

**DPHHS/CHILD CARE LICENSING**  
**EXTENDED REGISTRATION / LICENSING ATTESTATION DOCUMENT**

I, \_\_\_\_\_, as director of \_\_\_\_\_,  
(director name) (facility name)

located at \_\_\_\_\_.  
(facility address – street, city, state, zip)

do hereby attest that I am in compliance and as required by child care licensing policy with the following items:

- Effective Public Liability
  - Effective Begin Date \_\_\_\_\_ to Expiration Date \_\_\_\_\_ and Covers \_\_\_\_\_ Children
- Effective Fire Insurance
  - Effective Begin Date \_\_\_\_\_ to Expiration Date \_\_\_\_\_ .
- All approved caregivers are currently certified in Infant, Child, and Adult CPR and First Aid;
- Have obtained as appropriate, approved fire and health inspection reports (as determined by those jurisdictions);
- All caregivers who are employed for 160 hours or more have attained 8 hours of approved training. Training may be verified on the Internet as applicable. See [www.mtecp.org](http://www.mtecp.org) for details.

I have submitted the following information, with this document:

- Current and complete Staff List (DPHHS-QAD/CCL-040A)
- Verification of staff training, which may not be included within the Early Childhood Project Training database (such as college transcripts or CARE course certificates).

If I am to relocate my facility, I will submit the following items **prior** to relocation and the effective beginning date of operation:

- Change of Address Form
- Verification of insurance for new address
- Attestation concerning compliance with the rules
- New square footage/ floor plan

I also understand that if I fail to maintain full compliance with the rules and regulations, the department can:

- Issue a notice of deficient practice through the deficiency notice (and maintain the 2 or 3 year certificate);
- Take other corrective actions (such as instituting a training program, directed plan of correction); or
- Reduce the registration/license back to a one year certificate.

**Day Care Provider Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**TO BE COMPLETED BY A NOTARY PUBLIC:**

Taken, Sworn, and subscribed before me, this \_\_\_\_\_ day of \_\_\_\_\_ A.D. \_\_\_\_\_

\_\_\_\_\_  
(Notary Public for the State of Montana)

Residing at \_\_\_\_\_

My Commission Expires \_\_\_\_\_

## DAY CARE FACILITY - STAFF LIST

DIRECTOR NAME: \_\_\_\_\_ PV#: \_\_\_\_\_  
 FACILITY NAME: \_\_\_\_\_  
 MAILING ADDRESS: \_\_\_\_\_  
 CITY STATE ZIP: \_\_\_\_\_

**Please Note:** All caregivers and individuals working / living in the home over 18 years of age must be listed. If someone is not listed below, they will be taken off the approved caregiver list.

Full Name	Date of Birth	SS#	CPR Exp	Position
Employee Mailing Address	City /ZIP code	PS#	First Aid Exp	Approval Date
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				