STEVENS COUNTY HUMAN SERVICES

400 Colorado Ave, Ste 104
MORRIS, MN 56267
Phone: (320) 208-6600
FAX: (320) 589 - 3972
JOANIE MURPHY, DIRECTOR

LICENSED FAMILY CHILD CARE REQUEST FOR VARIANCE

Provider Name: ____

Address/City/Zip: ____

Class of License: _________ How long have you been licensed: __________

Rule/Statute # variance is being requested for: ______________________________

Time Period for Variance: ____________________ Total number of days: _____________

List days of week and hours of day if appropriate: ______________________________

Have you had a variance approved in the past 12 months? _________yes _________no

If yes, for what dates? ____

What is the total number of days the variance was in effect? ________________________

For whom is the variance for? Name of child(ren) ______________________________

Briefly describe how you will be out of compliance:

____

____

____

If the variance is approved, what specific alternative measures will you provide so the health, safety, and protection of the children in your care are ensured?

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____

Provider Signature: ______________________________ Date: ____________________

OFFICE USE ONLY

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I recommend: __________ approval _________ denial of this request

Remarks: ____

____

Licensor's signature ______________________________________ Date: _____________

_________APPROVED _________DENIED

Supervisor's signature: ____________________________________ Date: _____________

FAMILY CHILD CARE ENROLLMENT LIST

List all children including your own, under 11 years of age, who will be in attendance if your request is approved for a Variance of Section 502.0367. please indicate which child(ren) the variance is for.

PROVIDER'S NAME:_____ ADDRESS:_____

LICENSE CLASS: A B1 B2 C1 C2 C3 D

Child's Name First/Last	Birth date	Age Group / I T PS SA	Indicate how many children in each age group will be in attendance each day.						
				MON	TUE	WED	THU	FRI	
			INF						AM
									PM
			TOD						AM
									PM
			PRE-SCH						AM
									PM
			SA						AM
									PM
			TOTAL						AM
									PM
				Comments					