



Northeast District Department of Health

69 South Main Street, Unit 4

Brooklyn, CT 06234

Phone - (860) 774-7350 / Fax - (860) 774-1308

www.nddh.org

DAY CARE APPLICATION

Program Name: _____

Program Street Address: _____

Program Mailing Address: _____

Operator/Manager: _____

Address: _____

Establishment License No.: _____ Telephone No.: _____ Fax No. _____

Licensed Capacity: _____ Age of Children: _____ Hours of Operation : _____

Meal Program

Brought by Children: _____

Prepared on Site: _____

If Prepared, What Type:

Breakfast: _____ AM Snack: _____ Lunch: _____ PM Snack: _____ Dinner: _____

Water Supply

Sewage Disposal

City: _____ Well: _____

City: _____ Well: _____

Type of Well: _____

Last Date Pumped: _____

Last Date Tested: _____

Submit Copy of Analysis

Submit Copy of Receipt

Name (Please Print)

Signature

Date

NDDH Use

Only: Fee: _____ Receipt#: _____ Check #: _____ Date: _____