ENROLLMENT REGISTRATION FORM

SSM Health Child Care Center
723 S. Orchard St.
Madison, WI 53715
(608) 255-4880

In order to ensure accurate consideration for admission to the Center and placement on the waiting list, please fill out this form **completely** and return it with your **$45 (per child) Nonrefundable Registration Fee**. Please make **check** payable to **SSM Health St. Mary's Hospital - Madison**.

Parent/Guardian Name #1: ______________________________

Home Address (Street): ______________________________

(City, State, Zip): ______________________________

Home/Cell Phone No. (**Circle** One): ______________________________

Email Address (personal): ______________________________

Place of Employment: ______________________ Work Phone: ______________
(If SSM Health, please list Department/Unit)

Parent/Guardian Name #2: ______________________________

Home Address (Street): ______________________________

(City, State, Zip): ______________________________

Home/Cell Phone No. (**Circle** One): ______________________________

E-mail Address (personal): ______________________________

Place of Employment: ______________________ Work Phone: ______________
(If SSM Health, please list Department/Unit)

Child's Name: ______________________ Gender (**Circle** One): M F

Child's birthdate/anticipated birthdate: ______________________ Age: ______________

Requested Type of Enrollment:
Please **circle** one of the following: **SSM Health Employee** **Community Family**
Please **check** (X) one of the following: _____ **Full-time** _____ **Part-time Fixed (SSM Health only)**
In the grid below, write in the arrival and departure times on the days your child will be attending:

Day(s):	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival:					
Departure:					

Requested Date of Enrollment: ______________________________

Date Check Received: ____________ Check Date: ____________ Check #: ____________

Amount: ____________ Age Group: ____________ SSMHCCC Staff Initials: ____________