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 email@nddh.org

Sanitarian Approved
Initial:__________
Date: __________
Emailed:_________

DAY CARE APPLICATION

Program Name: ____

Program Street Address: ____

Program Mailing Address: ____

Operator/Manager: ____

Address: ____

Billing Email:____

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

City: ________Well: ________
Type of Well: ______________
Last Date Tested: ___________
Submit Copy of Analysis

Sewage Disposal

City: _________Well: ___________
Last Date Pumped: _______________
Submit Copy of Receipt

______________________________ ______________________________
Name (Please Print) **Signature**

Date ____

NDDH Use Only
Date:___________ Fee:_______ Check #_________ CC E-Check Cash Receipt #________________
Date:___________ Fee:_______ Check #_________ CC E-Check Cash Receipt #________________

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