GOVERNMENT OF BERMUDA
Ministry of Health
Department of Health

DAY CARE PROVIDER REGISTRATION RENEWAL FORM

Return to the Child Care Programme by email: childcare@gov.bm or in person/mail: Child Care Quality Assurance Programme, Ministry of Health, Continental Building, 25 Church Street, Hamilton, HM 12

SECTION A: *Personal Information* – **PLEASE PRINT IN BLUE INK**		
Business Name:		
Provider Name:		
First	***Middle***	***Last***
Physical Address:		
No.	***Street Address***	***Parish and Postal Code***
Mailing Address : ***(if different from above):***		
No.	***Street Address***	***Parish and Postal Code***
Telephone:	Cellular:	Other:
E-mail:		
First Aid Training Date: ***(dd/mm/yy)***		
CPR Expiry Date: ***(dd/mm/yy)***		
SCARS Training Date: ***(dd/mm/yy)***		
Household Members		
Names: (use back of form for more names):	Police Check:	
	☐	☐
	☐	☐
	☐	☐
Emergency/Scheduled Relief*:		
Emergency/Scheduled Relief Contact:		
*Please provide name(s) or policy for closing for emergency or scheduled leave (e.g. vacation)		

SECTION B: Screening Questions:

Circle Yes or No for all questions.
If you answer yes to any of the following questions provide an explanation in the space below.

1. Have you been convicted of, pled guilty or no contest to a crime in Bermuda or any other country?	☐	☐
2. Have you had any disciplinary or probationary action taken against you by any licensing authority in Bermuda or another country? This includes probation, suspension, revocation or denial of a license.	☐	☐
3. Have you had any form of investigation or disciplinary action by any health or social services related agency in Bermuda or another country?	☐	☐
4. Do you have a mental or physical condition and/or drug or alcohol dependency which could interfere with your current ability to be a day care provider?	☐	☐

SECTION C: *Access to Information*

Can the Department of Health share my contact information with people looking for day care providers?	Yes	No
Would you like to add your contact details to the Ministry of Health's mailing list?	Yes	No

SECTION D: *Continuing Professional Development:* Please document any training hours you have received for the registration period you are applying.
1. Name of Activity:
Topic Covered:
Number of Hours:
Date Completed:
Instructional Method:
Name of organisation giving the training:
2. Name of Activity:
Topic Covered:
Number of Hours:
Date Completed:
Instructional Method:
Name of organisation giving the training:
3. Name of Activity:
Topic Covered:
Number of Hours:
Date Completed:
Instructional Method:
Name of organisation giving the training:
4. Name of Activity:
Topic Covered:
Number of Hours:
Date Completed:
Instructional Method:
Name of organisation giving the training:
5. Name of Activity:
Topic Covered:
Number of Hours:
Date Completed:
Instructional Method:
Name of organisation giving the training:
6. Name of Activity:
Topic Covered:
Number of Hours:
Date Completed:
Instructional Method:

Name of organisation giving the training:
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 and possible prosecution. I agree to notify Ministry of Health of any changes to the information provided in this registration form. I agree for Ministry of Health to contact relevant persons (including but not limited to regulatory and government entities) to verify the information provided in this application.
Printed Name:
Signature:
Date: ***(dd/mm/yy)***

OFFICE USE ONLY				
Date Received:		SCARS Certificate(s)	YES	NO
Fee Payable: $		CPR Certificate(s):	YES	NO
Receipt No.:		Entered into database:	YES	NO
Programme Manager:	Approved:	Conditions:		
Programme Manager Signature:				