MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

APPLICATION FOR LICENSE REVISION

SAVE
PRINT
RESET

LEGAL NAME OF FACILITY	FACILITY DVN

FACILITY ADDRESS (STREET, CITY, AND ZIP CODE)

OWNER	EMAIL ADDRESS	TELEPHONE NUMBER

LICENSE REVISION REQUESTED: Check appropriate box and indicate change in corresponding column.

☐ ADDRESS (Not location)	
☐ AGE RANGE	
☐ CAPACITY	
☐ HOURS OF CARE	☐ 6 a.m. – 9 p.m. ☐ 9 p.m. – 6 a.m. ☐ 6 a.m. – 6 a.m.
☐ NAME	
☐ NUMBER OF CHILDREN UNDER AGE 2	
☐ OTHER	

SIGNATURE OF OWNER(S)/BOARD CHAIRPERSON/DESIGNEE ►	TITLE	DATE
	Select Title	

OFFICE USE ONLY

THE FOLLOWING LICENSING REQUIREMENTS MUST BE MET PRIOR TO RECEIVING A REVISED LICENSE:	COMPLIANCE DATE

RECOMMENDATION/DECISION

☐ **APPROVED** ☐ **DENIED**

CHILD CARE FACILITY SPECIALIST	DATE	CHILD CARE SUPERVISOR	DATE

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