**Application for consent to licence or sub-let part of an ECEC facility**

**Please provide details below.**

* + 1. **Lessee / Tenant Details**

|  |  |
| --- | --- |
| **Lessee’s Name** |  |
| **Mailing Address** |  |
| **ACN/ABN Number** |  |
| **Contact Officer** |  |
| **Phone** |  |
| **Email** |  |

* + 1. **Lease Details**

|  |  |
| --- | --- |
| **Real Property Description** | Lot       on       Plan |
| **Street Address of Property** |  |
| **Part or whole of the Lot leased**  *(Select one.)* | Part  Whole |
| **Co-located with a School** | Yes  No |
| **Name of School** |  |
| **Lessee’s Service Type**  *(Select one.)* | Kindergarten  Long day care centre  Limited hours care  Early Years Centre  Children and Family Centre  Child and Family Support Hubs |

* + 1. **Secondary Provider’s Details and Proposed Complementary Services**

*Please add more proposed complementary services if needed.*

* 1. **Proposed Complementary Service 1**

|  |  |
| --- | --- |
| **Secondary Provider’s Name** |  |
| **Mailing Address** |  |
| **ACN/ABN Number** |  |
| **Contact Officer** |  |
| **Phone** |  |
| **Email** |  |
| **Proposed Delivery Day**  *(Select all appropriate.)* | Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday |
| **Proposed Delivery Time/Term of licence or sub-lease** | Time of Delivery:  Term of Delivery: |
| **Complementary Service Type**  *(Select all appropriate.)* | Playgroup  Early learning programs  Transition to school programs  Outside school hours care / vacation care  Adjunct care  Child health services  Maternal health services (including maternity services)  Health promotion activities  Parent/family information, support services  Child support services  Other services. Please specify. |
| **Area to be licensed or sub-leased** - Include schematic drawings |  |
| **Is a licence fee, service charge or cost recovery payable by secondary provider? If yes, how much, when is it payable and how was this calculated?** |  |
| **Attached copy of licence or sub-lease**  **NOTE: A copy of this document must be supplied in order for the application to be processed.** | Yes  No |

* 1. **Proposed Complementary Service 2**

|  |  |
| --- | --- |
| **Secondary Provider’s Name** |  |
| **Mailing Address** |  |
| **ACN/ABN Number** |  |
| **Contact Officer** |  |
| **Phone** |  |
| **Email** |  |
| **Proposed Delivery Day**  *(Select all appropriate.)* | Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday |
| **Proposed Delivery Time/Term of licence or sub-lease** |  |
| **Complementary Service Type**  *(Select all appropriate.)* | Playgroup  Early learning programs  Transition to school programs  Outside school hours care / vacation care  Adjunct care  Child health services  Maternal health services (including maternity services)  Health promotion activities  Parent/family information, support services  Child support services  Other services. Please specify. |
| **Area to be licensed or sub-leased** - Include schematic drawings |  |
| **Is a licence fee, service charge or cost recovery payable by secondary provider? If yes, how much, when is it payable and how was this calculated?** |  |
| **Attached copy of licence or sub-lease**  **NOTE: A copy of this document must be supplied in order for the application to be processed.** | Yes  No |

* + 1. **Existing Complementary Services at ECEC Facility**

|  |  |
| --- | --- |
| **Are there any complementary services currently provided at the lease property?** | Yes  No |

*If yes, please provide details of any existing complementary services.*

*Please add more existing complementary services if needed.*

* 1. **Existing complementary service 1**

|  |  |
| --- | --- |
| **Secondary Provider’s Name** |  |
| **Mailing Address** |  |
| **ACN/ABN Number** |  |
| **Contact Officer** |  |
| **Phone** |  |
| **Email** |  |
| **Delivery Day**  *(Select all appropriate.)* | Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday |
| **Delivery Time** |  |
| **Complementary Service Type**  *(Select all appropriate.)* | Playgroup  Early learning programs  Transition to school programs  Outside school hours care / vacation care  Adjunct care  Child health services  Maternal health services (including maternity services)  Health promotion activities  Parent/family information, support services  Child support services  Other services. Please specify. |
| **Area to be licensed or sub-leased** – Attach schematic drawings |  |
| **Is a licence fee, service charge or cost recovery payable by secondary provider? If yes, how much, when is it payable and how was this calculated?** |  |
| **Attached copy of licence or sub-lease**  **NOTE: A copy of this document must be supplied in order for the application to be processed.** | Yes  No |

*I declare that all information provided in this application is true and correct.*

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| **Signed by:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(Lessee delegate’s signature)*  **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Position:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Witnessed by:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(Witness’ signature)*  **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Position:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**For Early Childhood and Education Improvement Division’s Use Only**

**Date application received:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **HPERM ref:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Application processed by:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(Full name)*  **Position:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Once you have completed all sections please submit the completed application form to:  Early Childhood and Education Improvement  Department of Education  PO Box 15033  CITY EAST QLD 4002  OR  ecec.facilities@qed.qld.gov.au  Should you require further information or have an enquiry, please contact  (07) 3328 6719 |