Longwood Medical Area Child Care Center
Waitlist Application Form

First Parent/ Guardian Name:

_____   _____
First   Last

Relationship to child: _____   Cell Phone: _____

Place of Employment and Work ID: *Please only list the institution that pays your salary & benefits.*

_____   _____
Employer   ID #

Preferred Email (s): _____

Second Parent/ Guardian Name:

_____   _____
First   Last

Relationship to child: _____   Cell Phone: _____

Place of Employment and Work ID: *Please only list the institution that pays your salary & benefits.*

_____   _____
Employer   ID #

Preferred Email (s): _____

Child's Home Address:

_____
Street Address

_____
City   State   Zip

Child(ren) Information:

_____
First Name   Last Name   DOB/Estimated DOB   Gender (M, F, Unknown)

_____
First Name   Last Name   DOB/Estimated DOB   Gender (M, F, Unknown)

_____
First Name   Last Name   DOB/Estimated DOB   Gender (M, F, Unknown)

Desired Care:

_____   _____   _____
Month   Day   Year

_____ Full Time
_____ Part Time *Part time care must include a Monday or Friday

Preferred days of care if part time: Monday   _____
                                            Tuesday   _____
                                            Wednesday   _____
                                            Thursday   _____
                                            Friday   _____

Notes to provider:

_____   _____
Signature of Parent or Guardian   Date

Prior to enrollment, LMACCC verifies employment status of applicants with their Human Resource Department using the employee ID number indicated above. LMACCC reserves the right to share enrollment status with LMACCC's consortium member institutions.

Application Fees: $50 for the first application *(includes all children reflected on initial application)*
                  $25 for additional application
Payment can be made by submitting a personal/bank check or money order payable to "LMACCC"

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