pennsylvania
OFFICE OF CHILD DEVELOPMENT AND EARLY LEARNING

Provider Survey/Facility Information Sheet

Facility Name:			
Facility Address:			
Email:		**Phone:**	

Current Director or Primary Staff Person: _____

Designated Person in Charge: _____

Does Designee have access to all locked files when in charge? ◯ Y ◯ N

Total # of children currently enrolled:_____Maximum # of children served in facility at any given time _____

Ages of children in care throughout the year (check all applicable age groups)

Infant		Preschool	
Young Toddler		Young School- Age	
Older Toddler		Older School Age	

Days and Hours of Operation:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Enter times above or N/A if closed						

Months of Operation: (Choose one) If multiple, please list:

All

Does program administer medication: ◯ Y ◯ N Does program prepare and serve meals: ◯ Y ◯ N

Is there a pool on site? ◯ Y ◯ N Do children in program go swimming? ◯ Y ◯ N

If yes, where _____

Do children in program go on walks off the premises? ◯ Y ◯ N If yes, where _____

Do children in program go on field trips? ◯ Y ◯ N If yes, where _____

Is transportation provided? ◯ Y ◯ N # of Vehicles_____ Type/s of Vehicle/s _____

# of staff employed _____ # of seasonal staff _____ # of volunteers _____

Any significant facility changes since last certificate was issued? ◯ Y ◯ N

If yes, please describe:

Name of person completing form_____Title _____

Signature_____Date _____

Department Use Only

Renewal Inspection Date:	PCID:
Renewal Inspection Completed By:	
Director or Primary Staff Form of ID:	Type: Expiration Date:
Name of Staff Person for verified ID:	
Qualification Level/Position of Staff Verified:	