STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CHILD CARE LICENSING

LAS VEGAS OFFICE	ELKO OFFICE	CARSON CITY OFFICE
3811 W. Charleston Blvd Ste 210 Las Vegas, Nevada 89102 Phone: 702-486-3822 Fax: 702-486-6660	1010 Ruby Vista Drive Suite, 101 Elko, Nevada 89801 Phone: 775-753-1237 Fax: 775-753-1336	727 Fairview Drive, Suite E Carson City, Nevada 89701 Phone: 775-684-4463 Fax: 775-684-4464

RENEWAL APPLICATION FOR CHILD CARE FACILITY LICENSE

All applications must be complete, signed and returned to the appropriate office referenced above.
Any application that is incomplete and/or not signed will be returned without processing.
LICENSES ARE NOT TRANSFERABLE FROM ONE OWNER TO ANOTHER AND ARE VALID ONLY FOR THE PREMISES DESCRIBED ON THE LICENSE.

1. IDENTIFYING INFORMATION:

Owner: _____
Child Care Facility: _____
Physical Address: _____City:_____ State: _____ Zip: _____
Mailing Address if different from physical address: _____
Telephone: _____Fax: _____Email: _____
Corporate Office: _____City: _____State: _____Zip: ____ _____
Corporate Contact Person: _____
Telephone: _____ Fax: _____Email: _____
Citizenship: _____ If not U.S., provide explanation:
_____

2. ACTION REQUESTED: RENWAL APPLICATION/LICENSE

TYPE OF FACILITY

Check all that apply √	Number of requested spaces for children:		Ages of children:
☐ Center	Center	_____	___ to ___
☐ Nursery for Infants & Toddlers	Nursery (Under 2 years.)	_____	___ to ___
☐ Additional Before & After School	3 slots or 10% (If approved)	_____	___ to ___
☐ Care for Ill Children(CIC)	CIC	_____	___ to ___
☐ Accommodation	Accommodation	_____	___ to ___
Designated Operator-Name_____			
☐ Extended Accommodation	Extended Accommodation	_____	___ to ___
Designated Operator -Name_____			
☐ Institution	Type ☐ Residential ☐ Educational ☐ Shelter Care	_____	___ to ___
☐ Special Event	Special Event	_____	___ to ___
☐ Other_____	Other	_____	___ to ___

Director Application(s): Check all that apply AND insert all names. √

Submitted for:	Name:
☐ Facility Director	_____
☐ Infant Toddler Nursery	_____
☐ Care for Ill Children	_____
☐ Preschool	_____
☐ Institution	_____

3. OWNERSHIP: Check one √

☐ Individual proprietorship: (Identify owner name, address, and persons having ownership of 10% or more.)
☐ Corporation: (Identify Corporation name, address; officers by name, title, address and telephone number.)
☐ Partnership: (Identify each partner by name, address and telephone number.)
☐ Other: (Describe the ownership arrangement and identify the owner(s) by name, address and telephone number.)
(If incorporated, date of incorporation _____ in the State of _____ and operated for ☐ Profit ☐ Non-profit)
_____
_____
_____

Provide the and percentage of stock, shares, partnership or other equity interest of each officer, member of the board of directors, trustees, stockholders, partners, or other persons who have greater than 25 percent interest in the facility:

Last Name	First Name	Middle	Date of Birth	SSN	Address	Telephone	% Interest

4. BACKGROUND CHECKS:

Each of the persons listed in this application have attested to the applicant that they have no pending charges and:

a) Have never been convicted of a felony;
b) Have never been in violation of any federal or state law regulating child abuse and/or neglect or contributory delinquency;
c) Have never been in violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drugs as defined in chapter 454 of NRS;
d) Have never been in violation of any federal or state law regarding murder, manslaughter or mayhem; any other violation involving the use of a firearm or other deadly weapon; assault with intent to kill or to commit sexual assault or mayhem; sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;
e) Have never been found in violation of any local, state or federal law which arises from or is otherwise related to the individual's relationship to a child care facility;
f) Have not currently or in the past had previous interest in a licensed child care facility that has been any of the following:
   (i) Closed as a result of a license suspension or revocation;
   (ii) Involuntarily terminated for any reason; or
   (iii) Convicted of child abuse, neglect or exploitation.
g) Convicted of any other crime involving physical harm to a person or if a criminal action is pending against the person.

