

Apple Blossom Day Homes

DIVISION OF NICKEL ENTERPRISES LTD
20042 Kensington Postal Outlet
Medicine Hat, AB
T1A 8M4



PROVIDER APPLICATION FOR:

Name:

Address:

Mailing Address (if different from above):

Postal Code:

Phone:

Email:

Social Insurance Number:

BACKGROUND CHECK

Other residents of your home, who are over 12 years of age:

Relationship:

Relationship:

Does your whole family support you in this application to become a Day Home Provider?

Yes No

Have you completed any classes in Early Childhood Education, psychology, nutrition, crafts, etc? Yes No

Are you interested in increasing your knowledge and understanding of young children?

Yes No

If so, by what means?

Personal reading and research Training Sessions College Classes

Meetings Workshops Other

Do you have any special abilities or interests that would help you to relate to the children?

Do you normally plan ahead in daily activities, etc? Yes No

Do you smoke? Yes No

Have you experienced any of the following in the past five years:

a) Serious Illness:

b) Injury:

c) Health Problems:

d) Professional assistance with any emotional, psychological, behavioral, or psychiatric problems:

Do you have a valid driver's license at this time? Yes No

Do you have pets in your home? Yes No

Have you been a Day Home Provider in the past? Yes No

Which Agency were you with? Yes No

Do you have a valid First Aid Certificate? Yes No Expiry Date:

When would you be available to start caring for children?

Are you willing to provide care during extended hours (IE: evenings, weekends, holidays)?

Yes No

What hours would you be available? to

Do you have any preference in regards to the ages of children in your care?

Yes No

How many children would you be willing to care for?

Are you willing to provide care for children with Special Needs? Yes No

What makes you interested in becoming a Day Home Provider?

CRIMINAL RECORD CHECK

As part of the approval procedure, we require that you obtain the following documentation:

- a) Criminal Record Check: On all residents of your home, over the age of twelve years.
- b) Child Intervention Check (from CFSA): On all residents of your home, over the age of twelve years.

These checks can only be requested by the person who is the subject of the information. Therefore, it is the responsibility of the applicant to provide these results of these checks to our Agency.

Signature of Applicant:

Date:

REFERENCE CHECK

Apple Blossom Day Homes requires that you supply the names and addresses of three references. Each will be mailed a questionnaire regarding your suitability for our Day Home Program. We request that you have known these people at least three years, if possible. Do not include relatives.

1. Name:

Mailing Address:

City/Province:

Postal Code:

2. Name:

Mailing Address:

City/Province:

Postal Code:

3. Name:

Mailing Address:

City/Province:

Postal Code:

IMMUNIZATION VERIFICATION

In order to safeguard the children who may be placed in your care, we require that you provide verification that you and the other members of your household have been immunized. Please have this form signed at your local Health Unit, or provide copies of the immunization records for your family.

1. Name: Birthdate:

2. Name: Birthdate:

3. Name: Birthdate:

4. Name: Birthdate:

5. Name: Birthdate:

6. Name: Birthdate:

Other residents of this household:

1. Name: Birthdate:

2. Name: Birthdate:

I hereby declare that the above mentioned people are currently up to date in their immunizations.

Signature of Healthy Nurse:

Date:

DOCTORS REPORT

This is to certify that I have examined and found her to be in good health and capable of caring for young children, on a daily basis.

Doctor's Signature:

Date: