

**CT Department of Public Health
Community Based Regulation Section
Consultant/ Head Teacher Data Sheet**

(Attachment 9f)

**PLEASE PRINT - Please Enter Complete Information for Each Consultant and Head Teacher
Enter N/A (Not Applicable) for Questions That Do Not Apply**

Name of Person completing this form: _____

Position: _____ Date form completed: _____

Program Name: _____ License # _____

Street Address: _____ Town: _____ CT Zip: _____

Telephone #: (____)____ - _____ Fax #: (____)____ - _____ E-mail _____

Health Consultant (Required)

Last name: _____ First: _____ Middle initial: _____

Resident Street Address: _____ Town: _____ State: _____ Zip: _____

Telephone #: (____)____ - _____ Fax #: (____)____ - _____ E-mail: _____

Work Address: _____ Town: _____ State: _____ Zip: _____

Telephone #: (____)____ - _____ Fax #: (____)____ - _____ E-mail: _____

Professional license held: Physician Physician Assistant AP Registered Nurse Registered Nurse

Professional License #: _____ License Expiration Date: _____

Early Childhood Education Consultant (Required)

Last name: _____ First: _____ Middle initial: _____

Resident Street Address: _____ Town: _____ State: _____ Zip: _____

Telephone #: (____)____ - _____ Fax #: (____)____ - _____ E-mail: _____

Work Address: _____ Town: _____ State: _____ Zip: _____

Telephone #: (____)____ - _____ Fax #: (____)____ - _____ E-mail: _____

DPH approval on file: Yes No

Name at time of approval if different: _____

PLEASE BE SURE TO COMPLETE THE REVERSE SIDE OF THIS FORM

Dental Consultant (Required)

Last name: _____ First : _____ Middle initial : _____
Resident Street Address: _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Work Address: _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Professional license held: Licensed Dentist Dental hygienist
Professional License #: _____ Expiration Date: _____

Social Service Consultant (Required)

Last name: _____ First: _____ Middle initial: _____
Resident Street Address: _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Work Address: _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Professional degrees held: BSW BA/ BS - Field of study: _____
 MSW MA/MS - Field of study: _____
Professional License # (if applicable): _____ Expiration Date: _____

Registered Dietitian Consultant (Required for programs that serve meals)

Last name : _____ First: _____ Middle initial: _____
Resident Street Address: _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Work Address _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Professional license held: RD License/ID #: _____ Expiration Date: _____

Head Teacher(s) (Required)

Please complete this section for each Department Approved Head Teacher at this program. If your program has more than (1) Head Teacher, please submit this information as an attachment.

Last name: _____ First: _____ Middle initial: _____
Resident Street Address _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Work Address: _____ Town: _____ State: _____ Zip: _____
Telephone #: (____) _____ - _____ Fax #: (____) _____ - _____ E-mail: _____
Department approval on file: No Yes (if yes, please check) Under 3 Years Preschool School Age
Name at time of approval if different: _____

Please return this form to: Department of Public Health, Division of Community Based Regulation, 410 Capital Avenue MS#12 DAC, P.O. Box340308, Hartford, CT 06134-0308 or Fax (860) 509-7541