



**WEST HAVEN HEALTH DEPARTMENT**  
**355 MAIN STREET, 2<sup>nd</sup> FLOOR**  
**WEST HAVEN, CT 06516**  
**PHONE: (203) 937-3660      FAX: (203) 937-3976**  
[www.whhd.org](http://www.whhd.org)

**DAYCARE INSPECTION APPLICATION**  
**FEE: \$100**

FACILITY NAME: \_\_\_\_\_

FACILITY ADDRESS: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

NAME OF OWNER: \_\_\_\_\_

ADDRESS OF OWNER: \_\_\_\_\_

CONTACT PERSON NAME: \_\_\_\_\_

CONTACT PERSON PHONE: \_\_\_\_\_

**PURPOSE OF VISIT:**

NEW FACILITY:

LICENSE RENEWAL:

OTHER:

(SPECIFY) \_\_\_\_\_

APPLICANT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

BUILDING OFFICIAL: \_\_\_\_\_

**OFFICE USE ONLY**

FEE: \_\_\_\_\_

DATE PAID: \_\_\_\_\_