Office Use Only

CHILD CARE LICENSING PROGRAM

Division of Public Assistance
Child Care Program Office

FACILITY SCHEDULE REPORTING FORM

Name of Facility:_____

Name of Administrator:_____

Mailing Address of Facility:_____
(PO Box/Street) (City/State/Zip)

Phone Number:_____ Fax Number: _____

Email Address:_____ Effective Date: _____

Day of Week	Time Open	Time Closed
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		

Holiday Closures (mark with an "x" the days below you will be closed annually)

☐ Alaska Day ☐ Christmas Day ☐ Easter ☐ Independence Day ☐ Labor Day ☐ Memorial Day

☐ New Year's Day ☐ Presidents Day ☐ Seward's Day ☐ Thanksgiving ☐ Veterans Day

Other Closures (indicate the date and year or holiday you will be closed and mark with an "x")

☐_____ ☐_____ ☐_____

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