IF YOU AS THE APPLICANT, OWNER(S), OPERATOR(S), BOARD MEMBERS, VOLUNTEERS OR STAFF MEMBERS HAVE EVER BEEN ARRESTED OR CONVICTED OF ANY CRIMES, IDENTIFY THE PERSON BY NAME, RELATIONSHIP, BIRTH DATE, CRIME, STATE OF ARREST OR CONVICTION, DATE OF ARREST OR CONVICTION AND DISPOSITION OF ARREST(S). (All must be included regardless of the year occurred.)

Name	Relationship	Birth	Crime	State of Arrest/ Conviction	Date of Arrest/ Conviction	Disposition

FINGERPRINTS HAVE BEEN SUBMITTED IN NEVADA FOR ALL PERSONS INCLUDED IN THIS APPLICATION:

☐ **YES** ☐ **NO** If no, explain:_____

_____

Date and location where prints were submitted: _____

5. STAFF INFORMATION:

A complete listing of all staff members including owners, directors, teachers, support staff and any other person who is employed or providing services to the facility **must be attached.** This listing must be provided on the form designated by the Bureau. The Bureau must be immediately notified of any additional staff employed or leaving employment. Any staff employed must be fingerprinted within 3 working days from date of hire.

NUMBER OF STAFF EMPLOYED: _____

NUMBER OF STAFF UNDER 18 YEARS OF AGE:_____ (Must have completed an approved Child Development Course with verification attached.) ATTACHED: ☐ **Yes** ☐ **No** If no, explain:

No more than 50% of staff may be under 18 years of age. The facility may not operate without a staff member at least 18 years of age on duty. Staff members must be at least 16 years of age.

VOLUNTEERS USED IN FACILITY:_____ DESCRIBE DUTIES:_____

_____

LICENSE INFORMATION:
Are you or anyone listed in this application now licensed or have been previously licensed for the care of children or adults:
☐ **No** ☐ **Yes** **If yes, list the State, agency issuing license, type of license and license number.** _____
_____

Does the facility have a waiver**?** ☐ **No** ☐ **Yes** **If yes, list the regulation waived and when it was approved**. _____
_____

7. **FACILITY SERVICES: - (This page must be completed with current information)**

a) **FACILITY STATEMENT SUBMITTED TO BUREAU:** ☐ **Yes** ☐ **No** If no, explain**:** _____

b) **DAYS OF OPERATION**: (Be specific.) _____
_____

c) **HOURS OF OPERATION**: (Be specific.) _____
_____

d) **FOOD SERVICE PROVIDED**: (Include breakfast, lunch, and dinner, number of snacks and time served.) (Commercial kitchen equipment may be required by the Health Authority in preparation of meals and snacks.)
_____
_____

MILK DISPENSED: ☐ **No** ☐ **Yes** DRINKING WATER FREELY AVAILABLE TO CHILDREN: ☐ **No** ☐ **Yes**
SACK LUNCHES: ☐ **No** ☐ **Yes** If yes, include storage plan and alternate plan if child does not bring. _____
_____

CHILD CARE FOOD PROGRAM PARTICIPANT: ☐ **Yes** ☐ **No**

e) **PRESCRIBED MEDICATION DISPENSED**:
☐ **No** ☐ **Yes** If yes, include type, method of control, storage, person dispensing._____
_____

f) **EMERGENCY DISASTER PLAN SUBMITTED TO BUREAU:** ☐ **Yes** ☐ **No** If no, explain**:** _____

g) **SURVEILLANCE EQUIPMENT USED**: ☐ **No** ☐ **Yes** If yes, explain: _____

h) **BODIES OF WATER INCLUDING POOLS, SPAS, FOUNTAINS, STREAMS, FISH PONDS ETC.:** ☐ **No** ☐ **Yes**
If yes, explain.: _____
_____

(Note: Any body of water installed after this application must have prior approval from the Bureau before installation.)

i) **ASSESSMENT PLAN SUBMITTED TO BUREAU:** ☐ **Yes** ☐ **No** If no, explain**:** _____

j) **CURRICULUM PLAN SUBMITTED TO BUREAU:** ☐ **Yes** ☐ **No** If no, explain**:** _____

k) **STAFF ORIENTATION SUBMITTED TO BUREAU:** ☐ **Yes** ☐ **No** If no, explain**:** _____

l) **FACILITY ON PUBLIC WATER:** ☐ YES ☐ NO **WELL WATER:** ☐ YES ☐ NO **SEPTIC SYSTEM:** ☐ YES ☐ NO
If a well is used, what is the maximum capacity of the center (including both children and adults)? _____ If number is 25 or greater, contact the Safe Drinking Water Program at 775-687-9517 BEFORE proceeding with the application to ensure the water is from an approved water source. If facility is on a septic system, the facility shall provide written evidence that it is currently permitted from either the local jurisdiction authority or Bureau Water Pollution Control, as applicable, at (775) 687-4670 or (702) 486-2850. Please submit quality testing results for your well.

