The Jan & Niles Davies Learning Center
at Helen Hayes Hospital
Route 9W, West Haverstraw, NY 10993 Tel: 845-786-4595 • Fax: 845-786-4592

APPLICATION / WAIT LIST FORM

Date of application ___/___/___

Child's Name: ____

Date of Birth ___/___/___ or Due Date ___/___/___

HELEN HAYES EMPLOYEE? YES NO **(please circle one)**

If yes, are you a parent or grandparent? **(please circle one)**

If yes, what department(s)?____

Parent / Guardian:

______________________________	______________________________
Name	**Name**
______________________________	______________________________
Street Address	**Street Address**
______________________________	______________________________
Town / State / Zip	**Town / State / Zip**
______________ / ________________	______________ / ________________
Home Phone Work Phone	**Home Phone Work Phone**
______________________________	______________________________
E-mail address	**Cell / other phone**

NEW YORK STATE UNION AFFILIATION: ______________________________
(please specify which union)

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 CHILDCARE IS NEEDED: ____________________________

FOR TLC USE ONLY Date Received: _______________