PROVIDER DATA SHEET

2022

Authorization Number D-1793

Organization Name Children's Nutrition of Florida Inc.

1. Provider Information

Provider Name _____

Street Address _____

City _____ State FL Zip _____ County _____

Home Phone # _____ Cell Phone # _____

Email Address _____

2. List the names of all children under 13 that live in your home. (Enter "None" if not applicable)

_____

3. Days you provide care for children ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

4. Operating Hours (per DCF License) Start _____ Finish _____

5. Meals Claimed ☐ Breakfast ☐ Morning Snack ☐ Lunch ☐ Afternoon Snack ☐ Supper

6. Meal Times:

	Start	Finish
Breakfast		
Morning Snack		
Lunch		
Afternoon Snack		
Supper		

OFFICE USE ONLY (REQUESTED/APPROVED CHANGES)

Start	Finish

7. Holidays you will be serving and claiming meals

☐ New Years Day
☐ Good Friday
☐ Labor Day
☐ Fri. after Thanksgiving
☐ MLK Jr. Day
☐ Memorial Day
☐ Veteran's Day
☐ Colombus Day
☐ President's Day
☐ Independence Day
☐ Thanksgiving Day
☐ Christmas Day
☐ Christmas Eve

8. Is your name, address and phone number listed CONFIDENTIAL with DCF? ☐ Yes ☐ No

9. Do you transport children and if so, list times _____

I certify that all information on this Provider Data Sheet is true and correct.

_____
Provider's Signature

_____
Signature Date

Approved by _____

Title _____

Date _____