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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