

# Child Provider Application - Child Care Connection Network

Bear River Head Start  
95 W. 100 S. Suite 200  
Logan, UT 84321  
(435)755-0081

Name of Child Care Provider: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Last First Middle  
Street Address City ST Zip

Name of Child Care: \_\_\_\_\_

Child Care Telephone Number: \_\_\_\_\_ Home Telephone Number: \_\_\_\_\_

Are you licensed to provide child care? \_\_\_\_\_ License Number: \_\_\_\_\_

How long have you been licensed? \_\_\_\_\_ For how many children? \_\_\_\_\_

Of the children in your care, how many would qualify for Head Start Services? \_\_\_\_\_

Do you participate in the CACFP? \_\_\_\_\_ Are you CPR/First Aid Certified? \_\_\_\_\_

Do you have a CDA? \_\_\_\_\_

What Education or Experience do you have in the Child Care Profession? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there any other skills or qualifications that you have that would benefit the Child Care Connection Network? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Personal References

Name	Occupation	Phone	Address

I certify that all the information in this application is true and accurate

Signature of Applicant: \_\_\_\_\_ Date of Application: \_\_\_\_\_