Iowa Department of Human Services
CHILD CARE CENTER EVALUATION AND RECOMMENDATION FOR LICENSE

Name of Center: **Enrollment:** **License ID No.** *(Reapplications)*

Street: **City:** Iowa **Zip** **County:**

Mailing Address:

Director's Name: **Phone Number:**

On-Site Supervisor(s): **E-Mail:**

Date(s) of Visit:

[ ]**Licensing Visit** [ ]**Unannounced Visit** [ ]**Off Year Visit**

LICENSING VISITS

[ ]**New Application** [ ]**Re-Application** [ ]**NA**

Signed Application (470-0722) Received [ ]**Yes** [ ]**No** [ ]**NA** **Date Signed:**

FIRE INSPECTION [ ]**State** [ ]**Local** [ ]**NA** **Is Fire Inspection Approved?** [ ]**Yes** [ ]**No** [ ]**NA**

Date Inspected:

Comments :

LICENSE TYPE: [ ] **Child Care** [ ] **Preschool (ages 3-5 meets three hours or less per day)**

Financial Type: [ ] Profit [ ] Non-Profit [ ]NA

Accredition: [ ]Accredited [ ]NAEYC [ ]NSACA [ ]Other [ ] NA

Program Serves: [ ]Infants (0-23 mo.) [ ]2 Years [ ]Preschool-Age [ ]School-Age

[ ]Get-Well [ ]Evening Care [ ]Special Needs

SCHEDULE: [ ]Year-round [ ]School-Year [ ]Summer Only

HOURS:	*Year-round*	*School-Year*	*Summer Only*
Sunday	to	to	to
Monday	to	to	to
Tuesday	to	to	to
Wednesday	to	to	to
Thursday	to	to	to
Friday	to	to	to
Saturday	to	to	to

LICENSE CAPACITY	**Infants**	**2 Years**	**Preschool**	**School-Age**	**Capacity**
General					
Summer					

RECOMMENDATION FOR LICENSE:	
[ ]	**FULL** license from to
[ ]	**PROVISIONAL** license from to
[ ]	**DENIAL** of initial application
[ ]	**SUSPENSION** of license
[ ]	**REVOCATION** of license

Consultant's Signature: **Date:**

I. IF CURRENT LICENSE IS PROVISIONAL, IDENTIFY THE CORRECTIVE ACTIONS

II. IDENTIFY THE AREAS OBSERVED ON THE VISIT:

III. IDENTIFY THE OBSERVED STRENGTHS OF THE CENTER:

IV. IDENTIFY THE ASPECTS OF OPERATION THAT FALL BELOW THE STANDARDS REVIEWED:

V. SPECIAL NOTES/RECOMMENDATIONS: