**Application for consent to the variation**

**of the secondary use 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**

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| --- | --- |
| **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/TAFE**  *(Select one.)* | Yes  No |
| **Name of School/TAFE** |  |
| **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 Complementary Services Provided**

*Please add more complementary services if needed.*

* 1. **Complementary Service 1**

1. ***Secondary Provider’s Details***

|  |  |
| --- | --- |
| **Date of Consent Granted** |  |
| **Secondary Provider’s Name** |  |
| **Mailing Address** |  |
| **ACN/ABN Number** |  |
| **Contact Officer** |  |
| **Phone** |  |
| **Email** |  |

1. ***Current Complementary Service Arrangement***

|  |  |
| --- | --- |
| **Current Delivery Day**  *(Select all appropriate.)* | Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday |
| **Current Delivery Time/Term** |  |
| **Current 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. |

1. ***Variation to Complementary Service Arrangement***

**For variation only**

|  |  |
| --- | --- |
| **New Delivery Day**  *(Select all appropriate.)* | Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday |
| **New Delivery Time/Term** |  |
| **New 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. |
| **Other**  **Please comment** |  |

**Checklist (please ensure you have):**

Attached a copy of documentation regarding the agreement between you and the secondary provider(s) to change the arrangements for complementary services delivered at the ECEC facility.

*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](mailto:ecec.facilities@qed.qld.gov.au)  Should you require further information or have an enquiry, please contact  (07) 3328 6719 |