



GOVERNMENT OF BERMUDA
 Ministry of Health
 Department of Health

DAY CARE PROVIDER REGISTRATION RENEWAL FORM

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

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

Child Care Regulation Programme
 Ministry of Health, Continental Building, 25 Church Street, Hamilton HM12, Bermuda
Phone: (+1 441) 278-4900 **Email:** childcare@gov.bm

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?	Yes	No
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.	Yes	No
3. Have you had any form of investigation or disciplinary action by any health or social services related agency in Bermuda or another country?	Yes	No
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?	Yes	No

SECTION C: Access to Information

PATI disclaimer: This correspondence and any response thereof is subject to public disclosure under the Public Access to Information Act 2010. Most exempt records may be disclosed if it is in the public interest (s.21). Personal information, such as names and personal details of service users, patients, complaints, children and vulnerable adults, is exempt from disclosure (s.23). Information of people receiving discretionary benefit such as a licence is not personal information and can be disclosed (s.24 (1)). Commercial information and information received in confidence may be disclosed if it is in the public interest (s.25&s. 26).

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 the Child Care Regulation Programme of any changes to the information provided in this registration form.

I agree for the Child Care Regulation Programme 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:			