



Health Service Request

Facility name		License ID #	10 digit facility phone number	
Facility address		City	Zip code	County
Mailing address		City	Zip code	
Contact person's name and title			10 Digit telephone number - extension if any	
Previous name(s) of this center			<input type="checkbox"/> Copy of floor plan attached	
Previous address				
Name(s) of previous licensed centers at this location				
Directions to facility				
Child Care				
<input type="checkbox"/> Child care	<input type="checkbox"/> Summer only	License or application expiration date		Hours of operation A.M. - P.M.
<input type="checkbox"/> School age centers	<input type="checkbox"/> Seasonal	Days of operation		
<input type="checkbox"/> Family home provider	<input type="checkbox"/> Before/after care			
	<input type="checkbox"/> School year only			
Type of Health Service Requested				
<input type="checkbox"/> TA – w/licensor (on site)	<input type="checkbox"/> TA – w/o licensor (on site)	<input type="checkbox"/> Feasibility (on site)		
<input type="checkbox"/> Plan review (off site)	<input type="checkbox"/> Staffing/training – (see comments below)	<input type="checkbox"/> TA – Complaint (on site)		
<input type="checkbox"/> TA – complaint (staffing)				
Capacity				
Current licensed capacity	Requested number of children	Ages	through	years
				Number of infants
Licensor		Region	10 digit telephone number	Date completed
Licensor's comments:				
Health Specialist's name		Service area	10 digit telephone number	Date completed
Health Specialist's comments:				
<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved				