**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 ImprovementDepartment of EducationPO Box 15033CITY EAST QLD 4002ORecec.facilities@qed.qld.gov.auShould you require further information or have an enquiry, please contact (07) 3328 6719 |