



WAITING LIST FORM

Date: ____/____/____

Child's Name: _____

D.O.B: ____/____/____

Address: _____ P.C. _____

Mother's Name: _____ Father's Name: _____

D.O.B: _____ D.O.B: _____

Occupation: _____ Occupation: _____

Place of Work: _____ Place of Work: _____

CRN #'s: _____ CRN #'s: _____

Email: _____ Email: _____

Telephone: (home) _____ (work) _____

Number of Days Care required per Week: 1 2 3 4 5

Actual Days Required: MON TUE WED THU FRI

If you require less than 5 days per week are you prepared to accept any days that are allocated?

- Yes, I would be happy with whatever days are available.
- No, I specifically require the days circled above.

STARTING DATE REQUIRED: ____/____/____ OR ASAP
(Please insert approximate start date)

PRIORITY OF ACCESS: THESE ANSWERS WILL DETERMINE YOUR PRIORITY RATING.

PRIORITY 1

A Child at risk of serious abuse or neglect. YES NO

PRIORITY 2

If you answer yes to any of the following you could be required to provide proof under section 14 of the Family Assistance Act.

Are you a single parent who is working? YES NO

Are you a family with both parents working? YES NO

Are you studying for future employment? YES NO

Are you seeking employment or training? YES NO

PRIORITY 3

Any other child? YES NO

Does your child have additional needs? If yes, please specify:

I understand the Priority of Access conditions outlined and agree to notify the centre should my circumstances change.

Relationship to child: _____ Signature: _____