8. **INSURANCE:**

LIABILITY INSURANCE: (Certificate must specify 30 day cancellation clause and list the Bureau as the Certificate Holder.)
Name of company:_____ Contact Person:_____
Telephone:_____
Certificate of Insurance attached: ☐ **Yes** ☐ **No** If no, explain: _____

IF ANY TRANSPORTATION IS PROVIDED, COMPLETE THE FOLLOWING SECTION:
Nevada's child restraint law requires that a child be in an approved child restraint system if he/she is less than 6 years of age and weighs 60 pounds or less. Those passengers 6 years of age or older must be in seat belts or an approved child restraint system.

Transportation: ☐ To/From School ☐ Field Trips ☐ Other/Explain_____

VEHICLE INSURANCE: (Licensee must maintain a current list of all drivers with a copy of a current Driver's License.)
Name of company:_____ (Coverage must include transportation of children in care.)

Vehicle Type	Vehicle Year	Vehicle Make	Vehicle Model	Vehicle License Plate No.	Number of Children

9. USE OF FACILITY SPACE:

SIZE OF BUILDING:
USABLE INTERIOR SQUARE FEET:_____
(35 Square feet per child exclusive of halls, bathrooms, kitchen, office space and other non-usable space.)

PLAY YARD_____ SHADE SQ FEET_____
(37 ½ Square feet per number of children listed on license.)

TOTAL BUILDING OCCUPANCY LOAD (ADULTS AND CHILDREN)_____

CERTIFICATE OF OCCUPANCY ATTACHED: ☐ **Yes** ☐ **No** If no, explain: _____

FACILITY DRAWING: (Drawing may be attached to this application.)
PLEASE PROVIDE A DRAWING OF THE FACILITY IDENTIFYING ALL EXITS, ROOMS, FUNCTIONS AND AGES AND NUMBERS OF CHILDREN USING. IN ADDITION, LABEL DIAPERING AREAS, COMMODES, HANDWASHING SINKS, FOOD PREPARATION SINKS AND MOP SINKS.

SPACE IDENTIFIED FOR SPECIFIC USE **MAY NOT BE CHANGED** WITHOUT ADDITIONAL BUREAU APPROVAL INCLUDING DIAPERING CHANGING AREAS, INFANT/TODDLER NURSERY AREAS AND SINK USAGE.

I, _____, as _____

NAME **TITLE**

of the above named facility, understand this constitutes a request for licensure as specified in NAC 432A.200 and serves as the formal document upon which a licensure decision will be based. I agree to abide by the rules promulgated by the State of Nevada for a child care facility and do hereby state that the information provided on this application is true to the best of my knowledge and belief. I have read the Regulations and Standards pertaining to the specific type(s) of facility for which licensure is requested. I authorize release of such information as may pertain to the purpose of this application, including verification of the information supplied to the Bureau. I further understand that I am responsible for employing only those persons who qualify as defined in NRS 432A and NAC 432A. I agree to allow authorized representatives of Child Care Liccensing, upon presentation of proper identification, to enter the facility during hours of operation to review facility records and documents as necessary to ascertain compliance with the Nevada Revised Statutes and Nevada Administrative Code for child care licensing.

Signature_____Date_____

THE FACILITY/AGENCY MAY NOT BEGIN OPERATION WITHOUT A LICENSE ISSUED. LICENSES ARE NOT TRANSFERABLE FROM ONE OWNER TO ANOTHER AND ARE VALID ONLY FOR THE PREMISES DESCRIBED ON THE LICENSE.

	FEE SCHEDULE	**FEE ATTACHED**
CARE FOR 13 TO 50 CHILDREN	$100.00	**$**
CARE FOR 51 TO 100 CHILDREN	$150.00	**$**
CARE FOR 101 TO 150 CHILDREN	$200.00	**$**
CARE FOR 151 TO 200 CHILDREN	$250.00	**$**
CARE FOR MORE THAN 200 CHILDREN	$300.00	**$**

Persons with disabilities who require special accommodations or assistance completing this application should notify the Bureau of Services for Child Care at one of the above listed offices.

BUREAU USE ONLY

	Yes	**No**	**Return Date/Other**
APP. COMPLETE			
FEE INCLUDED/ AMOUNT:			
FEE CORRECT			
C OF O			
FIRE INSPECTION			
HEALTH INSPECTION			
APPROVED DIRECTOR(S)			
FBI CLEARANCE			
BUSINESS LICENSE			