



**APPLICATION / WAIT LIST FORM**

Date of application \_\_\_/\_\_\_/\_\_\_

Child's Name: \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ or Due Date \_\_\_/\_\_\_/\_\_\_

HELEN HAYES EMPLOYEE? YES NO \_\_\_\_\_ Parent \_\_\_\_\_ Grandparent  
(please circle one)

Parent / Guardian:

\_\_\_\_\_ Name

\_\_\_\_\_ Name

\_\_\_\_\_ Street Address

\_\_\_\_\_ Street Address

\_\_\_\_\_ Town / State / Zip

\_\_\_\_\_ Town / State / Zip

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Home Phone Work Phone

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Home Phone Work Phone

Cell Number \_\_\_\_\_

Cell Number \_\_\_\_\_

NEW YORK STATE UNION AFFILIATION: \_\_\_\_\_  
HHH (please check) Parent \_\_\_\_\_ Grandparent \_\_\_\_\_

DATE WHEN YOU WOULD LIKE CHILDCARE TO BEGIN: \_\_\_\_\_  
(This does not guarantee that your child will be enrolled on your requested date. Space must be available in your child's age group.)

**DAYS AND HOURS CHILDCARE IS NEEDED:** \_\_\_\_\_

FOR TLC USE ONLY Date Received: \_\_\_\_\_

Date Enrolled: \_\_\_\_\_

Return To: TLC Learning Center at Helen Hayes Hospital, Building 40, Route 9W, West Haverstraw, NY 10993 OR FAX 845-786-4592