

Child Development Centers Hours of Service Requested

Please indicate hours of service needed for your child/children

Child's Name: _____

Quarter/Year: _____ **Today's Date:** _____

DAYS:	START TIME: <i>Must be prior to 10:00 am</i>	END TIME:	Total Hours By Day	Part Time Day* (Up to 5 hours a day)
				Full Time Day* (Up to 10 hours a day)
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Total Number of Part Time Days / Full Time Days Per Week				

*The minimum billing is: 2 full time days **OR** 4 part time days **OR** 1 full time day **AND** 2 part time days

Parent/Guardian Signature: _____