



GOVERNMENT OF BERMUDA
Department of Health

DAY CARE PROVIDER CLOSURE NOTIFICATION

The information below will confirm you are closing your business as a Day Care Provider as per Section 76 of the Children Act 1998.

Section A: Personal Information

Business Name:

Day Care Provider Name:

First Middle Last

Physical Address:

No. Street Parish Postcode

Mailing Address:
(if different from above)

No. Street Parish Postcode

Telephone: Cellular:

E-mail Address:

Intended Closure Date: (dd/mm/yyyy)

Section B: Closure Information

Reason for closure: _____

Plan for relocating children/notifying family: _____

Section C: Declaration Statement

By my signature: _____

- I agree the information in this application and the information in any required or following documentation is true and accurate to the best of my knowledge. I understand that false statements may result in the denial or removal of my registration.
- I agree to notify the Department of Health of any changes to the information provided in this closure notification form.

Print Name: _____

Signature: _____

Date: _____

(dd/mm/yyyy)