Parent/Military Sponsor Name:____

SECTION B. CHILD CARE PROVIDER INFORMATION

Provider/Program Name: ____
(As is appears on license/registration)

Provider/Program Address: **(please indicate the address where care is provided)**

_______________________________________ _______________________ ________________ ________

Street Name and Number City State Zip Code

County in which care is provided: ________________________________

Provider/Program telephone number: (______)_______-_________ **E-Mail Address:**____________________________

Second Provider (if needed)

Provider/Program Name: ____
(As is appears on license/registration)

Provider/Program Address: **(please indicate the address where care is provided)**

_______________________________________ _______________________ ________________ ________

Street Name and Number City State Zip Code

County in which care is provided: ________________________________

Provider/Program telephone number: (______) _______-__________ **E-Mail Address:** ____________________________

Date Care Begins: ___/___ /_______ **Date Care Ended (if applicable):** ___/____/_______

NAMES OF CHILDREN TO BE CARED FOR THROUGH MILITARY SUBSIDY PROGRAMS

Name of Child(ren)	Date of Birth	Gender (M/F)	Provider/Program Name
1.			
2.			
3.			
4.			

SCHEDULE OF CARE

Name of Child(ren)	Days Children are in Care (Check all that apply)							Hours Children are in Care	
	SUN	MON	TUE	WED	THU	FRI	SAT	From	To
1.									
2.									
3.									
4.									