

Facility Information			
FACILITY NAME		TELEPHONE NUMBER ()	
PHYSICAL ADDRESS			
	Street	City	Province Postal Code
PREMISES	<input type="checkbox"/> Owned	<input type="checkbox"/> Leased	
BUSINESS TYPE <i>(Check only one)</i>	<input type="checkbox"/> Sole Proprietorship (e.g. a person)	<input type="checkbox"/> Indigenous Governing Body	
	<input type="checkbox"/> Partnership (e.g. two or more individuals or companies)	<input type="checkbox"/> Board of Education	
	<input type="checkbox"/> Not-for-Profit Organization / Society	<input type="checkbox"/> Corporation	
	<input type="checkbox"/> Local Government		

Proposed Care Programs			
Will the facility provide overnight care? <input type="checkbox"/> Yes <input type="checkbox"/> No			<i>Office Use Only</i>
Types of Care Programs			Approved Capacity
		Check all "service types" that apply	Proposed Capacity
			<i>(for data entry)</i>
301	Group Child Care (Under 36 Months)	<input type="checkbox"/>	
302	Group Child Care (30 Months to School Age)	<input type="checkbox"/>	
303	Preschool (30 Months to School Age)	<input type="checkbox"/>	
304	Family Child Care	<input type="checkbox"/>	
305	Group Child Care (School Age)	<input type="checkbox"/>	
306	School Age Care on School Grounds	<input type="checkbox"/>	
307	Recreational Care	<input type="checkbox"/>	
308	Occasional Child Care	<input type="checkbox"/>	
310	Multi-Age Child Care	<input type="checkbox"/>	
311	In-Home Multi-Age Child Care	<input type="checkbox"/>	
312	Child-Minding	<input type="checkbox"/>	
Maximum Capacity (# of children in care at any one time):			
Approved by LO:			
	Name <i>(please print)</i>	Signature	Date <i>(dd / mmm / yyyy)</i>

Licensee Information	
LICENSEE NAME	TELEPHONE NUMBER ()
BUSINESS ADDRESS	
	Street City Province Postal Code
E-MAIL ADDRESS	
I have previously operated and/or managed a community care facility. <input type="checkbox"/> Yes <input type="checkbox"/> No	

Designated Director Information (if a Corporation, Society or Board)

DESIGNATE DIRECTOR NAME	TELEPHONE NUMBER ()
E-MAIL ADDRESS	
Province or Territory where Director resides? <input type="checkbox"/> BC If other, please specify: _____	
Will the Director agree to be available to respond to inquiries within 24 hours of request and provide financial or other records of the community care facility upon request? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Manager Information

MANAGER NAME	TELEPHONE NUMBER ()
E-MAIL ADDRESS	
Is the Manager proposing to manage more than one licensed community care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Mailing Address and Email Address for Receiving Correspondence

(Check only one) <input type="checkbox"/> Same as Facility <input type="checkbox"/> Same as Licensee	E-MAIL ADDRESS		
<input type="checkbox"/> Other Address			
Street	City	Province	Postal Code

I am the Licensee / authorized by the Licensee to submit this Application for Licence.
 The personal information collected relates directly to, and is necessary for program operation per Section 26 of the *Freedom of Information and Protection of Privacy Act*.

DATE (dd / mmm / yyyy)	NAME (PLEASE PRINT)	SIGNATURE
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