GOVERNMENT OF BERMUDA
Ministry of Health
Department of Health

# DAY CARE PROVIDER CLOSURE NOTIFICATION

The information below will confirm you are closing your business as a Day Care Provider as per Section of the Children Act 1998.

| Section A: *Personal Information* – **PLEASE PRINT IN BLUE INK** | | |
|---|---|---|
| Business Name: | Provider Name:<br>First Middle Last | |
| Physical Address:<br>House name No. Street Parish Postcode | | |
| Mailing Address (if different from above):<br>No. Street Parish Postcode | | |
| Telephone: | Cellular: | Other: |
| E-mail: | | |

| Section B: *Closure Information* | |
|---|---|
| Date for closure: | (Day/Month/Year) |

**Declaration Statement:** By my signature :
I agree the information in this application and the information in any required or following documentation is true and accurate to the best of my knowledge. I understand that false statements may result in the denial or removal of my registration.

I agree to notify Environmental Health of any changes to the information provided in this closure notification form.

**Printed Name:**
**Signature:**
**Date:**