FOR OFFICE USE ONLY
Check Amount: _____
Check Number: _____
License Expiration: _____

STATE OF DELAWARE
OFFICE OF HEALTH FACILITIES LICENSING AND CERTIFICATION
(302) 292-3930
APPLICATION FOR PRESCRIBED PEDIATRIC EXTENDED CARE LICENSE

LICENSE ID: PPECC - _____

LEGAL NAME: _____

DBA NAME: _____

AGENCY ADDRESS: _____

_____

_____ _____ _____
CITY STATE ZIP CODE

ADMINISTRATOR/EMAIL: _____

DIRECTOR OF NURSING/EMAIL: _____

RN LICENSE # _____ EXP. DATE: _____

MEDICAL DIRECTOR/EMAIL:_____

MD LICENSE # _____ EXP. DATE: _____

PHONE NUMBERS: _____ _____
FACILITY NUMBER FACILITY FAX

EMAIL: _____

EMERGENCY CONTACT: _____ _____
NAME PHONE

EMAIL: _____
(EMERGENCY CONTACT MUST BE AVAILABLE AT ALL TIMES IN CASE OF WEATHER EMERGENCY, NATURAL DISASTERS, ETC.)

FACILITY TYPE: (PLEASE CHECK ALL THAT APPLY)

☐ PRIVATE ☐ NOT FOR PROFIT

☐ PUBLIC ☐ PROPRIETARY

☐ OTHER:_____

CURRENT ENROLLMENT: _____ CAPACITY: _____

EXPIRATION DATE OF CHILD CARE LICENSE ISSUED BY THE DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES: _____

DATE OF LAST POLICY AND PROCEDURE MANUAL REVIEW:_____

Please attach the most current of the following:

1. A list showing the names, addresses and percent of interest of each officer, director, and owner having an interest in the facility. Also attach a list of names and addresses of Advisory Board members if different from the preceding group.
2. Child Care Licensing Survey Report.
3. Changes in Medical director or Director of Nursing since last survey (if yes, please attach resume for each)_____

Days of Operation: _____

Hours of Operation: _____

Name of person completing this form: _____

Signature: _____

Title/Email: _____

Date: _____

Checks should be made payable to: **State of Delaware**

Initial Application Fee	Annual Licensure Fee:
$100.00	$50.00

Please complete and return application with Licensure Fee and Attachments to:

Office of Health Facilities Licensing & Certification
261 Chapman Road
Suite 200
Newark, DE 19702

For Office use Only

Application reviewed & Approved by: _____ Date: _____

Director/Designee: _____ Date: _____

Type of License: ☐ Annual ☐ Provisional

Licensure period: _____ to _____

License Sent Date: _____ Initials: _____

Tracking Update Date: _____ Initials: _____

Prescribed Pediatric Extended Care Center Services and Employee Information

Services Provided	Does your facility provide these services?		Are the services provided by employees of the facility?		Number of persons employed in each service	Are the services provided by contractors?		Number of contractors providing each service	Are services provided by both employees and contractors?		Total number of caregivers in each service
	Yes	No	Yes	No		Yes	No		Yes	No	
Registered Nurse											
Licensed Practical Nurse											
Physical Therapy											
Speech Therapy											
Audiology Services											
Occupational Therapy											
Nutritional Services											
Social Services											
Aide											
Child Life Specialist											
Developmentalist											
Physician											
Other (please list):											