

CHILD CARE FACILITY BOARD  
PALM BEACH COUNTY HEALTH DEPARTMENT  
P.O. Box 29, West Palm Beach, FL 33402

APPLICATION TO OPERATE A CHILD CARE FACILITY

INFORMATION IN THIS BOX TO BE COMPLETED BY THE PALM BEACH COUNTY HEALTH DEPARTMENT

Facility Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_

Owner Name: \_\_\_\_\_

Owner Real Property: \_\_\_\_\_

Total Capacity: \_\_\_\_\_

Capacity of Children over Age 2 Years: \_\_\_\_\_

Infant Capacity: \_\_\_\_\_

PBCHD Representative: \_\_\_\_\_

FOR OFFICE USE ONLY

Offender Search

Date: \_\_\_\_\_

By: \_\_\_\_\_

Result: Exact match, Yes or No

**Note:** All information on this application must be truthful and correct. This 2-page application must be completed in its entirety. An incomplete application will not be accepted. Please contact this office if there are any questions about completing this application. All unpaid administrative fines must be paid before your license can be renewed.

Application Date: \_\_\_\_\_

**I. FACILITY INFORMATION**

Name of Facility: \_\_\_\_\_

Address of Facility: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

1. Number of children under age 2 kept at the facility \_\_\_\_\_
2. Number of children over age 2 kept at the facility \_\_\_\_\_
3. Total capacity of facility \_\_\_\_\_

**II. OWNER OF BUSINESS:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

\_\_\_\_ Attach a copy of the current satisfactory fire inspection report from the fire department.

\_\_\_\_ Attach a copy of the Certificate of Liability Insurance with Palm Beach County Health Department as the certificate holder.

\_\_\_\_ Attach a copy of the Certificate of Worker's Comp. insurance with Palm Beach County Health Department as the certificate holder.

\_\_\_\_ Attach a corporate status report listing the corporate officers if there has been a change.

Expiration date of the lease or management agreement, if applicable, \_\_\_\_\_. Attach a copy if there has been a change.

### III OWNER OF REAL PROPERTY

Legal Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

#### ON-SITE DIRECTOR INFORMATION

Name of Director: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
First Middle (Maiden) Last

Director's Home Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
(P.O. Box or Street) City

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Director Credential Certificate Number: \_\_\_\_\_ Director Credential Level: \_\_\_\_\_ Certificate Expiration Date: \_\_\_\_\_

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 child care facility? \_\_\_\_ Yes \_\_\_\_ No

If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
*[Attach additional sheet(s) if necessary]*

It is agreed that the undersigned has received a copy of Chapter 77-620, Special Acts, 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 Laws, 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.

**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 Designated Representative

( \_\_\_\_\_ DATE \_\_\_\_\_  
Signature of Credentialed Director

\_\_\_\_\_  
Print Name

Attach a copy of the current DCF training transcript.

\_\_\_\_\_  
Title or Position in Facility