-In Care Only		
<input type="checkbox"/> Half Day	<input type="checkbox"/> After School	<input type="checkbox"/> Weekend Care	<input type="checkbox"/> Food Served	<input type="checkbox"/> Infant Care (0-1 yr)	<input type="checkbox"/> Infant Care (1-2yr)	
Days of operation: Mon Tue Wed Thu Fri Sat Sun			Hours of operation:			
Number of children under age 2 proposed to be kept at facility _____		Number of children over age 2 proposed to be kept at facility _____		Total capacity requested: _____		

II. APPLICANT INFORMATION

This application must be completed by the owner, the designated representative of the owner, or prospective owner.

Name of Applicant _____

Check One Owner Corporate Officer Designated Representative (Requires written authorization from a corporate officer)

Position or Title: _____ Role in Facility: _____

Applicant's Home Address (P.O. Box or Street Address)	City	State	Zip Code
Applicant's Telephone number, including Area Code			

ON-SITE DIRECTOR INFORMATION

Name of Director First	Middle (Maiden)	Last	
Director's Home Address (P.O. Box or Street)	City	Zip Code	Telephone Number ()
Director Credential Certificate Number	Director Credential Level	Certificate Expiration Date	

III. LEGAL OWNERSHIP OF CHILD CARE FACILITY (Complete One Section Only)

INDIVIDUAL

Name: First		Middle (Maiden)		Last	
Address (P.O. Box or Street Address)		City		Zip Code	Telephone Number ()
Role in Child Care Facility Operation (Attach additional sheets if necessary)					

PARTNERSHIP

(Attach a copy of the Partnership Agreement)

Name: First		Middle (Maiden)		Last	
Address (P.O. Box or Street Address)		City		Zip Code	Telephone Number ()
Role in Child Care Facility Operation (Attach additional sheets if necessary)					

Name: First		Middle (Maiden)		Last	
Address (P.O. Box or Street Address)		City		Zip Code	Telephone Number ()
Role in Child Care Facility Operation (Attach additional sheets if necessary)					

CORPORATION

(Attach current Articles of Incorporation and Certificate of Status/Certificate of Authorization from Dept. of State)

Name:		Corporate #: _____			
Telephone Number, including area code:		Incorporated in which state? _____			
		Is the corporation registered with the Florida Secretary of State? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, please register prior to submitting an application.)			
Address (P.O. Box or Street Address)		City	State	Zip Code	
Attach a list of Director's names, and the title/office, address, and telephone number for each Director. Also attach the street address of the corporation's registered office, and the name and telephone number of the corporation's registered agent. Failure to continuously maintain a registered office and/or a registered agent in Florida is grounds for revocation of this license.					
All corporations must include a current Certificate of Status (domestic corporation), or a Certificate of Authorization (foreign corporation) with this application. Failure by any corporation to comply with all requirements under Chapter 607, Florida Statutes, is grounds for revocation of this license.					

OTHER ENTITY

(These are programs operated by School Boards, before and after school programs, and other non-incorporated entities.)

Name of Entity:					
Entity's Designated Representative: First		Middle (Maiden)		Last	
Address (P.O. Box or Street Address)		City	State	Zip Code	Telephone Number ()

IV. OWNER OF REAL PROPERTY

Legal Name: First		Middle (Maiden)		Last		Telephone Number ()
Address (P.O. Box or Street Address)		City		State	Zip Code	

V. ATTESTATION

Has the facility owner, applicant, or director ever had a license denied, revoked or suspended in any state or jurisdiction or has been the subject of a disciplinary action or had been fined while operating a child care facility or family day care home or employed in a childcare facility?

Yes No *If Yes, please explain:* _____

[Attach additional sheet(s) if necessary]

I hereby attest that the information contained in this section is truthful and correct under penalty of perjury. _____
Initial

Have you or anyone identified as a party to ownership ever held a license (child care, foster care, cosmetology, etc.) with any state agency in any capacity other than a driver's license?

Yes No *If Yes, where, what type of license, license number, and under what name?* _____

[Attach additional sheet(s) if necessary]

It is agreed that the undersigned has received a copy of Chapter 77-620, Laws of Florida, as amended, the Palm Beach County Rules and Regulations Governing Child Care Facilities and other applicable regulations adopted by reference therein, and will adhere to the provisions of these Statutes, Rules, and Regulations.

Pursuant to the Palm Beach County Rules and Regulations Governing Child Care Facilities, child enrichment service providers shall be of good moral character based upon screening, using Level 2 standards in Chapter 435, F. S. If this facility utilizes a child enrichment service provider, it is the responsibility of the director to ensure that the child enrichment service provider is screened accordingly and parents/guardians provide written consent before a child may participate in activities conducted by the child enrichment service provider. Your signature on this application indicates your understanding and compliance with the law.

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), personally identifiable health information must be protected from disclosure and maintained in a manner to prevent inadvertent disclosure to the public and to otherwise assure the privacy of such information. Your signature on this application indicates that you agree to comply with the requirements of HIPAA by protecting the confidentiality of employee and children's health records in your possession.

Pursuant to section 435.05(3), F.S., each employer must attest via signed affidavit compliance with the provisions of chapter 435.04, F.S. By signing below, I _____ Applicant of _____ Child Care Facility, do hereby affirm that all child care personnel meet the statutory requirements for background screening.

Falsification of application information is grounds for denial or revocation of the license to operate a child care facility. Under penalty of perjury I hereby attest that the information contained in this application is truthful and correct.

This application may be withdrawn at any time the applicant so desires. _____ DATE _____
Signature of Owner or Organization's Designated Representative

Sworn to and subscribed before me this _____ day of _____, 20_____

SIGNATURE OF NOTARY PUBLIC, STATE OF FLORIDA

Print, Type, or Stamp Commissioned Name of Notary Public

Affiant personally known to notary OR

Affiant produced the following identification: _____

THIS APPLICATION REQUIRES THE WRITTEN APPROVAL OF THE FOLLOWING AGENCIES:

Building Department: _____ Date: _____
Print Name Signature

Comments: _____

Zoning Department: _____ Date: _____
Print Name Signature

Approved Capacity: _____ Comments: _____

Fire Department: _____ Date: _____
Print Name Signature

Comments: _____

CHILD CARE ADVISORY COUNCIL: _____ **Date:** _____