LS_____

Arizona Department of Health Services
OFFICE OF CHILD CARE LICENSING
APPLICANT, STAFF AND RESIDENT REPORT

Applicant/Facility Name		CDC/SGH Number
Address	City	Zip

*Applicant **Staff Members Residents Provider	Job Title/ Relation-ship	HighSch diploma or GED Date Mo/Yr	Hire Date Mo/Yr	***Fingerprint Registration	
				Clearance Card Exp Date	Date Affidavit Completed

* Lic/Cert Applicant
** List all staff members at the facility
*** Anyone 18 yrs or older must be fingerprinted and registered

Please keep a copy for your records and return the original copy to the Office of Child Care Licensing.

By signing below, I declare that the information on this form is accurate and complete.

This form is optional.

Applicant/Director/Provider Printed Name Signature Date