DFS-303 (11-06) County: ____________

APPLICATION FOR CERFICATION/REGISTRATION

Type of License ____________ **License Fee** $ ____________

Type of Certification ____________

Name ____________

Address ____________

City ____________ State ____________ Zip Code ____________

Telephone Number ____________

Employer's Name ____________

Address ____________

City ____________ State ____________ Zip Code ____________

Telephone Number ____________ Establishment Number ____________

Date ____________

I hereby certify that al work perfmormed by me will be in accordance with the requirements set forth by the Cabinet for Health and Family Services.

Signature of Applicant ____________

Authorized Representative ____________

Name of Local Health Dept. ____________