

APPLICATION FORM FOR REGISTRATION OF CHILD DAY CARE CENTRE

1. Name of Child Day Care Centre

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Address of child day care centre

.....

(Please annex site plan and location plan)

Phone no. Fax no.

Email address:.....

Name of Owner/Director:.....

Other Names:

Maiden Name (if applicable):

Address of Owner/Director:

.....

National Identity Card no.

Phone no.

Name of Manager:

Other Names:

Maiden Name (if applicable):

Address of Manager:

.....

Email address

National Identity Card no.

Phone no. Mobile no.

2. Expected number of children (*please specify age groups*) –

Age groups	Boy	Girl	Number of children
14 weeks < 1 year			
1 year < 2 years			
2 years < 3 years			

3. Total number of employees –

Name	Occupation	Male	Female	Details of qualifications	No. of employees
	*Manager				
	*Assistant Manager				
	*				
	*				
	*Child Caregiver				
	*Assistant Child Caregiver				
	Cook			Food Handler's Certificate	
	Attendant				
	Cleaner				
	Driver				

	Others (Specify)				
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**Please produce evidence of qualifications or experience, medical certificate and certificate of character in respect of every employee*

4. Building and premises/space available –

- (a) please state the number of rooms available and specify the area of each room –

No. of rooms	Size/area

- (b) please state whether the following facilities are available –

Facilities	Yes	No	If yes, specify area
Kitchen			
Toilet			
Bathroom			
Laundry			
Playground			
Park			
Living room/restroom			

Others (<i>Please specify</i>)			
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5. Equipment and furniture –

- (a) no. of cots
- (b) no. of tables
- (c) no. of chairs
- (d) no. of cupboards
- (e) pedagogical toys (*please attach list*)
- (f) no. of fire extinguishers
- (g) no. of mattresses
- (h) no. of first aid boxes
- (i) other(s) (*please specify*)

Please state whether clearance has been obtained from – (*Please tick as appropriate*)

- | | | |
|---|------------------------------|-----------------------------|
| (a) the Ministry of Health and Wellness | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (b) the local authority | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (c) the Mauritius Fire and Rescue Service | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (d) anyother authority/authority (to specify) | | |

6. Days and hours of operation –

- (a) Weekdays Hours
- (b) Saturdays Hours
- (c) Sundays Hours
- and public holidays

7. Services provided

Please attach lists of development activities (indoor activities/ outdoor activities)

8. Other services (*Please tick as appropriate*) –

Transport	<input type="checkbox"/>	Washing and Ironing	<input type="checkbox"/>
Bath	<input type="checkbox"/>	Medical services*	<input type="checkbox"/>
Meal	<input type="checkbox"/>	Psychological Services*	<input type="checkbox"/>

If other(s), please specify

*Please indicate whether there is a visiting nutritionist?

Yes ☐ No ☐

If yes, state frequency

*Please indicate whether there is a visiting pediatrician?

Yes ☐ No ☐

If yes, state frequency:

*Please indicate whether there is a visiting psychologist?

Yes ☐ No ☐

If yes, state frequency

9. Monthly fees per head –

(*Please indicate if different fees are claimed under the same age group*)

Age groups	Amount
14 weeks < 1 year	
1 year < 2 years	
2 years < 3 years	

.....

Signature of Manager

Date

FOR OFFICE USE ONLY

Date of receipt of documents:

Documents verified on:

Name of officer:

Signature of officer:

Grade:

Date: